

OAKDEN

A SHAMEFUL CHAPTER IN SOUTH AUSTRALIA'S HISTORY

A REPORT BY
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INDEPENDENT COMMISSIONER AGAINST CORRUPTION

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Oakden: A Shameful Chapter in South Australia's History

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ACRONYMS AND ABBREVIATIONS

A number of acronyms and abbreviations are used throughout this report. Most are summarised here.

AACQA	Australian Aged Care Quality Agency
AACQA Act	<i>Australian Aged Care Quality Agency Act 2013 (Cth)</i>
ACH	ACH Group
ACSAA	Commonwealth Aged Care Safety and Accreditation Agency
ACSQHC	Australian Commissioner on Safety and Quality in Health Care
AGD	Attorney-General's Department
AHPRA	Australian Health Practitioner Regulation Agency
AHPRA Act	<i>Health Practitioner Regulation National Law (South Australia) Act 2010 (SA)</i>
AMMHD	Adelaide Metropolitan Mental Health Directorate
ANMF	The Australian Nursing and Midwifery Federation
BPSD	Behavioural and Psychological Symptoms of Dementia
CALHN	Central Adelaide Local Health Network
CE	Chief Executive
CEO	Chief Executive Officer
Clements	Clements House
CNAHS	Central Northern Adelaide Health Service
COO	Chief Operating Officer
CPC	Clinical Practice Consultant
CSC	The Clinical Services Coordinator
CSO	Crown Solicitor's Office
CVS	Community Visitor Scheme
DPP	Director of Public Prosecutions
EOI	Expression of Interest
FMHS	Forensic Mental Health Service
FOI	Freedom of Information
FTE	Full Time Employee
GA Act	<i>Guardianship and Administration Act 1993 (SA)</i>
HCA	<i>Health Care Act 2008 (SA)</i>
HCSC Act	<i>Health and Community Services Complaints Act 2004 (SA)</i>
HCSCC	Health and Community Services Complaints Commissioner
ICAC	Independent Commissioner Against Corruption
ICBU	Intensive Care Behavioural Unit
LHN	Local Health Network
Makk	Makk House

McLeay	McLeay House
MHA	<i>Mental Health Act 2009 (SA)</i>
MHA 1993	<i>Mental Health Act 1993 (SA)</i>
MOC	Model of Care
NALHN	Northern Adelaide Local Health Network
NCTIC	National Centre for Trauma Informed Care
NGO	Non-Government Organisation
NMHSPF	National Mental Health Service Planning Framework
Northgate	Northgate Aged Care Facility
OCP	Office of the Chief Psychiatrist
OPA	Office of the Public Advocate
OPI	Office for Public Integrity
OPMHS	Older Persons Mental Health Service
OPMHSM	Older Persons Mental Health Service Model
PCV	Principal Community Visitor
PSA	The Public Service Association
RACF	Residential Aged Care Facilities
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SAC	Safety Assessment Code
SAHC Act	<i>South Australian Health Commission Act 1976 (SA)</i>
SALHN	Southern Adelaide Local Health Network
SASMOA	South Australia Salaried Medical Officers Association
SLS	Safety Learning System
TCU	Transitional Care Unit
The Aged Care Act	<i>Aged Care Act 1997 (Cth)</i>
The Agency	Commonwealth Aged Care Standards and Accreditation Agency
The Department	The Department of Health and Ageing
The Evidence Act	<i>Evidence Act 1929 (SA)</i>
The ICAC Act	<i>Independent Commissioner Against Corruption Act 2012 (SA)</i>
The Ombudsman Act	<i>Ombudsman Act 1972 (SA)</i>
The Review	Review of National Aged Care Quality Regulatory Processes
The Royal Commissions Act	<i>Royal Commissions Act 1917 (SA)</i>

PERSONALIA

The following list sets out most of the individuals referred to in this report:

Mr Josh Abbott	Ministerial Liaison Officer to the Hon. Leesa Vlahos MP
Mr Michael Abbott QC	Counsel for Mrs Vlahos
Ms Lorraine Allen	Niece of the Graham Rollbusch, former consumer at Oakden (2005 to 2008)
Dr Michelle Atchison	Chair, RANZCP (SA)
Ms Lorraine Baff	Wife of Jim Baff, consumer at Oakden (2014 to 2017)
Ms Carolanne Barkla	Chief Executive of the Aged Rights Advocacy Service Member of the SA Health Oakden Response Plan Oversight Committee
Ms Carla Baron	Consultant brought to Oakden following failed accreditation (2007 to 2008)
Mr Neil Baron	Consultant brought to Oakden following failed accreditation (2007 to 2008)
Mr Tom Besanko	Counsel Assisting the Independent Commissioner Against Corruption
The Hon. Zoe Bettison MP	Minister for Ageing
Mr Jim Birch	Chief Executive of the Department of Human Services (2003)
Mr Alan Bottrill	Manager of State-Wide Services, OPMHS (2006 to 2012)
Mr Tony Boyle	Industrial Officer, United Voice
Monsignor David Cappel	Chair of the Social Inclusion Board which published the Stepping Up Report
Ms Kate Carnell AO	Co-author of the Carnell Report
Mr John Cartwright	Consumer at Makk House who was restrained by two pelvic restraints secured to his chair in April 2010
Ms Jay Christie	Placement facilitator, Australian Nursing and Midwifery Education Centre who organised placements for nursing students at Oakden
Ms Mariah Cid	Clinical Nurse, Oakden
Mr Ken Claughton	Husband of an Oakden consumer
Ms Steven Cleland	Agency nurse who worked at Oakden (2006 to 2008)
The Hon. Dr Susan Close MP	Then Chief of Staff to the Hon. Gail Gago (2007)
Mr David Coombes	Acting Chief Executive Officer of North West Adelaide Health Services (1999)
Mr Maurice Corcoran	Principal Community Visitor (2011 to Present) Member of the SA Health Oakden Response Plan Oversight Committee
Mr Michael Cousins	Chief Executive of the Health Consumer Alliance

Ms Elizabeth Dabars	Branch Secretary of the Australian Nursing Federation
Ms Sangeeta Dhanorkar	Agency nurse who worked at Oakden (2015 to 2017)
Dr Russell Draper	Clinical Director of OPMHS, NALHN (2004 to 2017)
Ms Julie Dundon	Nutritionist at Nutrition Professionals Australia
Ms Learne Durrington	Executive Director Mental Health Services, CNAHS (until 2008)
Ms Lesley Dwyer	Acting Chief Executive Officer CNALHS (2009) Chief Operating Officer AHS
Ms Karleen Edwards	CEO of CNAHS (July 2007 to November 2009)
The Hon. Justine Elliott	Former Federal Minister for Ageing
Dr Patrick Flynn	Psychiatrist working at Oakden in various roles (1991 to 2016)
Senior Constable Craig Foster-Lynham	Police Officer involved in investigation of death of Mr Rollbusch (2008)
Mr Don Frater	Deputy Chief Executive, SA Health (current)
The Hon. Gail Gago MLC	Minister for Mental Health and Substance Abuse (2006 to 2008)
Ms Anne Gale	The Public Advocate Member of the SA Health Oakden Response Plan Oversight Committee
Mr Karim Goel	Clinical Services Coordinator, Makk and McLeay houses (2013 to 2017)
Associate Professor Des Graham	Director, Clinical Reform, Mental Health Services and Programs (2003)
Dr Rachael Gray	Counsel for Mrs Vlahos
Dr Aaron Groves	Chief Psychiatrist (February 2015 to November 2017)
Ms Paula Hakesley	Director, Mental Health Services (2010-2011) Director, Adelaide Metropolitan Mental Health Directorate (2011-2012)
Ms Jacheline (Jackie) Hanson	Chief Executive Officer, NALHN (2015 to 2018)
Ms Julie Harrison	Manager for Strategic Development, CNAHS (until December 2007) Acting Aged Care Director, CNAHS between (December 2007 to July 2010) Service Manager with responsibility for Oakden (July 2010 to January 2013) Service Manager for OPMHS and FMHS (January 2013 to October 2014) Acting Director of the Mental Health Directorate (October 2014 to February 2015) Service Manager (February 2015 to January 2016)

Mr Peter Healey	Solicitor Assisting the Independent Commissioner Against Corruption
The Hon. John Hill MP	Minister for Health (2005 to 2011) Minister for Health and Ageing (2011 to 2013) Minister for Mental Health and Substance Abuse (2010 to 2013)
Ms Christine Hillingdon	Enrolled nurse who worked at Hillcrest and then Oakden (1982 to 2008)
Dr Margaret Honeyman	Chief Psychiatrist (2010 to 2012)
Mr Chad Jacobi	Counsel for Mrs Vlahos
Mr Rod Jensen	Director Legal Services, Independent Commissioner Against Corruption
Mr Stewart Johnston	Son of the Helen Johnston, former consumer at Oakden (2008)
Ms Vickie Kaminski	Chief Executive, SA Health
Prof Brendon Kearney	Executive Director to the Minister for Health (2002)
Ms Alma Krecu	Daughter of the late Ermanno Serpo, consumer at Oakden (2013 to 2016)
Mr Mark Leggett	Acting Director of Mental Health Operations (2010 to 2011) Deputy Director of Mental Health Operations (2011 to 2013)
Mr Alan Lilly	Co-author of the Stafrace and Lilly Report
The Hon. Dr Jane Lomax-Smith MP	Minister for Mental Health and Substance Abuse (2008 to 2010)
Ms Dianne Mack	Daughter of John Mack, consumer at Oakden (2016 to 2016)
Ms Margot Mains	Chief Executive Officer, NALHN (2011 to 2014)
Ms Leah Manuel	Ministerial advisor to Minister John Hill
Mr Steven Marshall MP	Leader of the Opposition
Ms Michelle Martin	Daughter of the late Ms Martin, consumer at Oakden (2006 to 2008)
Mr Mark Martin	Husband of the late Cheryl Martin, consumer at Oakden (2006 to 2008)
Mr Alec Mathie	Agency nurse who worked at Oakden (2001)
Prof Alexander McFarlane	Professor at the University of Adelaide (current)
Mr Sam McGrath	Solicitor Assisting the Independent Commissioner Against Corruption
Dr Brian McKenny	Interim Chief Psychiatrist (2017 to Present) Member of the SA Health Oakden Response Plan Oversight Committee
Mr Scott McMullen	Chief Operating Officer, NALHN (2015 to Present)

Dr Duncan McKellar	Consultant psychiatrist with NALHN, occasionally worked at Oakden Member of the Review Team established by Dr Groves Member of the SA Health Oakden Response Plan Oversight Committee
Mr Adam Monkhouse	Manager Project Coordination for the Information Unit Oakden, SA Health
Mr Andrew Modra	Senior Project Officer Quality Improvement
Ms Fiona Meredith	Clinical Psychologist who worked at Oakden (2008)
Mr Peter Morris	Agency carer who worked at Oakden (2005 to 2010)
Mr Arthur Moutakis	Consumer Advisor and Consumer Liaison Officer, NALHN (2007 to 2017)
Ms Bernadette Mulholland	Senior Industrial Officer, SASMOA (2013 to Present) Chief Executive of the Council on the Ageing
Ms Jane Mussared	Member of the SA Health Oakden Response Plan Oversight Committee
Ms Vicki Nagy	Senior Human Resources Consultant
Ms Maggie Nagyszollosi	Wife of Alphonz Nagyszollosi, former consumer at Oakden (2007 to 2011)
Mr Chris Northcott	Social worker who worked at Oakden (2008 to 2009)
Ms Leonie Nowland	General Manager of Mental Health, Mental Health Directorate NALHN (2012 to 2013) Executive Director Mental Health NALHN (2013 to 2014) Director of Operational Strategy (Health Department (2014 to 2015) Director of Operational Strategy NALHN (2015)
Ms Sharon Olsson	Director of Nursing (January to March 2008)
Ms Vanessa Owen	Executive Director of Nursing and Midwifery, NALHN (2012-2013) Executive Director of Nursing and Midwifery and Clinical Governance Services, NALHN (2013 to present)
Mr Peter Palmer	Consumer at Oakden who allegedly murdered Mr Rollbusch in 2008
Prof Ron Paterson ONZM	Co-author of the Carnell Report
Mr Harry Patsouris	Solicitor for Mrs Vlahos
Ms Merrilyn Penery	Nurse at Oakden (2000 to 2004) Clinical Nurse Consultant at Oakden (2005 to 2012) Clinical Practice Consultant, OPMHS (2012 to 2017)
Mr Tim Picton	Ministerial Advisor to the Hon. Jack Snelling MP
Ms Catherine Pirie	Agency nurse who worked at Oakden (2003 to 2006)
Ms Maria Portolesi	Daughter of former consumer at Clements House

Dr Elaine Pretorius	Consultant physician with NALHN (2004 to 2010) Divisional Director of Medical Sub-specialties at NALHN (2010 to Present) Acting Director of Medical Services (2016)
Prof Nicholas Procter	Member of the Review Team established by Dr Groves
Dr Elias Rafalowicz	Executive Director of Mental Health, CNAHS (2008 to 2010) Clinical Director of Mental Health Division, NALHN (2011 to 2015) Senior Consultant Psychiatrist (2016 to Present)
The Hon. Mike Rann MP	Premier of South Australia (2005)
Mr Len Richards	Former Deputy Chief Executive of SA Health
Mr Michael Riches	Chief Executive Officer, Independent Commissioner Against Corruption
Ms Jenny Richter	Deputy Chief Executive of the Department of Health (2011 to 2016) Interim Chief Executive Officer, CALHN (May 2017) Chief Executive Officer, CALHN (June 2017 to Present)
Dr Sally Rischbieth	Consultant medical specialist and psychiatry consultant (2005 to present)
Mr Graham Rollbusch	Consumer at Makk House who was allegedly murdered by Mr Palmer 28 February 2008
Mr Michael Rungie	CEO of ACH (2008)
Dr Sujeeve Sanmugantham	Acting Divisional Director for Mental Health, NALHN (March to July 2016). Divisional Director for Mental Health, NALHN (July 2016 to Present)
Mr Alan Scarborough	Director of Nursing in various Health Networks (2006 to 2013)
Ms Anne Schneyder	Nutritionist at Nutrition Professionals Australia
Ms Caterina Serpo	Wife of the late Ermanno Serpo, consumer at Oakden (2013 to 2016)
Mr Ervino Serpo	Son of the late Ermanno Serpo, consumer at Oakden (2013 to 2016)
Mr Chris Sexton	General Manager, Statewide Mental Health Services, Department of Health (2007 to 2012).
Ms Katherine Shephard	Deputy Chair, RANZCP (SA Branch)
Dr Tony Sherbon	Former Chief Executive of the Department of Health
Mr Stephen Simon	Assistant to the Risk Manager, NALHN (2010 to 2013) Risk Manager and Patient Safety Officer, NALHN (2013 to present)

Mr Kerim Skelton	Nursing Director of OPMHS (2007 to 2010) Nursing Director of Clinical Practice (2010 to 2016)
Ms Trudy Smith-Sparrow	Interim Nursing Director for Mental Health Services, NALHN (2016 to 2017) Nursing Director of Medical Subspecialties (2017 to present)
The Hon. Jack Snelling MP	Minister for Health and Ageing (2013 to 2014) Minster for Health (2014 to 2017) Minister for Mental Health and Substance Abuse (2013 to 2016)
Mrs Barbara Spriggs	Wife of Mr Bob Spriggs, former consumer at Oakden (2016)
Mr Bob Spriggs	Consumer at Oakden in 2016 who passed away on 18 July 2016
Ms Kerry Spriggs	Daughter of Bob and Barbara Spriggs
Dr Simon Stafrace	Co-author of the Stafrace and Lilly Report (2008)
Mr David Stevens	Aged Care Assessor who assessed Oakden in December 2007
The Hon. Lea Stevens MP	Minister for Health (2002)
Ms Paula Stirling	Solicitor at Crown Solicitor's Office
Dr Tom Stubbs	Chair SA Health Oakden Response Plan Oversight Committee
Mr David Swan	Chief Executive of SA Health (2010 to 2016)
Ms Del Thompson	Clinic Risk Manager, Office of the Chief Psychiatrist Member of the Review Team established by Dr Groves
Mr Daniel Torzyn	Clinical Services Coordinator at Clements House (2013 to 2016) Acting Nursing Director of Forensics and OPMHS, NALHN (2016 to 2017)
Mr Kurt Towers	Interim Director, Mental Health Strategy and Operations, NALHN (2015 to 2016)
Mr Steve Tully	Health and Community Services Complaints Commissioner
Dr Panayiotis (Peter) Tyllis	Chief Psychiatrist (2011 to 2015)
The Hon. Mrs Leesa Vlahos	Minister for Mental Health and Substance Abuse (2016 to 2017)
Mr Michael Wait SC	Crown Solicitor for the State of South Australia
Mr David Waterford	Former member of the Social Inclusion Board
The Hon. Jay Weatherill MP	Premier of South Australia
Ms Rosalind Webb	Daughter of the Colin Webb, former consumer at Oakden (2004 to 2006)
Ms Maria West	Director of Mental Health Strategy and Operations, NALHN (2015 to 2017)
Dr Rebecca Wheatley	Senior Medical Practitioner who worked at Oakden between 2015 and 2017
Mr Derek Wright	Director Mental Health Operations (2007 to 2012)
The Hon. Ken Wyatt AM MP	Federal Minister for Aged Care

EXECUTIVE SUMMARY

INTRODUCTION

The consumers¹ who resided at the Oakden Older Persons Mental Health Service (Oakden Facility)² were some of the most frail and vulnerable persons in our community. They did not have a voice. They were obliged to live in a facility which could only be described as a disgrace, and in which they received very poor care. The process and procedures were such that they were forgotten and ignored. The State did not provide them with the level of care that they deserved.

Every South Australian should be outraged at the way in which these consumers were treated. It represents a shameful chapter in this State's history.

It should not have happened.

It must never happen again.

I have prepared this report as a consequence of an investigation I carried out into potential serious or systemic maladministration in public administration associated with the Oakden Facility. Later in this report I explain in more detail why I decided to conduct this investigation.

The report is necessarily long and detailed. It highlights systemic failings in processes and oversight that allowed the events at the Oakden Facility to occur for more than a decade largely without intervention.

The evidence I received was astonishing.

It pointed to a regime that existed whereby serious complaints about care were not appropriately addressed.

Mechanisms that were designed to ensure serious matters were escalated either failed or were simply not applied. Those directly responsible for the facility actively sought to manage matters 'in-house'. A culture of secrecy developed.

Persons in authority outside of the Oakden Facility were unaware of the systemic failings occurring in the facility. They ought to have known of those failings.

Opportunities for intervention were missed.

Early in the investigation a number of my staff and I visited the Oakden Facility. My staff and I formed the opinion that it was a disgrace. It should not have been used to house anyone let alone frail and vulnerable consumers.

What occurred at the Oakden Facility is a shocking indictment on its management and oversight.

¹ The Chief Psychiatrist's report entitled 'The Review of the Oakden Older Person's Mental Health Service' referred to people who resided at the Oakden Facility as consumers. The Northern Adelaide Local Health Network also referred to them as consumers. I will use the same term.

² I will variously refer to the Oakden Older Persons Mental Health Service as the Oakden Facility, Oakden or the Facility.

PRELIMINARY OBSERVATIONS

I acknowledge the significant media and community interest in this report. I also appreciate the timing of the delivery of this report in the context of the State's political landscape.

This investigation took longer than I had hoped. There were delays in receiving all of the relevant documents and the volume of material ultimately received was significant.

In all more than 350,000 pages of information was received. Examinations were held over 22 sitting days resulting in almost 2,200 pages of transcript.

More recently, a number of individuals with an interest in my report made submissions that required careful consideration and determination.

All of these factors contributed to the time taken to finish the investigation.

I was not given access to Cabinet Documents despite requesting them. My investigation and this report has been completed without the benefit of seeing those documents (if any existed).

There are, no doubt, a number of persons who are interested in my findings. No doubt many will have certain expectations as to those findings and the persons in respect of whom those findings are made.

Against those expectations I say the following.

The findings I make are derived entirely from my assessment of the evidence received, together with my assessment of those persons who gave evidence before me and after having received and considered submissions made by counsel assisting me and by interested parties.

In short I have followed the facts.

I have made findings based on the evidence and my assessment of it.

As an administrative decision maker I must have regard to any relevant consideration and I must not have regard to any irrelevant consideration.

I must not make findings based upon or influenced by popular or political expectation as that would be an improper exercise of power and an egregious abuse of my office.

I am satisfied that the findings I have made in this report are properly informed by the evidence and submissions I have received.

WHAT IS TO BE LEARNED

In respect of the Oakden Facility I have heard on a number of occasions various individuals assert that they were 'fixing the problem'. It appears to me that those statements were based upon the assertion that the problem was being fixed by closing the Oakden Facility and transferring consumers into alternative care.

The closure of the Oakden Facility was, of course, entirely necessary and appropriate.

But, with respect, that was not fixing the problem.

What was being done was taking action to resolve the consequences of the problem. The problem was the regime that existed that enabled the Oakden Facility and its operations to deteriorate to such an extraordinarily poor state and to operate in that way for such an extended period of time without any meaningful intervention.

Closing the Oakden Facility without fully and properly understanding how and why the facility and its operations could deteriorate to such an extent, seemingly unchecked, leaves open the very real possibility that similar failures could be perpetuated in the future in other settings.

For that reason I think this report ought to be considered by all public officers in positions of authority, irrespective of the agency within which they are employed.

This report offers some salient lessons about identifying and properly dealing with complaints, the consequences of attempting to 'contain' issues of concern and withhold information from senior persons and the extraordinary dangers associated with poor oversight, poor systems, unacceptable work practices and poor workplace culture.

Above all it highlights what can occur when staff do not step up and take action in the face of serious issues. I appreciate that it is not always easy to step up in such circumstances. But that is what is expected of every person engaged in public administration and particularly so in respect of public officers in positions of authority who have information that might expose serious or systemic issues of corruption, misconduct or maladministration.

This investigation has firmly reinforced my view that the legislation under which I operate ought to be amended to give me the discretion to conduct investigations of this kind in public. I will explain why I continue to hold that view in Chapter 2.

It has also reinforced my view that the existing legislative scheme by which I can investigate serious or systemic misconduct and maladministration in public administration is unnecessarily convoluted and clumsy.

There is a tension between the Act which provides jurisdiction to investigate and the Acts which provide the powers during the investigation. That tension allowed for an argument to be made three persons that after carrying out an investigation in private I could not prepare a report that identified anyone unless those persons consented. The tensions could be resolved if the ICAC Act were modified to seamlessly include the powers of investigation and reporting in respect of misconduct and maladministration.

I have previously proposed to the Government that the powers to investigate such conduct be found by a more direct route than is presently the case. The Government did not accept my proposal.

I am hopeful that these issues will be considered again.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

The summary of findings that follow should not be taken as a substitute for reading the report in its entirety. Only by reading the whole of the report can the reader understand the evidence that I considered and my reasoning. Without reading the report in its entirety context will be lost.

The following summary does not represent all of the findings that I have made in my report.

I have agonised over the findings. While I am satisfied that they are appropriate given the evidence and submissions before me, I am left with a level of discomfort. The extent to which senior persons in positions of authority outside of the Oakden Facility did not know about what was occurring at the facility was breathtaking.

One might ask rhetorically how, in a modern society, an arm of government charged with caring for some of our most vulnerable citizens could provide such abysmal care over such an extended period of time without intervention. However, the evidence I have received makes it quite clear that, to a large extent, what was occurring at the Oakden Facility was unknown to ministers and chief executives.

To me that is astonishing. They ought to have known.

Nevertheless, each Minister who had responsibility for the Oakden Facility is responsible for its failures.

So too is each Chief Executive Officer who presided over the agency responsible for the facility.

So too is each executive or manager who knew of the woeful state of affairs and failed to take appropriate action to ensure that persons in authority, who were in a position and who had the power, ability and willingness to effect change, were informed.

In the end, the only person who took positive action upon becoming aware of the true state of affairs at the Oakden Facility was the current Chief Executive Officer of the Northern Adelaide Local Health Network, Ms Jackie Hanson.

It was Ms Hanson who commissioned the Chief Psychiatrist to conduct the review that resulted in the Oakden Report.³

Mrs Vlahos's assertion that she was the one who commissioned the report is not supported by the evidence. In my opinion her assertions were over-reach. She did not lead in addressing the crisis. She followed.

All but one Minister who had responsibility for the Oakden Facility over the past decade accepted some measure of responsibility for what occurred. Mrs Vlahos sought to deflect responsibility.

While I find that each Minister who had responsibility for the Oakden Facility was responsible for its failures the evidence does not support a finding of maladministration in respect of any of them.⁴

Some may find that a surprising result.

I will explain why I have come to that conclusion in the report. I will also comment upon ministerial responsibility and to what extent that has informed my decision making.

I have found that Dr Aaron Groves, the then Chief Psychiatrist, played a critical role in uncovering the egregious standard of care provided to consumers at the Oakden Facility. His review was thorough and his report comprehensive. However, I have also found that he could have taken steps to investigate Mrs Spriggs' complaint earlier in 2016. I have also found that he ought to have exercised his powers to make unannounced visits to the Oakden Facility before Mrs Spriggs made a complaint. Notwithstanding those findings, I am not satisfied that the evidence is sufficient for a finding of maladministration in respect of Dr Groves.

I have considered the position of the Principal Community Visitor and made some observations about his powers to make unannounced visits to facilities such as Oakden. The Community Visitor Scheme for which he is responsible did not make any unannounced visits to the Oakden Facility prior to the commissioning of the Chief Psychiatrist and the review team to prepare the Oakden Report. The previous visits by the Community Visitor Scheme were, at least until the middle of 2016, not critical of the facility and the standard of care that was provided at the facility. I have made a recommendation in that respect.

Ms Swan, who was the former Chief Executive of the Department for Health and Ageing, was an impressive witness who accepted accountability as Chief Executive for the conduct

³ The Chief Psychiatrist's report entitled 'The Review of the Oakden Older Person's Mental Health Service'.

⁴ I have however made a number of adverse findings in respect of Mrs Vlahos all of which are set out in the report.

of all of the staff at the Oakden Facility and within the Northern Adelaide Local Health Network (NALHN).

I thought Ms Hanson was a very impressive witness. She volunteered that she was ultimately responsible for what occurred at the Oakden Facility. She did not attempt to deflect responsibility. I have found however that the evidence does not establish that Ms Hanson or her predecessor were aware of the matters that were subsequently found in the Oakden Report. Their responsibility arises because they were both at relevant times the Chief Executive Officer of NALHN.

I have devoted a chapter in this report to the mechanisms that were in place to ensure that complaints, reports and incidents relating to the Oakden Facility were investigated and were escalated to the appropriate authority within NALHN.

The evidence establishes that, in theory, there were sufficient mechanisms in place to ensure appropriate oversight in relation to complaints and reports and the investigation of incidents.

In practice however these systems failed because they depended too much upon individual reporting and individual judgement. As a result nearly all of the information about the poor standard of care at the Oakden Facility was confined to those who worked there.

The Oakden Facility was managed by a triumvirate. Three staff members, Dr Russell Draper, Ms Julie Harrison and Mr Kerim Skelton, had combined responsibility for the management of the facility.⁵ None of them had authority over the other two. They all had other responsibilities outside of Oakden.

Nobody had overall control over the facility. Nobody had fulltime responsibility solely for Oakden.

It was an extraordinary management structure.

Dr Draper, Ms Harrison and Mr Skelton each sought to avoid responsibility by pointing the finger at the other two.

Those three staff members, but particularly Ms Harrison and Mr Skelton, fostered a culture of secrecy within the Oakden Facility. They sought to keep matters 'in-house'.

Mr Arthur Moutakis, whose primary function was to manage complaints and reports about facilities within NALHN, played a part in fostering that culture. I have found that Mr Moutakis failed to appreciate the significance of the complaints he was receiving about the Oakden Facility. Rather than properly addressing the complaints, he appears to have adopted a course of simply accepting what he was told by staff at the Oakden Facility.

When he became aware of the sub-optimal nursing care being provided at the Oakden Facility, he reported that to Mr Skelton. However, when he became aware that there had been no improvement, he did nothing. He ought to have.

Similarly, Ms Pennery, who was most recently the Clinical Practice Consultant at the Oakden Facility, knew that serious concerns about nursing care were not being properly addressed. She had an opportunity to raise those matters with persons more senior within NALHN. She did not do so. She ought to have.

⁵ The periods during which each of them held responsibilities are outlined in this report.

There is no evidence to establish that other executives within NALHN were aware of the extent of the problems that were outlined in the Oakden Report.

However it is difficult to think that those who visited the Oakden Facility could not have realised how bad a facility it was.

This has been a troubling aspect of the investigation. Why did not those from NALHN who visited the Oakden Facility form the same impression that I did? When they visited they would have seen consumers in Makk and McLeay sitting, perhaps under restraint, in a corridor or alcove with only a television to entertain them. The consumers would be there all day.

But the evidence, as astonishing as it is, appears to be that no-one (perhaps with the exception of Dr Duncan McKellar) formed the opinion that the Oakden Facility was not fit for purpose until the Chief Psychiatrist and the review team commenced the review that ultimately led to the Oakden Report.

NALHN was the public authority which, at least in more recent times, was responsible for the Oakden Facility. Its practices, policies and procedures resulted in a substantial mismanagement of public resources, being the Oakden Facility itself and its operations.

I have found that NALHN engaged in maladministration in public administration.

I have made 13 recommendations:

Recommendation One: The Chief Executive of the Department of Health and Ageing (Chief Executive) review the clinical governance and management of mental health services within the overall clinical governance of each Local Health Network (LHN) to determine whether the management requirements of the *Mental Health Act 2009* (MHA) fit within the overall health governance structures.

Recommendation Two: The Chief Executive should, with the Chief Psychiatrist and the Chief Executive Officers (CEOs) of the LHNs, consider adopting management structures for the administration of the MHA to match those of overall mental health clinical governance structures, such that:

- the officer responsible for the clinical mental health care of a facility within a LHN is also responsible for the administration of the MHA at that facility; and
- the officer responsible for overseeing all clinical mental health care within a LHN has the responsibility for the administration of the MHA in that LHN.

Recommendation Three: The Chief Executive and the CEOs implement a structure to routinely remind all staff working at a treatment centre of the management structure in place at the centre; the assignment of responsibilities at the centre; and the expectations and responsibilities imposed upon each member of staff at the centre.

Recommendation Four: The Chief Executive direct all staff at facilities in a LHN where mental health services are being delivered to undergo training, as may be agreed by the Chief Executive, Chief Psychiatrist and CEOs, in the use of the Safety Learning System; the reporting obligations for staff under Commonwealth and State legislation and the relevant SA Health and LHN policies and procedures.

Recommendation Five: The Chief Psychiatrist review the use of the statutory power conferred on the Chief Psychiatrist under s 90(4) of the MHA to conduct inspections of an incorporated hospital, with a view to the Chief Psychiatrist exercising the power to conduct unannounced visits to facilities within LHNs more frequently than in the past.

Recommendation Six: The Principal Community Visitor review the use of the statutory power conferred on community visitors under ss 51(3) and 52 of the MHA to conduct unannounced inspections and visits of facilities within LHNs and treatment centres, with a view to community visitors exercising the power to conduct unannounced inspections and visits more frequently than in the past.

Recommendation Seven: The Minister for Mental Health and Substance Abuse (the Minister) cause a review to be conducted of the community visitor scheme (CVS) to determine whether the CVS should be amended to:

- require community visitors be trained in mental health care;
- require community visitors to possess certain qualifications in mental health care; and
- provide that some of the community visitors' current functions be discharged by persons with specialist qualifications in mental health.

Recommendation Eight: The Minister cause a review to be conducted to determine whether the MHA should be amended to impose positive obligations on the Chief Psychiatrist to ensure:

- that public officers within the LHNs delivering mental health services comply with their obligations under the MHA; and
- as far as practicable that an adequate standard of care is provided to persons with a mental illness who receive such care from a LHN;

and whether in that case the resources of the Office of the Chief Psychiatrist need to be increased; and

- if so to what extent; and
- whether the Chief Psychiatrist should be provided with further statutory powers to enable the Chief Psychiatrist to perform any such additional functions.

Recommendation Nine: The Minister cause a review to be conducted for the purpose of reporting publicly on the physical condition of all facilities at which mental health services are delivered in a LHN:

- for the purpose of determining whether the physical condition of those facilities are fit for the purpose for which they are being used; and
- if not in what respects the physical condition of any facility is not fit for purpose.

Recommendation Ten: The six recommendations contained in the Oakden Report be implemented, to the extent that they have not already been implemented.

Recommendation Eleven: The Chief Executive review the role of Consumer Advisor to determine whether:

- the duties and responsibilities of Consumer Advisors, so far as they relate to facilities at which mental health services are provided, are appropriate;
- Consumer Advisors require further training to assess the significance of complaints made about those facilities or services;
- Consumer Advisors should be required to report complaints in respect of facilities to particular persons or committees; and
- steps can be taken to ensure Consumer Advisors are independent of particular facilities.

Recommendation Twelve: The Chief Psychiatrist and the Chief Executive review the use of restrictive practices within each LHN with a view to the Chief Psychiatrist exercising power under s 90 of the MHA to issue new standards in relation to the use of restrictive practices and making the observance of those standards mandatory.

Recommendation Thirteen: The Chief Executive, in conjunction with the CEOs, review the level and nature of allied health staff support at facilities at which mental health services are provided by a LHN for the purpose of determining whether there are adequate allied health staff to provide the necessary support at such facilities.

CHAPTER 1: INTRODUCTION

1.1 HOW THIS INVESTIGATION CAME ABOUT

The office of Chief Psychiatrist is created by s 89 of the *Mental Health Act 2009* (MHA). The office must be held by a senior psychiatrist appointed to the position by the Governor.

The Chief Psychiatrist's functions are contained in s 90 of the MHA. One of those functions is to 'advise the Minister on issues relating to mental health and to report to the Minister any matters of concern relating to the care or treatment of patients': s 90(1)(d).

On 10 April 2017 Dr Aaron Groves the then Chief Psychiatrist wrote to then Minister for Mental Health and Substance Abuse, the Hon. Leesa Vlahos MP. On that occasion Dr Groves provided Minister Vlahos with a report entitled 'The Review of the Oakden Older Persons' Mental Health Service' (the Oakden Report) which was said to be provided in compliance with s 90(1)(d) of the MHA. There is a dispute as to who commissioned the Oakden Report which will need to be resolved on the evidence.⁶

Although I have no direct evidence I assume that the Oakden Report was considered by State Cabinet on 20 April 2017 and released to the public on the same day.⁷ I do not have any direct evidence because Cabinet declined my request to be provided Cabinet documents relevant to the matter.

In any event, upon its public release I read the Oakden Report.

I was shocked at its content.

I listened intently to commentary following the release of the report, and in particular the government's response to the findings.

I was concerned that notwithstanding the very serious findings and recommendations of the review panel no one appeared to be accepting responsibility for the manner in which the consumers at the Oakden Facility had been housed and for the standard of care which they received. I was concerned that unless it was established how the Oakden Facility and its operations had deteriorated to such a poor state, there was the possibility such events would be repeated in the future.

I was also aware that the Office for Public Integrity (OPI) had received a number of complaints and reports about the conduct of public officers at the Oakden Facility.

For completeness I set out those matters as well as matters received after the release of the Oakden Report and after I announced this investigation.

Between 2 September 2013 (being the day the OPI commenced operation) and 20 April 2017 (being the day that the Oakden Report was publicly released) the OPI received seven reports about issues relating to the Oakden Facility:

- Two matters related to alleged assaults on consumers by staff. Both matters were assessed as raising a potential issue of corruption and were referred to SA Police for investigation.
- Two matters alleged excessive force and improper seclusion of consumers. Both matters were assessed as raising a potential issue of misconduct and were referred to the Chief Executive of the Department of Health and Ageing (the Department).

⁶ There is a dispute between Ms Hanson who was the Chief Executive of NALHN and former Minister Mrs Vlahos as to who commissioned the report.

⁷ 'State Government to close Oakden Older Person's Mental Health Service' (News Release, 20 April 2017).

- One report alleged that a staff member had failed to report suspected misconduct to the OPI and the Australian Health Practitioner Regulation Agency (AHPRA). That matter was assessed as raising a potential issue of misconduct and was referred to the Chief Executive of the Department.
- One report alleged poor governance in respect of the use of nursing agency staff across mental health sites in NALHN (there was no particular reference to the Oakden Facility). That matter was referred to the Chief Executive of the Department.
- One report received on 15 February 2017 (after the Chief Psychiatrist had commenced his review) raised allegations that Oakden was failing to meet appropriate standards following an organisational review. The matter was assessed as raising a potential issue of misconduct and maladministration and was referred to the Chief Executive of the Department.

Between 21 April 2017 and 25 May 2017 (the day that I publicly announced my investigation) the OPI received four reports about the Oakden Facility:

- Two similar reports alleged that executives within NALHN knew about the issues at the Oakden Facility but did not take any action. These allegations were addressed during my investigation.
- Two reports alleged assault by a staff member on a consumer. Both matters were assessed as raising potential issues of corruption and were referred to SA Police for investigation.

After announcing my investigation, the OPI received eight reports and two complaints about Oakden:

- One report alleged assault by a staff member on a consumer. The matter was assessed as raising a potential issue of corruption and was referred to SA Police for investigation.
- One report alleged that two nurses attempted to catheterise a consumer with incorrect equipment and without consent. That matter was assessed as raising a potential issue of misconduct and was referred to the Chief Executive of the Department.
- One report alleged a failure of a nurse to follow up an invasive procedure that was apparently performed without the consumer's consent. That matter was assessed as raising a potential issue of misconduct and was referred to the Chief Executive of the Department.
- One report alleged that a nurse had failed to de-identify details of a consumer and the consumer's family in performance review documentation. No further action was taken by this office because NALHN had already taken appropriate action.
- One report alleged that a folder containing corporate records was missing from the Oakden Facility. The matter was assessed as raising a potential issue of corruption and was referred to SA Police for investigation.
- One report alleged that a nurse persistently behaved inappropriately towards consumers, including acting in an intimidating and threatening manner and failing to

appropriately toilet incontinent consumers. That matter was assessed as raising a potential issue of misconduct and was referred to the Chief Executive of the Department.

- One complaint alleged victimisation and defamation after raising issues about the Oakden Facility. The matter was assessed and I decided to take no further action in respect of the matter.
- One report was received from an Oakden staff member alleging impropriety in respect of an investigation into that staff member's conduct. The matter was assessed as raising a potential issue of misconduct and maladministration and was referred to the Chief Executive of the Department.
- One complaint was made by a former staff member of the Oakden Facility. The former staff member raised a number of issues associated with the Oakden Facility and concerning her own employment. Some matters were referred to the Chief Executive of the Department while no further action was taken in respect of others.
- One report alleged a failure of senior staff to provide appropriate leadership at the Oakden Facility. The matter was assessed as raising a potential issue of misconduct and maladministration and was referred to the Chief Executive of the Department. These allegations are also dealt with in this report.

Most of the matters brought to the OPI's attention occurred after the Oakden Report was published. The Oakden Report raised potential issues of serious or systemic maladministration in public administration.

For those reasons I determined that it would be appropriate for me to conduct an investigation. In order to do so, I had to rely on the rather convoluted and clumsy mechanism of exercising the powers of the South Australian Ombudsman (the Ombudsman).

I announced that I would conduct an investigation into the management and delivery of services at the Oakden Facility while giving evidence before the Crime and Public Integrity Committee on 25 May 2017.

At a press conference on 30 May 2017 I announced the Terms of Reference (ToR)⁸ that would guide my investigation:

The Independent Commissioner Against Corruption (Commissioner) will inquire into:

- 1) *Whether appropriate mechanisms were in place from 2007 to receive complaints and reports about the quality of care provided to patients at the Oakden Older Persons Mental Health facility (the facility);*
- 2) *Whether since 2007, information (including by way of complaints or reports) concerning sub-optimal care of patients at the facility (relevant information) was brought to the attention of senior staff at the facility, staff of the Northern Adelaide Local Health Network (or its predecessors), executive staff of the Department for Health and Ageing, a statutory office holder or any Minister of the Crown and, if so:*
 - a. *when that relevant information was communicated;*
 - b. *to whom the relevant information was communicated;*

⁸ I will variously refer to the Terms of Reference as 'ToR' or 'Terms of Reference'.

- c. *what action was taken by whom as a result of the receipt of the relevant information; and*
 - d. *if action was taken;*
 - i. *when that action was taken;*
 - ii. *who took the action;*
 - iii. *whether the action was taken in a timely and appropriate manner; or*
 - e. *if no action was taken:*
 - i. *the person or persons who decided not to take action;*
 - ii. *the reason or reasons for that decision;*
 - iii. *the reasonableness of the decision.*
- 3) *If relevant information was not brought to the attention of any person mentioned above:*
- a. *the person or persons who failed to communicate the relevant information;*
 - b. *the reason or reasons why the relevant information was not communicated;*
 - c. *the reasonableness of the decision.*
- 4) *Whether any person took steps to actively disguise and/or amend relevant information to protect individuals or government entities from reputational harm and/or to avoid or delay the timely and accurate disclosure of relevant information about the facility to senior staff, staff of the Northern Adelaide Local Health Network (or its predecessors), executive staff of the Department for Health and Ageing, a statutory office holder or any Minister of the Crown;*
- with a view to determining whether any public officer as defined in the Independent Commissioner Against Corruption Act 2012 engaged in conduct which involved substantial mismanagement in or in relation to the performance of official functions, thereby constituting maladministration in public administration.*

The Commissioner may amend these Terms of Reference as a consequence of information or evidence received during the course of the investigation.

The ToR were not amended in any way after they were made public.

1.2 THE ASSISTANCE THAT WAS RENDERED TO ME

I appointed Mr Tom Besanko as Counsel assisting me exercising the general power of a Commission under the *Royal Commissions Act 1917* (Royal Commissions Act).⁹

I also appointed Mr Sam McGrath and Mr Peter Healey, both of Cowell Clarke Solicitors to support me and assist Mr Besanko.

My Chief Executive Officer Mr Michael Riches made the arrangements for the appointment of the external lawyers. He also made the arrangements for the management of the investigation. He coordinated the proof reading and finalisation the report. He took on all my responsibilities over the last month while I wrote this report and provided valuable assistance throughout my investigation for which I am most grateful.

The management of my investigation was conducted by my Director of Legal Services, Rod Jensen, who organised the staff within my office to assist in the investigation and coordinated the external resources I had engaged.

A number of internal staff assisted in my investigation including Ms Ailie McDonald, Ms Emma Fox, Mrs Abbi O'Flaherty and Mrs Janet Rice. Over the last four days Ms Matilda Conlon, Ms McDonald, Ms Tracy Riddiford, Mr Adam Harrison, Mr Andrew Russ and Ms Helen Luu worked very long hours to proof read and typeset this report for publication.

I am indebted to all of the persons to whom I have referred for their hard work in assisting me carrying out my investigation and compiling this report.

I am particularly indebted to Mr Besanko and Mr Healey who worked over Christmas to ensure that Mr Besanko's submissions could be made available to all of the parties by 27 December 2017.

Mr Besanko provided me with two very helpful submissions. The first of 15 pages addressed the question of procedural fairness. I will discuss these submissions in Chapter 2.7 and it can be seen that I have agreed with all of his submissions. The second of 290 pages with appendices totalling 341 pages addressed the substance of the investigation. These submissions were written between 11 December 2017 and 27 December 2017 when they were published to all parties whose rights, interests or legitimate expectations could be affected if any of Mr Besanko's submissions were accepted.

I intend to follow the order in which Mr Besanko addressed his submissions for two reasons. First the parties can understand the way in which I have dealt with those submissions. Secondly, because the order of those submissions was clear and logical.

Some of the non-contentious information contained in those submissions has been replicated in this report.

⁹ Section 27(2)(b) is a power given to the ICAC for an investigation into corruption.

CHAPTER 2: JURISDICTION AND POWERS

2.1 JURISDICTION

One of the statutory functions of the ICAC is to identify serious or systemic misconduct or maladministration in public administration and to exercise the powers of an inquiry agency in dealing with conduct of that kind, if satisfied that it is in the public interest to do so: s 7(1)(ca) and (cb) of the ICAC Act.

Maladministration in public administration is defined in s 5(4) of the ICAC Act –

Maladministration in Public Administration

- (a) *means –*
 - (i) *conduct of a public officer, or a practice, policy or procedure of a public authority, that results in an irregular and unauthorised use of public money or substantial mismanagement of public resources; or*
 - (ii) *conduct of a public officer involving substantial mismanagement in or in relation to the performance of official functions; and*
- (b) *includes conduct resulting from impropriety, incompetence or negligence; and*
- (c) *is to be assessed having regard to relevant statutory provisions and administrative instructions and directions.*

Section 4(2) defines misconduct or maladministration in public administration that will be taken to be serious or systemic. It provides:

- (2) *For the purposes of this Act, misconduct or maladministration in public administration will be taken to be **serious or systemic** if the misconduct or maladministration –*
 - (a) *is of such a significant nature that it would undermine public confidence in the relevant public authority, or in public administration generally; and*
 - (b) *has significant implications for the relevant public authority or for public administration generally (rather than just for the individual public officer concerned).*

Section 17 of the ICAC Act establishes the OPI which has the function of receiving and assessing complaints about public administration from members of the public or reports about corruption, misconduct and maladministration from inquiry agencies, public authorities and public officers. The OPI is also empowered to refer complaints and reports to inquiry agencies, public authorities and public officers or to make a recommendation to the ICAC as to the action that ought to be taken.

The OPI must assess all complaints and reports and the manner of assessment is provided for in s 23(1) of the ICAC Act.

However s 23(2) is relevant.

It provides:

- (2) *The Commissioner may also assess, or require the Office to assess, according to the criteria set out in subsection (1), any other matter identified by the Commissioner acting on his or her own initiative or by the Commissioner or the Office in the course of performing functions under this or any other Act.*

It was that subsection upon which I relied for the purpose of instigating this investigation.

Section 24(2) deals with a matter which has been assessed as raising a potential issue of misconduct or maladministration in public administration. It provides:

- (2) *If a matter is assessed as raising a potential issue of misconduct or maladministration in public administration, the matter must be dealt with in 1 or more of the following ways:*
 - (a) *the matter may be referred to an inquiry agency;*
 - (b) *in the case of a matter raising potential issues of serious or systemic maladministration in public administration – the Commissioner may exercise the powers of an inquiry agency in dealing with the matter if satisfied that it is in the public interest to do so;*
 - (c) *in the case of a matter raising potential issues of serious or systemic misconduct in public administration – the Commissioner may exercise the powers of an inquiry agency in dealing with the matter if the Commissioner is satisfied that the matter must be dealt with in connection with a matter the subject of an investigation of a kind referred to in subsection (1)(a) or a matter being dealt with in accordance with paragraph (b);*
 - (d) *the matter may be referred to a public authority and directions or guidance may be given to the authority in respect of the matter.*

Section 24(2) requires the ICAC to deal with a matter in one of the four ways mentioned in that section. The word 'must' in the chapeau of the subsection makes one of the actions mentioned in the paragraph mandatory. Inaction is not permitted.

In this case I determined that the appropriate way to deal with this matter was by exercising the powers in s 24(2)(b) because I was of the opinion that the matters raised in the Oakden Report satisfied the threshold requirements of 'serious or systemic' and that it was in the public interest that I proceeded in that way.

An inquiry agency for the purpose of the ICAC Act means the Ombudsman or a person declared by regulation to be an inquiry agency: s 4. Because no other person has been declared by regulation to be an inquiry agency the only inquiry agency at present is the Ombudsman.

Section 36A provides the manner in which the ICAC can exercise the powers of an inquiry agency.

It provides:

- (1) *The Commissioner must, before deciding (in accordance with section 24(2)(b) or (c)) to exercise the powers of an inquiry agency in respect of a matter raising potential issues of misconduct or maladministration in public administration, take reasonable steps to obtain the views of the agency.*
- (2) *If the Commissioner decides (in accordance with section 24(2)(b) or (c)) to exercise the powers of an inquiry agency in respect of such a matter –*
 - (a) *the Commissioner may, by notice in writing to the agency, require that the agency refrain from taking action in respect of the matter or require that the agency only take action of a specified kind in relation to the matter; and*
 - (b) *the Commissioner –*
 - (i) *has all the powers of the agency; and*
 - (ii) *is bound by any statutory provisions governing the exercise of those powers (subject to such modifications as may be prescribed, or as may be necessary for the purpose),*
as if the Commissioner constituted the agency; and
 - (c) *the Commissioner must inform the agency of the outcome of the matter.*
- (3) *The Commissioner may at any time withdraw from exercising the powers of an inquiry agency, or decide to exercise such powers, as the Commissioner sees fit.*

The ICAC must take reasonable steps to obtain the views of the agency and if the ICAC decides to exercise the powers of an inquiry agency in respect of such a matter the ICAC may by notice in writing require that the agency refrain from taking action: s 36A(1) and (2)(a).

I wrote to the Ombudsman on 12 May 2017 seeking his views as to the exercise of his powers.

He responded on 19 May 2017 stating that he did not wish to make any comment in relation to the proposed exercise of his powers.

I decided to embark upon the investigation using the Ombudsman's powers.

On 25 May 2017 I advised the Ombudsman that I had received a further report about the Oakden Facility which I considered to be appropriate to be dealt with in conjunction with the matters raised in my letter of 12 May 2017. On the same day the Ombudsman advised that he had no objection.

Having decided to exercise the Ombudsman's powers, s 36A(2)(b) of the ICAC Act was engaged. According to that sub-section the ICAC has all the powers of the agency and is bound by any statutory provisions governing the exercise of those powers subject to such modifications as may be prescribed or as may be necessary for the purposes as if the ICAC constituted the agency. Those powers have not been modified by prescription.

Whether the powers have been modified as 'may be necessary for the purpose' will be found in the ICAC Act or the Ombudsman Act.

The Ombudsman Act has to be consulted to determine the powers given to the Ombudsman. The ICAC Act and the Ombudsman Act must be consulted to determine the statutory provisions governing the exercise of the powers given to the Ombudsman.

Section 36A of the ICAC Act is facultative in that it provides the ICAC with powers not contained in the ICAC Act itself. Section 36A does not purport to make the ICAC the Ombudsman or to create any other statutory office apart from the office held by the ICAC under the ICAC Act.

In a submission made to me by Mrs Vlahos it was asserted that I could not exercise the power given to the Ombudsman in s 26(3) of the Ombudsman Act because I was not the Ombudsman but the ICAC. That submission ignores the provisions of the s 36A and misunderstands the scheme of the ICAC Act which empowers the ICAC to exercise the powers of the Ombudsman.

The Ombudsman Act invests the Ombudsman with the power to investigate any administrative act: s 13(1). An 'administrative act' is defined in the Ombudsman Act. It is not the same as misconduct or maladministration, as those terms are defined in the ICAC Act.

The Ombudsman does not have jurisdiction under the Ombudsman Act to investigate misconduct or maladministration. The Ombudsman's jurisdiction to investigate those issues is derived from the ICAC Act and only upon a referral by the ICAC or the OPI to the Ombudsman under s 24(2)(a) of the ICAC Act.¹⁰

If the ICAC decides to exercise the powers of the Ombudsman the ICAC is not constrained by the jurisdiction of the Ombudsman. The ICAC's jurisdiction is engaged when the matter is dealt with in accordance with s 24(2)(b) or (c) of the ICAC Act. The jurisdiction that is engaged is not to investigate an administrative act but to investigate a potential issue of serious or systemic maladministration as that is defined in s 5 of the ICAC Act. In my opinion the Ombudsman's jurisdiction under the Ombudsman Act is irrelevant for the purposes of s 36A of the ICAC Act.

The Ombudsman Act is only relevant because it identifies the powers that may be exercised by the ICAC in the investigation of serious or systemic maladministration. It does not define the ICAC's jurisdiction.

However this raises one of the difficulties in investing the ICAC with the Ombudsman's powers. The powers given to the Ombudsman under the Ombudsman Act were designed to assist the Ombudsman investigating administrative acts. They were not designed for an investigation by the ICAC or the Ombudsman into serious or systemic misconduct or maladministration or indeed an investigation by the Ombudsman into a potential issue of misconduct or maladministration that is not serious or systemic. If the ICAC refers a matter to the Ombudsman pursuant to s 24(2)(a) the Ombudsman must also carry out the Ombudsman's investigation using powers designed to carry out an investigation into administrative acts.

¹⁰ See also *Ombudsman Act 1972* (SA) s 14B ('*The Ombudsman Act*').

I have previously recommended to the Government that it would be better to spell out the ICAC's powers to investigate misconduct or maladministration in the ICAC Act rather than have the power incorporated by reference to the Ombudsman Act.¹¹

The current regime creates some legislative tensions and it is a clumsy and overly complicated way of empowering the ICAC to investigate serious or systemic misconduct or maladministration.

The Government did not accept my recommendation.

2.2 POWERS OF INVESTIGATION

The principal power given to the Ombudsman to carry out an investigation is contained in s 19 of the Ombudsman Act which provides:

For the purposes of an investigation the Ombudsman has the powers of a commission as defined in the Royal Commissions Act 1917 and that Act applies as if –

- (a) the Ombudsman were a commission as so defined; and*
- (b) the subject matter of the investigation were set out in a commission of inquiry issued by the Governor under that Act.*

The powers given to a commission under the Royal Commissions Act are designed to enable a commission to carry out an investigation on behalf of the Executive arm of Government. The investigation need not necessarily concern conduct.¹²

I make that point to show the difficulties in using powers under different acts to investigate matters for which the powers were never designed.

Section 19 of the Ombudsman Act directs attention to the Royal Commissions Act to determine the principal powers given to the ICAC under s 36A of the ICAC Act.

The Royal Commissions Act provides that a commission may be constituted of a single commissioner or of two or more commissioners: s 4(1).

Where the ICAC is exercising the powers of a Royal Commission derived through s 36A of the ICAC Act and s 19 of the Ombudsman Act clearly the commission must be constituted by the ICAC alone.

Section 5 of the Royal Commissions Act empowers the commission to publish any information obtained in the exercise of the Commission's functions. The exercise of that power is entirely in the discretion of the commission. The manner of exercise of those powers is also unfettered. Those powers may be available to the Ombudsman when carrying out an investigation into an administrative act or when conducting an investigation into misconduct or maladministration on a referral by the ICAC or the OPI pursuant to s 24(2)(a) of the ICAC Act.

¹¹ Letter from the Independent Commissioner Against Corruption to the Deputy Premier the Hon. John Rau, 23 June 2016.

¹² For example the recent Nuclear Fuel Cycle Royal Commission was established by the South Australian Government to initiate an investigation into the potential for increasing South Australia's participation in the nuclear fuel cycle. That commission was not concerned with conduct.

The powers are also available to the ICAC when the ICAC is carrying out an investigation into serious or systemic misconduct or maladministration pursuant to s 24(2)(b) or (c) of the ICAC Act.

There are no threshold requirements that must be met before the powers are exercised by the Ombudsman or the ICAC.

Section 6 of the Royal Commissions Act provides that the commission may in connection with the exercise of the commissioner's functions take evidence in public or private.

However that section cannot apply if the Ombudsman is conducting an investigation because of s 18(2) of the Ombudsman Act which provides that every investigation under the Ombudsman Act must be conducted in private. 'Investigation' is defined in the Ombudsman Act to mean 'an investigation by the Ombudsman under this Act in relation to an administrative act'.¹³

As I have said an investigation carried out by the ICAC using the Ombudsman's powers is not an investigation into an administrative act.

However, in my opinion s 18(2) of the Ombudsman Act prevails over s 6 of the Royal Commissions Act and where the ICAC is conducting an investigation exercising the powers of the Ombudsman the ICAC must comply with s 18(2) and therefore conduct the investigation in private. That is because s 18(2) is properly a provision that governs the exercise of the powers of investigation given to the Ombudsman. By reason of s 36A(2)(b)(ii) of the ICAC Act I am bound by that provision.

This is a further example of the difficulty in investing the ICAC with powers that are designed for a commission and then curtailing those powers in the Ombudsman Act in circumstances where the exercise of those powers under that Act is directed towards an investigation of an administrative act.

Legislative change is needed.

A commission is not bound by the rules of practice of any court or tribunal as to procedure or the rules of evidence and the commissioner may inform the commissioner's mind on any matter in such manner as the commissioner thinks proper: s 7 of the Royal Commissions Act.

The powers of a commission are set out in s 10 of the Royal Commissions Act which provides:

The commission shall have the following powers, that is to say:

- (a) *they and each of them may by themselves, or by any person appointed by them to prosecute an inquiry, enter upon and inspect any land, building, place, or vessel, and inspect any goods and other things, the entry upon or inspection of which appears to them or him to be requisite;*
- (b) *they may require, by summons under the hand of the chairman or of the secretary acting under the direction of the chairman, the attendance of all such persons as they think fit to call before them, and may require answers or returns to such inquiries as they think fit to make;*

¹³ Ombudsman Act s 3(1).

- (c) *they may require, by summons under the hand of the chairman or of the secretary acting under the direction of the chairman, the production of any books, papers, documents or records;*
- (d) *they may inspect any books, papers, documents and records produced before them, and retain them for such reasonable periods as they think fit, and may make copies of such matters therein as are relevant to the inquiry or take extracts of such matters;*
- (e) *they may examine witnesses on oath, affirmation, or declaration, which may be administered by any commissioner.*

The powers of the commission in respect of witnesses are contained in s 11 of the Royal Commissions Act and s 11(1) is particularly relevant:

- (1) *If any person –*
 - (a) *who has been personally served with a summons to attend before the commission, and whose expenses, as provided in subsection (5) hereof, have been paid or tendered to him, neglects to attend in obedience to such summons; or*
 - (b) *wilfully insults the commission, or any commissioner; or*
 - (c) *by writing or speech uses words false and defamatory of the commission, or any commissioner; or*
 - (d) *misbehaves himself before the commission; or*
 - (e) *interrupts the proceedings of the commission; or*
 - (f) *being called or examined as a witness in any inquiry or any matter pending before the commission, refuses to be sworn, or to affirm or declare, or refuses or neglects to produce any books, papers, documents or records as required by a summons personally served upon him, or prevaricates in his evidence, or refuses to answer any lawful question,*

the chairman may commit such person to gaol for any term not exceeding three months or may impose on him a penalty not exceeding \$1 000, and in default of immediate payment of such penalty the chairman may commit the offender to gaol for any term not exceeding three months unless the penalty is sooner paid.

Section 13 of the Royal Commissions Act provides that any person giving evidence before the commission may be represented before the commissioner by counsel or a solicitor unless the commissioner otherwise directs.¹⁴

Section 16 provides some protection to witnesses. It provides:

A statement or disclosure made by any witness in answer to any question put to him by the commission or any of the commissioners shall not (except in proceedings for an offence against this Act) be admissible in evidence against him in any civil or criminal proceedings in any court.

¹⁴ I routinely allow any witness who wishes to be represented by counsel or a solicitor to be so represented.

The Royal Commissions Act therefore identifies the powers of the ICAC but those powers are subject to the statutory provisions governing the exercise of those powers contained in the Ombudsman Act because it is the powers of the Ombudsman that are given to the ICAC.

2.3 CABINET DOCUMENTS

Section 20 of the Ombudsman Act provides:

No obligation to maintain secrecy or other restriction upon the disclosure of information obtained by or furnished to persons in the service of the Crown or an agency to which this Act applies, whether imposed by any enactment or by a rule of law applies to the disclosure of information for the purposes of an investigation by the Ombudsman and, except as is provided in this Act, the Crown or an agency to which this Act applies is not entitled, in relation to any such investigation, to privilege in respect of the production of documents or the giving of evidence.

The effect of s 20 is to relieve a witness, who is in the service of the Crown or an agency to which the Ombudsman Act applies, of any obligation to maintain secrecy or other restriction upon the disclosure of information and, subject to the Ombudsman Act itself, deprives the Crown of the Crown's right to claim privilege in respect of the production of documents or the giving of evidence.

In my opinion this means that the Crown cannot claim public interest immunity or legal professional privilege in respect of the contents of any document nor can a person in the service of the Crown make that claim when giving evidence.

There is one exception which is contained in s 21 of the Ombudsman Act:

- (1) *No person shall be required or authorised by virtue of this Act –*
 - (a) *to furnish any information or answer any questions relating to the proceedings of the Cabinet or of any committee of the Cabinet; or*
 - (b) *to produce or inspect so much of any document as relates to any such proceedings.*
- (2) *For the purposes of this section a certificate issued under the hand of the Minister certifying that any information or question or any document or part of a document relates to the proceedings referred to in subsection (1) is conclusive evidence of the fact so certified.*

The effect of s 21 in my opinion is to allow a person, who has been summonsed to provide information or to give evidence or to produce or inspect documents, to refuse to provide that information or answer any questions or produce or inspect those documents if that information or the answers to those questions or the production or inspection of those documents relate to the proceedings of Cabinet or of any committee of the Cabinet.

Section 21(2) allows a Minister to issue a certificate that any particular information or question or part of a document relates to the proceedings of cabinet which will be conclusive evidence of the fact asserted in the certificate.

However, s 21 does not prevent a person furnishing the information sought or answering the questions asked or producing or inspecting the documents but rather allows the person who has been summonsed to claim that statutory protection on behalf of Cabinet.

On 31 October 2017 I wrote to the Crown Solicitor Mr Michael Wait SC, who had previously advised me that he was acting for the State of South Australia for the purposes of my investigation, requesting production of:

All documents brought into existence in the period between 1 January 2007 and 10 April 2017 (the date of the Chief Psychiatrist's report) recording or evidencing any consideration by Cabinet of the Oakden Older Persons Mental Health facility (including the Makk, McLeay, Clements and Zweck units) including but not limited to Cabinet submissions, Cabinet notes and minutes of Cabinet meetings.

On 2 November 2017 Mr Wait responded:

I refer to your letter dated 31 October 2017 requesting Cabinet documents relating to your investigation.

I note the terms of s 21 of the Ombudsman Act 1972 and I refer to the policy adopted by Cabinet that information regarding Cabinet decision-making will not be released to investigative agencies.

In accordance with Cabinet's policy, I am instructed to decline your request for documents.

On 3 November 2017 I responded:

I refer to your letter dated 2 November 2017.

I note your advice that you are instructed to decline the request for documents contained in my letter dated 31 October 2017.

Could you please advise:

- 1. Whether my request was considered by the Cabinet; and*
- 2. Whether the Minister has issued or intends to issue a certificate pursuant to s21(2) of the Ombudsman Act 1972 in relation to the documents I requested.*

I look forward to your response.

On 24 November 2017 Mr Wait responded:

I refer to your letter dated 3 November 2017.

In relation to your first question, I understand that you are aware that Cabinet has adopted a general policy that information regarding Cabinet decision-making will not be released to investigative agencies. Cabinet has not determined that there should be a departure from this general policy on this occasion.

In relation to your second question, given that the documents requested in your letter dated 31 October 2017 necessarily fall within the ambit of s 21(1) of the Ombudsman Act 1997 [sic], it is not clear to me what utility the provision of a certificate pursuant to s 21(2) of the Act might serve in the present circumstances. Could you please advise me if, nonetheless, you consider that a certificate may be appropriate? If so, I will take further instructions in relation to the provision of such a certificate.

Cabinet was entitled to rely on s 21 of the Ombudsman Act not to produce the documents sought. It would be inappropriate for me to criticise Cabinet for relying upon s 21.

However, as I have said, if Mr Wait had been authorised by the relevant Minister, he could have produced those documents.

As it stands, I was not provided with any documents evidencing any cabinet deliberations. I have proceeded to investigate the matter without the benefit of those documents (if any exist).

2.4 DEALING WITH RECOMMENDATIONS

Section 25 of the Ombudsman Act needs to be considered because it imposes obligations upon the Ombudsman in the circumstances mentioned in the section.

It provides:

- (1) *This section applies to any investigation conducted by the Ombudsman as a result of which the Ombudsman is of the opinion that the administrative act to which the investigation relates –*
 - (a) *appears to have been made contrary to law; or*
 - (b) *was unreasonable, unjust, oppressive or improperly discriminatory; or*
 - (c) *was in accordance with a rule of law or a provision of an enactment or a practice that is or may be unreasonable, unjust, oppressive or improperly discriminatory; or*
 - (d) *was done in the exercise of a power or discretion and was so done for an improper purpose or on irrelevant grounds or on the taking into account of irrelevant considerations; or*
 - (e) *was done in the exercise of a power or discretion and the reasons for the act were not but should have been given; or*
 - (f) *was based wholly or in part on a mistake of law or fact; or*
 - (g) *was wrong.*
- (1a) *This section does not apply to an investigation conducted under section 14.*
- (2) *In the case of an investigation to which this section applies in which the Ombudsman is of the opinion –*
 - (a) *that the subject matter of the investigation should be referred back to the appropriate agency for further consideration; or*
 - (b) *that action can be, and should be, taken to rectify, or mitigate or alter the effects of, the administrative act to which the investigation related; or*
 - (c) *that the practice in accordance with which the administrative act was done should be varied; or*
 - (d) *that any law in accordance with which or on the basis of which the action was taken should be amended or repealed; or*
 - (e) *that the reason for any administrative act should be given; or*

(f) *that any other steps should be taken,*

the Ombudsman must report that opinion and the reasons for it to the principal officer of the relevant agency and may make such recommendations as the Ombudsman thinks fit.

- (3) *The Ombudsman must send a copy of any report or recommendation made under subsection (2) to the responsible Minister and, in the case of a report or recommendation relating to the sheriff, to the State Courts Administration Council.*
- (4) *The principal officer of an agency in relation to which a recommendation is made under subsection (2) must, at the request of the Ombudsman, report to the Ombudsman within a time allowed in the request on what steps have been taken to give effect to the recommendation and, if no such steps have been taken, the reason for the inaction.*
- (5) *If it appears to the Ombudsman that appropriate steps have not been taken to give effect to a recommendation made under this section, the Ombudsman may make a report on the matter (containing a copy of the earlier report and the recommendation) to the Premier.*
- (6) *Where the Ombudsman reports to the Premier under subsection (5), the Ombudsman may forward copies of the report to the Speaker of the House of Assembly and the President of the Legislative Council with a request that they be laid before their respective Houses.*

I have previously held the view that s 25 is relevant and applicable in respect of a matter that I am investigating in which I am exercising the powers of the Ombudsman.

I have since had cause to reconsider that view.

I think it is arguable that s 25 has no application to an investigation that has been carried out by the ICAC in relation to a potential issue of serious or systemic maladministration in public administration.¹⁵

Section 25(1) is directed solely to 'an administrative act' which the Ombudsman's investigation reveals relates to one of the matters prescribed in that subsection.

Section 25(1) may not have any application when the investigation that was undertaken was not into an administrative act but an investigation into a potential issue of serious or systemic maladministration.

There is support for that proposition in s 25(1a). That sub-section provides that s 25 does not apply if the investigation is being carried out under s 14 of the Ombudsman Act which is engaged where either House of Parliament or a joint committee of those Houses have referred a matter to the Ombudsman for investigation and report, which is within the jurisdiction of the Ombudsman, and which the House or committee considers should be investigated: s 25(1a).

The purpose of s 25 is to provide a process where the Ombudsman is investigating an administrative act. Whether the section applies in the present investigation depends upon

¹⁵ Indeed in my opinion it also has no application where the Ombudsman is carrying out an investigation into misconduct or maladministration which has been referred by the ICAC pursuant to s 24(1)(a) of the ICAC Act.

the extent to which it is a power given to the Ombudsman or a provision that governs the exercise of those powers.

In the end I do not need to finally determine whether s 25 applies because (1) I intend to provide a copy of my report to the relevant Minister and to the heads of the relevant agencies and (2) the recommendations that were proposed by Mr Besanko¹⁶ and which I intend to make have all been accepted by the government.

My recommendations, having been made public in this report, will provide the appropriate basis for any person to follow and test the extent to which any action is taken on the recommendations.

2.5 CONFIDENTIALITY AND THE PUBLICATION OF A STATEMENT AND/OR REPORT

There are two other provisions of the Ombudsman Act that should be mentioned: s 26 and s 27.

Section 26 of the Ombudsman Act is headed 'Confidentiality, disclosure or information and publication of reports' and provides:

- (1) *A person engaged or formerly engaged in the administration of this Act must not disclose information obtained in the course of the administration of this Act except –*
 - (a) *for the purposes of the administration of this Act or proceedings under this Act or the Royal Commissions Act 1917; or*
 - (b) *for the purposes of the performance of official functions by an agency to which this Act applies, any agency or instrumentality of this State, the Commonwealth or another State or a Territory of the Commonwealth, or any other statutory authority or statutory office holder; or*
 - (c) *as authorised or required by the Ombudsman.*
- Maximum penalty: \$20 000.*
- (2) *The Ombudsman is only to authorise or require information to be disclosed if of the opinion that the disclosure is in the public interest (but a person to whom an authorisation or requirement is directed need not inquire into the basis of the authorisation or requirement).*
 - (3) *The Ombudsman may, if of the opinion that it is in the public interest to do so, cause a report on an investigation, or a statement about an investigation, or a decision not to investigate or to discontinue an investigation, to be published in such manner as the Ombudsman thinks fit.*
 - (4) *Information that has been disclosed under this section for a particular purpose must not be used for any other purpose by –*
 - (a) *the person to whom the information was disclosed; or*

¹⁶ As set out in his submissions that were provided to all interested parties.

- (b) *any other person who gains access to the information (whether properly or improperly and whether directly or indirectly) as a result of that disclosure.*

Maximum penalty: \$20 000.

The purpose of s 26(1) is to ensure that persons engaged in the administration of the Ombudsman Act do not disclose information obtained in the course of the administration of the Act except in the circumstances mentioned. It reinforces the privacy obligations in s 18(2) of the Ombudsman Act.

However s 26(2) empowers the Ombudsman to authorise the disclosure of that information if it is in the public interest. It also empowers the Ombudsman to require information to be disclosed. Section 26(2) therefore is not simply an exception to the powers in s 26(1). It provides a power in its own right.

Section 26(3) empowers the Ombudsman if he or she is of the opinion that it is in the public interest to do so to publish a report on an investigation or a statement about an investigation or of a decision not to investigate or to discontinue an investigation in such manner as the Ombudsman thinks fit.

Section 26(3) needs to be examined more closely.

On the face of it the powers in that subsection are given to the ICAC when exercising the powers of the Ombudsman by reason of s 36A of the ICAC Act: s 36A(2)(b)(i).

There are a number of powers or functions given in s 26(3) which are all predicated on the Ombudsman (or ICAC if it is a power to which s 36A refers¹⁷) being first satisfied that the exercise of power is in the public interest.

Unsurprisingly public interest is not defined. It does not mean simply that the public might be interested in the report although that would be relevant. The power can be exercised when it is in the public interest to exercise the power.

If it is thought to be in the public interest the following powers can be exercised by the Ombudsman (ICAC): publish a report on an investigation; publish a statement about an investigation; or publish a decision not to investigate or to discontinue an investigation.

The public interest will be informed in part by whether the publication is of a report, statement or decision. It will also be informed by whether those apart from the Ombudsman (ICAC) and the persons or authorities under investigation are aware of the investigation.

For example it would be unlikely to be in the public interest to publish a decision to discontinue an investigation if it were not known outside the Ombudsman's office that such an investigation had commenced.

If the threshold is met then a discretion arises as to the exercise of any of the powers that I have mentioned. The discretion is unfettered. The manner of the exercise of this discretion is also unfettered. That is clear by the words 'to be published in such manner as the Ombudsman thinks fit'. The words 'in the public interest' control the exercise of the power not the manner in which the power can be exercised. That would mean the publication can be made publicly. Put simply the Ombudsman can in the exercise of the Ombudsman's

¹⁷ For convenience such circumstances will be referred to as 'Ombudsman (ICAC)'.

discretion and if it is in the public interest to do so publish a report, statement or decision mentioned in s 26(3) in public.

In my report into the sale of land at Gillman I expressed the view that s 26(3) of the Ombudsman Act was available to the ICAC and that I could publish my report in public.¹⁸

No one had ever contended otherwise.¹⁹

2.6 PRELIMINARY DETERMINATION ON PUBLICATION OF REPORT

Three parties (Mrs Vlahos, Ms Harrison and Mr Karim Goel) in this investigation argued that I could not prepare a report setting out findings or recommendations that identified them unless they consented, a consent which they each refused to give.

Those parties relied for that contention on s 42 and in particular s 42(1a) of the ICAC Act. The argument was put a number of times in correspondence from Mrs Vlahos' solicitors during January of this year and again in her submissions in reply to counsel assisting's submissions on 25 January 2018 and further amplified in submissions made on 31 January 2018.²⁰ Ms Harrison and Mr Goel put that argument in their reply to counsel assisting's submissions.

I thought I should deal with that argument as a preliminary matter because if the argument reflected the proper construction of the ICAC Act and the Ombudsman Act I would not be able to write any meaningful or comprehensive report.

This inevitably led to a delay in the finalisation of the report. It was a distraction because I was forced to divert my attention from the consideration and analysis of the evidence and the submissions to deal with the argument raised by the three parties. While the distraction was regrettable, it was appropriate to address the matter as a preliminary point, so as to allow the parties to understand my determination and permit those parties to take action in the Supreme Court if they wished to take that course.

On 2 February 2018 I made my determination rejecting the argument. I determined that s 42 had no application to an investigation of this kind and that I could prepare a report and publish it publicly pursuant to s 26(3) of the Ombudsman Act if I thought it was in the public interest to do so. My statement containing this determination is Appendix 1.

I provided that determination to all parties who had an interest in the investigation on Friday 2 February 2018 and advised that I would receive written submissions from any of the parties by noon on Monday 5 February 2018 on the question of whether I should publish my statement containing my determination publicly on that day.

¹⁸ South Australia, Independent Commissioner Against Corruption, *Sale of State Owned Land at Gillman* (2015).

¹⁹ On 6 July the Premier said in Parliament that the families of the Oakden victims will get a public finding and 'I fully expect that it will be published'. He also said 'They will get a proper and full public explanation of this inquiry when it is published later this year, as I fully expect it to be'. South Australia, *Parliamentary Debates*, House of Assembly, 6 July 2017, 10493 (Hon. Jay Weatherill); On the same day the Deputy Premier said: 'I am absolutely convinced that the commissioner in undertaking this will thoroughly examine everything, will listen to everything they have to say and will leave no stone unturned on their behalf. Ultimately, as has just been observed, he will produce a public report wherein he will have had a chance to balance up all the allegations, all the responses, all the answers, and he will be in a position to satisfy, I think, the natural and entirely understandable feeling of the relatives of people who have been in that facility that the truth is discovered.' South Australia, *Parliamentary Debates*, House of Assembly, 6 July 2017, 10498 (Hon. John Rau).

²⁰ Mrs Vlahos' solicitors first put the argument on 5 January 2018 and again on 11 January 2018, 12 January 2018 and again in her submissions.

Mr Goel responded stating that he accepted that I have 'the power to prepare and publish a report in respect of the investigation'.²¹

Ms Harrison wrote that after considering my determination she 'no longer pursues her submissions in that regard'. She also urged me not to publish my determination because 'given Ms Harrison no longer pursues her submissions in that regard there is no utility in you publishing the statement addressing her submissions on that issue'.²²

Mrs Vlahos' solicitor wrote.²³

The former Minister had no general interest in making a submission about s 42(1a) of the ICAC Act. On behalf of the former Minister we made our submissions given the extremely damaging, erroneous and serious allegations made by your Counsel Assisting during the course of your Oakden Investigation. A very serious allegation made by your Counsel Assisting has now not been accepted by you. That our submissions were made in such a context is hardly surprising. That context, also explains why two others made submissions on s 42(1a). That no-one else made such a submission is unsurprising given the findings that your Counsel Assisting invited you to make.

...

We make it clear to you that the former Minister no longer makes any submission in relation to s 42(1a) for reasons in part referred to above.

Of course parties cannot elect not to pursue or no longer make submissions after a decision has been made in relation to their submissions. The time to take that action was before the decision was made.

I frankly do not understand what was meant by Mrs Vlahos not having a general interest in making a submission about s 42(1a) of the ICAC Act. I assume that her solicitor was acting upon her instructions to make the submission. Mrs Vlahos made the submission presumably to protect her own interests.

She made the submission in the face of Mr Besanko's submissions that there were nine reasons why the contention would fail. The reasons he identified were right. I have thought of some more reasons which are referred to below.

After I received Mrs Vlahos' submission I asked Mr Jensen to write to her solicitors regarding various matters including the paragraphs which I have set out above. He did so in a letter dated 5 February 2018 and sent electronically on the same day.

Her solicitors have not responded. I assume that the contentions Mrs Vlahos' legal representatives advanced were made on her instructions.

The correspondence from the three parties indicates that after reading my determination they accepted both it and my reasons.

Those parties sought a decision from me not to identify the three parties as having made the submission in my final report.

²¹ Letter from Shaw & Henderson on behalf of Mr Karim Goel to the Independent Commissioner Against Corruption, 5 February 2018.

²² Letter from Tindall Gask Bentley Lawyers on behalf of Ms Julie Harrison to the Independent Commissioner Against Corruption, 5 February 2018.

²³ Letter from Patsouris & Associates on behalf of Mrs Leesa Vlahos to the Independent Commissioner Against Corruption, 5 February 2018.

I see no reason why the three parties should not be identified. They were of course entitled to make any submission they wished to make but I am not persuaded that there is any proper reason not to identify them.

After I announced that I had made the determination there was considerable speculation in the media about who the persons might have been who made the submissions and the effect of those submissions.

It was suggested in the media that arguments had been put for 'the suppression' of those persons' names in the writing of any report.

The arguments that were advanced were not about suppression as that is understood in the *Evidence Act 1929 (SA)* (the *Evidence Act*).²⁴

The argument was that no one, including the three persons who put those submissions, could be identified in any report that was prepared without those persons consenting. The effect of the argument was that I could not identify anyone in the report, including the three persons who put the submission, unless those persons consented.

As I have said in the determination if that argument had been accepted I could not have written any meaningful report at all because it would be most unlikely that any person against whom an adverse finding might be made would consent to being identified. No one could have understood the contents of the report.

The determination speaks for itself. I have however considered the issue further and there are two additional reasons that support the opinion expressed in that determination.

First, s 3 of the ICAC Act identifies the primary objects of the Act and relevantly s 3(1)(c) provides:

3—Primary objects

- (1) *The primary objects of this Act are –*
 - (a) ...
 - (b) ...
 - (c) *to achieve an appropriate balance between the public interest in exposing corruption, misconduct and maladministration in public administration and the public interest in avoiding undue prejudice to a person's reputation (recognising that the balance may be weighted differently in relation to corruption in public administration as compared to misconduct or maladministration in public administration).*

A principal object of the ICAC Act is to achieve an appropriate balance as mentioned in s 3(1)(c). If s 42(1a) had the meaning contended for by the three parties there could be no balancing at all and s 3(1)(c) would be entirely frustrated. Moreover the words in parentheses would have no work to do at all. One of the primary objects of the ICAC Act would have to be ignored.

²⁴ *Evidence Act 1929 (SA)* s 69A ('*The Evidence Act*').

Secondly, s 7(4) of the ICAC Act provides:

The Commissioner is to perform his or her functions in a manner that –

- (a) *is as open and accountable as is practicable, while recognising, in particular, that –*
 - (i) *examinations relating to corruption in public administration must be conducted in private; and*
 - (ii) *other Acts will govern processes connected with how misconduct and maladministration in public administration is dealt with; and*
- (b) *deals as expeditiously as is practicable with allegations of corruption in public administration; and*
- (c) *as far as is practicable, deals with any allegation against a Member of Parliament or member of a council established under the Local Government Act 1999 before the expiry of his or her current term of office.*

Section 7(4) requires the ICAC to perform the ICAC's functions in a manner that is as open and accountable as practicable. Section 42(1a) provides a process which makes it difficult for the ICAC to be open and accountable when providing a report of the kind in s 42(1)(b). That supports a construction of s 42(1a) of the kind that I have mentioned in the determination.

Section 7(4)(a)(ii) also expressly recognises that other Acts will govern the processes connected with how misconduct and maladministration in public administration will be addressed.

That placitum is referring to the Ombudsman Act and the Royal Commissions Act and supports the conclusion at which I arrived that s 26(3) of the Ombudsman Act is the relevant statutory power that regulates the publication of reports following an investigation into misconduct or maladministration.²⁵

Section 27 need only to be mentioned to show it has no application in this investigation. Section 27 requires the Ombudsman to inform a complainant of the result of an investigation made on a complaint. That section does not arise in this case because there was no complainant. I embarked on this investigation on my own initiative.

2.7 PROCEDURAL FAIRNESS

The Ombudsman Act does not regulate the manner in which the investigation has to be carried out. Nor does the Royal Commissions Act except that the Royal Commissions Act provides in s 7 that the Commissioner is not bound by the rules of practice of any court or tribunal as to procedure or evidence and can conduct the proceedings and the commission can inform their minds on any matter in such manner as the commissioner considers proper.

²⁵ It could be argued that s 5 of the Royal Commissions Act also provides a power to publish without the commission needing to be satisfied as the Ombudsman must be under s 26(3) of the Ombudsman Act that publication is in the public interest to do so. However I do not need to decide that issue because I would not publish a report into serious or systemic maladministration unless I thought it was in the public interest to do so.

If those Acts do not regulate the process for an ICAC investigation as I have found then it must be that the process is regulated by the common law because the ICAC is for the purpose of an investigation of this kind an administrative decision maker and must comply with the general law.

Mr Besanko provided me with lengthy and very helpful submissions on the question as to whether in an investigation of this kind the ICAC needs to provide a person whose rights, interests or legitimate expectations might be adversely affected with procedural fairness.

When an administrative decision maker embarks upon an inquiry or investigation pursuant to a statutory power that may give rise to decisions which might adversely affect the interests, rights or perhaps the legitimate expectations of persons, those persons must be accorded procedural fairness, or as it is otherwise sometimes called, natural justice. That is a condition that attaches to the power and governs its exercise.²⁶

Not all decisions that are to be made give rise to an obligation to accord a person procedural fairness but an investigation of the kind I have conducted here is the kind that will give rise to a potential for a decision to be made that might be adverse to a person. In those circumstances it is necessary for such a person to be accorded procedural fairness.

There are two aspects of procedural fairness. The first aspect is the right to have an impartial and unbiased decision maker make a decision. The second aspect is to require a decision maker to give the person an opportunity to be heard before making a decision affecting that person's rights, interests or legitimate expectations.

In *Kioa v West* (1985) 159 CLR 550 Mason J identified the broad statement of principle:

The law has now developed to a point where it may be accepted that there is a common law duty to act fairly, in the sense of according procedural fairness, in the making of administrative decisions which affect rights, interests and legitimate expectations, subject only to the clear manifestation of a contrary statutory intention.

I accept Mr Besanko's submissions that there is no contrary statutory intention in any of the Acts governing these processes which could allow it to be said that the obligation to accord parties procedural fairness has been displaced. He concluded (rightly in my opinion) that there was nothing in the Ombudsman Act that as a matter of statutory construction meant that the decision maker need not accord a person whose rights, interests or legitimate expectations might be adversely affected with procedural fairness.

It is not only legal rights that may be affected that give rise to the obligation to accord procedural fairness. As the proposition identified by Mason J shows an 'interest' would be sufficient for the obligation to arise and an interest would include a person's reputation.

I have taken the view for the purpose of this investigation that procedural fairness should be accorded not only to persons who may be affected by the ultimate decisions in the investigation but to anyone who may suffer an adverse finding in relation to his or her conduct even if that finding does not amount to maladministration.

Mr Besanko submitted that the State of South Australia should also be permitted to be heard in relation to any potential finding or decision that might impact upon the State. I agreed with that submission.

²⁶ *Annetts v McCann* (1990) 170 CLR 597; *Kioa v West* (1985) 159 CLR 550; *Saeed v Minister for Immigration and Citizenship* (2010) 241 CLR 252.

Mr Besanko submitted:

20. *In summary, in my submission the Commissioner ought to proceed as follows.*
- 20.1 *The Commissioner should provide the Submissions of Counsel Assisting to persons, entities or bodies who in my submission should be the subject of an adverse finding, or a finding that would damage their reputation, including but not limited to a finding that they engaged in maladministration.*
- 20.2 *Parties to whom the Submissions of Counsel Assisting are provided should be given the opportunity to provide submissions in response to these submissions by 5pm on 25 January 2018.*
- 20.3 *Any person or party to whom the Submissions of Counsel Assisting are provided who wishes to make oral submissions, adduce further evidence before the Commissioner or access any evidence before the Commissioner, should be permitted to make such a request, providing that it is (1) in writing, (2) addressed to the Commissioner, (3) made by 5pm on 18 January 2018 and (4) accompanied by an explanation for the request.*
- 20.4 *The Commissioner should consider any such requests on a case by case basis. If any such request is granted, the hearing should take place in the week commencing 29 January 2018. Other interested parties cannot expect to receive notice of or be permitted to attend such a hearing.*
- 20.5 *Parties to whom the Submissions of Counsel Assisting are sent, and their legal advisors, should be reminded of the obligation under s 54(3) of the ICAC Act imposed upon persons who receive information knowing that the information is connected with a matter that forms or is the subject of, relevantly, a maladministration investigation by the Commissioner under s 24(2). Solicitors who are acting for two persons who were examined who receive these submissions or the Submissions of Counsel Assisting are not permitted to provide either document or the contents of them to their other client who did not receive either document (because they were not sufficiently interested in the proposed findings or recommendations).*
- 20.6 *The Commissioner should provide the following written authorisations for the purposes of s 54(3)(a) of the ICAC Act:*
- 20.6.1 *an authorisation permitting the Chief Executive of the Department of Health and Ageing to disclose the Submissions of Counsel Assisting to such persons within the Department of Health and Ageing or any of the Local Health Networks as may be necessary for the sole purpose of enabling the Chief Executive to take instructions in respect of and/or to prepare a response to the Submissions of Counsel Assisting; and*
- 20.6.2 *an authorisation permitting the Chief Executive Officer of NALHN to disclose the Submissions of Counsel Assisting to such persons within the Department of Health and Ageing or NALHN as may be necessary for the sole purpose of enabling the Chief Executive Officer to take instructions in*

respect of and/or to prepare a response to the Submissions of Counsel Assisting.

21. *For the avoidance of doubt, any person to whom the contents of the Submissions of Counsel Assisting (or the document itself) are disclosed by the Chief Executive of the Department of Health and Ageing or the Chief Executive Officer of NALHN is not authorised to provide that information (or the document) to any other person, save for the purpose of obtaining legal advice.*
22. *The Commissioner ought consider any requests for authorisations under s 54 made by any other party who receives the Submissions of Counsel Assisting on a case by case basis, including by the Chief Executive for the purpose of seeking instructions from the Chief Executive Officers of the Local Health Networks.*

I accepted all of Mr Besanko's submissions in that regard and proceeded accordingly.

On 18 December 2017 Mr Jensen emailed 31 persons or their legal representatives advising them that I had determined to proceed in that way and that counsel assisting's submissions would be provided to parties who were determined to have a sufficient interest in counsel assisting's submissions on 27 December 2017.²⁷ The 31 persons are identified in Appendix 2.

2.8 STANDARD OF PROOF

Although it is recognised that the concept of onus of proof does not apply in the exercise of powers under a royal commission it has also been recognised that the commission needs to determine whether it is satisfied that there is sufficient evidence to make a finding on any particular issue.

There are only two standards of proof: the criminal standard beyond reasonable doubt and the civil standard on the balance of probabilities.

Royal commissions ordinarily accept that the standard of proof for the making of such a finding ought to be in accordance with the civil standard and taking into account the principles in *Briginshaw v Briginshaw*.²⁸

In that case Dixon J said at 362:

But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters "reasonable satisfaction" should not be produced by inexact proofs, indefinite testimony, or indirect inferences.

I intend therefore to adopt the civil standard of proof and proceed to make findings on the balance of probabilities.

²⁷ Email from Mr Rod Jensen, 18 December 2017.

²⁸ (1938) 20 CLR 335.

However I will have regard to the matters referred to in *Briginshaw* in determining whether the evidence is of sufficient quality to make any finding.

2.9 PRIVATE VERSUS PUBLIC

Before turning to the report proper I wish to comment upon the requirement imposed upon me to conduct an investigation of this kind in private.

I have previously stated my views on whether investigations into serious or systemic maladministration should have to be carried out in private.²⁹

I have consistently expressed the view that the ICAC should have the discretion to hold some or all of an investigation of this kind in public.

I shall briefly mention why I hold that view.

The ICAC is empowered by the ICAC Act to investigate potential issues of corruption or serious or systemic misconduct or maladministration.

If the ICAC investigates corruption, which by definition must be criminal conduct³⁰ the ICAC uses the powers given to the ICAC by the ICAC Act.³¹ These powers include a coercive power to require persons to attend for examination in accordance with the procedure provided for in Schedule 2 of the ICAC Act. Whilst those powers are understandably necessary to investigate corruption those powers impact on the examinees' right to silence. Clause 3(3) of Schedule 2 requires those examinations to be in private.

I agree that investigations into corruption should be conducted in private. It is no different to the investigation of criminal offences carried out by other law enforcement agencies such as SA Police. Such investigations are routinely conducted in private. The premature disclosure of such investigations can prejudice many of the methods used to conduct such investigations.

But there is more to it.

The ICAC's power to investigate corruption is simply that. The ICAC does not make a finding at the end of the investigation as to whether the person or persons under investigation engaged in corruption.

Indeed the only decision that is made is whether the matter should be referred to the Director of Public Prosecutions (the DPP) for the DPP to consider whether the person or persons under investigation should be prosecuted. The ICAC has no say in whether a person should be prosecuted. That is properly a decision solely for the DPP.

It is argued that corruption investigations should be in public because coercive hearings of the kind I have mentioned if held in public act as a deterrent to those who would otherwise engage in corrupt conduct.

I am not sure that is so because the empirical evidence is not available. But let us suppose it to be.

If the DPP commences a prosecution then all of the evidence will become publicly known at the person's trial, subject to any suppression orders made. That trial will ordinarily play out in a public forum and the manner in which the investigation was undertaken, the conduct of the

²⁹ *Sale of State Owned Land at Gillman*, above n 18, 248.

³⁰ *Independent Commissioner Against Corruption 2012 (SA)* s 5(1) ('*The ICAC Act*').

³¹ *Ibid* pt IV div 2 sub-div 2.

parties during the trial, the manner in which the evidence is presented and the manner in which the presiding judicial officer conducts the trial will be in the open.

If a corruption investigation does not proceed to a prosecution the ICAC can proceed in a number of different ways.

If the ICAC is of the opinion that there is no evidence or insufficient evidence to establish that the suspected conduct occurred the ICAC would bring the investigation to a conclusion and it would not be publicly known that the person had ever been investigated. Indeed, the person himself or herself may not know that they have been the subject of an investigation. That is not unusual and is consistent with the way law enforcement agencies have operated for decades.

Alternatively if the ICAC is of the opinion that whilst the evidence would not support a criminal prosecution it could support a finding of misconduct or maladministration, there are mechanisms available in the ICAC Act to refer the matter to a public authority for investigation. Alternatively I may exercise the powers of the Ombudsman to investigate if I am satisfied that 1) the matter involves potential serious or systemic misconduct or maladministration and 2) it is in the public interest that I conduct the investigation. Section 56A permits the use of evidence obtained in the course of the original corruption investigation to be used for a subsequent investigation.

If the ICAC decides to exercise the powers of the Ombudsman to investigate the conduct then it is the ICAC that will determine whether a person(s) has engaged in misconduct or maladministration and the ICAC may publish a report.

If the ICAC proceeds in that way the ICAC must accord anyone whose rights, interests or possibly legitimate expectations might be adversely affected with procedural fairness. The ICAC must do so because the ICAC is ultimately the decision maker in terms of any findings.

The ICAC will make a decision, supported by reasons, as to whether the conduct has been established; provide a report on the investigation; and can publish a report on the matter if it is in the public interest to do so.

The processes for an investigation into corruption and an investigation into misconduct and maladministration are quite different. The purpose of the investigation is different, the ultimate decision maker is different and the procedure adopted is different.

When the ICAC investigates corruption, the ultimate decision maker is a court. When the ICAC investigates serious or systemic misconduct or maladministration, the ICAC is both the investigator and the decision maker.

The process requires, as this investigation demonstrates, a number of steps:

- the gathering of evidence
- an analysis of the evidence
- affording individuals procedural fairness
- considering any submissions made or further evidence presented
- coming to a decision
- writing a report
- publishing that report if it is in the public interest to do so

Because the ICAC has overall control of the process and is both the investigator and the decision maker it is critical that the process is transparent.

The process should be transparent so that those who read the ICAC's report can have confidence in the manner in which the ICAC conducted the process. They need to see the evidence unfold and understand the process adopted. They can see the manner in which

individuals are afforded procedural fairness and can satisfy themselves as to the appropriateness of the procedure adopted.

The ICAC process should be under public scrutiny because the ICAC has the power to make the ultimate decisions in respect of such investigation.

In this report I have made findings which will have an adverse effect on the reputation of a number of individuals.

Because the investigation had to be conducted in private the reader will simply have to assume that those individuals were provided with an adequate opportunity to address those potential findings and that my judgement in that regard was appropriate.

That is unsatisfactory.

The reader should not only be able to read my report but also be aware and examine the way in which the process was conducted. The only way that can occur is if the ICAC is permitted to proceed in public where satisfied that it is appropriate to do so.

For these reasons I remain of the view that when I conduct an investigation into potential serious or systemic misconduct or maladministration I should have the discretion to conduct some or all of that investigation in public.³²

That is the only way the process can be protected.

Some representatives of government argue that if the ICAC were permitted to proceed in public there might be potential consequences for the government because the allegations which form the subject matter of the investigations would be out in the public domain for some time before the government or a particular Minister had the opportunity to answer the allegations. That is hardly an unusual situation. A number of forums that operate in public would create the same consequence.

In my opinion it is a consequence for everyone who is called upon to answer serious allegations of impropriety in a range of settings. I ask rhetorically, why should the government which should be as transparent as possible stand in some privileged position when it is the executive's conduct that is under examination?

Next some representatives of government argue that some people will think that if the ICAC is investigating the conduct the matter is perceived to be more serious than it may be. In a sense it is suggested that an investigation of misconduct or maladministration by the ICAC in some way elevates the conduct to something it is not.

There is a risk that some members of the public might be confused as to the conduct that is under investigation but that can be explained in the investigation and would be explained in any report that is made public.

In any event the ICAC cannot embark upon any investigation into misconduct or maladministration unless the matter is serious or systemic as those words are defined in s 4(2) of the ICAC Act. Section 4(2) provides:

- (1) *For the purposes of this Act, misconduct or maladministration in public administration will be taken to be **serious or systemic** if the misconduct or maladministration –*

³² The Hon. Mr KP Duggan AM QC in the review that he concluded on his report prepared on the question of the ICAC Act which was tabled in Parliament on 1 December 2017 was of the view that subject to appropriate safeguards the ICAC should be able to carry out investigations into serious or systemic misconduct or maladministration in public.

- (a) *is of such a significant nature that it would undermine public confidence in the relevant public authority, or in public administration generally; and*
- (b) *has significant implications for the relevant public authority or for public administration generally (rather than just for the individual public officer concerned).*

That definition precludes the ICAC from investigating any misconduct or maladministration that is not significant or would not undermine public confidence in the public authority under investigation. Accordingly the only matters that I could investigate are matters of significance.

Some representatives of government also argue that if evidence were taken in public that might affect the way in which evidence was given or addressed.

I agree with that proposition. However I do not see it as a factor weighing against conducting an investigation in public.

Indeed, I query whether some of the witnesses who gave evidence before me during this investigation would have given their evidence in the same way had their evidence been heard in public. I also do not think that the argument that was advanced in respect of the publication of a report that did not identify a person without their consent would have been contended. Frankly I think the fact that the investigation had to be in private did not do some of the witnesses any favours.

The powers that I am given to investigate serious or systemic misconduct or maladministration are significant. The way in which I exercise those powers, the processes I adopt and the evidence that is given should be subject to public scrutiny.

In my opinion the government's reasons for requiring these investigations to be in private are almost entirely political and are designed to limit the damage that might ensue when its own conduct and processes are subject to scrutiny in public.

Of course, there will be occasions where principles of openness and transparency will be outweighed by other considerations which require certain evidence or perhaps process to remain private. That can be addressed by affording the ICAC with a discretion to conduct public hearings, as is afforded to every other mainland integrity agency in this country.

Whilst I understand the arguments advanced against public hearings, the integrity of the decision making process is more important which means that the process should be as transparent as possible.

CHAPTER 3: THE PROCESS

3.1 PUBLIC CALL FOR INFORMATION

When I announced the Terms of Reference on 30 May 2017 I also made a public call for information relevant to those terms. I sought information from members of the public who had, at any time in the preceding 10 years, either made a complaint or report about the Oakden Facility, or expressed a concern to a government agency or public officer about the Oakden Facility.

Over the ensuing weeks I received 44 contacts from members of the public. The information collected from those contacts was assessed and, where necessary, individuals who made contact were interviewed for the purposes of the investigation.

3.2 THE VISIT TO THE OAKDEN FACILITY

On Thursday 15 June 2017 I was shown through the Oakden facility by Ms Hanson the Chief Executive Officer of NALHN who was accompanied by a NALHN employee Mr Kurt Towers. I was accompanied on that visit by:

- Mr Tom Besanko, counsel assisting in the investigation
- Mr Sam McGrath, principal solicitor assisting in the investigation
- Mr Michael Riches, Chief Executive Officer, ICAC/OPI
- Mr Rod Jensen, Director Legal Services, ICAC

The last of the consumers who had resided in the Makk and McLeay Houses had left a few days before. There were no staff in those houses. They were deserted. However, it was a comprehensive tour and Ms Hanson described the manner in which the consumers were housed and the care which was provided to them. She made no attempt to gloss over the significant findings made in the Oakden Report.

Indeed she made it clear that she accepted those findings. She became emotional when she described the conditions under which the consumers were kept and cared for.

I was shocked by the facility.

I have recently visited most of the State's prisons. The Oakden Facility resembled a prison and a poorly designed one at that. It was also poorly maintained. The facility was depressing.

The grounds were a disgrace. Not only were they in a poor condition but they were small and uneven such that it would have been unsafe for consumers to walk around outside unsupervised and unaided.

The corridors were bare and bleak and separated by large, cold doors that appeared to have been kept shut and possibly locked most of the time. The entrance was uninviting.

The bathrooms were shared and were in a very poor condition. The furniture, to the extent that there was any, was old, dilapidated and falling apart. The equipment that was available to be viewed was antiquated, very tired and run-down.

The activities room was largely bare, which may have been because things had been removed or packed away.

There was an empty, sterile looking room at the end of one of the wards that was apparently used to lock a consumer in for periods of time.

The restraints that we were shown looked confronting.

The bedrooms were stark and foreboding.

There were no proper community areas for the consumers. The nursing area was segregated from the consumers and the nursing staff would have not been obviously available to the consumers.

It was at least as bad as the Chief Psychiatrist had described it in the Oakden Report.

What I was shown was consistent with the image that has been painted by a number of people. Consumers were essentially either left to wander the locked, cold corridors aimlessly or were placed into tired old chairs, from which they could not rise (because they were either restrained or placed in the chair in such a way that they could not get out unaided). Alternatively they were left unsupervised in a small alcove to stare at a TV for hours on end while the nurses locked themselves in the nurses station, much like prison guards.

I left the inspection feeling quite disturbed about the condition in which the consumers at Oakden, who were amongst the most vulnerable members of our society, were housed.

The inspection was important in order to better understand and contextualise the Oakden Report and the evidence that I would receive during the course of the investigation.

3.3 DOCUMENTATION

The investigation was provided with an extensive amount of documentary material.

Some of this material was provided in answer to summonses issued under the Royal Commissions Act. Some of it was produced voluntarily, either on request or gratuitously.

In all, the investigation received, by one means or another, approximately 44,200 documents (comprising in excess of 350,000 pages). The persons or entities who have produced documents in answer to a summons issued under the Royal Commissions Act are mentioned below. The persons or entities who voluntarily produced documents are listed in Appendix 3.

3.4 PRODUCTION OF DOCUMENTS

Early in my investigation I issued a number of summonses under s 10 of the Royal Commissions Act to various bodies and persons to produce copies of a range of documents relevant to my investigation. A total of 13 summonses were issued in the period between 1 June 2017 and 16 June 2017 to the following bodies and persons:

1. Ms Jackie Hanson, CEO, Northern Adelaide Local Health Network (1 June 2017)
2. Dr Aaron Groves, Chief Psychiatrist (1 June 2017)
3. The Hon. Jay Weatherill, Premier of South Australia (8 June 2017)
4. The Hon. Jack Snelling, Minister for Health (8 June 2017)
5. The Hon. Leesa Vlahos, Minister for Mental Health and Substance Abuse (8 June 2017)
6. Mr Maurice Corcoran, Principal Community Visitor (8 June 2017)
7. Ms Anne Gale, Public Advocate (8 June 2017)
8. Mr Steve Tully, Health and Community Services Complaints Commissioner (8 June 2017)
9. Ms Maria West, Director Mental Health Strategy and Operations, Northern Adelaide Local Health Network (15 June 2017)
10. Australian Nursing & Midwifery Federation (15 June 2017)
11. SA Salaried Medical Officers Association (15 June 2017)
12. Ms Jenny Richter, CEO, Central Adelaide Local Health Network (16 June 2017)

13. The Hon. Zoe Bettison, Minister for Ageing (16 June 2017)

Each of these bodies or persons complied with the summons issued to them although some sought extensions of time within which to do so and where appropriate I granted these extensions.

3.5 DELAYS IN PROVISION OF DOCUMENTS

Full compliance with the summonses issued to persons associated with SA Health³³ took the longest time and caused a significant delay to my investigation. It is necessary to provide some detail about the delay.

On 1 June 2017 I issued a summons for the production of documents to the CEO of NALHN, Ms Hanson. The summons was returnable on 21 June 2017.

On 16 June 2017 I issued a summons for the productions of documents to the CEO of CALHN, Ms Richter. The summons was returnable on 14 July 2017.

On 20 June 2017 I received a letter from Ms Hanson dated 16 June 2017 in which she advised that SA Health had established an Information Coordination Unit to assist SA Health (including NALHN, CALHN and the Chief Psychiatrist) to respond to the summonses relevant to it. Ms Hanson sought an extension of time to comply with the summons to 31 July 2017. I had little option but to accede to the request for an extension, but extended the time to 14 July 2017.

On 30 June 2017 the Crown Solicitor's Office (CSO) wrote to me and advised that the Crown Solicitor was instructed to advise South Australian public officers in relation to the production of documents pursuant to the summonses issued. The CSO advised that these public officers included the Premier, the Minister for Health, the Minister for Mental Health and Substance Abuse, the Minister for Ageing, the Public Advocate, the Health and Community Services Complaints Commissioner, the CEO NALHN, the Director Mental Health Strategy and Operations, NALHN, the CEO CALHN, the Chief Psychiatrist and the Principal Community Visitor.

The CSO also advised that 'the summons recipients have been actively engaged in the task of locating and collating the relevant documents for production and are on track to produce the majority of documents by the relevant summons return dates (or such extended dates as may have been previously approved by your office).'

On 12 July 2017 the acting CEO's of both NALHN and CALHN wrote to me and advised that:

... significant time and resources have been devoted to identifying and producing documents sought by the summonses. However, in the course of that work over recent weeks it has become increasingly apparent that relevant documents may be located in a very large range of areas and that the number of documents captured by the summonses is likely to be very large. The summons recipients intend to provide you with as much documentation as is possible by 14 July 2017. Despite the best efforts of staff involved in the searches, however, there remains a significant amount of documentation yet to be searched. The decision has been taken to invest in customised software so that the remaining searches can be conducted as quickly as possible.

³³ SA Health is the brand name for the health portfolio of services and agencies responsible to the Minister for Health, the Minister for Ageing, and Minister for Mental Health and Substance Abuse. The relevant portfolios falling under the SA Health brand name relevantly include the Department and NALHN.

On 14 July 2017 I received the first of what would be many bundles of documents from the CEOs of NALHN and CALHN. At the same time a further request for an extension of time to comply fully with the summons was considered and reluctantly granted.

On 19 July 2017 members of my staff met with representatives from the CSO and the SA Health Information Coordination Unit to discuss the progress of compliance with the summonses. At the meeting a detailed work plan was discussed 'to ensure every effort is being made to provide as much relevant information as possible by 4 August 2017.'

On 2 August 2017 the CEOs of NALHN and CALHN wrote to me again and advised that a number of challenges regarding the production of documents had been identified including the discovery of additional information sources in the form of a significant number of both electronic and hard copy records. The CEOs identified a framework for providing material to me on an ongoing 'fortnightly basis until complete.'

Over the course of the next three months I received many thousands of documents in electronic form from the CEOs of NALHN and CALHN on a fortnightly and sometimes weekly basis.

By letter dated 13 October 2017 I was advised by the CEOs of NALHN and CALHN that the expected completion date for the provision of material to me in answer to the summonses I issued was early November 2017. This would be a period of almost five months since I first issued the summonses.

In response I caused a letter dated 26 October 2017 to be sent to the CEOs of both NALHN and CALHN in which my concern over the significant delay to the timetable of my investigation was noted, and I set a date of 3 November 2017 for finalisation of production of documents in answer to the summonses, failing which I would call the summonses on to be further dealt with.

Under cover of letter dated 3 November 2017 the CEOs of both NALHN and CALHN forwarded the remaining records in answer to the summonses.

Both the volume of material received and the time taken to receive it exceeded my initial expectations and while I appreciate the work done by those involved in searching for, gathering, reviewing and providing the documents to me it caused a significant delay to my investigation.

The delay was most regrettable.

The documents were not provided within the timeframe of the original summonses. My investigation was informed from time to time that the sheer volume of material made it difficult to comply with the summonses.

In the end I do not think that the volume of documents was the sole reason for the extensive delay in their provision to me. Documents that are properly organised, indexed and stored (irrespective of their volume) are more capable of being identified and retrieved in a timely manner than documents that have suffered from poor record keeping practices.

I suspect that those tasked with compiling documents in answer to the summonses had a far more difficult job because the relevant documents were poorly indexed, ordered and stored to begin with.

3.6 DOCUMENT ANALYSIS

The majority of the documents produced both in answer to the summonses and voluntarily were provided in electronic form. Documents that were received in hardcopy were scanned and an electronic copy of the document created.

Every electronic document was then forensically imaged and uploaded into specialised indexing software. Each and every document was given a unique exhibit number to ensure each document could be individually tracked.

An extensive review of the documents that were produced in answer to the summonses, and those otherwise received by me, was conducted by my staff and by Mr Besanko, Mr McGrath and Mr Healey.

My staff undertook extensive searches of all of the documents produced to me utilising the indexing software and 'keywords'. A number of variations of key words were used to minimise the chances of important or relevant documents being overlooked. Document briefs were then created dealing with a range of topics, including for each witness who was examined. All of the documents produced in answer to the keyword searches were then reviewed, either by my staff, Mr Besanko, Mr McGrath or Mr Healey.

Mr Besanko reviewed each of the nearly 4000 documents collectively produced by Mr Weatherill, Mr Snelling and Mrs Vlahos.³⁴ He also reviewed each of the documents produced in answer to the keyword searches of all of the documents produced by my staff in respect of each of the 27 witnesses who were examined, and the documents annexed to the witness statements provided by some of the witnesses to me. He also reviewed a large number of other documents, which had been reviewed by others in the first instance, during the course of the investigation and the preparation of his submissions, including many of the documents produced by Mr Corcoran and Dr Groves.

Mr McGrath and Mr Healey reviewed the documents produced by the South Australian Salaried Medical Officers Association (SASMOA), the Australian Nursing and Midwifery Federation (ANMF), Mr Tully (the Health and Community Services Complaints Commissioner), as well as a number of other documents that were produced voluntarily (including by Mr Steven Marshall MP). They also reviewed a large number of the documents produced by Mr Corcoran, including all of the reports of the community visitors produced (many of which Mr Besanko also separately reviewed), and Dr Groves, as well as a large number of other documents which had been reviewed by others in the first instance.

My staff also reviewed all of the documents produced by The Hon. Zoe Bettison and Ms Gale, the Public Advocate.

The review of the documentary material produced was a particularly time consuming and resource intensive process, but one that was necessary in order to ensure the integrity of the investigation.

Given the total number of pages of the documents produced to me, and the resources I had available to conduct the investigation, a manual review of each and every document would have taken a considerably longer period of time and would have caused my investigation to extend well into 2018. I did not think that this was in the public interest.

Further, by reason of the extensive 'keyword' and manual searches that were conducted, I am confident that the relevant and important documents produced to me were identified and reviewed.

³⁴ Mr Weatherill produced 637 documents, Mr Snelling produced 2135 documents and Mrs Vlahos produced 1182 documents.

What is telling about the reviews that were conducted is the absence of documentary evidence that the vast majority of complaints, and serious issues and incidents, at the facility were escalated to the more senior members of NALHN and its predecessors, and the Ministers. I have found this surprising. However, there is nothing before me to suggest that there has not been full or proper compliance with the summonses, and I must act upon the evidence before me.

3.7 STATEMENT TAKING

I was aided in my investigation by the Crown Solicitor offering to assist a number of public officers and former public officers whose evidence was relevant to my investigation to prepare written statements for use in my investigation.

Through this assistance I received detailed written statements from the following people:

1. The Hon. John Snelling MP (dated 29 September 2017);
2. Ms Jackie Hanson (dated 10 October 2017);
3. The Hon. Gail Gago MP (dated 20 October 2017);
4. Ms Maria West (dated 24 October 2017 and 26 October 2017);
5. Ms Margot Mains (dated 26 October 2017); and
6. Ms Paula Hakesley (dated 30 October 2017).

The provision of these statements occurred over a longer than anticipated period and caused some delay to my investigation. However, the statements aided the examination process because witnesses were able to adopt their statements for the purpose of giving evidence before me.

I understand that the Crown Solicitor's Office also assisted Mrs Vlahos to prepare a written statement. A draft of the statement was provided by the Crown Solicitor's Office to Mrs Vlahos' legal representatives in late September 2017. Mrs Vlahos did not provide me with a signed final version of the statement. Instead she provided me with an unsigned written statement on Monday, 6 November 2017 which she adopted at the commencement of her examination on 9 November 2017.

The Crown Solicitor's Office provided an affidavit (the Corporate Affidavit) affirmed by Adam Monkhouse, the Manager Project Coordination for the Information Coordination Unit Oakden, SA Health. The affidavit set out, in considerable detail, various organisational structures and reporting lines that existed at various times in respect of the Oakden facility over the period covered by the Terms of Reference. This affidavit was most helpful in understanding who was responsible for what in respect of Oakden throughout the relevant period.

I am grateful for the Crown Solicitor's cooperation and assistance and indeed for the quality of the statements that were provided.

For convenience the persons who held relevant Ministerial, Chief Executive, Chief Executive Officer and statutory office positions over the relevant period are set out in Appendix 4.

3.8 WITNESSES INTERVIEWED

A total of 51 witnesses were interviewed by Mr McGrath and members of my staff. A number of witnesses were legally represented when interviewed. The witnesses who were interviewed are identified in Appendix 5.

3.9 WITNESSES WHO GAVE EVIDENCE

A total of 27 witnesses were examined before me. The persons who were examined are identified in Appendix 6.

The examination process took place between 17 October 2017 and 28 November 2017. It was not possible to conduct the examinations earlier because a number of documents had still not been provided.

The interviews and examinations took place in private.³⁵ Some but not all of the persons interviewed and examined were legally represented.

Section 13 of the Royal Commissions Act provides:

Unless the commission otherwise directs, any person giving evidence before the commission may, subject to anything prescribed, be represented before the commission by counsel or solicitor.

I allowed any person who wished to be represented to be represented.

I allowed the State of South Australia to be separately represented by Mr Wait SC. Mr Wait with Ms Paula Stirling also represented former Minister The Hon. Jack Snelling and former Minister The Hon. John Hill.

At the commencement of each examination I explained the process to the witnesses. If they were unrepresented, as most of them were, I explained their right to be represented and their legal rights whilst giving evidence and the questions to which they might object or refuse to answer. They were then asked to take an oath or affirmation. They were then examined by Mr Besanko. I also asked questions during the course of the examinations.

At the conclusion of an examination if the witness was unrepresented I invited the witness to make any additional statement that the witness wished. If the witness was represented I invited the witnesses' counsel to ask any questions of the witness which counsel thought were relevant.

The witnesses' evidence was transcribed. Each examination was video and audio recorded. Those recordings have been kept and will be retained as records relevant to the investigation.

During the examinations I received a number of documents which were received and marked with an exhibit number as I received them.

3.10 INTERSTATE AND OVERSEAS WITNESSES

A number of people relevant to my investigation had left their positions and moved interstate or in some instances overseas.

It was a challenge to locate some of these people and to make contact with them.

Some people travelled long distances to give evidence in examinations including four people who travelled from interstate. I am grateful to those people for making themselves available to assist my investigation.

³⁵ *Ombudsman Act* s 18(2).

3.11 PREPARATION AND DISSEMINATION OF SUBMISSIONS OF COUNSEL ASSISTING

As I have already said I proceeded in accordance with the process suggested by Mr Besanko in his submissions which I have mentioned in Chapter 2.

Having reviewed the documentary evidence and having heard from the witnesses I then invited Mr Besanko to prepare written submissions in respect of the evidence, including submissions as to any findings and/or recommendations that I ought to make.

Mr Besanko's submissions were provided to interested parties on 27 December 2017.³⁶ Interested parties included any person who, if Mr Besanko's submissions were accepted, might have a right, interest or legitimate expectation that might be adversely affected. The list of persons to whom the submissions were provided is set out in Appendix 7.

Mr Besanko's submissions were comprehensive and, at the conclusion of my investigation, I did not identify any person outside of his submissions who might be adversely affected by the content of this report.

The persons who were provided with Mr Besanko's submissions were invited to make whatever applications and submissions they wished to make in response.

The list of persons who made procedural and or substantive submissions is set out in Appendix 8.

None of the interested parties objected to the manner in which Mr Besanko said I should accord those parties procedural fairness except Mrs Vlahos who repeatedly complained that she was not being accorded procedural fairness. My understanding of her submissions on the point was that she asserted that given the submissions made by Mr Besanko she was not being given reasonable time or information to be able to respond, although she did respond within the required time and was provided all of the evidence that she sought.

No other party raised an issue in respect of the timetable for the preparation of submissions.

In Mr Jensen's email of 18 December 2017 parties were also advised that if they wished to make any additional application, such as to make oral submissions, adduce further evidence or access any evidence then those applications would need to be received by 18 January 2018.

Six of the interested parties made such an application.

Only one party, Mrs Vlahos, sought to make oral submissions and to cross examine a witness (Ms Hanson).

I agreed to allow her counsel to make oral submissions after cross examining Ms Hanson. I said that I would provide three hours for cross examination and submissions to be used as counsel wished. In the end Mrs Vlahos' counsel used the whole of that time to cross examine Ms Hanson so I did not hear any oral submissions.

Four parties, Ms Harrison, Ms Vanessa Owen, Mrs Vlahos and Ms Merylyn Penery sought further particulars. These were provided to them.

Four parties, Ms Harrison, Ms Owen, Dr Draper and Mrs Vlahos sought access to extracts from the transcript of the examinations. These were provided.

The same four parties also sought extracts from some of the statements tendered at the examinations. These were also provided.

³⁶ One of the interested parties was provided with Mr Besanko's submissions on 28 December 2017.

Four parties Ms Harrison, Ms Owen, Mrs Vlahos and Ms Penery sought copies of documents. These were provided.

Both Dr Groves and Ms Harrison applied to file affidavit evidence. I approved both applications.

In setting out my assessment of the evidence and my findings I will largely follow the same order that Mr Besanko did in his submission.

That way the interested parties can understand which of Mr Besanko's submissions I have accepted and where I have accepted the interested parties' submissions.

CHAPTER 4: THE RELEVANT LEGISLATION

4.1 THE HEALTH CARE ACT 2008

The principal Act currently regulating healthcare in South Australia is the *Health Care Act 2008* (HCA) which commenced, in the main on 13 March 2008.

The HCA repealed three Acts including the most relevant one, the *South Australian Health Commission Act 1976*.

The objects of the HCA are to enable the provision of an integrated health system that provides optimal health outcomes for South Australians; to facilitate the provision of safe, high quality health services that are focussed on the prevention and proper management of disease, illness and injury, and to facilitate efficiencies through the use of certain facilities for veterinary science; and facilitate a scheme for health services to meet recognised standards: s 4 HCA.

The HCA identifies the principles to be applied in connection with the operation of the administration of the Act the principal one of which is included in s 5(a):

- (a) *the protection of the public and the interests of people in need of care related to their health should be the highest priorities in the provision of health services.*

The Minister's functions are identified in s 6 of the HCA.

The Department is the relevant administrative unit in the public service that has the functions identified in s 7 of the HCA.

The Chief Executive of the Department has a range of principal functions, including to assist the Minister in connection with the administration of the HCA and to exercise the statutory powers conferred by the HCA. At the same time the Chief Executive is responsible to the Minister for the overall management, administration and provision of health services within the Minister's portfolio, and ensures that appropriate standards of patient care and service delivery are adopted and applied in the delivery of health services: s 7.

The HCA establishes the Health Performance Council, Health Advisory Councils and incorporates a number of hospitals.

The NALHN has been proclaimed as an incorporated hospital.³⁷

The HCA invests incorporated hospitals with certain powers: s 31 of the HCA.

The Chief Executive of the Department is responsible for the administration of an incorporated hospital: s 33(1).

The Chief Executive of the Department is empowered to appoint a person as a Chief Executive Officer of an incorporated hospital: s 33(2). That person is responsible to the Chief Executive of the Department.

³⁷ 'Health Care (Local Health Networks) Proclamation 2011' in South Australia, *South Australian Government Gazette*, 9 June 2011, 2547.

4.2 THE MENTAL HEALTH ACT 2009

The *Mental Health Act 2009* (MHA) commenced on 1 July 2010 and repealed the *Mental Health Act 1993* (MHA 1993).

The objects of the MHA are identified in s 6.

They are to ensure that persons with severe mental illness receive a comprehensive range of services of the highest standard for their treatment, care and rehabilitation with a goal of bringing about their recovery as far as is possible and retain their freedom, rights, dignity and self-respect as far as is consistent with their protection, the protection of the public and the proper delivery of services: s 6 of the MHA.

Section 7 identifies the MHA's guiding principles.

Section 7 applies to the Minister, the South Australian Civil and Administrative Tribunal (SACAT), the Chief Psychiatrist, health professionals and other persons and bodies involved in the administration of the MHA who are to be guided by the principles.

The principles include:

- (a) *mental health services should be designed to bring about the best therapeutic outcomes for patients, and, as far as possible, their recovery and participation in community life;*
- (ab) *mental health services should meet the highest levels of quality and safety;*
- (ac) *mental health services should (subject to this Act or any other Act) be provided in accordance with international treaties and agreements to which Australia is a signatory.*

Part 8 of the MHA deals with 'further protections for persons with mental illness'.

Relevantly for the purpose of this investigation, Division 2 of Part 8 of the MHA addresses those protections for persons with mental illness by providing for a community visitor scheme.

Section 50(1) of the MHA creates the position of Principal Community Visitor and s 50(2) creates such number of positions of community visitors as the Governor considers necessary for the proper performance of the community visitors' functions.

The person appointed as Principal Community Visitor or the persons appointed as community visitors may be appointed for three years.

The functions and powers of a community visitor are identified in s 51 of the MHA. Effectively the functions are to conduct visits and tours of treatment centres and community mental health facilities.

The community visitors have the further function of referring matters of concern relating to the organisation or delivery of mental health services or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body: s 51(1)(b) of the MHA.

Community visitors are also empowered to act as advocates.

The MHA prescribes a regime for the inspection of treatment centres and community mental health facilities and the frequency for those inspections: s 52 of the MHA.

Section 54 requires the Principal Community Visitor to forward a report to the Minister on 30 September in every year on the performance of the Community Visitor's functions during the

financial year ending the preceding 30 June and the Minister must within six days of receiving such a report have copies of the report laid before both Houses of Parliament: s 54(1) and (2) of the MHA.

The Principal Community Visitor is authorised to prepare a special report to the Minister on any matter arising out of the performance of the community visitor's functions. The Minister must cause copies of any such report to be laid before both Houses of Parliament within two weeks after receiving the report: s 54(3) of the MHA.

Section 54(5) of the MHA is interesting and provides:

If the Minister cannot comply with sub section (4) because Parliament is not sitting the Minister must deliver copies of the report to the President and the Speaker and the President and the Speaker must then –

- (a) immediately cause the report to be published; and*
- (b) lay the report before their respective Houses at the earliest opportunity.*

That sub-section recognises the importance of the Principal Community Visitor's reports becoming public as soon as possible.

The MHA identifies the Minister's functions in s 86 of MHA which the Minister may delegate to a particular person or body: s 87.

The MHA allows the Chief Executive of the Department to delegate his or her powers or functions to a particular person or body: s 88.

The MHA also creates the position of Chief Psychiatrist who is appointed by the Governor: s 89.

The Chief Psychiatrist's functions are identified in s 90(1) which provides:

The Chief Psychiatrist has the following functions:

- (a) to promote continuous improvement in the organisation and delivery of mental health services in South Australia;*
- (b) to monitor the treatment of voluntary inpatients and involuntary inpatients, and the use of restricted practices in relation to such patients;*
- (c) to monitor the administration of this Act and the standard of mental health care provided in South Australia;*
- (d) to advise the Minister on issues relating to mental health and to report to the Minister any matters of concern relating to the care or treatment of patients;*
- (e) any other functions assigned to the Chief Psychiatrist by this Act or any other Act or by the Minister.*

The MHA empowers the Chief Psychiatrist to have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the HCA to assist the Chief Psychiatrist to carry out the functions to which I have referred.

Section 90(5) provides:

For the purpose of sub section (4)(a), the Chief Psychiatrist may, at any reasonable time, enter the premises of an incorporated hospital and, while on the premises, may –

- (a) inspect the premises or any equipment or other thing on the premises; and*
- (b) require any person to produce any documents or records; and*
- (c) examine any document or records and take extract from, or make copies of, any of them.*

The Chief Psychiatrist like the Minister and the Chief Executive has the power to delegate a power or function to any particular person or body.

The Chief Psychiatrist must prepare a report for the Minister which contains information prescribed in s 92 of the MHA.

The Chief Psychiatrist's other powers and functions are not relevant for the purposes of this investigation.

CHAPTER 5: CHRONOLOGY³⁸

The Oakden Report addresses the history of the Oakden Facility and I have relied on that report in part for an understanding of the Oakden Facility's history.³⁹

However I think it is worthwhile setting out some of that history so that the reader can understand the Oakden Facility in the context of its history.

In November 1982 the Hon. Dr John Cornwall MLC, who was then Minister for Health, opened the Oakden Facility at the then Hillcrest Hospital. The Hillcrest Hospital was formerly called the Northfield Mental Hospital, which had opened in 1929. It was renamed as the Hillcrest Hospital in 1964. The Oakden Facility was then called a Psychogeriatric unit and was purpose built for older persons with mental illness.

The original consumers were older people who were suffering from a history of mental illness and for whom it was difficult to place in mainstream residential aged care.

Most of the early consumers were suffering from an organic brain disease such as Alzheimer's disease, whilst a minority of consumers suffered from mental illnesses unconnected with dementia.

In its original state the Oakden Facility consisted of:

- Howard House - 30 beds. An acute facility where elderly consumers were assessed and treated
- Clements House (Clements) - 27 beds. A long stay ward for elderly female consumers with Alzheimer's disease
- Albert Zweck House - 17 beds. A long stay ward that catered mainly for elderly men with Alzheimer's disease
- Makk House (Makk) - 27 beds. A long stay ward that catered mainly for elderly men with Alzheimer's disease
- McLeay House (McLeay) - 22 beds. A long stay ward that specialised in the treatment of elderly consumers with severe Alzheimer's disease

In 1992 the Health Ministers of the States and the Commonwealth agreed to a National Mental Health Policy. In the same year Hillcrest Hospital closed as did Howard House leaving only the four units mentioned above in the Oakden Facility.

In 1998 a decision was made to seek Commonwealth accreditation for Makk and McLeay houses as residential care facilities under the *Aged Care Act 1997* (Cth) (the Aged Care Act), and having those wards accredited as a nursing home.

It is likely that that decision was made to relieve the State of the whole of the cost of funding those wards which had been previously funded as specialist units.

In 1999 Mr David Coombes, who was the then Acting Chief Executive Officer of North West Adelaide Health Services, became concerned about the quality of care being delivered at the Oakden Facility and organised for a review to be undertaken.

On 8 August 2000 Makk and McLeay were accredited by the Australian Aged Care Quality Agency (AACQA)⁴⁰ for 12 months.

³⁸ Throughout this chapter a number of documents have been quoted. Within those documents are a number of spelling and grammatical errors that have not been marked with [sic].

³⁹ Oakden Review, *The Oakden Report: The report of the Oakden Review* (2017) 22 ('The Oakden Report').

When Makk and McLeay were accredited as nursing home facilities it meant that the concept of consumers having 'beds for life' applied. A 'bed for life' meant that a consumer was entitled to tenure in those wards until the consumer died. In contrast to private residential nursing care facilities there was no entry fee payable by consumers and medication was free. Those advantages likely discouraged consumers from transitioning to mainstream residential aged care facilities. As a consequence, movement through the wards slowed and Makk and McLeay became facilities that provided permanent placement to those who were admitted. This was unlike the model that had operated in the last decade of the twentieth century where the wards were used to transition people from independent living to privately run aged care facilities.

On 9 July 2001 Makk and McLeay were accredited for a further nine months.

On 19 October 2001 the Minister for Human Services in South Australia received a minute from the Director, Asset Services in which funding was sought to improve the facilities at Oakden in order to ensure that it continued to comply with the Commonwealth accreditation standards:

2.1 A recent audit undertaken by the Commonwealth Aged Care accreditation body at the Makk McLeay Nursing Home Age Care facility at Oakden did not achieve a satisfactory level of accreditation.

2.2 The accreditation teams were most critical of the institutional nature of the facility, which is inconsistent with the home-like atmosphere required in the Commonwealth standard.

2.3 The Oakden Aged Care Facility has been given nine months to address the critical issues identified in the audit. Failure to undertake the corrective action could result in loss of Commonwealth licences and revenue funding.

2.4 Approval was given by the Executive Director, Statewide, to appoint Russell & Yelland's as primary consultancy to undertake immediate assessment of the facilities and to prepare concept documents to demonstrate the feasibility of achieving sufficient compliance and to indicate the costs associated with this.⁴¹

On 8 May 2002 the Makk and McLeay wards were accredited for a further two years.

On 9 May 2002 Professor Brendon Kearney the then Executive Director to the Minister for Health, provided a minute to the Minister regarding the future of the Oakden Facility.

Professor Kearney said in that minute that 'maintaining the current facility at Oakden poses a number of risks. Any change to the role/function and management will require political/management and clinical leadership'.⁴²

He wrote:

2. Oakden campus is unsuitable to continue as a stand alone aged care mental health facility for the following reasons:

- Difficulty maintaining Commonwealth Accreditation*
- Need for capital investment estimate to be \$500,000*

⁴⁰ The Australian Aged Care Quality Agency as it is known now has gone by different names over the reference period, including Commonwealth Aged Care Safety and Accreditation Agency, and the Commonwealth Aged Care Standards and Accreditation Agency, but for the sake of clarity will be referred to as the AACQA throughout this Report.

⁴¹ Minute to the Minister for Human Services from Peter A Jackson re: Oakden Aged Care Accreditation Requirements, 19 October 2001, 2017-000535-E0004 (LVlahos1) DOC-000001127.

⁴² Minute to the Minister for Health from Professor Brendon Kearney re: Future of Oakden, 9 May 2002, 2017-000535-E0004 (LVlahos1) DOC-000001127.

- *Inconsistent with National Mental Health Strategy and agreed State Government mental health reform agenda to mainstream services*
 - *Difficulty in retaining appropriate skill mix nursing staff with continual excessive use of high cost agency staff.*
3. *Previous proposed changes to Oakden were met with the campaign of mis-information orchestrated by people opposed to change. Response from previous Government and the Department of Human Services was a commitment to ensure widespread consultation prior to any future planned changes.*

Summary

- *Maintaining Oakden campus in current form is not sustainable. Managing a transition to a new structure, role and function will require careful planning and complex consultations.⁴³*

I have received in evidence an unsigned and undated document apparently prepared in November 2002 by the then Minister for Health, the Hon. Lea Stevens. The document was apparently intended for Premier and Cabinet. The document included the following:

- 2.3 *The facility at Oakden is itself unsuitable to continue due to poor access to comprehensive geriatric acute care facilities and difficulty in maintaining Commonwealth aged care accreditation, need for significant capital investment by June 2003 to maintain standards and the difficulty in retaining skill mix of nursing staff with continual excessive use of high cost agency staff.*

...

- 4.1 *It is recommended that Cabinet notes the intention to begin a consultation with stakeholders in relation to the future provision of mental health services for older people currently provided by the Lyell McEwin Health Service – Oakden Campus.⁴⁴*

I do not know whether this document was ultimately considered by Cabinet because I was not given access to Cabinet documents.

In April 2003 the Minister for Health's Chief of Staff wrote to Mr Jim Birch, who was the Chief Executive of the Department of Human Services, asking whether a long term strategy had been developed for the future of the Oakden Facility as discussed with the Minister in April 2003.

In 2003 State and Commonwealth Ministers for Health agreed to the third National Mental Health Plan which proposed adopting a population health framework in which the mental health of older people would be highlighted as a priority.⁴⁵

It was agreed by those Ministers that over the next five years they would improve service responsiveness to older people especially those with diverse and complex needs and promote continuity of care.

⁴³ Ibid.

⁴⁴ Minute to the Premier for Cabinet from Hon. Lea Stevens MP re: Future provision of Mental Health Services for Older People currently provided by the Lyell McEwin Health Service – Oakden Service 11.2002 2017-000535-E0004 (LVlahos1) DOC-000001127.

⁴⁵ *The Oakden Report*, above n 39, 9.

On 15 July 2003 the Minister Stevens approved an increase in the previously approved funding provision for the upgrade of facilities at Makk and McLeay to meet the Commonwealth Aged Care accreditation standards.

On 21 August 2003 Associate Professor Des Graham, Director Clinical Reform, Mental Health Services and Programs, wrote an internal memorandum which included a draft minute to Minister Stevens which included an option that Oakden be refurbished as a 'Stand Alone Mental Health Facility for Older People'.

In that minute he noted that the disadvantages of the option that he proposed were:

- *Unsuitability of the Oakden facility due to poor access to a comprehensive geriatric acute care facilities and the difficulty in retaining skill mix of nursing staff with continual excessive use of high cost agency staff.*
- *The Commonwealth Accreditation Authority continues to provide support visits to the Oakden Campus. While the campus continues to maintain its accreditation status, any inability to meet accreditation requirements in the future may result in the imposition of sanctions, including the withdrawal of aged care licenses or the appointment of an administrator. This could result in considerable embarrassment for the state government.*
- *Further capital expenditure for the Oakden Campus would be required to meet 2008 Commonwealth certification standards, requiring a conversion of four bedroom units to an average of 1.5 residents per room.*
- *Upgrading of the Oakden campus to meet 2008 standards is not a cost beneficial option. It would be necessary to establish a purpose built facility reflecting contemporary standards and the delivery of aged care accommodation and services.⁴⁶*

He noted that there were minimal advantages for the option under discussion 'as the maintenance of stand alone Mental Health facilities directly contravene key policy directions at both State and National levels'.⁴⁷

He provided a summary and recommendation in which he wrote:

- *SA will continue to be criticised at a national level for non-compliance with the National Mental Health Strategy and the Commonwealth agreed to licenses at the Oakden site as an interim measure and will not agree to ongoing service provision on site.*
- *Decisions regarding the future delivery of aged care and mental health services of older people with mental health disorders must be made within the general context of decision making around implementation of the mental health reform process.*
- *A series of options has been presented in this brief regarding the future provision of aged care/mental health services currently provided by LMHS Oakden Campus*

...

⁴⁶ Minute from Des Graham to the Chief Executive Department of Human Services, attaching draft Minute to the Minister for Health from Jim Birch re: Future provision of Aged Care and Mental Health Services for Older People currently provided by Lyell McEwin Health Service (LMHS) – Oakden Campus, 21 August 2003, 2017-000535-E0004 (LVlahos1) DOC-000001127.

⁴⁷ Ibid.

- *It is recommended that you:*
 - *Note the contents of this briefing*
 - *Approve Option 3 [Implement reformed model of care – Mainstreaming of services to Private/Non Government Sector] as the approach for future delivery of services to older people with mental illness. This involves the mainstreaming of aged and mental health services to the Non Government/Private Sector in keeping with State Government commitments under the National Mental Health Strategy and SA Mental Health Reform process,*
 - *Approve the process outlined in this brief for transfer of licenses and implementation of the service model, as an appropriate process to ensure improved outcomes for consumers and carers*
 - *Provide advise [sic] regarding future actions to progress this matter, which may include preparation of a Cabinet Paper notifying intentions to commence discussions with key stakeholders regarding the future delivery of aged and mental health services.⁴⁸*

On 2 September 2003 Mr Birch provided a briefing note to Minister Stevens addressing the future of provision of aged care and mental health services then provided at the Oakden Facility including for refurbishment of Oakden and future options for service delivery.

On 4 November 2003 an advisor to Minister Stevens noted that Minister Stevens had approved a tender to proceed with construction for the Oakden Aged Care Redevelopment.

Sometime in 2004 Dr Russell Draper, a Psychiatrist, became the Director of Clinical Services at the Oakden Facility.

In or around 2004 Ms Merrilyn Penery commenced as the Clinical Practice Consultant (CPC).

On 26 March 2004 Makk and McLeay were accredited for a further one year. On 6 April 2005 Makk and McLeay were accredited for a further period of two years.

In August 2005 the then Premier Mike Rann commissioned the Social Inclusion Board which was headed by Monsignor David Cappo 'to prepare a major reform plan for the mental health system in South Australia'.⁴⁹

In October 2005 the Australian Health Ministers' Advisory Council issued a publication on National Safety Priorities in Mental Health: A National Plan for Reducing Harm.⁵⁰

On 4 November 2005 the Hon. John Hill became Minister for Health.

Sometime in 2006 Dr Tony Sherbon commenced as Chief Executive of SA Health.

On 9 January 2006 Minister Hill delegated to the Minister for Mental Health and Substance Abuse all of the powers and functions of the Minister for Health under the *South Australian Health Commission Act 1976* (SAHC Act).⁵¹

⁴⁸ Ibid.

⁴⁹ The former Premier of South Australia, the Hon. Mike Rann referred mental health reform to the Social Inclusion Board in August 2005 and requested advice on how to redesign the systems to deliver improved outcome for people experiencing mental health conditions.

⁵⁰ Affidavit of Dr Aaron Groves, 29 January 2018, annexure AG06.

On 23 March 2006 the Hon. Gail Gago became Minister for Mental Health and Minister Assisting the Minister for Health.

On 1 January 2007 Mr Kerim Skelton commenced as the Nursing Director at OPMHS.

On 15 February 2007 the South Australian Social Inclusion Board published 'Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012' (the Stepping Up Report) in response to the referral made by the Premier.⁵²

The Stepping Up Report states that over 1400 people were formally involved in consultation processes.⁵³ The Board apparently commissioned extensive research, examined evidence and considered advice of experts.⁵⁴

The Stepping Up Report made 41 recommendations in total.⁵⁵

The most relevant recommendation for this investigation is Recommendation 31 which states:⁵⁶

Recommendation 31

South Australia must have a clear plan of action for the future management of long-term aged residential care that is consistent with good practice and contemporary policy. A focus on earlier intervention is required, ensuring that people at risk and needing specialist services are identified and given priority access to services. Partnerships with the Commonwealth and aged care providers are essential to deliver a scalable and sustainable response.

The Stepping Up Report said in relation to Recommendation 31 that many participants argued that mental health services for older persons was neglected.⁵⁷ The Board set out its view that it was time for South Australia to commit to a strategic agenda for older people's services in partnership with the Commonwealth and the non-government sector.⁵⁸ It found that, the State should forge partnerships with non-government sector agencies that have the appropriate experience and track record in working with people with psycho-geriatric conditions.⁵⁹

The Stepping Up Report was adopted as Government policy.

The Premier said in response to the Stepping Up Report:

*The Government warmly welcomes Stepping Up and it will carefully consider this thoughtful plan with the aim of bringing about even greater change for the better.*⁶⁰

Recommendation 31 is particularly relevant to issues that developed at Oakden because from at least 2007, when the Stepping Up Report was released, there appears to have been

⁵¹ Affidavit of Adam Dennis Monkhouse, 21 September 2017, 159.

⁵² South Australian Social Inclusion Board, *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012* (2007).

⁵³ Ibid 3.

⁵⁴ Ibid 4.

⁵⁵ Ibid x-xv.

⁵⁶ Ibid xiv.

⁵⁷ Ibid 68.

⁵⁸ Ibid 69.

⁵⁹ Ibid: The Social Inclusion Board said that '...the time has come for South Australia to commit to a strategic agenda for older people's services, in partnership with the Commonwealth and the non-Government sector'.

⁶⁰ Statement of Margot Mains, 26 October 2017, 91.

an understanding that, in accordance with Recommendation 31, there would need to be a closer relationship with external bodies including potentially an outsourcing of the Oakden Facility.

The Stepping Up Report recommended that the status quo should continue and that the State and the Commonwealth could examine the scope for further licensing of long term care beds in the State's system.

In December 2007 the AACQA identified non-compliance with 25 of 44 standards.⁶¹

In December 2007 Mr Neil Baron and Mrs Carla Baron, aged care consultants, were engaged to assist in re-obtaining accreditation.

On 3 December 2007 Mr Arthur Moutakis commenced as a Consumer Adviser and later Consumer Liaison Officer.

On 7 and 9 December 2007 the AACQA visited Makk and McLeay in response to two complaints that had been made by relatives. On 10 December 2007 the AACQA began an unannounced three day review audit of Makk and McLeay. Apparently a duress alarm system was not operating which posed a danger to those in the facility.

On 11 December 2007 the AACQA was alerted to an aggressive incident by a consumer towards a nurse which the AACQA commenced to investigate.

On 12 December 2007 the Makk and McLeay Nursing Home was advised that the AACQA had recommended to the Commonwealth Department of Health and Ageing that sanctions be imposed due to the assessment of the serious risk to the health, safety or wellbeing of persons receiving care.⁶²

On the same day the AACQA served notice of its decision to impose sanctions on Makk and McLeay Nursing Home under 's 67 – 5 of the Commonwealth Aged Care Act', to take effect for a period of six months commencing on 12 December 2007, and ceasing to have effect on 11 June 2008. On the same day the AACQA prepared a Serious Risk Report in respect of Makk and McLeay.

On 13 December 2007 Dr Susan Close who was then Chief of Staff to Minister Gago emailed Dr Sherbon informing him:

The Minister has asked me to pass on to you that she wishes to:

- 1. Undertake a review of the circumstances of this withdrawal of accreditation.*
- 2. Investigate why the alarm was not working at the time and any history of difficulties with the alarm.*
- 3. Ensure, to the extent reasonably practicable that the alarm is working reliably henceforth.*
- 4. Resolve any staffing issues your review identifies and as identified by the audit by the Commonwealth.*

⁶¹ Gail Gago, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 23 January 2018, 2.

⁶² Notice of Decision to Impose Sanctions Under s 67.5 of the *Aged Care Act 1997* (Cth), 12 December 2007, 2017-000535-E0004 (LVlahos1) DOC-000001113.

*I would appreciate your keeping me up to date with the progress on these matters.*⁶³

On 13 December 2007 Minister Gago requested the Department of Health to initiate a review of the circumstances of the sanctions imposed and investigate why the alarm was not working, rectify the issue and resolve any staffing issues identified in the reviews.⁶⁴

On 14 December 2007 the AACQA published its Serious Risk Report.⁶⁵

On 14 December 2007 Minister Gago's office received a minute from Ms Karleen Edwards, CEO CNAHS, regarding the AACQA decision to impose sanctions on Makk and McLeay.⁶⁶

Eventually it was found that Makk and McLeay Nursing Home failed to meet 25 of the 44 Commonwealth standards.

On 14 December 2007 Mr Derek Wright, who was then Director Mental Health Operations emailed Dr Close setting out a plan of action in response to the AACQA's notice.

On the same day Dr Sherbon emailed Dr Close and Mr Wright advising that he had appointed someone to investigate the process to repair the duress alarm system.

Ms Edwards who was copied into the action plan also responded by email to Dr Sherbon.⁶⁷

Tony – a further update tonight having spoken to Learne. There would appear to be some significant concern over the nursing practices at Oakden – I understand particularly in terms of restraint (pharmacological/physical). As Derek has advised, Learne has appointed two external senior clinicians to progress a crisis response (a Clinical Consultant from aged care at RGH and an experienced Aged Care Nurse from Community Mental Health) to ensure we provide appropriate clinical care to the residents. They will also attend the family meeting next week and attend the staff meeting on Monday. I understand that given these concerns the Commonwealth is also likely to require us to appoint a Mental Health Nursing Adviser (from their approved list) to assist with the suite of actions we need to undertake in our response plan.

On 20 December 2007 Ms Edwards drafted a minute to the Minister's office regarding the sanctions and the proposed response.

On 21 December 2007 Minister Gago was advised of the steps that had been taken and were to be taken in response to the sanctions imposed by the AACQA which included.⁶⁸

- *A response plan has been implemented. This identified:*
 - *immediate action for in the first week to manage the highest risks*
 - *practice improvement in weeks 2-4 and*
 - *the implementation of systems in months 2 – 6.*
- *A Clinical Leadership Group comprising an additional senior consultant psychiatrist and senior nurse, as well as an occupational therapist and psychologist has been identified to*

⁶³ Email from Dr Susan Close to Dr Tony Sherbon re Oakden, 13 December 2007, 2017-000535-E0007 (AGroves2) DOC-000000062.

⁶⁴ Statement of Hon Gail Gago, 20 October 2017, [69].

⁶⁵ Ibid [48].

⁶⁶ Minute from Karleen Edwards to the Office of the Minister for Mental Health and Substance Abuse, received by the Minister's Office on 14 December 2007, 2017-000535-E0004 (LVlahos1) DOC-000001113.

⁶⁷ Email from Ms Karleen Edwards to Dr Sherbon re Plan for Makk & McLeay, 14 December 2007, 2017-000535-E0007 (AGroves2) DOC-000000078.

⁶⁸ Minute from Karleen Edwards to the Office of the Minister for Mental Health and Substance Abuse re: update on sanctions and review audit findings of Makk and McLeay Nursing Home, 21 December 2007, 2017-000535-E0004 (LVlahos1) DOC-000001127.

work with senior staff during the first week to reassess the care needs of residents with behaviour management problems.

- *The number of nursing staff has been increased.*
- *The first component of repair to the duress alarm system is complete.*
- *The home's restraint policy has been reviewed in line with best practice.*
- *A review has been completed by Rod Bishop, Consulting, of actions taken to address the problems with the Duress Alar [sic]. A copy of the report is attached.*
- *Contact has been made with Dr Simon Stafrace, Director Psychiatric Services, Bayside Health, about undertaking a Clinical review of our service. Bayside Health provides a similar service to that of Makk & McLeay.*
- *All residents who are chemically and/or physically restrained are monitored regularly, and these processes are audited for compliance with procedure.*
- *Staff are receiving education and training in relation to the management of difficult and aggressive behaviours.*
- *Daily updates are provided to staff on the progress of the actions (as attached).*
- *Meetings are occurring with the families of residents to discuss concerns and suggestions.*

On 24 December 2007 Ms Harrison commenced as Acting Aged Care Director, CNAHS.

In late 2007 or early 2008 Ms Julie Dundon and Ms Anne Schneyder, both Advanced Accredited Practising Dieticians practising as Nutrition Professionals Australia were engaged to review the nutritional care of 55 residents and review the overall system for nutrition care at Makk and McLeay Aged Care Facility.

They wrote two reports that were published in January 2008; the first entitled 'Makk and McLeay Aged Care Facility Interim Menu and Resident Review January 2008' (the Interim Report), and the second entitled 'Menu and Nutrition Care Improvement Report: Makk and McLeay Aged Care Facility'. The second report is technical in nature and nothing further needs to be said about it although it repeats some of the criticisms mentioned in the Interim Report.

The Interim Report dated January 2008 was damning of the care being offered to consumers at Makk and McLeay.

The authors wrote:⁶⁹

The current menu does not meet the nutrition requirements as evidenced by the unacceptable incidence of malnutrition (almost two thirds of residents are either moderately or severely malnourished). This is as a result of a complete systems breakdown, which includes poor communication between staff regarding nutrition needs, acceptance of weight loss as a normal progression and lack of adequate fortification of food.

The issues addressed in this summary require immediate attention. The management at Makk and McLeay are required to take a leadership role to ensure the safety and improved nutrition of all residents in their care.

They assessed 51 residents and found:

- *Only 19 residents were identified as well nourished, with the remainder 18 as moderately malnourished and 14 severely malnourished*

⁶⁹ Document entitled 'Makk & McLeay Aged care Facility Interim menu and resident review', January 2008, 2017-000535-E0020 (ASchneyder1) DOC-000000020.

- Most residents have been reviewed by the Dietician and Speech Pathologist however recommendations have not been implemented consistently
- The special diet list is not consistent with the documented care plan
- Weigh scales are unreliable and it has been identified in November that they are inaccurate – no remedial action has been taken to date
- A Residents preference list is occasionally completed, documented and placed in care plan. No communication is provided to the food service to enable provision of acceptable food for the resident.
- Grossly inadequate fortification of texture modified meals and supplemented fluids.
- No system to ensure residents obtain the correct meal (and therefore texture), snacks and nourishing fluids.
- Residents requiring finger foods are provided with mostly high fat items such as pies and pasties at **all** meals.

They made a series of recommendations to address the problems that they identified and concluded:

The poor nutritional status of residents at Makk and McLeay are the worst we have reviewed in our 25-30 years of practice. The situation must be rectified immediately. Within the next 5-10 business days a full menu review will be complete with further recommendations. Management at all levels will need to be committed and engaged in the improvement process in both the short and long term.

In January 2008 Mr and Mrs Baron withdrew as aged care consultants. This was because of concerns they had about the facility and the lack of willingness by others to effect meaningful change at the facility.⁷⁰

On 3 January 2008 Ms Fiona Meredith a psychologist accepted an appointment to undertake behavioural assessments for some 21 residents of Makk and McLeay Nursing Home who had exhibited behaviours of concern.

By 4 January 2008 the serious risks at the Oakden Facility had been mitigated.⁷¹

On 16 January 2008 Ms Janine Buob prepared a report raising concerns that the facility was malodorous, gloomy and uninviting; there was a lack of leadership; there was an excessive use of agency staff; there was a lack of medical supervision; there was medical mismanagement at the facility; there were documentation issues at the facility; and the staff lacked the required knowledge and education.⁷²

On 21 January 2008 Ms Meredith presented a document that she had written, entitled 'Recommendations to Management',⁷³ to a management meeting at the Oakden Facility which was attended by Mr Chris Sexton (Acting General Manager of Mental Health Services), Ms Sharon Olsson (Acting Director of Nursing at Oakden), Ms Harrison, Ms Rebecca Graham and Mr Kerim Skelton (Nursing Director), and spoke to the document for 15 minutes. She advised the meeting of her grave concerns that management were not

⁷⁰ Record of Interview, Adelaide, 13 July 2017, 40.43-41.28 (Mr Neil Baron and Mrs Carla Baron).

⁷¹ Gail Gago, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 23 January 2018, 2.

⁷² Document entitled 'Report: Observations in Makk and McLeay Nursing Home and Suggestions for Improvement' 16 January 2008, RD-2, 2017-000535-E0016 (JHanson5)(JRichter5) DOC-000000999.

⁷³ Document entitled 'The Management of Behavioural and Psychological Symptoms of Dementia in the Makk and McLeay Nursing Home, Oakden Campus – a Summary of Findings prepared by Fiona Meredith', 15 February 2008, 2017-000535-E0004 (LVlahos1) DOC-000001105.

responding to staff recommendations.⁷⁴ She said that she received no feedback in respect of her presentation.

On 23 January 2008 Ms Meredith conducted a behaviour assessment on Mr Peter Palmer.

On 31 January 2008 a meeting was held at the Oakden Facility attended by Mr Sexton, Ms Olsson, Ms Harrison, Mr Moutakis and Mr Andrew Modra (Senior Project Officer Quality Improvement) and consumers and their families.

The minutes of the meeting relevantly state:⁷⁵

Nurse Advisors

- *Relatives queried why the Baron's had withdrawn as nurse advisors. Chis advised at the previous meeting that they had withdrawn on Wednesday 16 January. There were issues in dealing with the complex nature of the structures in place.*
- *Chris Sexton advised the meeting that negotiations were still on going with Neil and Carla Baron following their withdrawal as Nurse Advisors*
- *As soon as information was available regarding the Nurse Advisor role relatives would be informed by letter.*

Management Structure

- *Chris also advised that discussions were being held with a senior executive from the private Aged Care sector to come and provide expert contemporary advice and direction. This person has extensive experience regarding the Aged Care Accreditation process.*
- *The service also advised that Sharon Olsson will be returning to her substantive position based at Glenside but will remain involved at Makk & McLeay as Nursing Education was a key component of Sharon's role.*
- *Mr Alan Scarborough the Strategic Director of Nursing for Central Northern Adelaide Health Service will spend part of his time at Oakden to ensure nursing improvements that are implemented are followed up and evaluated. Alan comes with enormous experience in nursing leadership.*
- *Chris highlighted the ongoing commitment of a large number of staff to ensure improvements occur at Makk & McLeay and most importantly are sustainable in the long term*

A question was asked, why was it allowed to get so bad and what are we doing about fixing it

- *The meeting discussed concerns re why did the Home become non compliant.*
- *We are trying to fix the system, not just implement band-aid solutions that fall down again in six month time.*
- *There is no single factor that can be attributable to actual cause of our failure at the Review Audit in December.*
- *We are working with the Commonwealth Department of Health and Aging and the Aged Care Standard and Accreditation Agency to fix the problems.*
- *The Commonwealth and the Agency have advised we are making progress.*

By February 2008 the AACQA still identified non-compliance with 16 of 44 standards.⁷⁶

⁷⁴ Signed witness statement of Fiona Meredith relative to the death of Graham Rollbusch, 23 May 2017, 2017-000535-E0004 (LVlahos1) DOC-000000980.

⁷⁵ Minutes from Makk & McLeay Nursing Home Residents and Families Meeting, 31 January 2008, 2017-000535-E0004 (LVlahos1) DOC-000001129.

⁷⁶ Gail Gago, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 23 January 2018, 2.

On 11 February 2008 a Parliamentary Briefing note was provided to Minister Gago in which it was stated:

- *Due to the level of non-compliance and the issues regarding clinical practice that have been uncovered in the Audit Report, it is proposed to have an external review of the Home. It is planned to invite Aged Care specialists from Victoria, who provide a similar service to that provided by Makk & McLeay Nursing Home whereby Commonwealth aged care bed licences are integral to state operated extended care mental health services for older people.*
- *It is difficult to accurately predict the result of the Review Audit to be undertaken in late February however, it is possible that compliance may not be achieved against all standards.*
- ...
- *Since the Review Audit report the Home has substantially reduced the use of chemical (pharmacological) restraint.*
- *A support visit by the Agency on January 22 found that the level of physical restraint had 'clearly been reduced'.*
- *The Home has engaged a wound specialist from The Queen Elizabeth Hospital to assess residents and educate staff on proper wound management techniques. This has led to a change in our clinical practice on how we manage wounds and the development of wound treatment resources that are currently being used in the Home.*
- *The Home is currently reviewing its lifestyle and activities program with the view to appointing a full time Lifestyle and Volunteers coordinator.*
- *The Home is seeking advice from contemporary Nursing Homes on optimal activities programs to meet the needs on Aged dementia sufferers such as the use of sensory boards and life stories.*
- *Two serious risk issues were identified at the time of audit and reported in The Advertiser. These were:*
- *Serious Risk 1 – the unreliability of the duress alarm system;*
- *Serious Risk 2 – concerns regarding the management needs of residents who exhibit challenging behaviours.⁷⁷*

Sometime after 14 December 2007 Dr Simon Stafrace, Director of Psychiatry at the Alfred Hospital in Melbourne and a specialist in the psychiatry of older persons and Mr Alan Lilly, Executive Director – Rehabilitation, Aged & Community Care for Bayside Health in Melbourne a Registered Psychiatric Nurse were commissioned to review and report on the Makk and McLeay Nursing Home.

The review took place on 21 and 22 February 2008 and they reported very shortly thereafter.⁷⁸ The Terms of Reference are identified in Appendix 3 of the report.

⁷⁷ Minute from Nicki Dantalos to the Office of the Minister for Mental Health and Substance Abuse re: Makk and McLeay Nursing Home, 5 May 2008, 2017-000535-E0004 (LVlahos1) DOC-000001127.

Dr Stafrace and Mr Lilly summarised their findings:

During the course of the review, it was evident that the MMNH was intended to be functioning as part of a broader mental health directorate and further, as part of a major health service. However, the reviewers believe that the effectiveness of the organisation has been hindered, to its detriment, by the number of successive changes in organisational governance. These changes appear to have resulted in a loss of focus on the core business of aged mental health care services and the residential care component in particular. The reviewers would propose that by virtue of its Commonwealth funding, regulatory and accreditation framework and its dual specialist mental health and aged care functions, the MMNH requires a high level of clinical and operational leadership which is focussed on achieving each of its core functions. The reviewers believe that this has only become evidence to the organisation since sanctions were imposed in December 2007 and recognise that strategies have been put in place to remediate the situation. However, it is also recognised that much still needs to be done to ensure that sustainability is achieved. In this regard, the reviewers make the following recommendations:...

They made a number of recommendations to address the matters mentioned, not all of which need to be identified for the purpose of this investigation. However they recommended that 'a single point of accountability at unit level be established.' As a consequence of the finding 'the accountability for the unit was diluted and effectively made the Nursing Director the single point of accountability for the Nursing Home'.⁷⁹

On 28 February 2008 Mr Graham Rollbusch a consumer at Makk House was murdered. Mr Palmer who was a consumer at Makk House was suspected of being responsible for Mr Rollbusch's death.

On 1 March 2008 Ms Meredith informed Mr Wright that she had prepared a behavioural assessment report about Mr Palmer and she was concerned the report did not appear in Mr Palmer's case notes.⁸⁰

On 19 March 2008 the Hon. Justine Elliott who was the then Federal Minister for Ageing wrote to Minister Gago regarding the failure of Makk and McLeay Nursing Home to meet the AACQA's accreditation standards and offered funding for the appointment of a dedicated clinical adviser.⁸¹

On 21 March 2008 Minister Gago responded saying:

In addition, since the conclusion of the audit completed on 5 March 2008, further progress towards full compliance with the Accreditation Standards has been made. This progress does not appear to have been taken into account in the making of the decision to revoke accreditation. Therefore, the South Australian Department of Health may also seek review of this decision in light of this additional progress.

I wholeheartedly agree that the health, safety and wellbeing of the residents is paramount and I am committed to ensuring that all appropriate measures are put in place to ensure residents receive high quality care and accommodation.

⁷⁸ Document entitled 'Report on the Review of the Makk & McLeay Nursing Home' authored by Dr Simon Stafrace, and Mr Alan Lilly, 21-22 February 2008, 2017-000535-E0005 (JWeatherill1) DOC-000000087.

⁷⁹ Ibid 9.

⁸⁰ Record of interview, Adelaide, 7 September 2017, 55.32-56.25 (Fiona Meredith).

⁸¹ Letter from the Hon. Justine Elliot, Federal Minister for Ageing to the Hon. Gail Gago, 6 March 2008, 2017-000535-E0004 (LVlahos1) DOC-000001129.

*I wish to assure you that I view this matter very seriously and am taking immediate action to engage the assistance of another aged care expert organisation in the management and oversight of the Home.*⁸²

On 28 March 2008 Minister Gago visited the Oakden Facility.⁸³

On 1 April 2008 Minister Gago made a ministerial statement regarding the state of compliance with the AACQA standards in which she said that she had directed CNAHS to:

- 1) *Partner with an expert aged residential care organisation to jointly provide services at Oakden on a daily basis; and*
- 2) *Initiate a limited tender process with three experienced and respected aged care providers with a closing date of 2 April 2008.*⁸⁴

On 4 April 2008 Dr Sherbon met with Ms Elizabeth Dabars, Branch Secretary of the Australian Nursing Federation about the management contract proposed for Makk and McLeay.⁸⁵

Makk and McLeay were reaccredited for six months by the AACQA after meeting the standards during a February site audit.

On 7 April 2008 the decision by the AACQA to revoke Makk and McLeay accreditation was overturned and that decision was provided to the Executive Director Mental Health Ms Learne Durrington on 9 April 2008.

On 14 April 2008 the ACH Group joined in partnership with the government to assist in the day to day management of Makk and McLeay which Minister Gago confirmed in a ministerial statement on 29 April 2008.⁸⁶

On 30 May 2008 Mr Baron wrote to Minister Gago and Minister Elliott:⁸⁷

Some residents are locked up in the morning in a lockdown area known as 'Red' and kept there until evening. They have no access to their rooms or beds. At present there is no acceptable program to facilitate their leisure and lifestyle, independence, emotional support, privacy and dignity, choice and decision making or cultural and spiritual needs. It has been identified by the Aged Care Standards and Accreditation Agency that staff have not suitable training with which to meet resident needs. One example being:

On Tuesday May 27th 2008 two relatives observed staff wiping up a urine spill with feeding bibs in this area. They did not attempt to either wash or disinfect the area. Staff appear not to have basic understanding of hygiene or any attempt at providing any degree of dignity for their charges.

Both of you should have more than ample evidence of the lack of this facility to function as a compliant Commonwealth funded facility. It is extremely agonizing for representatives to have to witness breaches of the required duty of care on a daily basis. It is even more difficult to have to then recall the events in minute detail with which to provide a complaint to the

⁸² Letter from Minister the Hon. Gail Gago to the Federal Minister for Ageing Hon. Justine Elliot, 21 March 2008, 2017-000535-E0004 (LVlahos1) DOC-000001129.

⁸³ Statement of the Hon. Gail Gago, 20 October 2017, [100].

⁸⁴ Document entitled 'Gail Gago Min Statement 1 April 2008', 1 April 2008, 2017-000535-E0005 (JWeatherill1) DOC-000000336.

⁸⁵ Letter from Dr Tony Sherbon to Ms Elizabeth Dabars, 7 April 2008, 2017-000535-E0005 (JWeatherill1) DOC-000000376.

⁸⁶ The ACH Group is a not for profit community organisation 'promoting opportunities and services to support good lives for older people': Document entitled 'Gail Gago Min Statement 1 April 2008', 1 April 2008, 2017-000535-E0005 (JWeatherill1) DOC-000000336.

⁸⁷ Letter from the Makk & McLeay Support Group to Hon Gail Gago and Hon Justine Elliot, 30 May 2008, 2017-000535-E0004 (LVlahos1) DOC-000001124.

Department of Ageing's Complaints Investigation Scheme. But they are finally finding the strength to do so, previously having been scared of retribution to their loved ones if they complained. They are aware that in bringing this issue to you that they do expose themselves to the snide looks, comments and innuendo from staff that have been a feature of their attempt to provide for their loved ones and can only hope that this would be taken into consideration in all of your dealings over these matters.

By June 2008 the AACQA still identified non-compliance with 8 of 44 standards.⁸⁸

On 3 June 2008 a proposal was made for long term plan to be created for Oakden which was to be described as the Older Persons Mental Health Service Model (OPMHS).⁸⁹ It never eventuated.

In June 2008 Ms Meredith and Ms Olsson report their concerns about the standard of care at Oakden to the Health Ombudsman and the Health Complaints Commission both of whom declined to investigate.⁹⁰

On 13 June 2008 all sanctions were revoked by the Department of Health and the AACQA.

On 1 July 2008 Minister Gago responded to Mr Baron's letter of 30 May 2008 and said *inter alia*:

I am pleased to advise you of the recruitment of a highly skilled and experienced Lifestyle Coordinator, who is responsible for providing a program to residents to address their leisure and lifestyle needs. In addition, the organisation has a comprehensive staff education and training program, which is supported by performance reviews.

I have been informed that the specific incidents referred to in your correspondence are being investigated and staff are continuing to be provided with appropriate education and training. The organisation encourages consumer feedback, as it is a vital part of improving our service. Consumers and their carers have the right to make complaints and the service will not tolerate any act of retributions towards any consumer or their relative making a complaint. Any sign of this occurring would be subject to staff disciplinary measures in accordance with the Human Resources policy and procedure.

*Further, I understand that all residents and/or their representatives have regular opportunities to meet with staff, either through regular planned consumer group meetings or individual meetings. I continue to encourage all relatives to meet with management at the Makk and McLeay Nursing Home, as they are best placed to resolve any issues.*⁹¹

On 3 July 2008 the Minister for Health delegated to the Minister for Mental Health and Substance Abuse all of the powers and functions of the Minister for Health under the HCA.⁹²

On 7 July 2008 the AACQA deemed Makk and McLeay to be compliant with all 44 expected outcomes.

On 24 July 2008 the Hon. Gail Gago ceased to be Minister for Mental Health and Substance Abuse and the Hon. Dr Jane Lomax-Smith became Minister in her stead.

⁸⁸ Gail Gago, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 23 January 2018, 3.

⁸⁹ Statement of the Hon. Gail Gago, 20 October 2017, [51].

⁹⁰ Record of interview, Adelaide, 7 September 2017, 73.30-74.19 (Fiona Meredith).

⁹¹ Draft response letter from the Hon. Gail Gago to Neil Baron, 2017-000535-E0004 (LVlahos1) DOC-000001124; Statement of the Hon. Gail Gago, 20 October 2017, [113].

⁹² Statement of the Hon. Gail Gago, 20 October 2017, [34].

Between 4 and 6 August 2008 a complete site audit was conducted by the AACQA which decided that Makk and McLeay met all 44 aged care accreditation standards.

On 15 August 2008 Michael Rungie, CEO of the ACH Group, wrote to Dr Sherbon recommending that CNHAS transfer the full management functions for Makk and McLeay Nursing Home, involving the long term care and accommodation of residents, and the transition of residents from Makk and McLeay to other mainstream aged care services, to ACH.

In that letter he wrote:

'ACH Group is very conscious that the gains at M&M remain vulnerable and that substantive continuing action around change in the culture of M&M and the way mental health services for older people is managed at Oakden is required to build on and maintain the gains made'.⁹³

On 26 to 28 August 2008 the AACQA made an unannounced visit to the Oakden Facility and recommended that Makk and McLeay be accredited as they met all 44 expected outcomes.⁹⁴

On 9 September 2008 Makk and McLeay Nursing Home was reaccredited for six months.

On 3 October 2008 the AACQA conducted a spot audit focussed on 3 accreditation outcomes and Makk and McLeay were found to be compliant.

On 17 October 2008 Mr Wright authorised an internal memorandum to the Chief Executive regarding the letter written by Mr Rungie and in that memorandum stated:

- In subsequent conversations with the Director of Mental Health Operations the CEO of the ACH Group stated he wished to withdraw his letter and pursue solutions through the ongoing relationships between CNAHS and ACH.
- It is recommended that this matter be closed.⁹⁵

On 31 October 2008 the CEO of CNAHS provided a minute to Minister Lomax-Smith noting that due to recent events including the loss of accreditation by Makk and McLeay a decision had been made to conduct a review of Mental Health Nursing across CNAHS.

On 2 December 2008 the Minister noted the minute but wrote 'this doesn't explain why this is necessary, how much it will cost or what it will mean'.⁹⁶

On 11 March 2009 Ms Harrison provided a statement to Senior Constable Craig Foster-Lynam in relation to the death of Mr Rollbusch.⁹⁷

⁹³ Letter from Mike Rungie to Dr Tony Sherbon, re: ACH Group Proposal for Makk and McLeay (M&M) and Oakden, 15 August 2008, 2017-000535-E0005 (JWeatherill1) DOC-000000374.

⁹⁴ Minute from Elias Rafalowicz to the Minister for Mental Health and Substance Abuse re: Makk and McLeay Nursing Home – Accreditation update', 15 October 2008, 2017-000535-E0004 (LVlahos1) DOC-000001154.

⁹⁵ Minute to the Chief Executive from David Swan Director Mental Health Operations re: ACH Group Proposal for Makk and McLeay (M&M) and Oakden, 20 October 2008, 2017-000535-E0005 (JWeatherill1) DOC-000000374.

⁹⁶ Minute from Karleen Edwards to Minister for Mental Health and Substance Abuse re: Building the Future for Mental Health Nursing Central Northern Adelaide Health Service – Process for Developing a Strategic Plan, 31 October 2008, 2017-000535-E0004 (LVlahos1) DOC-000001137.

⁹⁷ Unsigned statement of Julie Harrison provided to Senior Constable Foster-Lynam, 11 March 2009, exhibit JH-2, 2017-000535-E0016 (JHanson5)(JRichter5) DOC-000004780; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 27.23-28 (Julie Harrison).

On 8 April 2009 Senior Constable Foster-Lynam emailed Ms Harrison requesting a copy of Ms Meredith's behavioural assessment reports for the persons she examined at the Oakden Facility in January 2008.⁹⁸ Senior Constable Foster-Lynam received a copy of Ms Meredith's report from Ms Harrison sometime after 8 April 2009.⁹⁹

In 2010 the Federal Government issued the National Standards for Mental Health Services.¹⁰⁰

In March 2010 the Sunday Mail requested information under Freedom of Information (FOI) legislation relating to professional conduct and grievance complaints against CNAHS, Mental Health Directorate, OPMHS.

On 25 March 2010 the Hon. Dr Jane Lomax-Smith ceased to be Minister for Health and Substance Abuse and the Hon. John Hill became Minister in addition to being Minister for Health.

On 9 June 2010 the Acting CEO of CNAHS provided a minute to Minister Hill:

- *On 28 April 2010 a resident of Makk House, Mr Cartwright, was reported by nursing staff commencing day shift, to have been restrained by two pelvic restraints secured to his chair, which were in turn secured to a wall mounted rail. Mr Cartwright was released from the restraints and the incident was reported to senior staff.*
- ...
- *Initial investigation of this incident on 28 April 2010 found there was no evidence of the required assessment and review processes to support restraint of Mr Cartwright as per the MMNH Restraint – Physical Policy (Attachment 1).*
- *The method of restraint of Mr Cartwright was in breach of the Aged Care Act (1997) and organisational policy, and falls within the scope of requiring mandatory notification of elder abuse to the Commonwealth Department of Health and Ageing and SA Police.*
- *The two nursing staff were immediately placed under supervised practice and have received written confirmation of the notifications that have been made and advised that an internal investigation will occur.*
- *CNAHS Mental Health Directorate investigation interviews have occurred and human resource principles and processes adhered to.*
- *Staff training and a review of Makk and McLeay policies and procedures in relation to elder abuse has been facilitated.*¹⁰¹

On 30 June 2010 Minister Hill determined that the Oakden Facility should be an approved treatment centre pursuant to s 96 of the MHA from 1 July 2010, which was the date of commencement of the MHA.

On 30 June 2010 Mr Skelton commenced as the Nursing Director, Clinical Practice.

In July 2010 Ms Harrison commenced as Service Manager with responsibility for Oakden.

Sometime in 2011 Dr Sherbon resigned from his position.

In March 2011 Mr David Swan commenced as Chief Executive of SA Health.

⁹⁸ Ms Harrison did not recall being asked to provide a copy of the report to SA Police: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 27.29-33 (Julie Harrison); email from Craig Foster-Lynam to Julie Harrison re: Makk and McLeay Report, 8 April 2009, exhibit JH-2, 2017-000535-E0016 (JHanson5)(JRichter5) DOC-000000944.

⁹⁹ Record of interview, Adelaide, 7 September 2017, 59.2-7 (Fiona Meredith).

¹⁰⁰ Affidavit of Dr Aaron Groves, 29 January 2018, annexure AG05.

¹⁰¹ Minute from Lesley Dwyer to the Office of the Minister for Mental Health and Substance Abuse re John Cartwright: Allegation by Nursing Staff of Elder Abuse, 9 June 2010, 2017-000535-E0004 (LVlahos1) DOC-000001170.

On 21 April 2011 the ACH Group's contract expired.

On 17 May 2011 Ms Leah Manuel (an advisor to Mr Hill) sought a briefing in relation to Makk and McLeay wards and their adherences to standards.¹⁰²

On 30 June 2011 the Minister established the Northern Adelaide Local Health Network Health Advisory Council Inc. pursuant to s 15 of the HCA.

On 1 July 2011 the services and facilities that previously formed part of the responsibilities of the Adelaide Health Service and relevantly related to sub-acute and mental health services in the Northern Adelaide area were transferred to NALHN. Although the proclamation provided for the transfer of mental health services in the Northern Adelaide area (which would on its terms have included the Oakden Facility) to NALHN, mental health services including the Oakden Facility formed part of an Adelaide Metropolitan Mental Health Directorate (AMMHD), which reported directly into the Department of Health. As such, from 1 July 2011 the Oakden Facility fell within the remit of the Department of Health albeit with a collaborative reporting line into NALHN.

On 1 July 2011 the CVS commenced in South Australia and Mr Maurice Corcoran became the PCV.

On 15 August 2011 Ms Margot Mains commenced as the Chief Executive Officer of NALHN.

A model of care was prepared in about 2012 but was not ultimately implemented.¹⁰³

On 23 April 2012 Ms Leonie Nowland commenced as the General Manager of Mental Health, AMMHD.

In September 2012 the AACQA issued the National Safety and Quality Health Service Standards.¹⁰⁴

On 18 October 2012 PKF (Chartered Accountants and Business Advisers) wrote a report to Mr Alan Bottrill, the Manager of Older Persons State-wide Mental Health Service. The report concluded that it was necessary to:

- *Finalise an options document concerning the model of non-acute inpatient services to be contracted to an NGO (Non-Government Organisation).*
- *Provide a plan for the transition of OPMHS Oakden to an NGO.*
- *Prepare a business case for the OPMHS Oakden transition to an NGO*
- *Advise on the costs allowed for NGO's to purpose build ICBU's (Intensive Care Behavioural Units)/TCU's (Transitional Care Units) in the Northern, Southern and Central metropolitan areas.*
- *Facilitate the valuation of land and buildings at Oakden Campus including identifying any issues pertaining to timing related to sale and the use of funds from any such sale.*
- *Review workings detailing savings from closure of Acacia and Jacaranda units at Glenside to be used with other savings identified within the business case (OPHMS 'Business Plan').*¹⁰⁵

¹⁰² Crown Solicitor, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, 7.

¹⁰³ Will Snow, on behalf of Dr Russell Draper, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, 6.

¹⁰⁴ Affidavit of Dr Aaron Groves, 29 January 2018, annexure AG04.

¹⁰⁵ Letter from Kyffin Thompson to Alan Bottrill re: engagement to provide consultancy services to the Management of Older Persons Mental Health Services (OPMHS) – Oakden, 18 October 2012, 2017-000535-E0005 (JWeatherill1) DOC-000000310.

In December 2012 SA Health approved the transition of governance arrangements for mental health services from the AMMHD to the relevant metropolitan local health networks.

In January 2013 Ms Harrison commenced as Service Manager for OPMHS and FMHS.

On 21 January 2013 the Hon. Jack Snelling became Minister for Health and Ageing and Minister for Mental Health and Substance Abuse.

On 31 January 2013 Ms Vanessa Owen commenced as the Executive Director of Nursing and Midwifery, NALHN.

From 31 January 2013 the transition, which required the relevant mental health services to report into NALHN, commenced.

In May 2013 Mr Karim Goel commenced as the Clinical Services Coordinator at Makk and McLeay.

On 27 June 2013 Ms Mains requested a meeting with Ms Nowland and the Chief Executive (CE) to discuss outsourcing of the Oakden facility.¹⁰⁶

On 26 July 2013 Ms Mains provided a memorandum to the CE of SA Health seeking approval for an Expression of Interest (EOI) to be published to assess interest and capability from the non-government organisation (NGO) (private provider sector) to operate OPMHS non acute inpatient services at Oakden which, if successful, would lead to the transfer of that service to that sector.¹⁰⁷

On 19 August 2013 the Chief Executive of SA Health approved the request contained in Ms Mains' internal memorandum dated 26 July 2013, subject to there being a communications plan, consultation with the unions, and preparation of details of the anticipated savings.¹⁰⁸

On 22 August 2013 Ms Mains met with Ms Nowland to discuss the requirements for outsourcing the Oakden Facility.

On 6 September 2013 the Minister for Mental Health and Substance Abuse met with the Royal Australian and New Zealand College of Psychiatrists (RANZCP) at which the planned sale of psychiatric geriatric beds located at the Oakden Facility was discussed. A minute was prepared by Ms Jenny Richter who was then Deputy Chief Executive System Performance to the Minister. Ms Richter wrote:

It is envisaged that a residential aged care facility provider will be better placed to manage the nursing home beds than Mental Health OPMHS would provide the specialist mental health input into the nursing home, consisted with the 'Stepping Up Report' recommendations.¹⁰⁹

She said in that minute that the proposal was being discussed with the Unions before the pathway forward was developed for consideration by the Government.

On 16 September 2013 Ms Mains provided a memorandum to the CE, SA Health regarding the transfer of OPMHS non-acute in patient services at the Oakden Facility to a private

¹⁰⁶ Statement of Margot Mains, [63].

¹⁰⁷ Internal Memorandum from Margot Mains to Chief Executive SA Health re: Transfer of Older Persons Mental Health Service (OPMHS) Non Acute Inpatient Services at Oakden to a Non-Government Organisation or Private Sector Provider, 26 July 2013, 2017-000535-E0005 (JWeatherill1) DOC-000000321.

¹⁰⁸ Ibid.

¹⁰⁹ Minute from Jenny Richter to the Office of the Minister for Mental Health and Substance Abuse re: meeting with the Royal Australian & New Zealand College of Psychiatrists (RANZCP) – Friday 6 September 2013, 6 September 2013, 2017-000535-E0009 (JSnelling1) DOC-000001679.

provider or NGO. The memorandum noted that there had been 'in principle opposition' from the unions.¹¹⁰

Mr David Swan, CE of SA Health, approved the minute from Margot Mains to be forwarded to the office of the Minister for Health and Substance Abuse which was received in that office on 23 September 2013 and which was approved by the Hon. Jack Snelling on 21 October 2013.

On 17 October 2013 Ms Mains met with representatives of the South Australia Salaried Medical Officers Association (SASMOA), the Australian Nursing and Midwifery Federation (ANMF), the Public Service Association (PSA) and United Voice in order to consult with the unions on the outsourcing proposal.

On 17 October 2013 Ms Mains provided a minute to the office of the Minister regarding the meeting with the Unions at which was present Ms Mains, Ms Nowland, Ms Bernadette Mulholland (Industrial Liaison Officer, SASMOA), Mr Simon Johnson (Industrial Officer, ANMF), Ms Samantha Gordon (Industrial Officer, PSA) and Mr Tony Boyle (Industrial Officer, United Voice) at which it was discussed that expressions of interest regarding the operation of OPMHS non-acute bedded services were being sought. On 21 October 2013 the Minister noted the contents of the memorandum of 17 October 2013.¹¹¹

On 7 November 2013 Ms Mains provided a minute to the office of the Minister regarding the implementation process of the launch of the EOI process for seeking to privatise the non-acute in patient services at the Oakden Facility, which was authorised by Mr David Swan, CE of SA Health on the same day and which was received in the Minister's office on 12 November 2013.¹¹²

On 8 November 2013 Ms Mains met with staff at the Oakden Facility to discuss the outsourcing proposal. On that same day Ms Mains met with relatives of consumers to discuss the effect of the proposal.

On 12 November 2013 the RANZCP Branch Committee meeting was informed:

*A meeting was held recently with the Minister. The Chair attended along with Dr K Houen and Dr K Shephard. Discussion took place regarding: Old aged beds based at Hillcrest Hospital, cultural problems in the south, Ernst & Young review and the new Hugh service. The major focus was the issues in the south, with Ms J Richter driving the discussion. It was felt that the Minister was being misinformed and is not receiving the correct advice regarding this issue.*¹¹³

The persons who attended the meeting with RANZCP and the Minister for Health Mental and Substance Abuse were listed as:

- The Hon. Jack Snelling;
- Mr Tim Picton (Ministerial Advisor);
- Mr David Davies (Executive Director, Mental Health and Substance Abuse);
- Dr Peter Tyllis (Chief Psychiatrist/Director Mental Health Policy);

¹¹⁰ Minute from Margot Mains to the Office of the Minister for Mental Health and Substance Abuse re: transfer of Old Persons Mental Health Services – non acute in-patient services to a private provider/Non-government organisation, 16 September 2013, 2017-000535-E0004 (LVlahos1) DOC-000001179.

¹¹¹ Minute from CEO NALHN to the Minister for Health and Ageing re: NALHN Older Persons Mental Health Services (OPMHS) Oakden Campus Proposal, 17 October 2013, 2017-000535-E0005 (JWeatherill1) DOC-000000287.

¹¹² Minute from Margot Mains to the Office of the Minister for Mental Health and Substance Abuse re Transfer of Older Persons Mental Health services (OPMHS) Non acute inpatient services to a private provider(s), 7 November 2013, 2017-000535-E0005 (JWeatherill1) DOC-000000322.

¹¹³ Document entitled 'SA Branch Committee Minutes', 12 November 2013; Record of interview, Adelaide, 1 September 2017, 19.33-20.11 (Dr Michelle Atchison and Dr Katherine Shephard).

- Dr Michelle Atchison (Chair, RANZCP);
- Dr Kate Houen (RANZCP Branch Committee Member); and
- Dr Katherine Shephard (RANZCP Branch Committee Member).

On 20 November 2013 the Minister noted Ms Mains' minute dated 7 November 2013.

In December 2013 Mr Daniel Torzyn commenced in the role of Clinical Services Coordinator, Clements House.

On 11 December 2013 Ms Mains wrote to Mr Ken Claughton (husband of a consumer) informing him that NALHN was exploring partnership opportunities to manage the day to day operation of non-acute inpatients services at the Oakden Facility.¹¹⁴

On 13 January 2014 Ms Nowland declined a request for additional psychiatric staffing.¹¹⁵

On 15 March 2014 an election was held in South Australia for the South Australian Parliament.

On 26 March 2014 the Hon. Jack Snelling became Minister for Health.

On 2 April 2014 the RANZCP sought to arrange a meeting with Minister Snelling.

On 5 May 2014 Ms Mains prepared a minute for the Minister for Mental Health seeking approval for the implementation of an expression of interest to proceed in respect of the privatisation of non-acute in-patients services to a private provider or NGO.

On 6 May 2014 Mr Swan approved that minute which was received by the Minister for Health's office on 8 May 2014.

In May 2014 Ms Mains was directed to be involved in an electronic patient administration system project and therefore did not take any further steps to progress outsourcing or explore other options.

On 25 June 2014 Ms Richter who was then the Deputy CEO of System Performance and Dr Tyllis submitted a minute to the Parliamentary Secretary to the Minister for Health, Mrs Leesa Vlahos, for a meeting to be held with the RANZCP on 2 July 2014.

On 26 June 2014 an agenda was published for a meeting to be held between the RANZCP SA branch and the Minister for Mental Health and Substance Abuse.

The agenda for the meeting included the following items:

2. *Oakden – Old Age Unit – concerns about the state of the facility and medical staffing levels*¹¹⁶

On 30 June 2014 Dr Sally Rischbieth (Senior Consultant Psychiatrist, OPMHS) emailed Ms Mulholland stating:

Pat Flynn, who is the Consultant Psychiatrist at Oakden, has had sig cardiac issues and is on sick leave. It was about the stressfulness of this job that we wrote the

¹¹⁴ Letter from Ms Margot Mains, CEO NALHN, to Mr Ken Claughton, 11 December 2013, 2017-000535-E0005 (JWeatherill1) DOC-000000009.

¹¹⁵ Will Snow, on behalf of Dr Russell Draper, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, 10.

¹¹⁶ Agenda for meeting between RANZCP and Minister Snelling, 26 June 2014, 2017-000535-E0004 (LVlahos1) DOC-000000233.

*business plan some months ago but it was never approved due to funding issues. This may be our last chance to try and escalate things...*¹¹⁷

On the same day Dr Rischbieth emailed Ms Harrison, Ms Nowland and Dr Patrick Flynn expressing concerns about the lack of sufficient medical cover at the Oakden Facility and raising concerns about Dr Flynn's cardiac event and his need for more consultant input.

On 1 July 2014 Ms Mulholland emailed Ms Nowland:

As communicated in my telephone conversation to you, I spoke with Dr Pat Flynn today regarding the health impact the workload at Oakden has had on him. I understand that you are now aware of these matters including the potential for a critical adverse patient event arising from the lack of medical staffing at Oakden.

I had previously expressed, on several occasions in emails to NALHN, SASMOA's concerns regarding the workload of medical officers, insufficient medical staffing and the concerns regarding patient care. On each occasion this was rejected and as a result Dr Flynn appears to have suffered the consequences.

*I have requested an immediate meeting with yourself and Dr Rischbieth who I understand from our conversation is filling in for Dr Draper. The purpose of this meeting would be for SASMOA to outline the critical health and safety issues for both medical staff and patients and to request increased senior medical staffing in the area. In fact, this needs to be done now as a matter of urgency.*¹¹⁸

On the same day Dr Rischbieth emailed Ms Mulholland regarding her conversation with Ms Harrison stating that she thought Ms Harrison's solution was 'woefully inadequate' and 'I don't think she has any idea of the issues there'. She also referred to Dr Flynn who she said 'has been working at the Oakden campus for 25 years at a very high level and this is the way she is dealing with it'.¹¹⁹

Ms Mulholland replied to Dr Rischbieth stating that 'I will alert Leonie to this in a roundabout way, Julie has never really got this issue and always gets quite aggressive when raised'.¹²⁰ On the same day Ms Mulholland emailed Ms Nowland raising concerns about the Department discussing SASMOA matters with members directly and not through SASMOA.

On 2 July 2014 Dr Rischbieth emailed Ms Mulholland reporting on a meeting she had with Ms Nowland who she said was very supportive regarding issues at Oakden. She wrote:

*...she suggested that I put the unit on the risk register, do a briefing paper for Margot and that the situation could be escalated to David Swan.*¹²¹

At the meeting with the RANZCP on 2 July 2014 which was attended by Minister Snelling and Parliamentary Secretary Vlahos, Dr Duncan McKellar (Consultant Psychiatrist, NALHN), raised concerns about the state of the Oakden Facility and the staffing levels at the facility and suggested that someone from the Minister's office visit the facility. Minister Snelling indicated that he considered that would be appropriate.

The draft minutes of the meeting held on 2 July 2014 were published on 8 July 2014:

¹¹⁷ Email from Dr Sally Rischbieth to Ms Bernadette Mulholland re Oakden, 30 June 2014, 2017-000535-E0027 (SASMOA1) DOC-000000007.

¹¹⁸ Email from Bernadette Mulholland to Leonie Nowland re Oakden, 1 July 2014, 2017-000535-E0027 (SASMOA1) DOC-000000051.

¹¹⁹ Email from Dr Sally Rischbieth to Ms Bernadette Mulholland re Oakden, 1 July 2014, 2017-000535-E0027 (SASMOA1) DOC-000000109.

¹²⁰ Ibid.

¹²¹ Email from Sally Rischbieth to Bernadette Mulholland, re Oakden, 2 July 2014, 2017-000535-E0027 (SASMOA1) DOC-000000010.

*Meeting with the Minister was held on 2nd July. K O'Brien, K Shephard, D McKellar and P Digman attended. Dr J Strobel attended the meeting in proxy of the Chief Psychiatrist, along with Parliamentary Secretary, Ms Leesa Vlahos and several other secretarial staff ... discussion around old aged services both country and Oakden. The meeting was seen as cordial ... Ms L Vlahos will be visiting James Nash House in the coming weeks and other sites.*¹²²

The minutes also suggested that a meeting be organised with the Minister for October 2014.

On 7 July 2014 Dr Rischbieth emailed Ms Mulholland regarding risk factors for Oakden and stated:

*I've drafted this risk register report to discuss at tomorrow's meeting. The risks seem to fit quite neatly into the Australian Quality Health Standards. Previously Julie has conceptualised this as needing to fit into nursing home accreditation standards which are quite different.*¹²³

On 11 July 2014 Ms Mulholland emailed Ms Nowland and Dr Rischbieth, Ms Harrison and Ms Mains confirming that she had met with them on 8 July 2014 and had raised concerns about the medical staffing at Oakden.

Ms Nowland responded to Ms Mulholland's email on the same day stating that the matter would be discussed on Ms Mulholland's return from leave.

The risk register was amended on 17 July 2014 and included the following:

*Improvements are required generally in the following areas: Oakden Campus (part of the Older Persons Mental Health Service) operated by SA Health is medically unsafe due to inadequate medical staffing numbers (and lack of clinical pharmacist) A significant number of National Safety and Quality Health Service Standards are not met. Risks include: Standard 1: Governance for safety and quality in Health Services Organisations. In particular, medical governance is severely compromised due to insufficient provision of medical practitioners to provide safe and high quality care for patients in the extended care and subacute beds at Oakden Campus. There is insufficient consultant psychiatric, geriatric and junior medical staff in the skills mix. Standard 2: Partnering with consumers and carers. Risk of escalating complaints from families and consumers who believe that adequate care needs are not being met. Standard 4: Medication safety. High number of patients (58) with complex medications managed by one 0.8FTE junior staff member substantially increases risk of medication errors. Standard 6: Clinical Handover, Medical handover between senior and junior staff, between resident and relieving medical staff, and between nursing to medical staff due to pressure of numbers. Risk of clinical incidents being unreported. JMO Staff practice errors due to insufficient supervision. Standard 9: Recognising and responding to clinical deterioration in acute health care. Not understanding changes in physiological observations, failure to communicate concerns. Other risks identified: - unnecessary expenditure due to increased length of stay, - Staff injury, stress and workcover demands. – Human rights violations, with inappropriate use of seclusion and restraint in vulnerable persons. – Unexpected deaths, and coronial enquiries.*¹²⁴

On 22 July 2014 Dr Rischbieth emailed Ms Mulholland stating:

Julie Harrison organised a meeting for Friday 25 at 12.30 to discuss medical cover at Oakden. I believe that Leonie and Russell are also invited, but I'm not sure if you're invited or not ... Pat Flynn has indicated again that he is not prepared or indeed able to put in the hours

¹²² Document entitled 'SA Branch Committee Minutes', 8 July 2014; Record of interview, Adelaide, 1 September 2017, 24.23-32 (Dr Michelle Atchison and Dr Katherine Shephard).

¹²³ Email from Dr Sally Rischbieth to Bernadette Mulholland re Risk factors for Oakden, 7 July 2014, 2017-000535-E0027 (SASMOA1) DOC-000000013.

¹²⁴ Document entitled 'Oakden campus – inadequate medical staff numbers', 17 July 2014, 2017-000535-E0011 (MWest1) DOC-000000328.

*required. Russell is trying to brush everything under the carpet as indeed I'm sure the others would like to as well.*¹²⁵

On 20 August 2014 Ms Mains wrote a minute to the Minister for Mental Health and Substance Abuse seeking approval for the implementation of an EOI process in respect to the privatisation of non-acute in-patient services to a private or NGO provider, which was superseded by a cabinet note.¹²⁶

On 16 September 2014 Dr Rischbieth emailed Ms Mulholland stating:

Just thought I'd let you know what's happening at Oakden as I'm unimpressed (but no longer directly involved).

*... it worries me that our management (both medical and other) value the Unit so lowly that they make no efforts to improve it. Perhaps they are just waiting for a major incident. Perhaps it would be a good time for a SafeWork SA review.*¹²⁷

On 18 September 2014 Ms Nowland emailed Ms Mulholland stating:

*Please be advised that Dr Russell Draper is finalising the necessary documents to commence the recruitment process.*¹²⁸

In October 2014 Ms Harrison commenced as Acting Director of the Mental Health Directorate.

On 10 October 2014 Ms Mains resigned from her position as Chief Executive Officer, NALHN.

In 2015 a 'business rules review' took place in consultation with the ANMF and Mr Skelton following which there was a slight increase to the staffing numbers at Oakden.¹²⁹

On 19 January 2015 Ms Jackie Hanson commenced as the Chief Executive Officer, NALHN.

In February 2015 Ms Harrison commenced as Service Manager.

On 3 February 2015 Parliamentary Secretary Vlahos became Parliamentary Secretary to Minister Snelling and was assigned to mental health and public policy by the Premier.

On 16 February 2015 Dr Aaron Groves was appointed Chief Psychiatrist.

On 4 March 2015 Ms Hanson provided the Minister for Mental Health and Substance Abuse with a minute and draft response letter for consideration, in a reply to a letter from the Hon. Tony Zappia MP, dated 16 December 2014. The minute stated:

- *Clements House has 24 beds however, due to gender mix and acuity of some consumers, over the past 2 years it has reduced the number of consumers it services to 21.*

¹²⁵ Email from Sally Rischbieth to Bernadette Mulholland re Meeting on Friday, 22 July 2014, 2017-000535-E0027 (SASMOA1) DOC-000000047.

¹²⁶ Minute from Margot Mains to the Office of the Minister for Mental Health and Substance Abuse re Options for the Transfer of Older persons Mental Health Services – non acute inpatient services to a private provider/non-government organisation' containing handwritten note 'Superseded by Cabinet note', 5 May 2014, 2017-000535-E0005 (JWeatherill1) DOC-000000285.

¹²⁷ Email from Sally Rischbieth to Bernadette Mulholland, re Oakden update, 16 September 2014, 2017-000535-E0027 (SASMOA1) DOC-000000022.

¹²⁸ Email from Leonie Nowland to Bernadette Mulholland re SMP for Oakden, 18 September 2014, 2017-000535-E0027 (SASMOA1) DOC-000000024.

¹²⁹ Michael Dadds, on behalf of Vanessa Owen, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 15 January 2018, 10; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 33.19-34.15 (Vanessa Owen).

- *Clements House day time staffing levels are six nursing staff for 21 consumers, representing an approximate ratio of 4 consumers per nursing staff member. This ratio is higher than other aged care services. In addition, Clements House nursing shifts operate with a 50-50 ratio of Registered Mental Health Nurses and Enrolled Nurses which is also higher than most other aged care services. Apart from nursing staff, the Clements House treating team is comprised of Consultant Psychiatrist, Medical Officer, Allied Health staff and Leisure and Lifestyle Program staff.*
- *Consumers at Clements House have varying care needs and approximately 3 years ago Clements House was upgraded and went from 4 bedded share rooms to double share rooms and it now consists of 6 single rooms and 9 share bedrooms. In addition, Clements House changed its environment to create two separate day time living areas enabling clients who are more challenging to be separated from those who are more vulnerable*
- *In relation to the constituent's fears about high risk of severe injury or death at the facility, the mental health staff are highly trained and skilled to manage and are aware of particular consumer's behaviours. Staff continue to receive regular education and training regarding the management of challenging behaviours.*
- *Regular risk assessments are conducted on all Clements House consumers and, where clinically indicated, consumers are separated into two day areas to assist with behavioural issues and to negate any potential risks.*
- *Staff remain on the floor of the Unit throughout the course of the day, engaging with and assessing clients, and provide supervision and close monitoring of clients where required.¹³⁰*

On 5 March 2015 Dr Groves wrote to Ms Hanson about incidents of restraint in mental health services to older persons stating:

- *In June 2014 an increase in reporting of restraint was noted in NALHN and this continued in subsequent months.*
- *On further investigation it was noted that an increase in reporting of mechanical restraint occurred on Oakden Campus over the same period, specifically in Clements and McLeay units.*
- *While the improvement in reporting of incidents is supported there is a need for further unpacking of this increase by NALHN to identify underlying factors and if determined appropriate to inform the development of a quality improvement plan.*
- *Incidence of restraint and seclusion across other NALHN sites has decreased in the same period.*
- *(provided Hanson) factsheet on the definitions of restraint and seclusion to assist staff in determining if an incident is a reportable restraint incident or not.¹³¹*

On 16 March 2015 at the mental health monthly performance meeting it was minuted that mental health was having problems recruiting staff. There were suggestions that all mental health would no longer use agency staff unless for unexpected absences.¹³²

¹³⁰ Minute from Jackie Hanson to the Office of the Minister for Mental Health and Substance Abuse re: Clements House Staffing Ratio, 4 March 2015, 2017-000535-E0005 (JWeatherill1) DOC-000000281

¹³¹ Letter from Dr Aaron Groves to Ms Jacheline Hanson, 5 March 2015, 2017-000535-E0007 (AGroves2) DOC-000000571.

On 16 March 2015 Dr Rischbieth emailed Ms Mulholland stating there are significant issues in NALHN old age as they are currently down to 1.3 FTE consultants covering the community team.¹³³

On 30 March 2015 Dr Rischbieth raised with Dr Draper and Dr Elias Rafalowicz, Clinical Director of the Mental Health Division, NALHN, her concern that there may be a sentinel event at Oakden if issues were not addressed.¹³⁴ Those concerns were repeated by Dr Rischbieth to others within NALHN management on 14 April 2015.

On 13 April 2015 Parliamentary Secretary Vlahos responded to the Hon. Tony Zappia's letter sent on 16 December 2014, on behalf of Minister Snelling, addressing staffing levels at Clements and practices in place to negate potential risks.¹³⁵

On 28 April 2015 SASMOA wrote to Ms Hanson expressing concerns with the lack of resourcing and funding, and stating it is only a matter of time before an adverse event occurs that could have been prevented, if adequate resourcing had been available. On 25 June 2015 Ms Hanson noted the concerns and confirmed she granted approval on 23 April 2015 to mental health to continue with existing locum arrangements to provide coverage for the sick leave being experienced within the team.¹³⁶

On 7 May 2015 an SA Health Restraint and Seclusion Reduction Policy Directive and Guideline was issued.¹³⁷

On 15 June 2015 Ms Owen commenced as Executive Director, Nursing and Midwifery, Clinical Governance.

On 27 August 2015 Ms Hanson sent a memorandum relating to the outsourcing of the Oakden Facility to Minister Snelling seeking approval to assess market interest and capability to take over the Oakden Facility. On 28 August 2015 Minister Snelling received a minute from Ms Hanson proposing to explore an EOI process with respect to the Oakden Facility.

Around September 2015 the social worker position at the Oakden Facility was removed as a result of a lack of funding. The removal concerned the PCV and Oakden staff.

In October 2015 a Review of Senior Leadership in Mental Health Services at NALHN was prepared for Ms Hanson. The report was not confined to the Oakden Facility. However, the report raised concerns about low morale at the Oakden Facility and that the staff were feeling undervalued and anxious because of uncertainty around future privatisation.¹³⁸

On 18 November 2015 Minister Snelling received a minute from Ms Hanson seeking approval to publish a request for information to assess market interest and capability.

¹³² Statement of Jacheline Hanson, 10 October 2017, annexure JRH19.

¹³³ Email from Dr Sally Rischbieth to Ms Bernadette Mulholland re: Mental Health Issues, 16 March 2015, 2017-000535-E0027 (SASMOA1) DOC-000000026.

¹³⁴ Record of interview, Adelaide, 5 October 2017, 67.19-68.24 (Dr Sally Rischbieth).

¹³⁵ Letter from Leesa Vlahos to Tony Zappia, 13 April 2015, 2017-000535-E0005 (JWeatherill1) DOC-000000083; Minute from Jackie Hanson (Chief Executive, NALHN) to the Office of the Minister for Mental Health and Substance Abuse re: Clements House Staffing Ratio, 2 March 2015, 2017-000535-E0005 (JWeatherill1) DOC-000000166; Internal Memorandum from Jackie Hanson (Chief Executive, NALHN) to the Office of the Minister for Mental Health and Substance Abuse re: Proposal to Assess Market Interest in Management of Older Persons Mental Health Service Non-acute Inpatient Services at Oakden, 17 November 2015, 2017-000535-E0005 (JWeatherill1) DOC-000000280; Letter from Tony Zappia to Minister Hon. Jack Snelling, 16 December 2014, 2017-000535-E0004 (LVlahos1) DOC-000000005; email from the Office of the Minister for Health to Tony Zappia, 23 December 2014, 2017-000535-E0004 (LVlahos1) DOC-000000425; draft letter from Hon. Jack Snelling to Tony Zappia, March 2015, 2017-000535-E0004 (LVlahos1) DOC-000000426.

¹³⁶ Letter from Jackie Hanson to David Pope re: Northern Mental Health Resourcing, 25 June 2015, 2017-000535-E0027 (SASMOA1) DOC-000000096.

¹³⁷ Will Snow, on behalf of Dr Russell Draper, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, 7.

¹³⁸ Presentation entitled 'Review of Senior Leadership in Mental Health Services NALHN Confidential Summary Report for CEO: Kathryn McEwen Organisational Psychologist', October 2015, 2017-000535-E0004 (LVlahos1) DOC-000001047.

On 30 November 2015 Minister Snelling approved the request contained within this minute.

On 3 December 2015 Ms Lorraine Baff reported concerns to Minister Snelling's office about an assault on a consumer at the Oakden Facility.

In December 2015 Ms Nowland resigned from her position as Director of Mental Health Strategy and Operations, NALHN.

In January 2016 Mr Kurt Towers commenced as the Interim Director of Mental Health Strategy and Operations, NALHN.

In January 2016 Dr Draper commenced as Clinical Director performing the duties of Director of Electroconvulsive Therapy.

In January 2016 Ms Harrison resigned from her position as Service Manager.

Minister Snelling resigned as Minister for Mental Health and Substance Abuse on 19 January 2016. On that same day Mrs Vlahos was appointed in his stead.

Although approval had been given by Minister Snelling in his capacity as Minister for Mental Health and Substance Abuse to proceed with publishing a request for information to assess market interest and capability, Ms Hanson considered it necessary to obtain approval from Minister Vlahos because she had been appointed as the new Minister for Mental Health and Substance Abuse.¹³⁹

In February 2016 Mr Robert Spriggs (consumer at the Oakden Facility) was referred to the Royal Adelaide Hospital after it was discovered he had significant bruising without explanation.

On 1 February 2016 Minister Vlahos requested a briefing from the Department in preparation for a meeting with Mr Corcoran.¹⁴⁰

On 22 February 2016 Minister Vlahos met with Mr Swan where they discussed OPMHS, beds and population, the *Mental Health (Review) Amendment Bill 2015* and Ministerial Directions.

On 11 April 2016 Ms Hanson told Minister Vlahos that there were cultural and operational issues at the Oakden Facility.¹⁴¹

On 19 April 2016 Minister Vlahos made a Ministerial Determination listing Oakden Services for Older People as an approved treatment centre pursuant to section 96 of the MHA.

In May 2016 Mr Towers initiated regular meetings involving NALHN and Mr Corcoran.¹⁴²

In May 2016 Mr Skelton resigned as Nursing Director and Mr Torzyn commenced as Acting Nursing Director.

On 13 May 2016 a nurse in the company of another nurse unsuccessfully attempted a catheterisation procedure on a consumer at the Oakden Facility in circumstances where the nurse had failed to obtain the consent of the consumer.¹⁴³ The incident was not reported on the SLS nor was it reported to AHPRA.

¹³⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 117.20-118.9 (Jacheline Hanson).

¹⁴⁰ Email from Michelle Srpek (Office of Hon Leesa Vlahos) to the Office of the Chief Executive Department for Communities and Social Inclusion requesting a brief in relation to a meeting between the Minister and Maurice Corcoran AM (Principal Community Visitor), 1 February 2016, 2017-000535-E0004 (LVlahos1) DOC-000000010.

¹⁴¹ Statement of the Hon. Leesa Vlahos, [64].

¹⁴² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 14.38-15.14 (Maurice Corcoran).

¹⁴³ Statement of Maria West, 24 October 2017, annexure MLW218.

On 1 June 2016 Mrs Barbara Spriggs met with Mr Corcoran to raise concerns about the treatment and care of her husband Mr Spriggs while a consumer at the Oakden Facility.¹⁴⁴

On 3 June 2016 Dr Groves emailed Mr Scott McMullen, Chief Operating Officer, NALHN, and Ms Hanson stating that the rates of restraint in the older persons program in NALHN remained far too high. Dr Groves described the rates as extraordinary.¹⁴⁵

On 7 June 2016 Mr Corcoran telephoned Mr Torzyn to advise him of the concerns raised by Mrs Spriggs and that a detailed summary would be provided.¹⁴⁶

On 9 June 2016 Mr Corcoran contacted Dr Groves to advise him that he had discussed the complaint made by Mrs Spriggs with Mr Torzyn and that there would be an investigation.¹⁴⁷

On 9 June 2016 Mr Corcoran emailed Dr Groves in relation to an overmedication incident, bruising that had been suffered by Mr Spriggs and an inappropriate request about payment.¹⁴⁸ Specifically, Mrs Spriggs was seeking an explanation regarding the bumps and bruises on Mr Spriggs, the large bruise on his hip and the total falls he had during his time at the Oakden Facility. Mrs Spriggs told Mr Corcoran that the Oakden Facility staff only contacted her following one fall and she thought there may have been other instances of falls.

On 15 June 2016 Ms Maria West was appointed as Director, Mental Health Strategy and Operations.

On 30 June 2016 a consumer passed away after being left unattended and choking on a piece of food.

On 30 June 2016 Dr Groves conducted an announced visit of the Oakden Facility.¹⁴⁹ He was the first Chief Psychiatrist to visit the Oakden Facility since the establishment of the role in 1 July 2010.

On 11 July 2016 Dr Groves emailed Dr Sujeeve Sanmuganatham, Acting Divisional Director for Mental Health, NALHN, following his tour of the Oakden Facility with possible immediate and short term actions for the Oakden Facility, stating:

Thank you for facilitating the visit to Oakden Campus for Del and myself, we appreciated both the opportunity and the time from all of you in helping us to have a better understanding of the obstacles staff face in providing care to people in difficult circumstances.

While the long term goal for older persons services at Oakden is to improve the physical environment and enable the use of trauma informed care and sensory modulation we have given some thought to possible immediate and short term actions you could consider. This includes:

- *asking for a full OT assessment and sensory assessment on any person who is being transferred from 1H, SE or Ward 18 before accepting the transfer;*
- *looking at education for all staff on an understanding of sensory modulation and importance;*

¹⁴⁴ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁴⁵ Email from Aaron Groves to Scott McMullen, cc Jackie Hanson re Restraint rates in Older Adult, 3 June 2016, 2017-000535-E0007 (AGroves2) DOC-000000634.

¹⁴⁶ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁴⁷ Ibid.

¹⁴⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 54.47-55.32 (Maurice Corcoran).

¹⁴⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 53.35-40 (Aaron Groves).

- choosing a mental health nurse as a champion who can do a sensory modulation course / spend some time with an OT somewhere for experience, which they could then bring back to Oakden;
- considering if the allocation you have for psychologist time can be converted to OT position as an interim measure and;
- reviewing the data collection to see what may be useful in demonstrating your need for an improved environment, appropriate staffing and upskilling and training. For example, is there a difference in the restraint use on people who are recent transfers from 1H, SE or Ward 18, can you compare PRN and restrain and pre and post transfer, and whether some restraints are used more on certain days?

*I would also encourage ongoing attendance by Beccy and Dan on the state-wide Trauma Informed Practice Working Group (this has replaced the Minimising Restrictive Practice Working Group), their input is welcome and I would have they may get ideas from other that they can use in their current environments even if changing that environment remains difficult.*¹⁵⁰

On 18 July 2016 Mr Spriggs, who was the subject matter of the complaint to Mr Corcoran, passed away.

On 20 July 2016 Mrs Spriggs requested Mr Corcoran to provide an update about her complaint. Mr Corcoran contacted Mr Torzyn and was advised that Mr Moutakis was conducting an investigation. Mr Torzyn acknowledged that the complaint was serious and would also be escalated. Mr Moutakis later contacted Mr Corcoran to advise that a response should be received within the following 7 days. Mr Corcoran advised Dr Groves that Mr Moutakis would be investigating but raised concerns about the independence of Consumer Liaison Officers with respect to internal investigations.¹⁵¹

On 24 July 2016 Mr Torzyn contacted Mr Corcoran to determine whether Mr Moutakis had contacted Mr Corcoran.¹⁵²

On 25 July 2016 Mr Moutakis informed Mr Corcoran that the report relating to the complaint by Mrs Spriggs would not be released until 29 July 2016.¹⁵³

On 27 July 2016 the Community Visitor Scheme (CVS) May report was emailed to Ms West. The email stated that Mr Corcoran had been advised that an investigation was to follow regarding concerns raised by Mrs Spriggs and the report should be received on 29 July 2016.¹⁵⁴

On 1 August 2016 Mr Torzyn emailed Mr Corcoran to inform him that the report by Mr Moutakis would be delayed but would be provided that coming week.¹⁵⁵

On 5 August 2016 Mr Moutakis emailed Ms West a draft response to the CVS regarding the Spriggs complaint.¹⁵⁶ On 8 August Ms West approved the letter which was sent on her behalf to Dr Elaine Pretorius, Acting Director of Medical Services, NALHN.¹⁵⁷

On 10 August Dr Pretorius emailed Ms Hanson stating:

¹⁵⁰ Email from Dr Aaron Groves to Dr Sanmuganatham Sujeeve re Visit to Oakden, 2017-000535-E0007 (AGroves2) DOC-000000655.

¹⁵¹ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁵² Ibid.

¹⁵³ Ibid.

¹⁵⁴ Email from Connie Migliore to Maria West re Community Visitor Scheme Mental Health Visit June Reports, 27 July 2016, 2017-000535-E0003 (MCorcoran1) DOC-000000300.

¹⁵⁵ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁵⁶ Email from Arthur Moutakis to Maria West re Spriggs Robert 280716 HCSCC NAHLN EDMS direct response [sic], 5 August 2016, 2017-000535-E0011 (MWest1) DOC-000000011.

¹⁵⁷ Email from Ms West to Ms Sheehy, 8 August 2016, 2017-000535-E0011 (MWest1) DOC-000000009.

*I believe this letter contains serious allegations and I am not sure the response recognises it. Further, I am not sure it is appropriate for me to sign off, I think there are some concerns with regard abuse and use of restraints.*¹⁵⁸

On 15 August 2016, following the email from Dr Pretorius, Ms Hanson emailed Ms West and Ms Owen stating her intention to seek advice from Dr Groves regarding a possible investigation by his office into the Spriggs complaint.

On 15 August 2016 Ms West contacted Dr Groves about the Spriggs complaint. Dr Groves indicated that he was happy to receive material relating to the complaint.¹⁵⁹

On 19 August 2016 the CVS contacted Mr Torzyn and Mr Moutakis seeking an update on the report into the Spriggs complaint. Mr Moutakis responded that the response was with the Office of the Chief Executive for consideration. Mr Torzyn also contacted the CVS asking for the contact details for Mrs Spriggs.¹⁶⁰ Separately, Ms West emailed Dr Groves the Spriggs complaint and materials relating to the matter.¹⁶¹

On 22 August 2016 Mr Torzyn contacted the CVS indicating he would contact Mrs Spriggs.¹⁶²

On 23 August 2016 Dr Groves met with Dr Sujeeve and raised concerns that Dr Sujeeve had not been involved in finalising the investigation.¹⁶³

On 25 August 2016 Dr Groves met with Ms Hanson to discuss the CVS Report and the Spriggs matter.¹⁶⁴ It is not certain what was discussed at the meeting. However, Dr Groves gave evidence that he raised concerns that NALHN was not responding appropriately to Mr Corcoran. Ms Hanson does not recall the conversation.¹⁶⁵

On 30 August 2016 Mr Moutakis contacted Mr Corcoran and advised that the report into the Spriggs complaint had been finalised pending release by the CEO, NALHN.¹⁶⁶ In August 2016 SA Health and NALHN entered into a service level agreement for the 2016/17 financial year. The service level agreement was signed by Ms Hanson and Mr Swan. The objectives of the service level agreement were to promote accountability to government and the community and to provide the framework for the NALHN performance agreement. The agreement included the 'health service priorities' for 2016/17, but the Oakden Facility was not mentioned.

In September 2016 Dr Draper resigned from the OPMHS Clinical Governance Committee.¹⁶⁷

In September 2016 Mr Swan resigned from his position as Chief Executive, SA Health.

In September 2016 Ms Vickie Kaminski commenced as Interim Chief Executive, SA Health.

¹⁵⁸ Statement of Maria West, 24 October 2017, [126], annexure MLW106; Email from Dr Elaine Pretorius to Jackie Hanson, 10 August 2016, 2017-000535-E0011 (MWest1) DOC-000000009.

¹⁵⁹ Email chain between Maria West, Jackie Hanson, Vanessa Owen re Spriggs Robert 280716 HCSCC NAHLN EDMS direct response [sic], 15 August 2016, 2017-000535-E0011 (MWest1) DOC-000000007.

¹⁶⁰ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁶¹ Email from Maria West to Aaron Groves re Spriggs complaint, 19 August 2016, 2017-000535-E0011 (MWest1) DOC-000000010.

¹⁶² Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁶³ Bill Athanasellis, on behalf of Dr Aaron Groves, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, [68].

¹⁶⁴ Ibid [69].

¹⁶⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 89.34-47 (Jacheline Hanson).

¹⁶⁶ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁶⁷ Will Snow, on behalf of Dr Russell Draper, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, 10.

On 2 September 2016 Mr Corcoran contacted Ms West complaining of the delays in receiving a report into the Spriggs complaint. Ms West advised that the response had been provided to the Office of the Chief Psychiatrist for review before it was sent. Mr Corcoran contacted Dr Groves to confirm that the report had been provided for his approval.¹⁶⁸

On 6 September 2016 the CVS Report stated that staff at the Oakden Facility had reported concerns regarding allied health to the CVS. The CVS Report said there was no occupational therapist or social worker available on site.¹⁶⁹

On 7 September 2016 Mr Corcoran emailed Dr Groves raising concerns about the delay in receiving a response to the Spriggs complaint.¹⁷⁰

On 30 September 2016 in accordance with his statutory duty Mr Corcoran sent his annual report to Minister Vlahos' office which contained concerns in relation to the Oakden Facility.¹⁷¹

Minister Vlahos read this report over the next few weeks in October.¹⁷²

The report referred to issues faced at the Oakden Facility and the significant delays in response to complaints. In providing the report to Minister Vlahos, Mr Corcoran expressed his concern that the Oakden Facility was classified as sub-acute and this was affecting the funding that the Oakden Facility was receiving. Specifically, Mr Corcoran stated:

6.10 Specific concerns

The CVS holds significant concerns regarding Oakden Services for Older People which has arisen from both visit reports and a range of individual investigations that have been undertaken as a result of specific complaints that we have made on behalf of individuals and families. The CVS has a strong working relationship with the senior leaders and managers of Oakden Services for Older People, and commends the dedication these staff have to care for acutely unwell older people transferred from other acute mental health units. Yet for reasons unknown, Oakden is classified as 'sub-acute' and therefore attracts less funding than the other older persons acute units.

Staff at Oakden have explained they receive the most challenging clients of the acute wards, yet the mental health unit has lost a number of Allied Health roles, particularly the Social Worker role who was responsible to secure appropriate accommodation for clients and the psychologist who has worked on behavioural plans. This has placed pressure on the leadership to take on additional responsibilities to fulfil what these Allied Health roles offered.

Community visitors and the CVS office have received concerns from three families regarding the treatment and care of their loved ones at Oakden. These have included reported frequent falls, observed bruising, medication errors; increased sleepiness, drowsiness, and reported decline of daily functioning. It was also commented that there are not enough staff available on wards, and it has been reported that Oakden use 1 staff member to 4 client ratio, whereas acute units may use 1 staff member to 3 client ratio. Staff and senior leaders within this unit are highly dedicated and strive to do the best they can with the limited resources available.

6.10.1 Recommendation

That a review is undertaken of the clinical hours in contrast to patient acuity at Older Persons Mental Health Services at Oakden to ensure the provision of quality and safe care to patients residing in this facility.¹⁷³

¹⁶⁸ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁶⁹ Statement of Maria West, 24 October 2017, annexure MLW81.

¹⁷⁰ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁷¹ Ibid.

¹⁷² Statement of the Hon. Leesa Vlahos, 38.46-39.16.

On 30 September 2016 Dr Groves sent his annual report to Minister Vlahos' office but his annual report made no mention of the Oakden Facility.¹⁷⁴

In October 2016 Ms West received approval to propose a part-time social worker position at the Oakden Facility.¹⁷⁵

On 4 October 2016 Ms Hanson provided Mr Len Richards, Deputy Chief Executive SA Health, and Dr Groves with NALHN's proposal to target zero restraint in NALHN.¹⁷⁶

On 6 October 2016 Mr Goel emailed Mr Torzyn, Ms Owen, Ms West, Ms Vicki Nagy (Senior Human Resources Consultant) and Ms Trudy Smith-Sparrow (Interim Nursing Director) raising his concerns about staff culture and attitude, stating he considered that patient care was being affected. He said a serious incident might occur.¹⁷⁷

On 10 October 2016 Mr Corcoran emailed Dr Groves and Ms West requesting an update on the report into the Spriggs complaint.¹⁷⁸

On 14 October 2016 Mr Corcoran wrote to Minister Vlahos about the Oakden Facility and the lack of response that had been received from NALHN regarding the Spriggs complaint.¹⁷⁹

I am writing to express my concerns regarding Oakden Services for Older People, a service which cares for older clients with a mental illness that has three wards Makk, Mcleay and Clements. Since June 2016, the Community Visitor Scheme has received a number of concerns from clients' families and Community Visitors regarding client treatment and care, and operational issues affecting the quality of care and services to clients.

I would like to acknowledge that Oakden has a team of dedicated senior staff who constantly exceed their job role to care for acutely unwell older people with significant behavioural and cognitive issues. However, Oakden receives some of the most challenging clients from other older persons acute wards and yet (for reasons unknown), Oakden is classified as 'sub-acute'. Because of this sub-acute classification, Oakden receives less funding than the other older persons' acute units which impacts on their staff to patient ratios. What's more, Oakden has also lost a number of Allied Health roles such as a Social Worker, Psychologist and Occupational Therapist, which has placed pressure on senior staff to take on additional responsibilities to fulfil what these Allied Health roles offered.

Families have reported to Community Visitors and our office their concerns regarding the lack of staff availability within the unit. I am aware that Oakden use 1 staff member to 4-client ratio, whereas acute units may use 1 staff member to 3-client ratio. Consequentially, clients are receiving less personal attention and support from nursing staff, are at increased risk of falls and it has been reported by families that clients can be left waiting for significant periods to receive assistance or monitoring from staff.

It is evident that these above issues have contributed to three families directly contacting my office to complain about the treatment and care of their loved ones at this facility. We have assisted these families with complaints about issues and

¹⁷³ Principal Community Visitor Annual Report – Mental Health Services 2015-16, 30 September 2016, 2017-000535-E0003 (MCorcoran1) DOC-000000371.

¹⁷⁴ Affidavit of Dr Aaron Groves, 29 January 2018, annexure AG01.

¹⁷⁵ Statement of Maria West, 24 October 2017, 63.

¹⁷⁶ Ibid, 61, annexure MLW168.

¹⁷⁷ Joseph Henderson, on behalf of Karim Goel, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, [19].

¹⁷⁸ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁷⁹ Letter from Maurice Corcoran to Minister the Hon Leesa Vlahos re: Oakden Services for Older People, 14 October 2016, 2017-000535-E0003 (MCorcoran1) DOC-000000640.

incidents that have occurred and they and I have been frustrated with the lack of response to these complaints. This is especially so with one of the first matters I reported to Oakden concerning Mr Robert Spriggs (now deceased) in June 2016. Despite numerous follow-ups to Oakden and NALHN management by our office, we have still not received a formal response in over 4 months.

Mrs Barbara Spriggs personally met with me at my office to discuss a range of concerns about her husband's care at Oakden. We provided details on these issues with Oakden, and I know an investigation occurred at Oakden regarding this complaint through the Consumer Liaison Officer. However, despite significant follow up with Oakden, NALHN, and the Chief Psychiatrists Office, no response or report has been provided to Mrs Spriggs or the CVS.

This is extremely disappointing for Mrs Spriggs who pursued her complaints in the hope other clients and families will not experience the trauma and stress that her family has. Of further concern is Mrs Spriggs' daughter, Kerry, has experienced significant trauma relating to the way in which her father was cared for while in Oakden and is engaged in psychological therapy to work through this trauma.

When I last spoke to Mrs Spriggs, I indicated that I was intending to write to you to escalate our concerns, which includes highlighting how her husband was treated and the impact this had on her and her family. I also said that you, as Minister for Mental Health, would want to know about the circumstances surrounding her husband's care while at Oakden. At that time, Mrs Spriggs indicated her interest and that of her daughter to accompany myself and meet you to share their story with you personally.

I am happy to assist your office coordinate a meeting with the family. Furthermore, I believe that given the number of issues and incidents that have arisen, the staffing issues, and limited availability of staff and Allied Health Services, suggest further investigation is required to understand the current operations and management of Oakden Services for Older People.

I recommend an independent review of Oakden Services for Older People. I believe this is required to ensure that our elderly South Australian citizens continue to receive the treatment, care and support they deserve.

I welcome the opportunity to discuss any of these matters with you further in person to provide additional detail of the concerns regarding Oakden Services for Older People.¹⁸⁰

On 18 October 2016 a staff member from Minister Vlahos' office requested a meeting with NALHN to understand the contents of the letter from Mr Corcoran of 14 October 2016.¹⁸¹

On 7 November 2016 Minister Vlahos' staff member noted the request for the briefing had not been answered and was overdue.¹⁸²

On 10 November 2016 the CVS contacted Minister Vlahos' office as no response or acknowledgement had been received to Mr Corcoran's letter of 14 October 2016.¹⁸³

On 11 November 2016 Ms Hanson prepared a minute to the Office of the Minister for Mental Health and Substance Abuse, addressing the concerns raised by Mr Corcoran.¹⁸⁴ The

¹⁸⁰ Letter from Maurice Corcoran to Minister the Hon Leesa Vlahos re: Oakden Services for Older People, 14 October 2016, 2017-000535-E0003 (MCorcoran1) DOC-000000640

¹⁸¹ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10(c)(i).

¹⁸² Ibid 10(c)(iii).

¹⁸³ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

purpose of the minute was to provide the Minister with a draft response for consideration in reply to Mr Corcoran regarding concerns about consumer treatment and care at the Oakden Facility.

On 15 November 2016 Mr Corcoran spoke with a staff member in Minister Vlahos' office regarding the failure to receive a response in relation to the Spriggs complaint. On that same day Mrs Spriggs met with Mr Corcoran to discuss how the complaint could be progressed.¹⁸⁵

On 16 November 2016 Mr Corcoran spoke with a staff member in Minister Vlahos' office and was advised that a meeting would be arranged with Mrs Spriggs, Minister Vlahos and a senior representative of NALHN. Mr Corcoran contacted Ms West to provide an update.¹⁸⁶

On 17 November 2016 Mrs Vlahos and Dr Groves met with representatives of the RANZCP where issues were discussed relating to the Oakden Facility. At the meeting Dr McKellar raised concerns that the Oakden Facility contained vulnerable persons; the facility was being neglected; and that there was illegal restraint and seclusion being used on the consumers there.

On 22 November 2016 Ms Hanson signed a minute to the Office of the Minister for Mental Health and Substance Abuse. The minute asked the Minister to note NALHN's intention to publish two EOIs to assess interest and capability from the NGO or private provider sector to operate OPMHS non-acute inpatient services. Attached to the minute was a communication plan that stated:

It is intended that the Oakden site be sold off and the Commonwealth licenses to provide the Makk and Mcleay Nursing Home beds be sold to an independent provider. Residents have right of tenure entitlements; which means they will retain their beds with the new provider. In transferring the residents to the new provider, their long-term needs must be assessed including the suitability of the alternative accommodation, to ensure the affected residents are not disadvantaged. Under the Australian Aged Care Act, written notice of the move must be provided to residents at least 14 days before any transfer to a new service provider/accommodation can occur. SA Health intends to maintain the admission and discharge rights for Clements House, which means a tender process will be required to procure an appropriate service provider.

*SA Health intends to maintain the admission and discharge rights for Clements House, which means a tender process will be required to procure an appropriate service provider.*¹⁸⁷

On 22 November 2016 the CVS followed-up the Minister's office regarding the proposed meeting in relation to the Spriggs complaint.¹⁸⁸

On 24 November 2016 an anonymous complaint was made to the Office of Minister Snelling about a consumer being secluded; a lack of paperwork; medications and bullying issues:

This is to blow the whistle on one of the age care facilities I had worked a few times in the facility at Oakden last year. My agency was Yna and I no longer work form them so they can't do anything to me like stop given me work and I am going back to NSW.

¹⁸⁴ Minute from Jackie Hanson (Chief Executive, NALHN) to the Office of the Minister for Mental Health and Substance Abuse re: Community Visitor Concerns about Older Persons Mental Health Services – Oakden Campus, 11 November 2016, 2017-000535-E0005 (JWeatherill1) DOC-000000031; Statement of Jacheline Hanson, 10 October 2017, 27, annexure JRH30.

¹⁸⁵ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁸⁶ Ibid.

¹⁸⁷ Minute from Jackie Hanson to the Office of the Minister for Mental Health and Substance Abuse re Transfer of Northern Adelaide Local Health Network Older Persons Mental Health Service non acute inpatient services at Oakden to a Non-Government Organisation or Private Sector Provider, 22 November 2016, 2017-000535-E0004 (LVlahos1) DOC-000001076.

¹⁸⁸ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

Clements House at Oakden, they have patients in two areas most of the day and three or four times during the day they lock up a resident called Lisa Fox in a separate room for long period.

She is not checked on and only allowed out for meals and the odd time to toilet her; this depends on which group of staff is working that day. She wears an all in one suit and it takes two staff to do this.

I did pluck up the courage one day to report to the CNC Dan Torzyn but he never around much as I think he has too much work to do.

As far as I know there is no paperwork authorising this, and no hourly checks done and one time when I was working in Clements house she had soiled her clothes and I had to ask for help to get her cleaned up.

She is an prisoner in that room, its not just one staff who do this, it seems to be most of the staff, mostly the staff who are working in Zweck area.

Dan Torzyn is in charge and I feel that he should be accountable, you need to ask questions.

...

Late July or early August, someone a family member had brought in some food and left it on a table and one of the patient got to it and choked on it. What you don't know about this.

Were was the staff that was on duties, did anyone get reported to the nurses board. The staff that on duty should be held responsible. This is now up to you to do something about this.

Also management bullying staff and this as gone to the union.

Need to ask about the doctor reducing medication.¹⁸⁹

In December 2016 Minister Vlahos raised concerns with Ms Hanson that she did not have enough confidence in NALHN, with respect to the outsourcing proposal or sufficient information as to how the process would be managed in the public arena, and so requested an action plan.¹⁹⁰

In December 2016, Ms Kaminski commenced as Chief Executive, SA Health.

On 1 December 2016 Minister Vlahos tabled the Chief Psychiatrist's Annual Report and the Principal Community Visitor's Annual Report.¹⁹¹

On 6 December 2016 Mr Corcoran spoke with a staff member in Minister Vlahos' office regarding the Spriggs complaint and that it had not been addressed for 6 months.¹⁹² Separately, Dr Groves contacted Ms Hanson on 6 December 2016 to raise concerns about a misleading briefing minute that had been sent to Minister Vlahos regarding the Spriggs complaint.¹⁹³

On the same day Ms Hanson and Dr Groves discussed Mr Corcoran's complaint and Dr Groves indicated that he had not intended on undertaking his own investigation.

¹⁸⁹ Letter to Hon. Jack Snelling, received 24 November 2016, 2017-000535-E0004 (LVlahos1) DOC-000001080

¹⁹⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 119.14-24 (Jacheline Hanson)

¹⁹¹ South Australia, *Parliamentary Debates*, House of Assembly, 1 December 2016, 8288 (Hon. Leesa Vlahos).

It was the last sitting day of Parliament

¹⁹² Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2; Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10(d).

¹⁹³ Statement of Jacheline Hanson, 10 October 2017, annexure JRH31.

On 7 December 2016 a member of Minister Vlahos' staff emailed the Minister's Chief of Staff and sought advice on how to best approach NALHN's delay.¹⁹⁴

On 7 December 2016 a member of Minister Vlahos' staff made a file note that he had requested an urgent briefing from NALHN.¹⁹⁵

On 7 December 2016 a member of Minister Vlahos' staff contacted Mr Corcoran. No date for a meeting with Mrs Spriggs was agreed but there was mention of the Minister requiring further information from NALHN so that the Minister was fully informed.¹⁹⁶

On 7 December 2016 a member of Minister Vlahos' staff, on behalf of the Minister, asked Ms Hanson to ask someone to contact the Spriggs family.¹⁹⁷ Ms West later contacted the CVS seeking to make contact with Mrs Spriggs.¹⁹⁸ Separately, Dr Groves emailed Ms Hanson and the Office of Minister Vlahos to confirm that errors in the briefing minute would be rectified.¹⁹⁹

On 8 December 2016 Minister Snelling received a minute regarding an EOI to assess interest and capability in the private sector with respect to the Oakden Facility.

On 13 December 2016 Ms Hanson signed a minute to the Office of the Minister for Mental Health and Substance Abuse. The purpose of the minute was to provide the Minister with a draft response for consideration in reply to Mr Corcoran regarding concerns about consumer treatment and care, and operational issues affecting quality of care and services provided at Oakden. It is disputed whether a draft letter was annexed to that minute.²⁰⁰

SUMMARY

- *Nursing staff to consumer ratio at Oakden Campus is consistent with the current Nursing/Midwifery (South Australian Public Sector) Enterprise Agreement 2016 and the number of staff is considered adequate to provide safe and high quality care.*
- *Oakden Campus has access to Allied Health Services available through Ward 1H, Lyell McEwin Hospital.*
- *OPMHS is proposing to fund an additional part-time Social Worker and is reviewing the consumer need for allied health staff at Oakden Campus*
- *The Safety Learning System utilised to report clinical incidents indicates a decreasing trend in the number of falls at the Oakden Campus.*
- *All consumers admitted to Oakden Campus have a Falls Assessment completed, with a care plan developed, implemented and evaluated according to information from the Falls Assessment.*
- *There has been no reported consumer feedback to indicate issues with delays in receiving assistance or monitoring from Oakden staff.*
- *The attached draft response invites the Community Visitor Scheme (CVS) to provide more information about this issue to enable an investigation.*

¹⁹⁴ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10](f).

¹⁹⁵ Ibid, 10(c)(iv).

¹⁹⁶ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁹⁷ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10(g).

¹⁹⁸ Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

¹⁹⁹ Bill Athanasellis, on behalf of Dr Aaron Groves, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, [82].

²⁰⁰ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10(i); Statement of Jacheline Hanson, 10 October 2017, annexure JRH35.

- Mr Corcoran wrote direct to OPMHS in relation -to concerns raised by Mrs Spriggs in relation to the care and treatment provided to the late Mr Spriggs.
- Due to the seriousness and complexity of Ms Spriggs' complaint the NALHN Chief Executive Officer sought advice from the Office of the Chief Psychiatrist (OCP). The outcome of this conversation was for NALHN to continue with the internal review and provide a response to Mr Maurice Corcoran addressing his concerns.
- The Director, Mental Health Strategy and Operations, NALHN has spoken to both the Community Visitor and Mrs Spriggs on Wednesday 7 December 2016.
- A meeting has been scheduled for Mrs Spriggs to meet with the NALHN Chief Executive Officer and Director, Mental Health Strategy - this meeting has been scheduled for Thursday 15 December 2016.
- NALHM OPMHS is committed to continuous service improvement, learning from the experiences of consumers and their families and encouraging staff education. To this end, a new initiative in partnership with Professor Nicholas Procter, University of South Australia, of which commenced in November 2016.
- This new initiative involves delivering a series of short teaching sessions on-site with nursing staff working at Oakden.
- The key topics covered included engaging with behavioural states associated with dementia; assessing sensory modulation; when responding to difficult and challenging cognitive and behavioural states, trauma informed practice initiatives for people aged over sixty-five (65) and alternatives to restraint and restrictive practices.²⁰¹

On 15 December 2016 the Office of Minister Vlahos recorded the request to NALHN for a briefing was overdue.²⁰²

On 15 December 2016 Mrs Spriggs and her children met with Ms Hanson, Mr Corcoran and Ms West to discuss the Spriggs complaint.²⁰³

On 16 December 2016 Ms Hanson wrote a letter to Mrs Spriggs apologising for NALHN's long delay in providing a response to her complaint.²⁰⁴ Ms Hanson stated there were a number of mechanisms that did not progress as they should have and the result was a break in the chain of processes and considerable delays. Ms Hanson stated she had undertaken an internal investigation into the concerns raised in June 2016. The investigation included talking with staff, screening the case notes and other documents relating to Mr Spriggs' care, and looking through the incident reporting system. Ms Hanson said she had taken some actions to address some of the areas of concern – primarily education initiatives to increase staff competency. Ms Hanson said the Oakden Facility service was working alongside Adult Mental Health In-patient Services in the development of Sensory Modulation practice and was relaunching the Falls Prevention Programme. Ms Hanson stated:

*I agree an external review would be very helpful in identifying the areas where Northern Adelaide Local Health Network needs to focus in order to improve standards of care. I am giving this matter the highest priority and am currently exploring the best way to commission this review which we will undertake in early 2017. I would like to share the results and recommendations with you when the review report is complete.*²⁰⁵

²⁰¹ Minute from Jackie Hanson to the Office of the Minister for Mental Health and Substance Abuse re Community Visitor concerns about Older Persons Mental Health Services – Oakden Campus, 13 December 2016, 2017-000535-E0014 (JHanson1)(JRichter1) DOC-000000651.

²⁰² Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, [10(c)(v)].

²⁰³ It appears Mr Corcoran provided an incorrect date. Other parties who attended the meeting with the Spriggs family said the meeting occurred on 15 December: Maurice Corcoran, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 5 January 2018, attachment 2.

²⁰⁴ Letter from Jackie Hanson to Barbara Spriggs, 16 December 2016, 2017-000535-E0004 (LVlahos1) DOC-000000667.

²⁰⁵ Ibid.

On 16 December 2016 following a phone conversation with Ms Hanson, Dr Groves emailed Ms Hanson with the subject line 'Spriggs'.²⁰⁶ Dr Groves raised concerns with overall clinical governance across the state. Dr Groves discussed his powers under the MHA and said that neither of his predecessors ever undertook an investigation due to resourcing issues. Dr Groves said:

*This type of independent review, should be linked with a comprehensive clinical governance system in MH in LHNs, I do not think it is currently comprehensive enough and if it was the situation you currently have would have been alerted to a long time ago.*²⁰⁷

Minister Vlahos said that on 19 December 2016 she met with Ms Hanson.²⁰⁸

On 20 December 2016 Ms Hanson met with Dr Groves and Mr Richards where she raised concerns about the level of clinical care provided at the Oakden Facility. Ms Hanson requested that Dr Groves undertake an external independent review of the Oakden Facility.²⁰⁹ Ms Hanson gave evidence that the terms of reference for the review were discussed at the meeting.²¹⁰

On 20 December 2016 Ms Hanson and Dr Groves exchanged emails concerning the composition of the review team and terms of reference. Dr Groves provided Ms Hanson with a list of people who had confirmed their availability to assist with the review and sought confirmation from Ms Hanson that the review makes reference to Mr Spriggs. Ms Hanson replied stating the Terms of Reference could fit around the complaint from a family. Dr Groves responded by saying the review could be based around recent SAC1 and SAC2 complaints so it does not look like a 'witch hunt'.²¹¹ There does not appear to have been a response to this proposed variation.

Ms Hanson's evidence was that she met with Minister Vlahos on 22 December 2016. Minister Vlahos denied there was a meeting on that date. Her evidence was that she flew to Sydney early that morning and was not in Adelaide for the rest of that day.²¹²

On 22 December 2016 Ms Hanson received an email from Ms West outlining a telephone conversation between her and Dr Rebecca Wheatley, senior medical practitioner, who had made a recent complaint about a staff member at Clements House. Ms West suggested widening the review to include Clements House.²¹³

On 9 January 2017 Ms Hanson assigned a Senior Nurse Manager to the Oakden Facility to oversee a process of ensuring best clinical care and protecting rights.²¹⁴

On 13 January 2017 Ms Hanson signed a minute to Minister Vlahos' office noting a review of Oakden OPMHS had been commissioned and that the review would commence on 16 January 2017.²¹⁵

²⁰⁶ Statement of Jacheline Hanson, 10 October 2017, [138], annexure JRH40.

²⁰⁷ Ibid.

²⁰⁸ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018; extract from diary of Mrs Vlahos from 19 December 2016 to 25 December 2016.

²⁰⁹ Ibid 7; *The Oakden Report*, above n 39, 1.

²¹⁰ Statement of Jacheline Hanson, 10 October 2017, 32; email from Juan Legaspi to Chris Burford, Anna Bartsch, and Jason Gillick re Oakden timeline, 27 April 2017, 2017-000535-E0005 (JWeatherill1) DOC-000000115; document entitled 'Timeline', provided by the Office of the Premier, 2017-000535-E0005 (JWeatherill1) DOC-000000118; document entitled 'Oakden Timeline', produced by the Office of the Premier, 2017-000535-E0005 (JWeatherill1) DOC-000000329.

²¹¹ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10(x)(i)-(iii).

²¹² Mrs Vlahos' QANTAS e-ticket itinerary from Adelaide to Sydney on 22 December at 8:15am.

²¹³ Statement of Jacheline Hanson, 10 October 2017, [140], annexure JRH42.

²¹⁴ *The Oakden Report*, above n 39, 3.

²¹⁵ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 31 January 2018, 10(y)-(z).

SUMMARY

- In response to concerns regarding safety and standards of care delivered at the Oakden Service the Office of the Chief Psychiatrist will conduct a review with the purpose of making recommendations about the management, culture and standards of care in 2016.
- The review team will consist of:
 - Dr Aaron Groves, Chief Psychiatrist, Department for Health and Ageing
 - Professor Nicholas Proctor, University of South Australia
 - Dr Duncan McKellar, Central Adelaide Local Health Network
 - Ms Del Thompson, Clinical Risk Manager, Office of the Chief Psychiatrist
- Under the Terms of Reference (attached) the team will consider, review and make recommendations about the current Model of Care, and whether there are variations in practice to the model and if the model is aligned with current best practice standards for delivery of care for older persons with a mental illness.
- Staff and other key stakeholders have been informed of the review.
- All relevant industrial bodies have received correspondence on 4 January 2017 informing them of the review and were also provided with the Terms of Reference.

BACKGROUND

- The Older Persons Mental Health Service at Oakden Campus provides transitional and extended care for mentally ill older residents with challenging behaviours.
- The wards located at Oakden are known as Makk, McLeay and Clements and attract fifty-five (55) Commonwealth bed licences.
- The Clements ward is a state-wide transitional care service providing a holistic, multi-disciplinary, short term rehabilitation service, following an acute admission. It provides twenty-four (24) hour specialist mental health care for residents who require mental health nursing support and rehabilitation support to enable residents to move to a residential care facility, other supported accommodation, or their own home.
- The Makk and McLeay wards provide a statewide specialist mental health and geriatric residential care for its residents, whose challenging behaviours have prevented them from residing in mainstream aged care facilities.²¹⁶

On 17 January 2017 Minister Vlahos responded to Mr Corcoran's letter dated 14 October 2016. Mrs Vlahos stated:

I am deeply unhappy with the time it has taken for the Oakden service to engage with the Spriggs family.

The concerns raised by this case is greatly concerning and I have asked for a review of the Oakden OPMHS to be conducted. This will be a clinical review led by the Chief Psychiatrist, that will look at staffing and clinical practice across the entire service. The review began yesterday and I expect the report to be presented to me within eight weeks.

I am advised that Ms Jackie Hanson, Chief Executive Officer of the Northern Adelaide Local Health Network, has met with the family and listened to their concerns. I have also made it an expectation for the family to be taken through the findings of the report.

I wish to convey my condolences to the Spriggs family, and it is a matter that I do not want to happen again.²¹⁷

Dr Groves' review was publicly announced on 17 January 2017.

²¹⁶ Minute from Jackie Hanson to the Office of the Minister for Mental Health and Substance Abuse re Review of Oakden Older Persons Mental Health Service – Northern Adelaide Local Health Network (NALHN), 13 January 2017, 2017-000535-E0013 (JHanson3)(JRichter3) DOC-000000179.

²¹⁷ Letter from the Hon. Leesa Vlahos to Maurice Corcoran, 17 January 2017, 2017-000535-E0004 (LVlahos1) DOC-000000404.

On 20 January 2017 Minister Vlahos' office received a minute from Ms Hanson (signed by Ms Hanson on 13 January 2017) in relation to the review by Dr Groves.

In early February 2017 Ms Kaminski, CE SA Health, and Ms Hanson decided that they should request Dr Groves provide a preliminary report.

On 9 February 2017 the Review team agreed to provide a preliminary report for the consideration of Ms Kaminski and Ms Hanson.

On 9 February 2017 a number of staff members at the Oakden Facility were stood-down from duty pending an investigation. Ms West gave evidence that the general process involved an initial decision indicating an intention to suspend the relevant officer. This would be sent by way of letter under Ms West's name, ordinarily following a decision by an Executive to verbally suspend the officer.²¹⁸

On 10 February 2017 Minister Vlahos visited the Oakden Facility for the first time.

On or about 11 February 2017 three more staff members at the Oakden Facility were stood-down from duty.

On 14 February 2017 Ms West telephoned SA Police and reported the Spriggs matter to Superintendent Guy Buckley.²¹⁹ On 15 February 2017 Ms West provided further information by email to Superintendent Buckley.²²⁰

On 15 February 2017 the review team met with families and carers of the consumers at the Oakden Facility at the premises of the Office of the Public Advocate (OPA).²²¹

On 15 February 2017 Minister Vlahos made her first Parliamentary statement about the Oakden Facility. She said:

Late last year, I agreed to an independent review, led by the Chief Psychiatrist under the Mental Health Act 2009, into services and care provided at the Oakden older person's mental health facility. This review was initiated in response to feedback from a family about the treatment their relative had received while a patient at the Oakden campus. I spoke about this previously, at the commencement of this review. I wish to update the house about the actions and interim steps that my department has taken as this review continues.

The review commenced in mid-January this year. Its terms of reference cover areas including the service's model of care, the staffing model and cultural practices, risk management and risk mitigation practices and restrictive practice guidelines to ensure SA Health standards and national best practice are met in a contemporary framework. While families have reported many positive experiences and good levels of care at the Oakden facility, I am advised that initial investigations have found indications of some instances where patient care within the facility are not consistent with the high standard we would expect.

I am advised that the Northern Adelaide Local Health Network has taken immediate steps to ensure the treatment of consumers and quality of care at Oakden is one of the highest standard. These steps have included introducing further senior clinical support at Oakden seven days a week, engaging additional senior clinical nurses to provide focused clinical leadership after hours and on weekends, ensuring there is senior support on site for staff, patients and their families 24-hours a day seven days a week and the recruitment of a mental health clinical pharmacist.

²¹⁸ Statement of Maria West, 24 October 2017, 84, [244]-[245].

²¹⁹ Ibid 47-8, annexure MLW145.

²²⁰ Ibid 48, [167], annexure MLW145.

²²¹ *The Oakden Report*, above n 39, 5.

*I am advised that the Oakden consumers' families have been contacted as part of this review and informed about the review's investigations to date, the measures introduced to ensure appropriate care for their relatives and to seek any further feedback they may have about the care that their family member receive is ongoing at Oakden. I am expecting the final findings of the Chief Psychiatrist and the review's recommendations to be delivered to the government and to be considered at the end of March. I will ensure that the review's findings are shared with patients' families and staff.*²²²

On about 17 February 2017 Dr Groves provided a preliminary report to Ms Kaminski. The evidence suggests that Ms Kaminski requested Dr Groves to prepare a preliminary report.²²³ Minister Vlahos did not read the preliminary report until preparing for her ICAC examination.²²⁴

The preliminary report included extensive findings:

Findings

The Oakden Review Team through the interviews held to date, site visits and a review of selected clinical case notes has found the following:

- 1. There has been a failure of governance relating to the OPMHS at Oakden Campus. This includes a lack of effective monitoring to ensure safe and appropriate standards of care, a lack of advocacy for consumers and staff, a failure to respond to concerns raised repeatedly by a variety of stakeholders and repeated decisions that neglected staffing, resources and maintenance of adequate infrastructure. This failure of governance has resulted in harm to consumers, distress and suffering for some families and carers and undue stress and work related harm to some staff.*
- 2. Previous senior mental health management in NALHN have not understood or responded to the specialist nature of older persons mental health services and do not appear to have prioritised addressing the problems that were known within the older persons mental health service over many years.*
- 3. Consumers, carers and family members have not been treated with a level of respect and dignity to a standard that would be expected in any health setting.*
- 4. Personal care has not been provided at an appropriate standard. This includes the following issues, which require urgent remediation:*
 - a) There has been inadequate practice and supervision of consistent quality in levels of nursing care.*
 - b) Appropriate levels of hygiene have not been adequately or consistently provided for consumers. This includes inadequate management of incontinence and personal activities of daily living.*
 - c) Consumers' personal property has not been maintained; including loss, damage and unexplained disappearance of personal belongings. Families and carers have reported financial loss and distress relating to this unexplained disappearance of personal belongings and mismanagement of consumers' clothing, including poor laundering practices, repeated loss of newly purchased items and finding consumers dressed in other consumers' and mismatched clothes.*

²²² Document entitled 'Timeline', provided by the Office of the Premier, 2017-000535-E0005 (JWeatherill1) DOC-000000118; document entitled 'Oakden Timeline', produced by the Office of the Premier, 2017-000535-E0005 (JWeatherill1) DOC-000000329.

²²³ Internal memorandum from Dr Aaron Groves to Chief Executive SA Health re: Chief Psychiatrist Review into the Provision of Care and Treatment at Oakden Campus – Preliminary Report, 17 February 2017, 2017-000535-E0005 (JWeatherill1) DOC-000000035; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 100.7-39 (Aaron Groves).

²²⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 148.21-28 (Hon. Leesa Vlahos).

- d) *There has been an absence of adequate and clinically appropriate personal, functional and lifestyle stimulation for consumers, resulting in boredom, loss of dignity and clinical deterioration.*
5. *There have not been adequate strategies in place to provide a safe environment for consumers, carers or staff. This includes the following:*
 - a) *There have been repeated incidents where consumers have injured other consumers.*
 - b) *There have been repeated incidents of consumers injuring staff, and staff injuring consumers.*
 - c) *Whilst some incidents have been reported and have led to appropriate investigations and repercussions for specific staff there is evidence of incidents that have not been reported and are reflective of a culture of practice amongst some staff that is of the highest concern.*
 - d) *There has not been an adequate strategy in place to mitigate the risk of falls.*
 6. *There has been excessive, inappropriate and at times unapproved use of physical and mechanical restraint and inappropriate seclusion. In particular, there has been excessive and unnecessary use of pelvic restraints, contributing to clinical deterioration of consumers. For many family members this use of restraint has caused them significant distress.*
 7. *There has not been an adequate provision of a multidisciplinary team to provide the level of care required for the complex care needs of the cohort of Oakden OPMH. This has included:*
 - a) *There has been inadequate medical leadership for the service.*
 - b) *There has been inadequate training and supervision of junior medical staff and this has had a direct impact on their capacity to adequately perform their duties.*
 - c) *There has been inadequate specialist geriatric medicine support for the service.*
 - d) *There has been a significant deficit in the number of members of a multidisciplinary team required to meet the needs of the complex care needs of the cohort. In particular occupational therapy, clinical psychology, clinical pharmacy, social worker, podiatrist, dental care, speech pathologist, and diversional therapists.*
 - e) *There has not been sufficient nursing staff with the appropriate levels of training, education, skill development to match the complex needs of the cohort.*
 - f) *There have been no adequate resources provided to ensure an appropriate program of professional development, supervision and continuing education and training for staff.*
 8. *The infrastructure provided at the Oakden Campus is inadequate to provide the therapeutic environment required for the complex care needs of the cohort. There have been large levels of risk in the environmental layout which does not allow for adequate levels of observation. The clinical environment is unpleasant and noisy. There has been no adequate maintenance or replacement schedule in place for the furniture and equipment in use at the facility-which is unfit for purpose. There is inadequate lighting and ventilation. Equipment and access to lifestyle care and support of consumers is inadequate and requiring repair.*
 9. *There have been inadequate processes in place for engagement with families and carers, providing opportunity for feedback, development and review of consumer care plans which has resulted in a lack of timely responsive adjustment of care provided to individual consumers.*
 10. *The culture of Oakden has been characterised by disrespect, lack of courtesy, institutionalised behaviours and poor and ineffective communication. This has led to low morale, a sense of hopelessness and helplessness. The review also found both very defensive behaviour and examples of overt hostility. Some staff felt unable to speak out for fear of retribution and this has extended to family members who also fear retribution to their loved ones.²²⁵*

On 19 February 2017 Mr Moutakis ceased as the Consumer Liaison Officer, NALHN.

²²⁵ Preliminary Report of the: Chief Psychiatrist review into the provision of care and treatment at Oakden Campus, Older Persons Mental Health Services, February 2017, 2017-000535-E0007 (AGroves2) DOC-000000931.

On 20 February 2017 a doctor at the Oakden Facility was stood-down.²²⁶

On 28 February 2017 the AACQA undertook an inspection of the facility.²²⁷

In March 2017 Mr Corcoran conducted an unannounced visit of the Oakden Facility.²²⁸

On 3 March 2017 Ms Hanson received an email from Dr Groves. Dr Groves was told that in 2016 there were staff in Makk and McLeay Houses who had not been appropriately credentialed and had been moved to Clements House during an unannounced visit from the AACQA. Ms Hanson sought a formal response in relation to this matter from Ms West.²²⁹

On 6 March 2017 the AACQA commenced a review audit of Makk and McLeay.²³⁰

On 8 March 2017 representatives of RANZCP wrote to Minister Vlahos regarding Oakden.

Through the recent media reports, the RANZCP is aware of three staff being suspended in relation to an investigation of the Spriggs' complaint. While the RANZCP is supportive of diligent investigation and review of errors in clinical practice, we also support a systems-focused analysis of such errors, rather than processes that target individuals.

*The problems at Oakden are much more significant than problems with individuals' practice and reflect a whole service that has had deficits in governance over a prolonged period, resulting in neglect of resourcing and an absence of a workable model of care underpinning provision of a safe and sustainable care and work environment. This is what the RANZCP and other stakeholders have been seeking to bring to attention of the government and health service over several years.*²³¹

On 11 March 2017 a further staff member at the Oakden Facility was stood-down from duty.

On 16 March 2017 two further staff members at the Oakden Facility were stood-down from duty.

On 17 March 2017 the AACQA finalised a review audit of Makk and McLeay and notified Ms West of its decision to impose sanctions on the accreditation of Makk and McLeay Houses. The Delegate of the Secretary of the Department of Health stated he was satisfied that NALHN did not comply with one or more responsibilities under Part 4.1, 4.2 or 4.3 of the *Aged Care Act 1997* and due to the non-compliance, there was an immediate and severe risk to the safety, health or wellbeing of care recipients at Makk and McLeay Nursing Home.

On 17 March 2017 a further staff member at the Oakden Facility was stood-down from duty.

On 20 March 2017 a further staff member at the Oakden Facility was stood-down from duty.

On 27 March 2017 the AACQA wrote to Ms West informing her that Makk and McLeay had failed to meet 15 of the 44 Commonwealth standards.²³² The letter outlined the areas where the accreditation standard had not been met and sought a response to the specific evidence provided to determine whether the failure to meet the Accreditation Standards has placed, or

²²⁶ Email from Don Frater to Sam Runnel re: Oakden, 20 February 2017, 2017-000535-E0004 (LVlahos1) DOC-000000128.

²²⁷ *The Oakden Report*, above n 39, 7; Statement of Maria West, 24 October 2017, 72.

²²⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 24.45-25.5 (Maurice Corcoran).

²²⁹ Statement of Jacheline Hanson, 10 October 2017, 41, annexure JRH63.

²³⁰ Email from Marie Mitchell on behalf of Australian Aged Care Quality Agency to Maria West re advice of review audit decision, 7 April 2017, 2017-000535-E0005 (JWeatherill1) DOC-000000069; Statement of Maria West, 24 October 2017, 72.

²³¹ Letter from Dr Michelle Atchison to Hon. Leesa Vlahos re: Older Persons' Mental Health Services at Oakden (OPMHS), 8 March 2017, 2017-000535-E0004 (LVlahos1) DOC-000000167.

²³² Document entitled 'Oakden Timeline', produced by the Office of the Premier, 2017-000535-E0005 (JWeatherill1) DOC-000000329; Letter from Virginia Matthews to Maria West re possible serious risk to the safety, health or wellbeing of a care recipient, 27 March 2017, 2017-000535-E0004 (JWeatherill1) DOC-000000274; Statement of Jacheline Hanson, 10 October 2017 41, annexure JRH64.

may place, the safety, health or wellbeing of a care recipient at serious risk under clause 2.63(2) of the Quality Agency Principles 2013.

On 28 March 2017 Minister Vlahos made her second Parliamentary statement about the Oakden Facility. She said:

I rise to update the house about the Oakden Older Persons Mental Health Services facility. In late February 2017, the Australian Aged Care Quality Agency made an announced visit to Oakden. This involved a return on Monday 6 March 2017 for an unannounced review audit, and six days were spent assessing the facility against 44 standards of accreditation.

I am advised that the Northern Adelaide Local Health Network was informed on 17 March 2017 that 15 of the 44 standards relating to education and staff development, regulatory compliance and continuous improvements in care were deemed not met in two wards, Makk and McLeay, despite the Oakden campus previously achieving full accreditation against those 44 standards in February 2016 and being accredited through to 30 April 2019. As result of the most recent advice, the Commonwealth Department of Health has now imposed three sanctions on the Makk and McLeay aged-care facility relating to financial payments to the facility and aged-care provider status.

I am advised that the Northern Adelaide Local Health Network was taking, and continues to take, immediate steps to ensure that the quality of care at Oakden is of the highest standard and that all residents are safe. I am also advised that the steps taken include employing a new clinical practice coordinator with extensive experience in aged care and dementia care to provide clinical and operational oversight at Oakden, that the consultant psychiatrist position has been increased, and that three after-hours registered nurses have been engaged to provide additional clinical leadership after hours and on weekends.

Oakden also now employs a part-time social worker and occupational therapist to ensure residents receive comprehensive services. A nurse adviser has also commenced at Oakden to provide high-level regulatory independent advice to management. A senior clinical pharmacist has commenced, and a part-time clinical pharmacist has been employed. The director of pharmacy is also providing face-to-face orientation on the online training modules for medication management. Medication education plans have also been developed and implemented for both medical and nursing staff.

I am further advised that the chief executive is looking closely at the practices of all staff employed at the Oakden facility and that some staff have been stood down from their duties. As these staffing matters are subject to ongoing investigation, I do not intend to make further comments at this time.

I want to make it very clear that the South Australian government takes a zero tolerance approach to any allegations of substandard care toward some of our most frail and vulnerable South Australians, and I reiterate that the Chief Psychiatrist is undertaking a systemic independent review of the Oakden facility. I am advised that while the Chief Psychiatrist has decided to focus his review on 2016, he will, in his review, look at the historical practices at the Oakden facility and the circumstances that may have led to substandard care.

I also want to make it absolutely clear that the Chief Psychiatrist is an independent statutory officer and has powers under the Mental Health Act 2009 to investigate matters of concern about safety and quality as he sees fit and can also recommend, as part of his review, further investigations. I am awaiting the findings of the Chief Psychiatrist's review at the end of this

*month, and we will share the findings and the recommendations as well as the state government's response with the care recipients' families and staff.*²³³

On 29 March 2017 Minister Vlahos met with RANZCP delegates Dr Atchison, Dr Shephard and Ms Fay Millington, Policy Officer RANZCP SA Branch, to discuss the Oakden Facility.

In March/April 2017 further staff members at the Oakden Facility were suspended or placed on alternate duties pending an investigation.²³⁴

On 5 April 2017 an employee received a letter of intent to terminate employment.²³⁵

On 7 April 2017 the AACQA issued a non-compliance notice for Makk and McLeay.

On 10 April 2017 Dr Groves finalised the Oakden Report and provided it to Minister Vlahos.²³⁶ The report raised serious concerns about the Oakden Facility.

On 20 April 2017 Minister Vlahos met with Mrs Spriggs and Dr Groves.

On 20 April 2017 the Oakden Report was considered by Cabinet and immediately after made publicly available.

On 20 April 2017 Minister Vlahos made an announcement that Oakden would be closed. The consumers living at Oakden would be transferred to appropriate alternate facilities:

The Makk and McLeay Nursing Home at the Older Person's Mental Health Service, Oakden, will close as part of the State Government's response to an independent review into the service.

The State Government has accepted all of the review's recommendations and will transition Makk and McLeay residents to alternative mental health or aged care facilities over the coming months.

Alternative options for residents are likely to include refurbished facilities at Northgate Aged Care Services, which will be specially adapted for residents and other appropriate residential aged care homes.

A new statewide model of care will also be developed for the treatment of older people in South Australia with severe mental illness and severe and extreme behavioural and psychological symptoms of dementia (BPSD).

To date, 8 staff have also been stood down pending a full investigation, 21 staff have been reported to the Australian Health Practitioner Regulation Agency (AHPRA) and 3 incidents reported to SA Police.

Background

In December 2016, an independent review was commissioned to look at care provided at the Oakden Older Person's Mental Health Service after concerns were raised by the family of a consumer about the treatment their relative received as a resident.

The review team was led by the State's Chief Psychiatrist, Dr Aaron Groves and included a panel of mental health experts; Professor Nicholas Procter, Dr Duncan McKellar and Ms Del Thomson.

Over recent months the Northern Adelaide Local Health Network has implemented a number of actions to improve the level of care and well-being of patients in the care of the Older Person's Mental Health Service.

²³³ Document entitled 'Oakden Timeline', produced by the Office of the Premier, 2017-000535-E0005 (JWeatherill1) DOC-000000329.

²³⁴ Statement of Maria West, 24 October 2017, 84, annexure MLW212.

²³⁵ Ibid.

²³⁶ *The Oakden Report*, above n 39.

These have included employing a new senior clinical pharmacist, senior nursing staff and increasing the hours of the consultant psychiatrist.

SA Health has today contacted the families of residents to inform them of the report, SA Health's response and how this will impact on their family member.

A full copy of the review and the State Government's response is available www.sahealth.sa.gov.au

Any families who want to discuss any aspect of their family member's care can contact (08) 7485 4369.

Quotes attributable to Mental Health Minister Leesa Vlahos

In December last year I became aware of concerns about the care of a resident at the Makk and McLeay Older Person Mental Health Facility at Oakden.

In response, with the CEO of the Northern Adelaide Local Health Network, I commissioned an independent review of the service to be led by the State's Chief Psychiatrist, Dr Aaron Groves and supported by a panel of experts.

Dr Groves' report is deeply concerning and the practices outlined within the report are reprehensible. It requires a swift and significant response from the State Government.

The report makes it clear that, while recent efforts have been made to improve the quality of care provided to residents, the Oakden facility is not suitable to provide modern and appropriate care to some of our most vulnerable consumers.

SA Health will now work with the families to transition their loved ones to alternative places of care.

Quotes attributable to SA Health Chief Executive Vickie Kaminski

The independent review by the Chief Psychiatrist includes disturbing examples about inappropriate care provided to residents at the Older Person's Mental Health Service at Oakden.

This is completely unacceptable. The safety and well-being of our residents must always be our first priority and, in a number of instances at Oakden, this has not occurred.

Since the review began, we have introduced a number of measures to improve the level of care provide.

We will now sit down with each of the residents' families to work through the most appropriate place for their loved ones to move to get the care they need.

It's also important we work with our staff to ensure they have the appropriate knowledge, resources and skills to deliver high quality care.

We will develop a state-wide Older Person's Mental Health Service Model of Care across all our health networks that aligns with best practice to ensure we see dramatic improvements in how care is delivered to older people in our community with severe mental illness.²³⁷

In or around May 2017 the Coroner announced that the inquest into the death of Mr Rollbusch would be re-opened.

On 3 May 2017 the Premier Weatherill met with several people who had or had had family members in the Oakden Facility, including Mrs Spriggs, Ms Baff and Mr Stewart Johnston.

On 5 May 2017 an anonymous report was made to the Office for Public Integrity (OPI) about the conduct of NALHN Executive level employees. The report was assessed by the OPI as raising a potential issue of misconduct or maladministration in public administration pursuant to s 23(1)(b) of the ICAC Act.

²³⁷ News Release by Hon. Leesa Vlahos re State Government to Close Oakden Older Person's Mental Health Service, 20 April 2017, 2017-000535-E0004 (LVlahos1) DOC-000000310.

On 5 May 2017 Premier and Minister Vlahos visited the Oakden Facility.

On 10 May 2017 the OPI received a further report alleging that Executive level employees of NALHN were aware of the issues at the Oakden Facility but did not take any action. The report was assessed by the OPI as raising a potential issue of misconduct or maladministration in public administration pursuant to s 23(1)(ab) of the ICAC Act.

On 16 May 2017 Minister Vlahos made a Ministerial Statement about the Oakden Facility and the ongoing Government response to the Oakden Report. She said:

I rise to update the house on the ongoing government response to the Chief Psychiatrist's report into the Oakden older persons mental health facility. The Chief Psychiatrist's report uncovered shocking examples of systemic elder abuse at Oakden dating back to 2001. Underpinning the abuse was the entrenched culture of cover-up identified in the Oakden report which the government is determined to end. We have a zero tolerance approach to further elder abuse, and underpinning the abuse was the entrenched culture.

I wish to update the house on steps that have been recently undertaken to enforce these standards. I wish to inform the house that a staff member working at the Oakden facility has been suspended. The matter was immediately referred to SA Police following an allegation of abuse reported to the new clinical head of unit on Saturday 13 May. The removal of the staff member related to an alleged incident witnessed by a family member of another patient on Tuesday 9 May that was not reported until Saturday 13 May.

This takes the current number of people suspended from the workplace to 10, pending further investigation. In addition, one person has resigned and one person has been terminated. These figures will likely continue to change in accordance with the status of investigations by SA Health, AHPRA, SA Police and the commonwealth Australian Aged Care Quality Agency. Given the number of staff issues uncovered subsequent to the Oakden report, outside legal counsel has been engaged to assist, and we need to act swiftly and effectively to deal with the safety concerns.

I have written to AHPRA to request that they expedite their investigations and, as I have said previously, I expect any worker with allegations of violence or abuse against them to be stood down immediately until matters are properly dealt with. Further, I have asked the SA Health chief executive, Vickie Kaminski, to thoroughly investigate claims by family in the media yesterday that an Oakden staff member previously accused of assault remains employed. Whilst I am advised that this matter had been investigated previously, I have instructed a review of any previous investigations so that I can be satisfied that they were conducted properly. I will report to the families affected and the house when information becomes available.

I completely understand the anger and despair of the families, and a number of measures have been put in place to support them. The Premier and I have met with a number of family members of residents of the Oakden facility. There is an existing hotline for families to contact regarding any concerns they have about their loved ones. To date, 21 calls have been received on this line. I reiterate to the families my offer and the Premier's offer to continue to discuss their family's concerns and situation with me.

A new team of senior clinicians has been installed at Oakden to oversee the closure of the Makk and McLeay wards and the transfer of residents to the Northgate site and other appropriate facilities. These senior clinicians, led by the new Clinical Head of Unit, Dr Duncan McKellar, are working closely with residents and their families to ensure the move to the new facilities is as smooth as possible. I have been advised that the service has contacted 20 families to date in relation to the transition, with more meetings to follow.

Along with the implementation of the six recommendations contained in the Chief Psychiatrist's report, a number of other measures have been put in place to review what went wrong at Oakden. The state government has given notice to expand the terms of reference

for the elder abuse joint committee to consider the Oakden review. This will include addressing issues raised by the Hon. Kelly Vincent MLC in relation to the selection and screening of staff in the aged-care sector. I intend to appoint an external expert to oversee the implementation of the government's response to the Oakden report.

The South Australian government also welcomes the Commonwealth Senate inquiry into the Australian Aged Care Quality Agency and the accreditation process. This comes on top of the review by the commonwealth agency, announced by the federal aged-care minister, the Hon. Ken Wyatt MP. Clearly, the accreditation system is failing the people it is designed to protect, given that Oakden received full accreditation from the commonwealth agency as recently as March 2016 through to 2019.

What occurred at Oakden over a protracted period of time is completely unacceptable, and its discovery has provoked a national debate on the state of aged-care standards across our country. I reiterate my apology and the government's apology to the residents and families of the Oakden site, past and present. What occurred should not have happened, and the South Australian government is dedicated to ensuring this cannot occur again.

In closing, I want to reassure the South Australian public that I will disclose all important information regarding Oakden. From the outset, I have been transparent in releasing relevant documentation, including the Chief Psychiatrist's disturbing report, as I am determined to ensure that this will never happen again.²³⁸

On 24 May 2017 representatives of RANZCP wrote to Minister Vlahos expressing concerns about the next steps in implementing the recommendations of the Oakden Report.

On 25 May 2017 I announced, while giving evidence to Parliament's Crime and Public Integrity Policy Committee, that I would conduct an investigation into potential maladministration with respect to the management of Oakden.²³⁹

In June 2017 the SA Health Oakden Response Plan Oversight Committee was established to provide oversight and guidance to implementing the recommendations of Dr Groves.²⁴⁰

In June 2017 14 consumers from Makk and McLeay were relocated to the Northgate Aged Care Facility (Northgate). A further 12 were relocated to the resident aged care sector.

On 15 June 2017 the Commissioner, counsel assisting the Commissioner, the solicitor assisting the Commissioner and members of the Commissioner's staff inspected the Oakden Facility.

On 20 June 2017 Minister Snelling made a Ministerial Statement relating to the closure of Makk and McLeay and the move to Northgate.²⁴¹ Minister Snelling stated the State Government had accepted all six recommendations contained in the Oakden Report. Minister Snelling informed the House that 14 residents from the Makk and McLeay wards were relocated to Northgate on 14 June 2017. A further 12 residents were moved to the residential aged care sector.

On 1 July 2017 Mr Corcoran was re-appointed as PCV.

On 4 August 2017 Ms Penery's employment was terminated.

On 18 September 2017 Minister Snelling resigned as Minister for Health and Minister Vlahos resigned as Minister for Mental Health and Substance Abuse.

²³⁸ South Australia, *Parliamentary Debates*, House of Assembly, 16 May 2017, 9669-70 (Hon. Leesa Vlahos).

²³⁹ The Terms of Reference for the investigation were released to the public on 30 May 2017

²⁴⁰ Crown Solicitor, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, [33].

²⁴¹ Ministerial Statement by the Minister for Health, Jack Snelling re Update on Makk and McLeay closure and move to Northgate, 20 June 2017, 2017-000535-E0005 (JWeatherill1) DOC-000000613.

On 22 September 2017 the Oakden Facility was closed.

In October 2017 a Review of National Aged Care Quality Regulatory Processes (the Review) was conducted at the initiative of the Commonwealth Government, which was carried out by Ms Kate Carnell AO and Professor Ron Paterson ONZM who provided that report to the Federal Minister for Aged Care.²⁴²

The Review was carried out at a Federal level with specific focus on aged care issues.

The Review considered that the aged care quality regulatory processes worked well in most cases however there was a need to examine why they failed to detect longstanding failures at the Oakden Facility.²⁴³ While the Review did not focus on what went wrong at the Oakden Facility, the issues at the Oakden Facility were a catalyst for the Review and also the subject of a case study in the Review.

The Review apparently received more than 400 submissions; conducted over 40 consultations; and held consumer forums in Brisbane and Melbourne.²⁴⁴ The Review did not exercise any coercive investigative powers such as summonses or conducting examinations.

The Review identified 5 key elements of an effective regulatory system for aged care quality:

- 1) An integrated safety and quality regulatory
- 2) Information on care quality for consumers and providers
- 3) Supporting consumers and their representatives to exercise their rights
- 4) More effective accreditation and compliance monitoring
- 5) Enhanced complaints handling²⁴⁵

The Review discussed Australia's regulatory system at a Federal level.²⁴⁶ The Aged Care Act provides the regulatory framework including mechanisms to regulate quality (such as accreditation and monitoring of approved providers), managing non-compliance, complaints mechanisms, advocacy services, and the 17 Principles of Aged Care. This scheme is supplemented by the *Aged Care Quality Agency Act 2013* (Cth) (ACQA Act) which establishes the AACQA. The Aged Care Act also establishes the Office of the Aged Care Complaints Commissioner which plays a role in receiving and handling complaints.

The Aged Care Complaints Commissioner commenced operation in January 2016.²⁴⁷ However, it has existed in similar terms and going by different titles since May 2007.

Chapter 3 of the Review is entitled 'What went wrong at Oakden?'.

The Review considered that, from an aged care perspective, the history of the Oakden Facility is separated into three parts:²⁴⁸

- 1) the Oakden Facility until 2010, being the period in which the Oakden Facility was under close supervision by the Commonwealth;
- 2) the Oakden Facility from 2010 to 2017, being a period during which the Oakden Facility was granted long accreditation periods; and
- 3) the Oakden Facility in 2017, being when issues were identified.

The Review said that during the first period (until 2010) from the beginning of the Oakden Facility's time as a Commonwealth-subsidised facility there were issues with care. Those

²⁴² Kate Carnell, Ron Paterson, *Review of National Aged Care Quality Regulatory Processes*, October 2017, ii.

²⁴³ Ibid.

²⁴⁴ Ibid.

²⁴⁵ Ibid vii-x.

²⁴⁶ Ibid 6-8.

²⁴⁷ Ibid 8.

²⁴⁸ Ibid 29-37.

issues appeared as early as about 1999 and culminated in the failed accreditation in December 2007. During that time there were shorter re-accreditation periods provided to the Oakden Facility.

The Review said that during the second period (2010 to 2017) that the close supervision approach to the Oakden Facility appeared to change in 2010. In 2010 AACQA awarded accreditation for a three-year period. This coincided with a decreased engagement between the AACQA and the Oakden Facility including a mere two compulsory reports of incidents during 2010 which prompted one visit to the Oakden Facility and two instances of contact. In 2011 there were again two compulsory reports and there were two instances of contact but no visits. In 2012 there were three visits and no other instances of contact. All agency visits in that time reported compliance.

In 2013 a decision was made to accredit the Oakden Facility for a further three years. In 2013 (and indeed for 2014 and 2015) the only contact from the AACQA was one unannounced visit which the Review commented was the minimum possible contact under Government policy.²⁴⁹

The Review said that between 2010 and 2016 there were 6 years of 'minimal oversight'.²⁵⁰

The Review said that the third period (2017) was defined by the incident involving Mr Spriggs and the Oakden Report. The Review said that although the incident involving Mr Spriggs occurred in early 2016 and was the subject of complaints in June 2016, the Commonwealth regulatory agencies only became aware of the complaint on about 17 January 2017 when the matters were discussed on an ABC Adelaide news story. The matters involving Mr Spriggs were not identified in the re-accreditation audit in February 2016 or the unannounced assessment visit in November 2016. Despite becoming aware in January 2017 a review was not conducted by the Federal agencies until February 2017 which reported some significant issues at the Oakden Facility.

A follow-up review audit occurred in March 2017 which found that there were significant quality of care issues at the Oakden Facility and a determination made to sanction the Oakden Facility.

The Review identified three issues with accreditation which became evident from the issues at the Oakden Facility.²⁵¹ The first was that some of the expected outcomes under the standards were inappropriate and many have been in place for a long time. The second was that accreditation needed to look deeply into a service. The third was that services may prepare for accreditation.

The Review stated that the Oakden Facility should never have received three-year accreditations.²⁵² The Review acknowledges that issues at Oakden identified a flaw in the Commonwealth's system.

The ultimate conclusion with respect to the Oakden Facility was that there were significant failures of care and that the Commonwealth's regulatory framework failed to detect them.²⁵³

The outcome of the Review was that 10 recommendations were made:

- 1) *Establish an independent Aged Care Quality and Safety Commission to centralise accreditation, compliance and complaints handling.*
- 2) *The Aged Care Commission will develop and manage a centralised database for real-time information sharing.*

²⁴⁹ Ibid 34-35.

²⁵⁰ Ibid 35.

²⁵¹ Ibid 44-5.

²⁵² Ibid 47.

²⁵³ Ibid 49-50.

- 3) *All residential aged care services in receipt of Commonwealth funding must participate in the National Quality Indicators Program.*
- 4) *The Aged Care Commission will implement a star-rated system for public reporting of provider performance.*
- 5) *The Aged Care Commission will support consumers and their representatives to exercise their rights.*
- 6) *Enact a serious incident response scheme for aged care.*
- 7) *Aged care standards will limit the use of restrictive practices in residential aged care.*
- 8) *Ongoing accreditation, with unannounced visits, to assure safety and quality of residential aged care.*
- 9) *Ensure that assessment against Standards is consistent, objective and reflective of current expectations of care.*
- 10) *Enhance complaints handling.*²⁵⁴

The Minister for Aged Care, the Hon Ken Wyatt AM MP, announced broad support for the direction of the report.

The Review addressed other matters which are not directly relevant to this report.

On 24 November 2017 Dr Draper resigned from his employment with NALHN.²⁵⁵

On 13 February 2018 the Commonwealth Senate's Community Affairs References Committee published an interim report in relation to the 'Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practiced.' The interim report includes a chapter on the Oakden Facility that details the complaints from families of residents, the model of care, concerns about the care provided by staff, and recommendations and suggestions from the witnesses. The interim report states:

*[m]ost of all, the committee is deeply concerned that warning signs in relation to resident health were not heeded, such as unexplained bruising, medication mismanagement and falls, and that complaints from members and community advocates were ignored.*²⁵⁶

The Community Affairs References Committee is due to report on 28 November 2018.

In or around February 2018 Ms Hanson resigned from her position as CEO, NALHN.

On 15 February 2018 Mrs Vlahos relinquished her position on Labor's Legislative Council ticket for the upcoming state election.

On 15 February 2018 Premier Weatherill released a statement acknowledging Mrs Vlahos' decision not to contest the next state election.

By the date of this report the final consumers who were at the Oakden Facility have been relocated elsewhere and the facility has been closed.²⁵⁷ Many of the consumers have been moved into mainstream aged care facilities, which raises an issue as to whether it was necessary in the first place for such consumers to be located at the Oakden Facility.

²⁵⁴ Ibid xi-xiii.

²⁵⁵ Will Snow, on behalf of Dr Russell Draper, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, 5.

²⁵⁶ Community Affairs References Committee, Senate, *Interim Report: Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical standards are maintained and practiced* (2018) 30, [2.73].

²⁵⁷ In June 2017, 14 residents from the Makk and McLeay wards were relocated to the Northgate Aged Care facility. A further 12 were relocated to the residential aged care sector. Oakden was closed on 22 September 2017.

CHAPTER 6: THE OAKDEN REPORT

Because the Oakden Report was critical to the decision to carry out this investigation it is necessary to understand its contents.

In my opinion the catalyst for the review were the incidents involving consumer, Mr Bob Spriggs.²⁵⁸ Mr Spriggs had been referred to the Royal Adelaide Hospital with very significant bruising to his hip and no satisfactory explanation was given as to how the bruising was caused. Mr Spriggs' family raised concerns with the Principal Community Visitor, Mr Corcoran on 1 June 2016.

On 7 June 2016 Mr Corcoran conveyed Mrs Spriggs' concerns to Mr Torzyn and advised that a detailed summary would be provided. On 9 June 2016 Mr Corcoran spoke to Dr Groves and advised him that he had discussed Mrs Spriggs' complaint with Mr Torzyn and that there would be an investigation.

Having not received a satisfactory response on 14 October 2016 Mr Corcoran wrote to Minister Vlahos.

After a good deal of inactivity Ms Hanson met with Mrs Spriggs on 15 December 2016.

Shortly after that meeting on 20 December 2016 Dr Aaron Groves, the Chief Psychiatrist, was requested to undertake an independent review of the Oakden Facility and to provide a report by April 2017.²⁵⁹

The Chief Psychiatrist was asked to identify the Terms of Reference, which he did on 22 December 2016. Those Terms also identified 'the review team' which included Professor Nicholas Proctor, University of South Australia, Dr Duncan McKellar, Central Adelaide Local Health Network (CALHN); and Ms Del Thompson, Clinic Risk Manager, Office of the Chief Psychiatrist.²⁶⁰ The persons making up the review team were chosen by Dr Groves after consultation with Ms Hanson.

The Terms of Reference with which the review panel was concerned and upon which the Oakden Report was written are contained in Appendix 1 to that report.

The purpose of the review was:

*[t]o conduct a review of the older persons mental health service at Oakden Campus Oakden with the purpose of making recommendations about the management, culture and standards of care in 2016.*²⁶¹

The review panel was to report to Ms Hanson even though the statutory obligation was to the Minister.²⁶²

The report was damning of the Oakden Facility and of the standard of clinical care provided at that Facility.

The review panel made a number of findings which it relied upon for the six separate recommendations that were contained in the report.

One of the recommendations was that the Facility should ultimately be closed but in the interim that a new purpose built facility should be completed prior to the Facility's closure.

²⁵⁸ *The Oakden Report*, above n 39, 2.

²⁵⁹ *Ibid* 1.

²⁶⁰ The Biographical Statements for each of these persons are contained in Appendix Two of the Oakden report.

²⁶¹ *The Oakden Report*, above n 39, Appendix 1.

²⁶² *Ibid* Appendix 2.

No one has seriously doubted the findings made by the review panel or with any of the recommendations made.

Indeed the evidence which I have taken rather suggests that no other findings or conclusions could have been reached, which is an indictment of those who had responsibility for the Facility and the level of clinical care that was provided at that Facility.

Between December 2016 and April 2017 the Review interviewed a total of 53 staff members; met with 17 persons who had family members at Oakden; reviewed the clinical files of nine current (at that time) and seven former consumers; considered the relevant policies and procedures; conducted on-site visits; inspected mental health facilities in other States as a comparator; sought information from persons such as the Principal Community Visitor; and reviewed a significant number of documents.²⁶³

It was a very comprehensive review and it was conducted expeditiously.

It was not the purpose of this investigation to investigate again the matters upon which the review panel had reported.

The Oakden Report was finalised on 10 April 2017 and provided to Minister Vlahos on that date, and I think considered by Cabinet on 20 April 2017 (although I do not have any evidence of that) the same day it was released to the public.

The Oakden Report set out a detailed history of the issues at Oakden. It is not necessary to refer to it in detail here as many of the events referred to are set out in the chronology in this report.

The Oakden Report made six key findings in relation to issues at Oakden. I have marked in bold the findings that I think are most critical, although I do not mean by that to discount any of the findings in the Oakden Report.

Finding 1 of the Oakden Report was:²⁶⁴

The Review makes the following finding in relation to the Model of care at Oakden:

- It was unable to find a satisfactory, specific MOC that had been developed for the types of services provided at Oakden, in particular, this issue was not satisfactorily addressed in the unendorsed 2012 Model of Service for OPMHS.*
- There has been no clear articulation of the cohorts for whom services on the Oakden Campus are to be provided and how this should be achieved with regard to staffing profiles, resources or infrastructure.*
- Further, expectation of a CMHT-led, in-reach model as described in the unendorsed 2012 Model had not been supported by the degree of commensurate change within the resources; skills and capacity; or changes in practice; within the OPMHS community teams that would be necessary, if the changes aspired to in the Model were to be achieved.*
- As a result, the Model described in 2012 has been unable to prevent ongoing deterioration in the Oakden service. This is a result of two factors; namely the Model was not endorsed, is largely unknown in the OPMHS sector and it has not been implemented in a systematic manner; and secondly it identified aspirations that have not been supported by further strategic planning, resource allocation or investment.*

²⁶³ *The Oakden Report*, above n 39, 4-8.

²⁶⁴ *Ibid* 31-2.

- *The Executive of OPMHS in all LHNs has relied on the 2012 Model. This has contributed to the deficits now evident at the Oakden Campus because of the disconnection between an unfunded aspirational document and the real-world challenges of the service, when no process to identify the resources needed to implement a new model is made.*
- *All other LHNs have continued to rely on the Oakden service without having made any arrangements to provide sub-acute and non acute Tier 6 and 7 BPSD services and Transitional Care for older consumers within their own catchment areas.*
- *The unendorsed 2012 Model of Care as it relates to both Tier 6 and 7 BPSD was not in keeping with International or National Best practice and in particular is not supported by the best practice examples in New South Wales, Victoria and Western Australia.*
- *The Model of Care that is provided at Oakden is not in keeping with current best practice for the people they intend to serve who have functional mental illness and there is no relationship between best practice for people with Tier 6 and 7 BPSD and what is currently provided.*

In summary, Oakden is not providing the right care, at the right time from the right team.

Finding 2 of the Oakden Report was:²⁶⁵

The Review finds that the Oakden facility is more like a mental institution from the middle of the last century than a modern Older Person's Mental Health Facility.

- ***Oakden was not well designed or modern for the time it was built and is now entirely unsuitable for its current purpose. It meets none of the expectations of a modern mental health service for older consumers with severe and incapacitating mental illnesses.***
- *The substandard quality of the infrastructure is likely to have led to considerable difficulty providing appropriate management of the most severe challenging behaviours of Dementia. Furthermore, the infrastructure has led to low morale and frustration among staff and led to some visitors becoming distressed by the environment in which their loved one has to reside.*

Finding 3 of the Oakden Report was:²⁶⁶

The Review makes the following finding in relation to staffing models:

- ***It was unable to establish a true and accurate staffing profile or FTE which restricted the Review's ability to accurately comment on this Term of Reference with the certainty it desired.***
- ***It was also restricted in its ability to address the adequacy of staffing as a consequence of the previous finding, that there was no defined and endorsed model of care for the service, to compare the staffing to.***
- *A preliminary analysis of the provided staffing model against the Optimal Staffing Profile from the NMHPSF for a service of this type found it did not meet the levels that are required and that the mix of disciplines is incorrect.*

²⁶⁵ Ibid 57.

²⁶⁶ Ibid 65.

- **Staff were not provided with adequate opportunity to meet their mandatory training requirements, let alone access desirable training to assist them in caring for and improving services for the consumer cohort. While just over 50% of staff had completed a Performance Review and Development, what may have been included as 'Development Activities' is not clear.**
- **There is a lack of attention to ensuring staff are able to prevent and respond to Elder Abuse.**
- **The available staffing profile showed a reliance on Personal Care Assistants and a shortage of trained Mental Health Nurses. This was most apparent in the small number of Enrolled Nurses, Assistants in Nursing and Registered Mental Health Nurses. However this apparent shortfall is more profound when taking into account the poor levels of skill and training of many of the Nursing staff.**
- **The provided staffing profile showed a marked shortfall in Allied Health staffing levels. Over several years, Oakden has had insufficient access to Social Work, Occupational Therapy, Psychology and Clinical Pharmacy services that would be critical for ensuring the service provided a high level of safe care.**
- **The Medical staffing levels of Oakden, in particular Consultant Psychiatrists, are significantly short of what is determined adequate for a service of this type. The level of Consultant Psychiatrist input into the service should be at a level of 0.6 FTE in the medium term depending on the Model of Care that is finalised. However this minor shortfall in Consultant Psychiatrist input is magnified by the long term shortfall that has existed for many years.**
- **The result of such a shortfall is a marked reduction in the number of specialist interventions and an overall lack of specialised treatment plans which leads to a significant difference to the level of specialised care provided.**

Finding 4 of the Oakden Report was:²⁶⁷

The Review found that there was a failure of governance, particularly clinical governance, at the Oakden OPMHS. This failure was across all components of a Clinical Governance Framework.

Specifically the Review finds:

- **warning signs such as the rate of injuries, medication errors, excessive mechanical restraint, numerous falls, unexplained bruising, failed accreditation, poor documentation and unidentified clinical deterioration were present but the signs were not heeded;**
- **responsibility for clinical outcomes was not owned, there was no one who was clearly in charge;**
- **the priorities at Oakden were never clear to staff, but they did not include putting consumers at the centre of care and ensuring high quality and safe care, furthermore there was no clear definition of what good care was the focus became about compliance and accreditation not improvement;**

²⁶⁷ Ibid 89.

- *leadership was poor, those in charge did not take the actions needed to have a system in place that would deliver good governance, in particular they did not seem to either know or appreciate what NALHN Executive leadership expected of them, they seemed to think it was someone else's role;*
- *staff were frightened to report when things went wrong, they thought they would be blamed and many senior staff thought it better not to know, this is a fatal flaw;*
- *staff continued to make the same mistakes as there was no culture to learn by these mistakes;*
- *the education, training and professional development that should underpin excellent care was seriously deficient and focussed in areas that are out of date and irrelevant, areas such as trauma informed care, sensory modulation, falls prevention and safeguarding against elder abuse are critical;*
- *there were no identifiable process to support greater clinical effectiveness;*
- *open disclosure was rare, and external scrutiny was not encouraged;*
- *there was failure to properly resolve clinical risk when it was (rarely) appropriately raised and this led to a subsequent reluctance to raise it again, staff felt helpless and that the situation was hopeless;*
- *standards of care were poor but not closely monitored, as a result there were no systems of continuous improvement, this was not seen as a priority;*
- *professional accountability was weak, inconsistent and led to some staff not being sanctioned for unacceptable behaviour;*
- *considerable information contained within SLS and a range of other systems was not used to improve care. It was treated as if it were a chore rather than a source of important data to drive change, and;*
- *information from families and carers was not sourced as actively as it should have, complaints were managed as something that needed to be covered over as part of the nature of the work the service must do rather than as a source of important information to aid improvement.*

These findings were entirely consistent with the findings of Francis in Stafford and provide another example that is consistent with what was found in the review of Clinical Governance in Central Adelaide Local Health Network in 2016.

Finding 5 of the Oakden Review was:²⁶⁸

The Review found that there was a dominant culture in Oakden.

This culture was characterised by, poor morale, disrespect and bickering, secrecy, an inwardly looking approach, control, a sense of entitlement and indifference. This culture led to a loss of dignity and of rights for those in Oakden, both consumers and staff.

²⁶⁸ Ibid 100.

There was also sub-culture of those who cared. They respected and valued the consumer and sought to value this at all time. This group are a small minority, who are unlikely to last long in Oakden before the influence of the dominant culture takes over.

As is often the case, the dominant culture makes it very difficult for those who want good things to flourish. Instead they are become [sic] more frustrated, eventually needing to either leave, because they cannot conform to the dominant culture, or because they can no longer protest and not be heard, or leave. For many, they leave rather than become “acculturated”, for others who may have no other options; they slowly become part of the system.

A number of senior staff are standard bearers. They have an inordinate influence on the culture of Oakden; they are people who have made Oakden what it is today, a service much like those of the 1980s, and to some extent an extension of the culture from mental institutions of the middle of the last century.

There is however a number of staff at middle levels of seniority that have been at Oakden for less than three (3) years. Some of them are part of the solution for Oakden; they are the future and need to be encouraged as part of a new future.

Changing the culture of Oakden will take time; the primary focus should be on patient care and allowing people to take pride in their work.

The management- initiated introduction of a number of senior staff, a range of Allied health staff, an increase in specialist staff as well as a clear expectation that things will change has had an immediate positive impact. This may be temporary if a concerted approach to changing the culture is not put in place.

Furthermore, attention to a number of matters that might lead to disciplinary action, has led to a change in those who are leading what happens in Oakden.

Finding 6 of the Oakden Report was:²⁶⁹

The Review found that staff working at Oakden did not have the sufficient level of training which would allow them to understand the requirements and restrictions associated with the use and monitoring of restrictive practices.

This lack of training led staff to exercise powers in the use of restrictive practices that were beyond those outlined in the relevant legislation framework.

This Review makes the following findings in relation to Restrictive Practices:

- ***There has been a failure at Oakden to implement an action plan that utilises trauma informed principles and is consistent with the 6 core strategies and the SA Health Restraint and Seclusion Reduction Policy Directive, the Restraint and Seclusion in Mental Health Services Policy Guideline and Toolkit;***
- ***There has been ongoing, repeated use of restrictive practices at Oakden that has contravened legislation, national standards, state policy and local procedures and likely implemented for staff convenience and or used as punishment;***

²⁶⁹ Ibid 113.

- ***There was a lack of leadership towards changing restrictive practices demonstrated by failure to respond to requests or support staff who were attempting to implement positive change;***
- *When data was eventually collected, as required, it was not used to inform practice or encourage reflection of current practices;*
- *Staff were not presented with opportunities to engage in training that focused on prevention and de-escalation and or the use of prevention tools;*
- *There was a lack of reflective practice including the debriefing of staff, consumers or carers following the use of any restrictive practices, this is known to assist in preventing further incidents;*
- *Consumer and carer roles were not used at Oakden to assist in promoting a consumer centred approach; and*
- *It is noted that there has been a dramatic decrease in the use of restrictive practices following the recent introduction of management initiated activities.*

I have emphasised in bold a number of key issues that arise from the Oakden Report.

The Oakden Report was damning of the Facility itself, the absence of a model of care; the leadership at the Facility; the staff at the Facility (except for a small minority); the training of the staff; the standard of care offered to consumers at the Facility; and the inappropriate use of restraints to manage those consumers.

The Oakden Report had the effect for which it was designed, which was to shock NALHN and the Government more generally, into addressing the manner in which the consumers were housed and the care which was offered to them.

The Report made the following six recommendations in relation to these findings (bold added for emphasis):

Recommendation One:²⁷⁰

SA Health should develop a specialised contemporary Model of Care that addresses the State's obligation to provide high quality care to people over 65 years of age who live with the most severe forms of disabling mental illness and for those people with the most severe and extreme Behavioural and Psychological manifestations of Dementia.

- *This Model should be developed as a partnership between all LHNs across the state and be led by suitability qualified clinical experts in the field of Older Person Mental Health. It should involve the full range of possible partners to such a model including, but not limited to, Consumers, Carers, Experts in Geriatric Care, referrers, staff, the RACF sector and other providers of BPSD services.*
- *The Model should draw reference from the NSW plan for specialised OPMH and by those providing similar services in Victoria and NSW.*
- *The Model should rely on detailed population-based planning, taking into consideration but not being bound by the NMHSPF version 2.1.*

²⁷⁰ Ibid 32.

- *The Model should be supported by a Business case that identifies the funding needed to implement the new model and take proper account of the need for funding to allow the transition from the current service to a future model.*
- *The Model should identify the range of service needed across the continuum of care; between services provided in a person's home (including Hospital in the Home), those in other residential settings, acute inpatient services, and transitional care; that will allow for the proper care to Older South Australians who experience BPSD or who have Severe Mental illness. It is estimated that SA currently has need of between 60 and 90 Transitional care beds.*
- *The model should identify as a priority the site(s) for a purpose built unit for People with Tier 7 BPSD and that unit(s) be constructed in consideration of the full range of services needed to provide high quality safe care. It is predicted unit(s) currently require 21 beds and will need 24 beds by 2021.*
- *The Model must take into account how to jointly operate services that are funded with Commonwealth Aged Care Funding and State Specialist Mental Health funding for people with BPSD, when they cannot be provided with service through the privately operated Residential Aged Care sector.*

The review recommends this process commences immediately and that the responsibility for progressing this be shared by all LHNs and should not be considered the sole province of NALHN.

...

Recommendation Two.²⁷¹

The Review recommends that in developing a new Model of Care the Oakden facility is not considered an appropriate facility for the provision of either a State-wide Specialist Intensive Care Behavioural Unit for consumers with Tier 7 BPSD or for the provision of Transitional Care Units for people aged over 65 with Severe Mental Illness or Tier 6 BPSD. When considering the provision of services that replace Oakden the following should apply in relation to infrastructure:

- ***The development and commissioning of new purpose built facilities needs to be completed prior to the full de-commissioning of the Oakden facility.***
- ***The commencement of the capital planning for the purpose build replacement of Oakden should occur immediately.***
- ***Facilities will be required to cater for a non acute longer stay unit for people with Tier 7 BPSD with pods no more than 8 beds, sub-acute transitional care units (TCUS) for people with Tier 6 BPSD and separate TCUs for people with severe functional mental illness.***
- ***Neither the Tier 6 nor Tier 7 services should be considered a bed for life.***
- ***Those people in Oakden who can transfer the Residential Aged Care Sector should do so.***

²⁷¹ Ibid 57.

- ***During the period before a replacement facility is available, concerted efforts should be put in place to substantially improve the physical amenity of the facility both inside and out.***

Capital planning should commence immediately with an aim of decommissioning Oakden at the earliest possible time.

...

Recommendation Three.²⁷²

The Review recommends that during the development of a new Model of Care for Specialist OPMHS in South Australia (Rec 1), significant consultation should be undertaken to identify the optimal mix of the full range of members of a Multi-Disciplinary service that is needed to provide adequate care for the defined target group for this service. This should include consideration of the following:

- ***the need to be advised of the adequate staffing levels, together with the level of demonstrated workforce competencies that are required to provide service benchmarked against relevant services in other jurisdictions, in particular NSW and Victoria that currently have viable effective services;***
- *that there should be a comprehensive approach to determining the full range of knowledge, skills and attributes within the workforce to ensure staff are able to provide high quality and safe services;*
- *mandatory training should be appropriate, it is imperative to understand elder abuse, safeguarding rights and the principles of trauma informed principles, it [sic] currently more important than understanding "Child Safe Environments"*
- *that in the transition period between Oakden as it is currently and a finalised staffing model for the range of replacement services, the following indicative minimum staffing levels of non-nursing staff should be provided:*
 - 1.0 FTE Consultant Psychiatrist (that holds FPOA accreditation),
 - 2.0 FTE Junior Medical Officer,
 - 0.2 FTE Geriatric Medicine (Registrar level or Equivalent),
 - 1.0 FTE Consumer or Carer Consultant,
 - 1.0 FTE Senior Occupational Therapist,
 - 0.5 FTE Occupational Therapist Assistant,
 - 1.0 FTE Social Worker,
 - 1.0 FTE Physiotherapist,
 - 0.4 FTE Clinical Psychologist,
 - Consumer and Carer consultants (which could apply across the entire NALHN OPMHS); complemented by
 - Sessional access to Podiatry, Dental therapy, Dietetics and Speech Therapy;
- *in addition, the occupational therapist must be qualified in sensory assessment and modulation and that all staff is [sic] trained in sensory modulation and trauma informed care in addition to having immediate access to their mandatory training requirements;*

²⁷² Ibid 66.

- a program to support better education, training, skills development and competency as well as a framework for clinical supervision is developed and delivered that incorporates as a minimum, elements related to comprehensive patient assessment and care planning, the Fundamentals of Care, person-centred evidence based care, cultural safety and competency and clinical documentation requirements;
- the Education program should contain a specific focus on the following Australian Commission on Safety and Quality in Health Care Standards in the context of the Older Persons Mental Health Service; preventing and controlling healthcare associated infections; medication safety; clinical handover; preventing and managing pressure injuries; recognising and responding to deterioration; and preventing falls and harm from falls; and further to this
- the Review recommends 8 hour day shifts with a 10 hour night duty, consistent with the SA Nursing Enterprise Agreement, to improve patient care and staff access to training and development opportunities.

This recommendation should align with the development of a new model of care.

...

Recommendation Four:²⁷³

The Review recommends that NALHN must establish a new clinical governance system at Oakden.

The Clinical Governance system should include the following features:

- *it should comply with the current NALHN governance framework and be accountable to the Divisional Director Mental Health. This position should ensure the appointment of a suitably qualified clinical head that is the single point of clinical accountable to them for the outcomes at Oakden;*
- *the clinical head should be part of the development of the new model of care and develop a clinical governance system at Oakden that is part of an overall system that covers all specialist Older Persons Mental Health Services in South Australia from community, to acute to long stay sub-acute and non-acute units;*
- *it should be informed by the National Model Clinical Governance Framework developed by the ACSQHC and address each of its elements;*
- *it should feature a focus on ceasing blame, encouraging openness, promoting the use of data and information to drive improvement, embracing continuous improvement and placing patient care as a priority, and bringing pride back into the provision of services at Oakden;*
- *it should also promote transparency, encourage staff to state openly their concerns, give all staff assistance to achieve the expectation of life-long learning, in order that a culture of safety and quality is created; and*
- *it should be developed in partnership with the other LHNs in order that as South Australia moves toward a system that integrates services for people with very severe and extreme BPSD and long term needs with severe mental illness there is a consistency of approach.*

²⁷³ Ibid 90.

This recommendation should be implemented immediately in the knowledge that change will require 3-5 years to make a sustained difference.

...

Recommendation Five:²⁷⁴

The Review recommends that NALHN needs to ensure the significant introduction of people in senior leadership positions at Oakden that can drive the change in culture required to one that has as its core principles the values of dignity, respect, care and kindness for both consumers and the staff that work there. This will need:

- ***the introduction of new staff who must be immediately visible and requires processes in place so that any deviation from this culture is handled appropriately;***
- ***the development of a program that addresses the culture and has components that include, introducing respectful behaviours, team building and effective team work, values based leadership, providing and receiving constructive feedback, effective problem solving and positive communication;***
- ***inclusion of the Nursing and Midwifery Board of Australia Code of Ethics, adoption of the Dignity in Care Principles and Safeguarding against Elder Abuse;***
- ***a strong engagement of Industrial bodies and Human Resources Management who must be part of a solution to Oakden, the balance between supporting those who have the attributes to work in a new culture at Oakden and ensuring those that do not, can find alternatives will be critical;***
- ***a number of staff who are critical to success will need support to engage in an agenda of changing the culture at a time when many staff will feel under enormous pressure;***
- ***support of senior executive positions in NALHN as well as other LHNs who have an equal responsibility for improving the outcomes of people who need to access Oakden service [sic]; and***
- ***other LHNs supporting NALHN by recognising that Oakden is a state-wide service and that they should contribute to the solution. This could take the form of encouraging Oakden staff to participate across all parts of the OPMHS program rather than being confined to Oakden.***

The Review considers the adoption of these recommendations to build a new positive, consumer-oriented, culture will take many months to develop and longer to become firmly established.

²⁷⁴ Ibid 100.

Recommendation Six.²⁷⁵

The Review recommends that NALHN immediately develop and implement an Action Plan which is based on Trauma Informed Principles and the six core strategies developed by NCTIC.

The Action Plan should:

- *be introduced as soon as possible, and ensure compliance with the SA Health Restraint and Seclusion Reduction Policy Directive and Restraint and Seclusion in Mental Health Services Policy Guideline;*
- *ensure all staff are aware of the legislative basis for restrictive practices;*
- *feature targets for markedly reduced rates of restrictive practice to be achieved, with milestones along the pathway to this outcome that can be achieved, within the next 3 months;*
- *enlist the assistance of expertise from a range of disciplines that can help rebuild a new approach to the management of severe and persistent challenging behaviours of dementia;*
- *be subject to external peer-review by those who operate similar services where restrictive practices are either rare or have been eliminated; and*
- *include an expectation that unannounced inspections from the Chief Psychiatrist and their office staff will occur to examine restrictive practices.*

Recommendations 1-3 dealt with the need for a model of care at the Oakden Facility but upon the assumption that the Oakden Facility was not an appropriate place to deliver the type of care the facility was purporting to offer. Recommendation 2 not only dealt with the need for a new facility but addressed the significant failure at Oakden, which was to assume that all consumers who were admitted to Oakden would stay there for the rest of their lives, even if they did not have an ongoing disabling mental illness.

In addition to the formal findings and recommendations set out above, the Oakden Report made a number of concerning comments about the issues at Oakden. These included:

- a) Oakden was viewed among staff as a place for the rest of a consumer's life and as a result the attitude of staff was that little effort was needed to manage consumers.²⁷⁶
- b) Oakden did not meet best practice in most respects.²⁷⁷
- c) Certain areas were unbearably hot in summer while other areas were damp, had poor ventilation or were highly perfumed to mask offensive odours.²⁷⁸
- d) The television was often on channels for the entertainment of staff, not consumers.²⁷⁹
- e) There was evidence of possum urine stains on the ceiling.²⁸⁰

²⁷⁵ Ibid 114.

²⁷⁶ Ibid 30.

²⁷⁷ Ibid 35.

²⁷⁸ Ibid.

²⁷⁹ Ibid.

²⁸⁰ Ibid 40.

- f) Much of the furniture was damaged, ripped or in poor condition.²⁸¹
- g) Outdoor areas were neglected.²⁸²
- h) There were concerns staff did not know their obligations to report elder abuse.²⁸³
- i) Interpersonal conflict between staff was high.²⁸⁴
- j) Staff did not know who was responsible for clinical outcomes and blamed others.²⁸⁵
- k) The staff focussed more on knowing what to say to ensure accreditation was obtained rather than knowing how to simply provide high quality care.²⁸⁶
- l) The entries on clinical notes were of little clinical value and there were often days without a relevant entry made. The notes used informal language not appropriate for clinical notes, were often contradictory, on occasions used inappropriate terms or contained errors.²⁸⁷
- m) Consumers were not treated with respect. They were left soiled and unbathed, not adequately fed and hydrated, mocked, ridiculed and treated with little dignity.²⁸⁸
- n) Low morale among staff and a toxic culture.²⁸⁹
- o) There was a culture of secrecy and inaction.²⁹⁰
- p) Repeated rough handling of consumers.²⁹¹

In his examination of each of the witnesses, Mr Besanko asked those witnesses whether they agreed with the findings and recommendations made in the Oakden Report.

Most of witnesses agreed with those findings and recommendations without qualification.²⁹² No one took issue with all of the findings or recommendations but some witnesses had some reservations.

Mr Skelton agreed with the findings except in relation to Finding 3 because he disagreed that the staff had not been educated on the question of response to elder abuse.²⁹³

In relation to Finding 6 he said that he thought the second bullet point under that finding, which was to the effect that the repeated use of restrictive practices at the Oakden Facility

²⁸¹ Ibid 41.

²⁸² Ibid 44.

²⁸³ Ibid 64.

²⁸⁴ Ibid 65.

²⁸⁵ Ibid 75.

²⁸⁶ Ibid 77.

²⁸⁷ Ibid 78.

²⁸⁸ Ibid 82.

²⁸⁹ Ibid 95.

²⁹⁰ Ibid 97.

²⁹¹ Ibid.

²⁹² Ms Hanson, Dr Rafalowicz, Ms Mains, Ms West, Mr Corcoran, Mr Simon, Dr Groves of course, Mr Swan, Ms Richter (insofar as she had read it), Mr Leggett, Dr Tyllis, Ms Nowland (insofar as she had read it) and Mr Snelling.

²⁹³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 101.30-102.14 (Kerim Skelton)

had contravened legislation, national standards, State policy and local procedures and had been used for staff convenience and/or as a punishment, was controversial.²⁹⁴

However, he agreed with the rest of the Oakden Report.

Dr Draper said that he agreed with most of the observations with some exceptions.²⁹⁵ He disagreed with the historical context.²⁹⁶ He thought the Oakden Report contained unjustified criticism of staff.²⁹⁷

He disagreed with the Oakden Report insofar as it was found that the use of mechanical restraints was contrary to SA Health policy.²⁹⁸ Indeed, he expressed the view that the use of restraints at the facility was not inappropriate in the circumstances. He disagreed with the finding that there was a culture of secrecy or a culture of keeping matters in house.²⁹⁹

However he agreed with the Oakden Report's conclusions as to the physical state of the facility and the inadequacies of clinical files.³⁰⁰

Mr Torzyn agreed with the Oakden Report except he had some reservations about the comments on restraint.³⁰¹

Ms Penery described the Oakden Report as reasonable³⁰² and agreed with Findings 1 to 3.³⁰³ She however disagreed with some but not all of the findings in Finding 4. She said the staff could and did raise complaints and concerns and said that medical errors were followed up and staff were educated and the rate of injuries reviewed.³⁰⁴

She said she did not necessarily agree with Finding 5³⁰⁵ as it related to 2007 but thought it more relevant in relation to recent times. She did not necessarily agree with Finding 6.³⁰⁶

Mr Swan did not disagree with the Oakden Report but said he was shocked, disappointed, angry and surprised at the contents of the report.³⁰⁷

Mr Hill also did not disagree with the contents of the Oakden Report but said that the report surprised him and he was disturbed.³⁰⁸

Mr Moutakis said that he found the Oakden Report compelling and that it opened his eyes.³⁰⁹ His only reservation was he did not observe restraints being used in the way described.³¹⁰

²⁹⁴ Ibid 126.3-127.10.

²⁹⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 94.22-28 (Russell Draper).

²⁹⁶ Ibid 40.18-42.

²⁹⁷ Ibid 41.36-42.5.

²⁹⁸ Ibid 43.6-9.

²⁹⁹ Ibid 53.40-54.5.

³⁰⁰ Ibid 42.38-43.4.

³⁰¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 50.32-51.12. (Daniel Torzyn).

³⁰² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 20.46-21.4 (Merrilyn Penery).

³⁰³ Ibid 21.36-22.9.

³⁰⁴ Ibid 22.30-23.19.

³⁰⁵ Ibid 23.21-23.27.

³⁰⁶ Ibid 26.29-26.45.

³⁰⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 20.33-40 (David Swan).

³⁰⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017 25.6-15 (John Hill).

³⁰⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 55.4-10 (Arthur Moutakis).

³¹⁰ Ibid 56.13-20.

As I have said Dr Tyllis agreed with the Oakden Report except that he said that as he had never visited Oakden there were matters contained in the report upon which he could not comment.³¹¹

Mr Snelling said he had not read the Oakden Report from cover to cover but was broadly familiar with the contents of it and its recommendations³¹² and he agreed that the report was damning of the state of the Oakden Facility and the quality of care provided.³¹³

Mr Goel said in an affidavit that he provided to the investigation that he was not surprised by the findings in the Oakden Report but that he disagreed with some comments.³¹⁴ He disagreed with the claim that staff were not provided with adequate opportunity to meet their mandatory requirements. He disagreed with the finding that there was a shortage of mental health nurses but said there was a shortage of personal care assistants.

He said that it was not that Oakden [management] did not want to know of the conditions but that NALHN did not want to know.³¹⁵

He disagreed with the comment on page 86 of the Oakden Report that clinical audits had not been routinely undertaken.

He also disagreed with the comment on page 90 of the Oakden Report that information from families and carers was not sourced as actively as it should have been. He said that he actively sourced information.

He disagreed with the comment that roster changes were made without consultation.

He also disagreed with statements of a carer on page 99 that 'we are not actively involved in any care plan review.'

He disagreed with a comment on page 113 of the Oakden Report that staff were not presented with opportunities to engage in training that focused on prevention.

He agreed with the comments on page 95 that 'HR practice of removing poor performing staff' and provided an example where a poor performer was sent to work with him. That person had had performance issues at James Nash House including difficulty working with others. After six months his contract was not renewed.

He however agreed that the building was insufficient.

Mrs Vlahos disagreed with two aspects of the Oakden Report. First she disagreed with the statement in the report that Ms Hanson had commissioned the report. Secondly, she disagreed with how certain aspects were described or as she put it 'phrased'.

The fact that there was so little disagreement with the findings and recommendations in the Oakden Report is by itself troubling.

If the contents of the Oakden Report were consistent with the observations made by the persons who were examined that might infer that the state of knowledge of the facility and whether it was fit for purpose and of the standard of care being offered at Oakden was more widespread than the witnesses admitted.

³¹¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 8 November 2017, 19.33-20.20 (Peter Tyllis).

³¹² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 60.40-43 (John James Snelling).

³¹³ Ibid 60.45-61.2

³¹⁴ Affidavit of Karim Goel, 23 December 2017.

³¹⁵ Affidavit of Karim Goel, 23 December 2017, [13].

However, I think that finding would be unfair. I think it more likely that the witnesses did not disagree with the findings found in the Oakden Report because some of them were not in a position to disagree because they did not know that the conditions were as bad as found.

The State has accepted all of the findings and recommendations contained in the Oakden Report. It either has implemented each of these recommendations or has advised that it is currently implementing them.³¹⁶

SA Health established the SA Health Oakden Response Plan Oversight Committee in June 2017³¹⁷ for the purpose of providing oversight and guidance in implementing the six recommendations set out in the Oakden report. Substantial working groups have been established to implement each of the recommendations. The Chair of the committee is Dr Tom Stubbs, and the membership of the committee relevantly includes Ms Hanson, Dr Brian McKenny, Dr Duncan McKellar, Mr Michael Cousins (CE, Health Consumer Alliance), Ms Carolanne Barkla (CE, Aged Rights Advocacy Service), Ms Jane Mussared (CE of the Council on the Ageing), Ms Anne Gale (Public Advocate), and Mr Maurice Corcoran (Principal Community Visitor) as well as representatives from within SA Health, NALHN, CALHN and SALHN. The State of South Australia provided me with a report on the progress of the response to the Oakden Recommendations all of which SA Health accepted. It is Appendix 9 to this report.

On 20 April 2017 it was announced that the Oakden Facility would be closed. Shortly after all consumers were relocated from the Oakden Facility, many into mainstream aged care residential facilities.

³¹⁶ Crown Solicitor, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, [33].

³¹⁷ *Ibid* [33], annexure A.

CHAPTER 7: WITNESSES

7.1 DISCLOSURE

I had not met any of the witnesses who gave evidence prior to being appointed as the ICAC in September 2013.

The Hon. Dr Lomax-Smith (Dr Lomax-Smith) did not give evidence but was interviewed by Mr McGrath. I have not met her.

I first met the former Minister for Mental Health and Substance Abuse, the Hon. Gail Gago (Ms Gago), when I attended a meeting of Cabinet shortly after my appointment as the ICAC.

The Hon. Jack Snelling (Mr Snelling) the former Minister for Health and the former Minister for Mental Health and Substance Abuse was also present at that Cabinet meeting. I have no recollection of speaking to either of them although I addressed the Cabinet as a whole. I met Ms Gago later on two or three occasions when I was investigating the conduct of a public officer who headed an agency which was part of her then portfolio in the Ministry that she then held. I spoke to her on the telephone. The only matters we discussed were matters pertinent to that investigation. I had not met the former Minister for Health and the Minister for Health and Ageing and the Minister for Mental Health and Substance Abuse the Hon. John Hill (Mr Hill) before he gave his evidence in this investigation.

As I have said I first met Mr Snelling at the Cabinet meeting at which I attended but I have no recollection of speaking with him at that time. I think the next time I met Mr Snelling was at a social occasion, which I think was at the Art Gallery and which was organised by either him or SA Health to farewell Mr David Swan, some time in August or September 2016.

I spoke to him at that time about Mr Swan's resignation. I saw Mr Snelling by chance in a restaurant in North Adelaide on one occasion when I was with my wife and we briefly exchanged pleasantries. I do not recollect meeting Mr Snelling other than on those occasions.

I met Mr Swan on a number of occasions after my appointment as the ICAC, in his capacity as the Chief Executive of the Department. The Department reported a number of matters to the OPI and on occasions Mr Swan would meet with me to explain the conduct about which he had become aware and to provide me with information to assist in the investigation that would follow his report to the OPI.

I probably met with him on about 10 occasions, but that is simply an estimate. We never discussed anything other than the business with which we were both concerned. I met him at the function that I have described at the Art Gallery and which was held for him to mark his retirement from SA Health. I think we discussed his time as Chief Executive and his future employment.

Ms Richter told me she had attended a number of sessions at which I had spoken and had asked questions during those sessions. I do not otherwise know Ms Richter.

I met Ms Hanson when she showed me and my party through the Oakden Facility. She reminded me at that time that I had met her previously, but I frankly cannot remember when that was or in what circumstances. I think she might have accompanied Mr Swan to a meeting with me in relation to one of SA Health's reports that had been made to the OPI, but I am not sure about that. I have not otherwise met her so far as I can remember.

I have not met any of the other witnesses, including Mrs Vlahos, prior to their giving evidence.

I have not spoken to any of the witnesses including the Ministers, Chief Executives or Chief Executive Officers since they gave their evidence.

7.2 GENERAL

In light of the public interest in my investigation, the nature and number of the witness examined (some of whom gave conflicting evidence) and the findings I have made, I think it is necessary that I say something about the manner in which each of the witnesses who were examined gave their evidence. What follows is based upon my impression of the witnesses when they gave their evidence and my review of the transcripts of their evidence (and the video recording of the examination in the case of Mrs Vlahos). I have taken into account the submissions made by those witnesses who replied to Mr Besanko's submissions.

In this section I shall deal with the evidence of all witnesses except Ms Hanson, Dr Groves and Mrs Vlahos. I shall deal with their evidence in separate sections in this chapter.

Mr Besanko provided me with most helpful submissions in relation to the witnesses and the findings that I should make in respect of those witnesses.

I think I should discuss each of the witnesses individually as Mr Besanko has done, and consider his submissions, having regard to the submissions made by the particular parties in response to those submissions.

I will start with the person who brought about the Oakden Report and the closure of the Oakden Facility.

Mrs Spriggs was a particularly impressive witness. I had spoken with her some months before she gave her evidence about her observations during the period when her husband was a consumer at the Oakden Facility. I thought her then to be an impressive and formidable woman.

When she gave her evidence she did so confidently, but without any rancour or exaggeration. I accept her evidence in its entirety.

There is no doubt that Mrs Spriggs was the catalyst that brought the Oakden Facility to the attention of the persons who ought to have known about the facility and the standard of care that was provided there. It was Mrs Spriggs' perseverance that brought about the commissioning of the Oakden Report and the consequences that followed from that report.

But for her determination to ensure that the appropriate persons in authority became aware of the gravity of the issues at the Oakden Facility, the facility might have continued providing inadequate care for a long time into the future.

Mrs Spriggs is to be commended for her perseverance in ensuring her complaint was appropriately considered.

Four of the former Ministers for Health or Ministers for Mental Health gave evidence. Ms Gago was unrepresented³¹⁸, Messrs Hill³¹⁹ and Snelling³²⁰ were represented by Mr Wait SC, the Crown Solicitor, and Ms Stirling, and Mrs Vlahos³²¹ by Mr Abbott QC and Mr Harry Patsouris (and after she had given her evidence also by two other counsel, Dr Rachael Gray and Mr Chad Jacobi). One other former Minister, Dr Lomax-Smith, was interviewed.

³¹⁸ The Minister for Mental Health and Substance Abuse between 23 March 2006 and 24 July 2008.

³¹⁹ The Minister for Health between 4 November 2006 and 21 October 2011, the Minister for Health and Ageing between 21 October 2011 and 21 January 2013 and the Minister for Mental Health and Substance Abuse between 25 March 2010 and 21 January 2013.

³²⁰ The Minister for Health between 26 March 2014 and 18 September 2017, the Minister for Health and Ageing between 21 January 2013 and 26 March 2014 and the Minister for Mental Health and Substance Abuse between 21 January 2013 and 19 January 2016.

³²¹ The Minister for Mental Health and Substance Abuse between 19 January 2016 and 18 September 2017.

Mr Besanko submitted and I agree that three of the four former Ministers examined were excellent witnesses. They were also very cooperative.

Ms Gago was well prepared and gave careful consistent answers without in any way trying to avoid questions. She was not asked directly for her views on the Oakden Report. She did however say in referring to the investigation 'I hope that some good can come out of this'.³²²

Mr Hill was also well prepared. He had taken the trouble to read all the relevant documents to prepare himself for his evidence. He answered all questions directly and without qualification, notwithstanding he had not been a Minister since 2013. I set out a part of his evidence which showed his willingness to take responsibility:

- Q. *Mr Hill, have you read the chief psychiatrist's report?*
- A. *I have.*
- Q. *Were you surprised by the observations and findings that the chief psychiatrist made in his report?*
- A. *I was disturbed by them. Yeah, I suppose I was surprised. I mean - well, not surprised in one sense because I'd seen the media reports before I read the chief psychiatrist's report, so I was expecting to read what he wrote. Look, yeah, I found it very disturbing and I'm very disappointed that I wasn't aware of - sufficiently aware of what was happening there to have done something about it when I had an opportunity to, to be perfectly frank. What I found very telling about his report, though, was his own observation towards the end that he and the other reviewers were shocked themselves and surprised to find things were as they were, because if the chief psychiatrist didn't know what was going on there, then, you know, who else in the system would? So that's what I found really surprising.*
- Q. *Who in your view is responsible for the failings identified in the chief psychiatrist's report?*
- A. *Well, I think he pins it on culture, and culture is a complex thing in any organisation, but, you know, it results from management and there are a variety of managers who looked after that facility and there were various levels of hierarchy, people who - including me as the Minister, so we all share some responsibility.*

Mr Snelling gave his evidence candidly without trying in any way to avoid the consequences of his answers. In one respect, which I will mention later, his answers could have led to adverse findings, but he did not try to avoid answering the questions. His answer to a question about his responsibility is instructive in this regard:

- Q. *Given that you never visited the facility and that you did not discuss it regularly with any of your senior executives at the department, and having regard to what you now know, having at least considered the chief psychiatrist's report, is it fair to say that Oakden was forgotten by you?*
- A. *No, I don't think it would be fair to say it was forgotten by me. I think it would be fair to say that it was not on my radar, and nor at the time was there any reason for it to be on my radar. With regard to me not having visited it, there would be many units within Health that in my time as Minister I didn't visit. As I indicated earlier in my evidence, I tended to prioritise my visits on the basis of the size and importance of the facility, the sort of working and I guess, to be honest, if there was political risk associated with that facility.*

³²² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 8 November 2017, 30.45 (Hon. Gail Gago MLC).

Oakden was not being raised by anyone in the media at the time, it wasn't an issue that was being raised with me by any of those stakeholders, qualifying that the College of Psychiatrists have indicated that they raised it with me, but I dispute their version of how they raised it to me or the emphasis that they would have put on it, and with regard to the complaints in the office, there were a couple of complaints about care to the office, but they were sporadic and not of a nature which would have enabled me or the office to join the dots. I'd also point out that even if I had visited the facility, I don't think that would have made a difference. I don't think I would have been in any position anymore than anyone else who visited the facility to note that there was serious abuse going on at the facility. I don't think it would have made any difference.

- Q. *Do you think that you as the former Minister for Health and Minister for Mental Health bear any responsibility for the failings identified by the chief psychiatrist in his report?*
- A. *Of course I do in that I was Minister at the time that this was happening, but I can honestly say to the Commission that having looked back at everything that came before me, everything that I was aware of at the time, is there any way as Minister I could have stopped this from happening, intervene any earlier, and my answer to that would be no. I'm not aware - I can't see anything in the evidence or the documentation I've gone through where I think I could have done anything differently. I think even if I had been more aware of the facility and what it had done, even if I had visited the facility on a regular basis, I honestly do not believe that any of that would have put me in a position where I could have intervened earlier than actually happened.*
- Q. *Is it fair to say, then, that absent a report in the nature of that which was provided by the chief psychiatrist, you don't believe you would have done anything differently?*
- A. *Absent the complaint made by the Spriggs' family – as I understand it what happened was the Spriggs' family were not satisfied with the answers that they were getting from the department, the principal community visitor was not satisfied, and the principal community visitor then elevated that to Minister Vlahos who then took the action which she did. So absent the Spriggs' family, or someone like that, making clear to me that there were very serious issues going on that went above and beyond just the occasional incident, no, I don't - I don't see - I honestly do not see that there was anything that I could have done based upon the information that was given to me that might have brought this matter to light any earlier than it was.*

Those three former Ministers were all witnesses of truth and I unhesitatingly accept their evidence as truthful and reliable, and evidence upon which I can act.

At times Dr Tyllis did not answer questions directly, but it was plain that this was not deliberate. I thought he was an honest witness and that his evidence was generally reliable.³²³

I thought Mr Corcoran made every effort to assist me in arriving at the truth.³²⁴ However, he did have a tendency to lose focus on the questions that were asked of him and to descend into detail that was unimportant. However, when he was redirected to the particular questions he answered them truthfully, even where on some occasions his answers did not

³²³ Dr Tyllis was the Chief Psychiatrist between November 2011 and January 2015.

³²⁴ Mr Corcoran was the inaugural and only PCV. He was appointed on 1 July 2011 and still holds office.

assist him. I formed the view that Mr Corcoran was an honest and reliable witness who did his best to assist my investigation.

Mr Swan³²⁵ travelled from interstate to give evidence. He was an excellent witness.

Ms Richter, the previous Deputy Chief Executive and now Chief Executive Officer (CEO) of Central Adelaide Local Health Network (CALHN),³²⁶ gave her evidence in a straightforward and helpful manner, although she genuinely did not have a good recollection of some events. I accept her evidence.

Ms Mains³²⁷ who was the previous CEO of NALHN was an honest and helpful witness who did her best to assist me. Her evidence can be relied upon.

Dr McKellar³²⁸ was an impressive witness. His opinions ought to be accepted for two reasons. First because he made observations of Oakden prior to becoming involved in the preparation of the Oakden Report and secondly because he was involved in the preparation of the Oakden Report. I found the opinions he expressed valuable.

Dr Rafalowicz³²⁹ has strong views about a number of matters, and in particular about the independency of the Stepping Up Report. In his evidence, like Dr Tyllis, he tended to be not responsive to the questions asked of him, but I formed the view that this was not because he was seeking to avoid the questions but did not concentrate on the questions sufficiently to answer them directly. I agree with the submission of Mr Besanko that Dr Rafalowicz, like Dr Tyllis, was not intending to be evasive. I thought Dr Rafalowicz was an honest and generally reliable witness.

Mr Stephen Simon³³⁰, like Dr Rafalowicz, holds strong opinions about certain issues within NALHN and took the opportunity of ventilating those opinions. He was in a position to form those opinions and those opinions should be accepted. He was a truthful and reliable witness.

Mr Mark Leggett³³¹ was a credible and reliable witness.

Ms Owen was honest and generally reliable even though some of her answers were non-responsive to the questions asked of her but she plainly was not being deliberately evasive.³³²

Ms West³³³ also often did not address questions directly, but I do not think that was intentional. She was clearly unhappy about her employment at NALHN coming to an end but I did not form the impression that this affected her evidence. Her evidence ought to be accepted.

Mr Torzyn³³⁴ was a good witness. His evidence was balanced notwithstanding he might have been thought to have been at least in part responsible for the standard of care offered at Oakden. However, he did not seek to shift responsibility to others or advance his own

³²⁵ The Chief Executive of SA Health between March 2011 and September 2016.

³²⁶ The Deputy Chief Executive Officer for the Department of Health between October 2011 and October 2016, the Interim Chief Executive Officer for CALHN in May 2017 and the Chief Executive Officer of CALHN from June 2017 until the present.

³²⁷ The Chief Executive Officer of NALHN between 15 August 2011 and 10 October 2014.

³²⁸ A consultant psychiatrist employed by NALHN who was a member of the review which wrote the Oakden Report.

³²⁹ The Executive Director of Mental Health CNAHS between 2008 and 2010, the Clinical Director of the Mental Health Division at NALHN between August 2011 and March 2016, and Senior Consultant Psychiatrist between March 2016 and the present.

³³⁰ The Assistant to the Risk Manager at NALHN between 2010 and 2013 and the Risk Manager and Patient Safety Officer at NALHN from 2013 until the present.

³³¹ The Acting Director of Mental Health Operations between late 2010 and October 2011 and the Deputy Director of Mental Health Operations between October 2011 and 2013.

³³² The Executive Director of Nursing and Midwifery NALHN from 31 January 2013 until 14 June 2015 and the Executive Director, Nursing and Midwifery, Clinical Governance Services NALHN from 15 June 2015 until the present.

³³³ The Director of Mental Health Strategy and operations, NALHN between 15 June 2016 and 14 December 2017.

³³⁴ The Clinical Services Coordinator at Clements House between December 2013 and May 2016 and the Acting Clinical Director of OPMHS, NALHN between May 2016 and May 2017.

interests by painting others in a negative light. I thought he was honest and I thought his evidence was reliable.

Mr Goel³³⁵ gave frank evidence about the facility and the standard of care that was offered at Oakden. By 2016 his relationship with many of the staff members had fractured, which clearly frustrated him. His evidence about the facility itself and the staff and the standard of care was consistent with the findings made in the Oakden Report, the objective documentary evidence and the evidence of other witnesses. I did form the impression, however, that he did try to distance himself from responsibility for what he observed at the facility and to direct the blame for failings onto others. I accept Mr Besanko's submissions that Mr Goel was conscious of the risk of adverse findings and that infected some of his evidence.

Ms Nowland³³⁶ was an impressive witness who answered questions directly and frankly. I accept her evidence.

Mr Sexton³³⁷ gave his evidence in a satisfactory manner. He did, however, seem to have a poor memory of events, which made his evidence of little assistance to my investigation.

Mr Moutakis³³⁸ was not a good witness because his answers were often lengthy, unstructured and non-responsive. He was also defensive and tried to paint himself in the best possible light. This was particularly so when he was asked about his knowledge of the issues identified in the Oakden Report and what action he took in response. At one stage I had to tell him to listen to the question and answer it, and not give an answer that was non-responsive.³³⁹ His evidence was inconsistent with documentary evidence in a number of respects. Mr Besanko submitted that I should treat his evidence with caution. I agree with that submission.

I found Ms Penery³⁴⁰ to be a defensive witness who sought to distance herself as much as possible from the findings in the Oakden Report. At times she appeared to agree with those findings, but then at other times disagree with them, or sought to identify what had been done in response as a means of justifying her position, and that of others with direct responsibility for the facility.

However, she did readily concede that she did not have a proper explanation for failing to lodge an SLS report in relation to a particular incident, which eventually led to her dismissal.

There are three other witnesses in respect of whom I have serious reservations about the quality of their evidence. They are three persons who had direct responsibility for the Oakden Facility, being Dr Russell Draper, who was the Clinical Director, Ms Julie Harrison, who was the Service Manager and Mr Kerim Skelton, who was the Nursing Director. Each of these three persons occupied these important positions of responsibility for most of the period covered by the Terms of Reference.

I think all three of those witnesses felt that they were under investigation in relation to their conduct, which was in fact the case because they had direct responsibility for the Oakden Facility during the relevant period. This affected their evidence.

³³⁵ The Clinical Services Coordinator at Makk and McLeay between May 2013 and February 2017.

³³⁶ General Manager of Mental Health, Mental Health Directorate NALHN between 23 April 2012 and April 2013, the Executive Director of Mental Health NALHN between April 2013 and May 2014, the Director of Operational Strategy between May 2014 and October 2014, the Director of Operational Strategy (Health Department) between October 2014 and March 2015 and the Director of Operational Strategy NALHN between April 2015 and December 2015.

³³⁷ General Manager, Statewide Mental Health Services, at the Department of Health between September 2007 and April 2012.

³³⁸ Consumer Advisor and later Consumer Liaison Officer at NALHN and its predecessors between 3 December 2007 and 19 February 2017.

³³⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 83.6-84.12 (Arthur Moutakis).

³⁴⁰ The Clinical Practice Consultant at OPMHS NALHN from 2004/5 until the present.

In my view they all tried to minimise their responsibility for the findings made in the Oakden Report. However, given the positions they occupied it was difficult for them to sensibly minimise their own responsibility when they could not explain how it was that the clinical care that was being offered at the Oakden Facility was as bad as the Oakden Report found.

They were directly responsible for the care that was offered to the consumers at the facility.

Dr Draper did not answer questions directly.³⁴¹ At one point I recommended to Dr Draper's solicitor that he advise Dr Draper as to how Dr Draper should answer questions in the examination.³⁴² I did this because I formed the view that he was being non-responsive and deliberately evasive in his answers. His evidence did not improve, and his answers continued to be non-responsive, inconsistent and lengthy. He was evasive and at times sought to tailor his evidence to paint himself in the best possible light and distance himself from any responsibility of what occurred at Oakden.³⁴³

Dr Draper said in his evidence that he felt that the use of restraints at the facility was appropriate,³⁴⁴ and he disagreed that the use of restraints at the facility was contrary to SA Health policies.³⁴⁵ This evidence is directly contrary to the evidence given by Dr Groves and Dr McKellar, and the findings made in the Oakden Report. Dr Groves gave evidence that the levels of restrictive practices at the facility were among the worst he had seen in the country (and it should be noted that he had worked in a number of different States prior to coming to South Australia),³⁴⁶ and that Dr McKellar gave evidence that in 2016, there were more incidents of mechanical restraint at the Oakden Facility than in the rest of Mental Health Services in the adult sector across the rest of the country,³⁴⁷ which is an incredible statistic.

Dr McKellar expressed the view that if Dr Draper did not know of the inappropriate use of restraint at the facility, he ought to have known. His evidence was:³⁴⁸

MR BESANKO:

Q. Did anyone say to you during the course of the review process that it was evident to them, or that any of the issues identified in the report were evident to them?

A. Dr Becky Wheatley was, in my view, very distressed by her role there as a senior medical practitioner and very frustrated by her efforts to escalate her concerns about what she believed to be human rights abuses that were occurring on the campus. So it was obvious to her, and she was working there on a daily basis. Was it obvious to Dr Russell Draper who was the clinical director who she would try to escalate things to? I can't say, but it would seem not.

Q. Dr Draper didn't say to you during the course of the review process that the issues were obvious to him?

A. No. Look, I know --

THE COMMISSIONER:

Q. From what you observed, it should have been obvious to him.

A. Absolutely. Yes, absolutely. Look, I know that his office was geographically only metres away from the doorway into McLeay where we know that people were - we know that in 2016 there were more incidents of mechanical restraint on that campus than in the rest of Mental Health Services in the adult sector across the rest of the

³⁴¹ Clinical Director of OPMHS NALHN from 2004 until January 2016, and Clinical Director performing the duties of Director of Electroconvulsive Therapy from January 2016 until 27 April 2017.

³⁴² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 32.2-5 (Russell Draper).

³⁴³ Ibid 44.37-54.5.

³⁴⁴ Ibid 31.34-47.

³⁴⁵ Ibid 43.6-9.

³⁴⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 84.40-86.23 (Aaron Groves).

³⁴⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 25.24-34 (Duncan McKellar).

³⁴⁸ Ibid 25.16-44.

country. That's a remarkable statistic. His office was just metres away from the door of one of those units. So I can't account for why there was no response to that.

Dr Draper should have appreciated (if he did not) that the use of restraints at the facility was inappropriate, and indeed in breach of the MHA. It was incumbent upon him to do something about this but he did nothing.

Dr Draper's evidence that the use of restraints at the facility was essentially appropriate and not in breach of the relevant policies and procedures (which it plainly was in many instances) must be rejected. It is an important reason why Dr Draper's evidence needs to be treated with caution.

Ms Harrison claimed that she had a poor memory.³⁴⁹ That might be so but I do not need to decide that. Her evidence was unsatisfactory because she could not answer the questions. It does not matter why. It means her evidence is less reliable.

Mr Skelton was a poor witness.³⁵⁰ His evidence in relation to the Oakden Report was unbelievable. He waxed and waned. At times he agreed with the Chief Psychiatrist's opinions and findings and at other times he disagreed. However, at all times he sought to exculpate himself by downplaying the state of his knowledge or the extent of the problems at the facility while he was there.

The Oakden Report said:³⁵¹

The second aspect was secrecy and inaction. The Review was told that a former Nursing Director (who was in place in 2016) had instructed a junior staff member to not report an allegation of professional misconduct of a nurse working at Oakden to the Australian Health Practitioner Regulation Agency (AHPRA). The message given to staff by the Nursing Director was, 'We will handle all of this in-house'. The consequence was a feeling among staff that anyone can get away with things they should not, and why would you bother letting people know it is not good enough, no one will do anything about it.

The Review is deeply concerned that such behaviour is an example of a type of secretive and self-serving style of culture that was both so pervasive and so widely condemned in most reviews of the factors that led to widespread human rights violations in Mental Institutions from the 19th Century onward.³⁵²

Mr Skelton claimed that he was not the person to which the Chief Psychiatrist was referring.

That evidence was false. It is clear that the Oakden Report was referring to Mr Skelton, who had directed Mr Torzyn not to make a report to AHPRA in 2016 and Mr Skelton knew that to be so.

I only accept the evidence of Dr Draper, Ms Harrison and Mr Skelton where it is consistent with objective documentary evidence.

³⁴⁹ Manager for Strategic Service Development at CNAHS up to December 2007, the Acting Aged Care Director at CNAHS between 24 December 2007 and July 2010, the Service Manager with responsibility for Oakden between July 2010 and January 2013, the Service Manager for OPMHS and FMHS with responsibility for Oakden between January 2013 and October 2014, the Acting Director of the Mental Health Directorate between October 2014 and February 2015 and the Service Manager with responsibility for Oakden between mid-2015 and January 2016.

³⁵⁰ The Nursing Director at OPMHS with responsibility between 1 January 2007 and 30 June 2010 and the Nursing Director, Clinical Practice, still with responsibility for Oakden between July 2010 and 20 May 2016.

³⁵¹ *The Oakden Report*, above n 39, 97.

³⁵² Australian Health Protection Regulation Agency (AHPRA) is established by uniform legislation across the States and Territories. In South Australia the relevant legislation is the *Health Practitioner Regulation National Law (South Australia) Act 2010* ('AHPRA Act').

Mr Besanko has suggested that I should accept the admissions they have made in their evidence to the extent that they have made admissions. I agree with that submission and will proceed accordingly. There is no reason not to do so.

7.3 MS HANSON

Ms Jackie Hanson is the present CEO of NALHN.³⁵³ She was an impressive witness who gave her evidence in a straightforward and direct manner. I was most impressed with the manner in which she gave her evidence. She was the only witness any party sought to cross-examine and she was cross-examined on 31 January 2018 for three hours by Mr Michael Abbott QC, who for that purpose appeared with Dr Gray, Mr Jacobi and Mr Patsouris on behalf of Mrs Vlahos. Ms Hanson was unrepresented.

Ms Hanson accompanied me, Mr Besanko, Mr McGrath, Mr Riches and Mr Jensen when we visited Oakden on 15 June 2017. It was evident from the way in which she behaved on that visit that she had been deeply affected by Mrs Spriggs' disclosure and the content of the Oakden Report. She had some difficulty in controlling her emotions as she described to me the premises and the way in which care was provided to the consumers at Oakden. She was visibly upset. It was evident to me then that she was deeply and genuinely shaken by the revelations that had been made.

Indeed she gave evidence that she felt 'sick' after meeting with Mrs Spriggs and hearing about Mr Spriggs' treatment at Oakden.

As I have said, Ms Hanson was cross-examined over a period of three hours by Mr Abbott on behalf of Mrs Vlahos. I thought much of the cross-examination was of little assistance but it did give me the opportunity of considering the reliability of Ms Hanson's evidence when she was placed under significant pressure.

Ms Hanson was examined by Mr Besanko on 2 November 2017. During the examination she said that she accepted all six of the recommendations set out by Dr Groves in the Oakden Report.³⁵⁴

Prior to the cross-examination Mrs Vlahos' lawyers had requested access to the written statement of Ms Hanson and the examination transcript of Ms Hanson.³⁵⁵ Both were provided.³⁵⁶

In her examination she volunteered the opinion that she was responsible for the facility and for what had happened.³⁵⁷

Accordingly as at the date of the cross-examination, Mrs Vlahos and her representatives were aware, or at least ought to have been if they read the transcript, that Ms Hanson accepted responsibility.

Despite that, Mr Abbott considered it necessary to take Ms Hanson through the individual findings in the Oakden Report and seek a response as to whether Ms Hanson accepted each of the findings.

Early into the cross-examination Ms Hanson said that she was already on the record on a number of occasions as having accepted responsibility for the period of time while she was in charge of NALHN,³⁵⁸ and that she had accepted all the findings in the Oakden Report.³⁵⁹

³⁵³ On Monday 13 February 2018 she announced that she would be resigning as the Chief Executive Officer.

³⁵⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 113.6 – 22 (Jacheline Hanson).

³⁵⁵ Email from Mr Harry Patsouris to Mr Rod Jensen, 1 January 2018.

³⁵⁶ Emails from Mr Rod Jensen to Mr Michael Abbott QC, 5 January 2018.

³⁵⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 18.45-19.10 (Jacheline Hanson).

Despite Ms Hanson clearly accepting responsibility and accepting all of the findings, Mr Abbott continued to take Ms Hanson through each of the six findings made by Dr Groves.³⁶⁰ That line of cross-examination was of very little assistance to the investigation, given that Ms Hanson had accepted responsibility for the findings and the recommendations during her examination on 2 November 2017, and had reiterated that early in her cross-examination.

The approach merely served to highlight one of the issues with the evidence of Mrs Vlahos, namely that she sought to blame others for what occurred at Oakden rather than materially accepting responsibility.

I thought Ms Hanson conducted herself during the cross-examination with quiet dignity. She answered all questions that were put to her by Mr Abbott, directly and without a hint of prevarication. She did not try to avoid her responsibility for Oakden. Indeed she readily accepted that responsibility, in contra-distinction to Mrs Vlahos.

She was as impressive a witness in cross examination as she was during her examination by Mr Besanko.

I accept her evidence.

Her evidence is at variance with the evidence of Mrs Vlahos on the question of who commissioned the Oakden Report. I discuss that evidence in Chapter 7.5 when discussing Mrs Vlahos' evidence. Except as to a possible meeting on 22 December 2016 whenever the evidence of Ms Hanson is in conflict with that of Mrs Vlahos, I prefer and accept Ms Hanson's evidence.

7.4 DR GROVES

Dr Groves³⁶¹ was an enigma.

He is in my assessment an intelligent man.

It is apparent from the transcript that when he was first interviewed by Mr McGrath he was completely frank about all of the matters upon which he was interviewed.

He gave most of his evidence in an impressive manner.

However, notwithstanding his solicitor's submissions to the contrary, some of his evidence must be treated with caution.

Although Dr Groves has to be congratulated for the Oakden Report, which exposed the poor state of the facility and the standard of care being provided at it, that report raised questions about his own conduct.

He was the Chief Psychiatrist between February 2015 and 17 November 2017 and he had the statutory responsibilities attached to that office.

He only visited Oakden once prior to being asked to conduct the review that led to the Oakden Report on 20 December 2016, and that was an announced visit³⁶² even though he

³⁵⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 January 2018, 9.41 – 46 (Jacheline Hanson).

³⁵⁹ Ibid 11.18 – 19.

³⁶⁰ Ibid 9.1 – 15.15.

³⁶¹ Dr Groves was the Chief Psychiatrist between February 2015 and 17 November 2017 and the principal author of the Oakden Report to which Ms Hanson agreed on 9 June 2016.

³⁶² Dr Groves visited Oakden on 30 June 2016 after a request to Oakden made on 3 June 2016: email from Aaron Groves to Scott McMullen, cc Jackie Hanson re Restraint rates in Older Adult, 3 June 2016, 2017-000535-E0007 (AGroves2) DOC-000000638.

was aware at that point of time that there was an unusually high use of restraints at the facility.

In his email on 3 June 2016 he described the use of restraints at the Oakden Facility as 'extraordinary'. On 9 June 2016 Mr Corcoran told him of Mrs Spriggs' complaint which Dr Groves thought was very serious.

The question that I find troubling is why, if he became aware that the facility was not fit for purpose when he visited the facility in June 2016, he did not do anything about it until 20 December 2016. He also does not appear to have noticed the standard of care being provided at the Oakden Facility on that first visit.

The other aspect of his evidence that was troubling was his failure to respond to Mr Corcoran's report of Mrs Spriggs' complaint on 9 June 2016.

Dr Groves' explanation for that failure was that he did not understand that anyone expected him to do anything in relation to Mrs Spriggs' complaint. He said that the complaint although serious was not such that he needed to commence his own investigation. I simply cannot accept that evidence, notwithstanding the submissions he has advanced. His evidence of having conversations with Ms Hanson, including on 25 August 2016, and Mr Corcoran is inconsistent with the documents. Further and in any event, the disclosure that Mr Corcoran made was very troubling in and of itself which should have prompted Dr Groves to investigate, irrespective of whether he was requested to do so by NALHN.

I think his failure to take any action in relation to Mrs Spriggs' complaint between June and 20 December 2016 is indicative of a failure to exercise his statutory functions attached to his office.

His evidence in relation to his statutory obligations was, I thought with the greatest respect to him, self-serving. He claimed that his function was to monitor treatment of in-patients rather than ensuring adequate care. That claim cannot stand in the face of the statutory power given to the Chief Psychiatrist to issue standards that are to be observed in the care or treatment of patients: s 90(2) of the MHA. In my opinion he took a legalistic approach to his functions to avoid criticism of his failure to become aware, before late December 2016, of the very serious matters he identified in January 2017, and reported on in his preliminary report in February 2017 and his final report in April 2017.

I will deal with all these matters in Chapter 13.

7.5 MRS VLAHOS

As I have said in Chapter 7.1, I had not met Mrs Vlahos before she gave evidence on 9 November 2017. Consequently, I do not know how she ordinarily behaves and conducts herself, particularly under pressure.

She provided her unsigned statement to my office on 6 November 2017, only three days before she gave evidence even though a draft statement had been provided to her, so I am told by the CSO, in late September 2017.

The statement that she provided was most unlike the other statements prepared by the CSO. It was curt and aggressive and generally unhelpful. It omitted a significant amount of information. She adopted the statement at the commencement of her evidence.

While Mrs Vlahos was giving evidence, and at the completion of her evidence, I formed the impression that she was a very poor witness. However, I thought that I should satisfy myself that my assessment of her as a witness was correct. I therefore viewed and listened to the video and audio of her giving evidence.

That confirmed in my mind that she was a very poor witness.

She was sometimes belligerent and aggressive. At other times she was sullen and surly. There were times whilst giving evidence when she became angry and on occasions she shouted at me. She was evasive in many of her answers and she frequently did not address the questions asked of her. She tended to make speeches. Much of her evidence was inherently inconsistent.

She blamed others for mistakes or failings whenever and wherever possible. She continually sought to exculpate herself from any responsibility for the findings made in the Oakden Report.

Why she chose to give evidence in this way is inexplicable in circumstances where it became apparent that she did not know about any of the serious issues identified in the Oakden Report until becoming aware of Mrs Spriggs' complaint, and the concerns expressed by Mr Corcoran, both in relation to that complaint and in his annual report for 2015/16 in October 2016.

There are five aspects of her evidence that I will address because they are all relevant to the assessment at which I have arrived.

The First Aspect

Mrs Vlahos consistently argued about things that did not matter.

For example in paragraphs 93 and 94 of her statement she said:

93. *On 3 July 2008 the Minister for Health purported to delegate to the Minister for Mental Health and Substance Abuse all the powers and functions of the Minister for Health under the Health Care Act 2008, insofar as those powers and functions related to, or concerned matters affecting the provision of mental health services, or services relating to substance abuse.*
94. *I understand that this delegation has remained in force since 3 July 2008. That delegation did not prevent the Minister for Health from carrying out the relevant functions or powers: s 9(3) Administrative Arrangements Act 1915. The relevant persons who became the Minister for Mental Health and Substance Abuse since 3 July 2008 are as follows:*

*Jane Lomax-Smith
John Hill
Gail Gago
Jack Snelling
Leesa Vlahos*

Notwithstanding this purported delegation the Minister for Health still maintained Ministerial responsibility for matters within the Ministerial portfolio.

Early in his examination Mr Besanko directed her attention to paragraph 93 of her statement and asked why she used the word 'purported' to describe the Minister for Health's delegation.

She refused to concede the validity of the delegation of the functions of the Minister for Health to her as Minister for Mental Health and Substance Abuse despite the fact that she exercised those powers as Minister for Mental Health and Substance Abuse pursuant to that delegation, because she said she had not seen the actual instrument of delegation. That was an absurd position for a Minister to take when she in fact had been exercising those delegated powers. The acceptance of the proposition could have done her no harm at all.

The Second Aspect

An issue that arose during the examination was the late tabling of the PCV's report made pursuant to s 54 of the MHA.

That section provides that the PCV must on or before 30 September in every year, forward a report to the Minister on the performance of the Community Visitor Scheme's functions during the financial year ending on the preceding 30 June and the Minister must within six sitting days after receiving the report under s 54(1) have copies of the report laid before both Houses of Parliament: s 54(2) of the MHA. Mr Corcoran complied with his statutory obligation and provided his report to Mrs Vlahos by 30 September 2016. The PCV's annual report was a comprehensive document. Relevantly it said:

- 6.10 *The CVS holds significant concerns regarding Oakden Services for Older People which has arisen from both visit reports and a range of individual investigations that have been undertaken as a result of specific complaints that we have made on behalf of individuals and families. The CVS have a strong working relationship with the senior leaders and managers of Oakden Services for Older People, and commends the dedication these staff have to care for acutely unwell older people transferred from other acute mental health units. Yet for reasons unknown, Oakden is classified as 'sub-acute' and therefore attracts less funding than the other older persons acute units. Staff at Oakden have explained that they receive the most challenging clients of the acute wards, yet the mental health unit has lost a number of Allied Health roles, particularly the Social Worker role who was responsible to secure appropriate accommodation for clients and the psychologist who has worked on Behavioural Plans. This has placed pressure on the leadership to take on additional responsibilities to fulfil what these Allied Health roles offered. Community Visitors and the CVS office have received concerns from three families regarding the treatment and care of their loved ones at Oakden. These have included reported frequent falls, observed bruising, medication errors, increased sleepiness, drowsiness and reported decline of daily functioning. It was also commented that there are not enough staff available on wards, and it has been reported that Oakden use 1 staff member to 4 client ratio, whereas acute units may use 1 staff member to 3 client ratio. Staff and senior leaders within this unit are highly dedicated and strive to do the best they can with the limited resources available.*

6.10.1 Recommendation

...

24. *That a review is undertaken of the clinical hours in contrast to patient acuity at Older Persons Mental Health Services at Oakden to ensure the provision of quality and safe care to patients residing in this facility.*

Mrs Vlahos did not comply with s 54(2) and did not table copies of the PCV's Report before both Houses of Parliament within six sitting days after receiving that report.

Instead she did not cause a copy of the report to be laid before the House of Assembly until the last sitting day of that House on 1 December 2016.

Mr Besanko took up that issue in his examination of Mrs Vlahos. He put to her that the report should have been tabled by 3 November 2016 because she had received it on 30 September 2016. She did not disagree with that proposition. She was then asked why she had not complied with the statutory duty.

She dealt with the issue very badly, particularly in view of her evidence that she had said she had read the PCV's annual report in October 2016 and was concerned about what he had said in relation to the Oakden Facility. She was evasive and gave a number of inconsistent explanations for her failure to comply with her statutory obligation.

She commenced by stating that she was waiting for a response from SA Health about the matters raised in the PCV's Annual Report.³⁶³

Next she said she had relied upon the advice of her staff and that it was not unknown for reports to be laid before both Houses of Parliament outside of the time provided for in the relevant Act when, as she put it, there were 'issues that involved questioning about the reports'.³⁶⁴

Her next explanation was that when she had read the Act and became aware of the obligation on her to lay the report before both Houses of Parliament, she was not aware of the particular time it imposed upon her to do so.³⁶⁵

She gave a further explanation, which was that the period between October and December 2016 was a 'fact finding period' during which 'we were establishing the scope of what was happening at Oakden' and that 'we wanted answers'.³⁶⁶

She gave a further explanation that she was told to lay the report before Parliament because there were a number of other reports to be laid before Parliament and that 'we wanted to do it in a sequenced manner'.³⁶⁷

Her next explanation was that whilst she knew the report needed to be laid before both Houses of Parliament she was not aware of the specific time within which she had to do so and she relied upon the advice of her staff to lay the report before Parliament on the last sitting day along with a number of other reports.³⁶⁸

She ultimately conceded that her failure to comply with her statutory obligations must have been an oversight.³⁶⁹

Her evidence in respect of her failure to comply with her statutory obligation was quite unsatisfactory.

In light of the evidence, it is open for me to infer that she made a conscious decision after reading the report in October, to delay the tabling of Mr Corcoran's Annual Report to avoid the scrutiny of Parliament of the contents of the report.

Not all of her explanations could be true. There cannot be seven different and in some instances mutually inconsistent reasons for her not tabling that report.

Mr Besanko was critical of Mrs Vlahos' evidence in regard to this topic. He submitted three possible explanations for the unsatisfactory evidence that she gave. First it might be that she lied.

Her counsel made submissions in regard to this aspect of her evidence.

70. *It should be apparent from what happened in Parliament on 1 December 2016 that some common factor across all portfolios was probably the reason that led to the tabling of all these reports on that date. In fact, there is an*

³⁶³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 71.31 – 72.22 (Hon. Leesa Vlahos).

³⁶⁴ Ibid 72.44 – 73.2.

³⁶⁵ Ibid 73.26.

³⁶⁶ Ibid 74.43.

³⁶⁷ Ibid 72.8.

³⁶⁸ Ibid 76.

³⁶⁹ Ibid 77.

obvious reason and this follows from an instruction about the order of government business in the House on that date. We refer to the fact that such a tabling, as Hansard records, occurs at the end of each recent Parliamentary year: see Hansard, House of Assembly, 4 December 2014, p3270 and 10 December 2015, p4053 and 30 November 2017, p12469. No inquiry appears to have been made by you into that, nor does it appear to have informed your Counsel Assisting's suggestion of falsity. As you would appreciate from the evidence of the former Minister, and from a review of some of the reports in 2016 and the evidence you elicited from another examinee, it is not uncommon for reports to be tabled later than required by the relevant statute. Given the frequency of such occurrence and the anodyne contents of such reports, only someone who was overly critical of the former Minister could suggest that the justification for the delay was concealment.

...

75. *As to the former Minister's oral evidence, the suggestion of your Counsel Assisting is that because there purportedly shift [sic] in the evidence of the former Minister, it was in some way inconsistent and therefore false.*
76. *At outset she said (T72) that she would need to review the calendar to consider why tabling the report wasn't done on time, and added that she had received advice about the reports due to be tabled being sequenced in a group. It is apparent from that answer that she did not know the reason other than the reason of 'sequencing', for any delay.*
77. *The same answer is given shortly later (T74) that she knew they had to be tabled, 'but the exact timeline I do not recollect, as I stated previously.' That is consistent throughout including in the wrap up question put by Counsel Assisting which reflects the actual position. She knew they needed to be tabled, and relied on advice as to when that would occur.*

...

79. *First, is the fact that inquiries were being made on the issues raised in the report. It is entirely consistent with the explanation given to make the observation that at the same time the substantive matters were being investigated and this formed part of the reason not to table earlier. The obvious reason for the delay rests in her not readily calling to mind the time frame and acting on advice to table all reports together.*
80. *Second, your Counsel Assisting suggests that she gave the explanation that it is not unknown to delay reports when questioning might occur with reference to this report. The implication drawn by your Counsel Assisting is that there was the same deliberate decision relating to this report. She plainly is not saying that. As the transcript shows (T72) her answer about her personal experience why reports might be tabled late is not explaining the delay to this report but was in response to a question about the need generally to comply with time limits.*

Mr Besanko also submitted that in the alternative to finding that she lied, it was open to me to find that her last answer was the truth, that she did not know that she had to lay the report before Parliament in accordance with s 54(2) of the MHA and that the late tabling of the report was not done to avoid the scrutiny of Parliament.

He put as a third possible finding that was open to me that although her evidence was not true she had convinced herself of the truth of the evidence.

Mrs Vlahos gave a number of different explanations for not tabling the report. If she truly did not know why she did not table the report in accordance with the MHA, she could surely have said so but that was not her evidence. She gave different explanations at different times.

After Ms Hanson was cross examined, Mr Abbott handed up pages 8285 to 8289 of Hansard for Thursday 1 December 2016 which showed that a number of Ministers tabled a number of documents on that day.

The former Minister tabled four documents as Minister for Mental Health and Substance Abuse including the PCV's Annual Report. I think my attention was drawn to Hansard to show that a number of Annual Reports were tabled on that day.

I do not know whether those other Annual Reports were tabled in accordance with each of the respective Minister's obligations.

In view of the multitude of different and in some cases inconsistent explanations that Mrs Vlahos gave, and in view of the way in which she gave her evidence, it is open to me to find that her evidence was deliberately untruthful.

I have exercised my mind as to whether I should find her to be a liar, but in the end I have concluded that I do not need to do so.

I think I should not make such a finding unless it necessarily forms part of a consideration of the Terms of Reference.³⁷⁰ A finding of dishonesty on her part for her evidence on this topic would not help me to address the Terms of Reference.

It is enough that I simply reject her evidence as unsatisfactory and unreliable.

Mrs Vlahos made an alternative submission in regard of this topic. She contended that I could not make any findings or recommendations of maladministration based upon the former Minister's conduct in not tabling the PCV's Annual Report within six sitting days after receiving the report, because tabling of the report pursuant to s 54(2) is part of the proceedings of Parliament and therefore the subject of parliamentary privilege. It was contended:

...the tabling of a report attracts that privilege in common with other activities, including speeches in Parliament, undertaken by its members.

It was then contended:

With respect to the proceedings of Parliament, the Houses of Parliament have exclusive authority to regulate their own affairs.

It was contended that if a Minister failed to lay a report, it was only for Parliament to determine whether the Minister had obstructed the business of Parliament.³⁷¹

³⁷⁰ In *Smith v New South Wales Bar Association (1992)* 176 CLR 256 Deane J said when speaking of when a Court should make a decision that a particular witness was untruthful:

There are many circumstances in which a trial judge – and the Court of Appeal in the present case was effectively sitting as a court of first instance – is required to consider whether a party or a witness has been deliberately untruthful in the course of giving evidence before it. An obvious example of such a case is where there is a direct conflict of evidence and it is apparent that there is no real possibility of honest mistake. Unless it be truly necessary for the purpose of disposing of the particular case, however, a specific finding that a party or witness has deliberately given false evidence is ultimately found to be mistaken the mistake was an honest one. As a consequence, material which serves only to establish that a party or other witness subjectively believes that his or her evidence is correct is likely to be in admission in the proceedings in which the evidence is given. And there is good reason for that. The length, cost and hazards of litigation would be intolerably increased if each party or other witness was required not only to deal with the issues before the particular court but also to anticipate the ultimate rejection of his or her evidence and seek to establish that, notwithstanding that it was mistaken, it was honestly given.

³⁷¹ At the hearing on 31 January 2018 I told her counsel that I did not intend to make a finding of maladministration for that failure.

Because I am not intending to make a finding of maladministration in regard to this issue I do not need to decide the limits of my jurisdiction.

However, there is one aspect of the argument which I should not be thought to have accepted.

When a document is laid before Parliament it is the document that attracts parliamentary privilege, not the Minister. By tabling the document, the document has all the protections that attach to anything said in Parliament. The document cannot be the subject of litigation because it has been tabled. The argument that was presented might conflate these issues.

In any event I do not need to decide that issue.

The Third Aspect

The Oakden Report was ultimately the consequence of a complaint made by Mrs Spriggs to the PCV on 1 June 2016, which had not been adequately addressed by NALHN between that time and 15 December 2016 when Mrs Spriggs and her two children met with Ms Hanson, Ms West and Mr Corcoran.

There was conflicting evidence with respect to who commissioned the Oakden Report.

Ms Hanson and Mrs Vlahos both claimed to be responsible for commissioning the report.

In her evidence when examined by Mr Besanko, Ms Hanson said that she made the decision to conduct a review on 16 December 2016.³⁷²

Ms Hanson said that she later met with Mrs Vlahos and: 'I described the meeting, my concerns, and my view around the review, with which she agreed'.³⁷³

She said she met with Dr Groves and Mr Richards on 20 December 2016 and requested a review.³⁷⁴

Ms Hanson said that she met with Mrs Spriggs on 15 December 2016, and that this was when she began to form the view that an independent review was necessary. She then met with Dr Groves on 20 December 2016 when it was agreed that he would conduct a review, and she met with Mrs Vlahos on 22 December 2016 and told her that Dr Groves would conduct a review. She said she informed the Minister that she had instructed Dr Groves to undertake a review of OPMHS³⁷⁵ and Minister Vlahos was in agreement.³⁷⁶

When asked who commissioned the review Ms Hanson said 'it was me'.³⁷⁷

Ms Hanson was taken to a news release that said that Mrs Vlahos commissioned the review which she said was incorrect.³⁷⁸ She said she raised issues with SA Health's media adviser regarding a media statement that stated Mrs Vlahos commissioned the review. Ms Hanson said 'she should not make this statement, because it's not correct'.³⁷⁹

In her cross examination Ms Hanson did not divert from the evidence that she gave in her examination. In cross examination she said by the time she drafted and signed the letter to

³⁷² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 104.32 – 42 (Jacheline Hanson).

³⁷³ Ibid 106.10-15.

³⁷⁴ Ibid 101.47 – 102.10.

³⁷⁵ Ibid 106.37-40.

³⁷⁶ Ibid 107.1-2.

³⁷⁷ Ibid 107.15-26.

³⁷⁸ Ibid 107.36-108.1.

³⁷⁹ Ibid 110.1-10.

go to Mrs Spriggs (on the Friday), she had concluded that she would conduct a review.³⁸⁰ Ms Hanson said that 'I advised Mrs Spriggs of the steps I had taken to improve services at Oakden and that I was pursuing an external review of the service'.³⁸¹

She said that on 20 December 2016 she called a meeting with Dr Groves and Len Richards to discuss the outcome of her meeting with Mrs Spriggs and her children, her concerns following the meeting and her 'desire to request that the Office of the Chief Psychiatrist undertake a review'.³⁸² Ms Hanson said she made the decision to commission the review prior to meeting with Dr Groves and Mr Richards.³⁸³

Ms Hanson further confirmed that her decision to commission a review had been made prior to meeting with Mrs Vlahos.³⁸⁴

Ms Hanson said that although she did not need the Minister's approval, Mrs Vlahos 'agreed' that it was an appropriate decision that had been made.³⁸⁵ She told Mrs Vlahos because she was informing all stakeholders.³⁸⁶

Ms Hanson told Mrs Vlahos at their meeting that she had met with Mrs Spriggs and she had serious concerns with the information the family had provided and as a result she would be conducting a review with the Office of the Chief Psychiatrist.³⁸⁷

She gave evidence that 'I was not seeking the Minister's imprimatur. I had made the decision and had the discussion as the Chief Executive Officer that a review would occur'.³⁸⁸

The purpose of the meeting with Mrs Vlahos 'was to ensure that the Minister knew what was going on following the meeting with the Spriggs family'.³⁸⁹

She said that '[a]fter I commissioned the Chief Psychiatrist's report in late December 2016, I began introducing in early January 2017 a number of interim measures...'.³⁹⁰

There is one aspect of Ms Hanson's evidence that I think is probably incorrect. She said in her examination that she met with Mrs Vlahos on 22 December 2016. Evidence was tendered that Mrs Vlahos flew to Sydney early that morning which would mean that such a meeting could not have occurred on that date.³⁹¹

Mr Abbott put to Ms Hanson that the meeting took place on 19 December 2016. Ms Hanson said the meeting occurred after she had met with Dr Groves and Mr Richards. I think the meeting did not take place on 22 December.

Mrs Vlahos said in her statement:

83. I understood that Jackie Hanson met with members of the Spriggs family on or about 15 December 2016.

84. As a result of that meeting I met with Jackie Hanson on 19 December 2016 and determined at that time that a review had to be conducted in relation to Oakden.

³⁸⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 January 2018, 69.43 – 70.4 (Jacheline Hanson).

³⁸¹ Statement of Jacheline Hanson, 10 October 2017, [126].

³⁸² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 January 2018, 59.40 – 46 (Jacheline Hanson).

³⁸³ Ibid 67.47-68.6.

³⁸⁴ Ibid 69.15-16.

³⁸⁵ Ibid 67.39-45.

³⁸⁶ Ibid 68.8-30.

³⁸⁷ Ibid 69.31-36.

³⁸⁸ Ibid 75.14-18.

³⁸⁹ Ibid 75.20-26.

³⁹⁰ Statement of Jacheline Hanson, 10 October 2017, [186].

³⁹¹ QANTAS e-ticket itinerary for Mrs Leesa Vlahos from Adelaide to Sydney at 8:15am 22.12.2016, JRH-16.

85. *I tasked Jackie Hanson with the responsibility to meet with Aaron Groves, the Chief Psychiatrist, to determine the terms of reference for the review and to come back to me as soon as possible in that regard.*

86. *The terms of reference for the review were signed off by me on 17 January 2017.*

87. *Between 19 December 2016 and the time I signed off on the terms work had already commenced in relation to the review.*

She later said, after referring to the letter Ms Hanson wrote to Mrs Spriggs on 16 December 2016, following Ms Hanson's meeting with Mrs Spriggs and her two children on 15 December 2016:

224. *The letter notes that Jackie Hanson had spoken with Barbara Spriggs on 15 December 2016.*

225. *The issues that were addressed in this letter were raised with me at a meeting I had with Jackie Hanson on 19 December 2016.*

226. *As a result of those concerns, I decided at that meeting that a review would be undertaken into Oakden.*

227. *The terms of reference for the review had not been determined at that meeting however the fact that a review should be undertaken was determined by me.*
(emphasis added)

228. *I understood that on 20 December 2016, Dr Aaron Groves and Jackie Hanson, were to meet to agree on the terms of reference for the Oakden review.*

229. *I was on personal leave between 2 January 2017 and 9 January 2017.*

230. *I announced the review into Oakden on 17 January 2017.*

On 1 February 2018, after the cross-examination of Ms Hanson, Mrs Vlahos produced an extract from her Outlook diary for the period 19-25 December 2016. The extract contains a reference to a meeting with Ms Hanson on Monday 19 December at 9am. This makes it more likely that the meeting occurred on 19 December.

Mrs Vlahos later exhibited to her statement her Ministerial Statement made on 15 February 2017 which is reproduced in Chapter 5.

She said:

'...late last year, I agreed to an independent review, led by the Chief Psychiatrist under the Mental Health Act 2009, into services and care provided at the Oakden older persons mental health facility.'

Mrs Vlahos made a public statement on 20 April 2017 that Oakden would be closed in which she said:

'In December 2016, an independent review was commissioned to look at care provided at the Oakden Older Persons Mental Health Service after concerns were raised by the family of a consumer about the treatment their relative received as a resident.'

However in that public statement under the heading 'Quotes attributed to Mental Health Minister Leesa Vlahos' she said:

In response, with the CEO of the Northern Adelaide Local Health Network, I commissioned an independent review of the service to be led by the State's Chief Psychiatrist, Dr Aaron Groves and supported by a panel of experts.
(emphasis added)

An ABC news release on or about 18 January 2017 quoted Mrs Vlahos as stating she 'triggered' the review.

A ministerial statement issued by Mrs Vlahos on 15 February 2017 stated that she 'agreed to an independent review'.

Mrs Vlahos returned to the language she 'agreed' to the review in a ministerial statement on 9 May 2017.

In Mrs Vlahos' written statement she describes the commissioning of the report as follows: she met with Ms Hanson and 'determined' at that time that a review would occur;³⁹² she tasked Ms Hanson with the responsibility to meet with Dr Groves to determine the terms of reference and come back to Mrs Vlahos as soon as possible;³⁹³ she 'decided' a review would take place;³⁹⁴ the fact that a review should be undertaken was 'determined by her';³⁹⁵ and she initiated and authorised the review.³⁹⁶

In Mrs Vlahos' examination she described the commissioning of the report in several different ways:

- Ms Hanson was 'recommending' that there be a review and that Mrs Vlahos indicated she 'wanted the review to take place' and she understood the 'review was going to happen';³⁹⁷
- Ms Hanson made the 'recommendation' which she 'completely supported' and 'agreed to' and she wanted the review to occur and for Ms Hanson to 'trigger it'. She gave her 'authority' to Ms Hanson to make the review happen;³⁹⁸
- she did not recall Ms Hanson saying she had already instructed Dr Groves, prior to meeting with Mrs Vlahos, to conduct an investigation into Oakden;³⁹⁹
- she did not recall Ms Hanson saying that she had already agreed with Mrs Spriggs that there would be a review;⁴⁰⁰
- Ms Hanson would have needed to seek her permission for there to be a review or the permission of Cabinet for any report into the review to be released;⁴⁰¹
- Ms Hanson said a review would be 'helpful' and she was 'supportive of that idea' and then 'empowered it by [her] decision as a Minister' that a review would take place;⁴⁰²
- Ms Hanson said a review would be 'helpful' but she thought it would not be helpful but rather 'necessary' and that was the reason she 'decided' there would be a review;⁴⁰³
- she 'empowered' Ms Hanson with the Chief Psychiatrist;⁴⁰⁴
- she may have told Ms Hanson that she 'wanted' her to arrange a review;⁴⁰⁵

³⁹² Statement of Hon. Leesa Vlahos, [84].

³⁹³ Ibid [85].

³⁹⁴ Ibid [226].

³⁹⁵ Ibid [227].

³⁹⁶ Ibid [268].

³⁹⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 105.18 – 25 (Hon. Leesa Vlahos).

³⁹⁸ Ibid 105.30-37.

³⁹⁹ Ibid 105.39-106.2.

⁴⁰⁰ Ibid 106.4-8.

⁴⁰¹ Ibid 107.10-18.

⁴⁰² Ibid 107.20-29.

⁴⁰³ Ibid 107.38-43.

⁴⁰⁴ Ibid 108.1-4.

⁴⁰⁵ Ibid 108.6-17.

- she gave Ms Hanson her ‘authority’ for the review to occur and as Ms Hanson was the chief executive she was expected then to get on with it;⁴⁰⁶
- Ms Hanson ‘consulted’ with her as her ‘consent’ was required;⁴⁰⁷
- she gave Ms Hanson her ‘imprimatur’ to conduct the review;⁴⁰⁸
- she gave Ms Hanson her ‘imprimatur’ and ‘empowered her’ to go and conduct the review ‘with the weight of the Minister behind her to ensure’ the report occurred;⁴⁰⁹
- she said to Ms Hanson ‘we will have a review’;⁴¹⁰
- she said she made it clear to Ms Hanson to ‘get on with it’ and it was her ‘decision’ that the review would take place; it (the review) was going to happen;⁴¹¹
- Ms Hanson said to her she had already spoken to the Chief Psychiatrist, but she understood from her staff that there was argy-bargy between Ms Hanson and Dr Groves and so she wanted it all sorted that there would be a review;⁴¹² and
- she took ownership of the situation by getting the report underway.⁴¹³

Mrs Vlahos expressly rejected the suggestion that Ms Hanson had already commissioned a review before speaking with her, but rather Ms Hanson was ‘considering’ a review and Mrs Vlahos ‘empowered’ Ms Hanson to then go and arrange for the review to be conducted.⁴¹⁴ Mrs Vlahos did not recall seeing the Terms of Reference for the Oakden Review.⁴¹⁵ She disagreed with the suggestion made by Dr Groves in the Oakden Report that Ms Hanson commissioned the review and said that reference was ‘unhelpful’.⁴¹⁶ She denied claiming credit for the Oakden Review for political reasons.⁴¹⁷

In her first written submissions of 25 January 2018, Mrs Vlahos’ position was that she decided a report was necessary and conveyed that view to Ms Hanson. The submissions went on to say:

...Minister might well apprehend that her agreement had been sought, that she had discussed the scope and endorsed a process yet to occur and that tasks would be performed on her behalf and on behalf of her Department, and that from the perspective of the CEO, she had taken action to raise the issue with the former Minister and undertaken the tasks requested of her by the former Minister.⁴¹⁸

The submissions are a significant retreat in that they do not assert that Mrs Vlahos commissioned the report and indeed take issue with Mr Besanko suggestions that that was what she said.

In her submissions in response to Mr Besanko’s submissions Mrs Vlahos said that she did not say in her statement that she had commissioned the report. She did not use the language of ‘commissioning’ in her statement but exhibited a public statement where she plainly made that claim.

However, she did say in her statement that:

I decided at that meeting that a review would be undertaken into Oakden.⁴¹⁹

⁴⁰⁶ Ibid 108.19-23.

⁴⁰⁷ Ibid 108.35-39.

⁴⁰⁸ Ibid 108.32-109.2.

⁴⁰⁹ Ibid 110.1-4.

⁴¹⁰ Ibid 112.6-12.

⁴¹¹ Ibid 118.28-42.

⁴¹² Ibid 118.44-120.2.

⁴¹³ Ibid 122.4-12.

⁴¹⁴ Ibid 109.25-32.

⁴¹⁵ Ibid 121.19-27.

⁴¹⁶ 111.41-112.4.

⁴¹⁷ 124.47-125.3.

⁴¹⁸ Michael Abbott QC, Dr Rachael Gray, Chad Jacobi on behalf of Leesa Vlahos, Response submission to the Independent Commissioner Against Corruption, *Independent Commissioner Against Corruption Oakden Maladministration Investigation*, 25 January 2018, [45].

⁴¹⁹ Statement of Hon Leesa Vlahos, [226].

Moreover, she also said:

*The terms of reference for the review had not been determined at that meeting however the fact that a review should be undertaken was determined by me.*⁴²⁰
(emphasis added)

Further, as set out above, Mrs Vlahos used the language of ‘commissioning’ in her public statement of 20 April 2017 which was annexed to her statement.

Mrs Vlahos, in her public statement and in her evidence, intended the public and me to understand that she was the moving force for the putting in place of the review which ultimately led to the Oakden Report.

In her second written submissions made on 31 January 2018 after her counsel had cross examined Ms Hanson, she talked of giving her ‘imprimatur’ to the review.

The final description offered by Mrs Vlahos in her second written submissions was that the Minister was ‘involved in the making of a final decision’.

Mrs Vlahos’ evidence of her role in the bringing about of the review changed from ‘commissioning’ or ‘triggering’ or ‘determining’ or ‘deciding’ that there should be a review, to ‘empowering’ or providing her ‘imprimatur’ to Ms Hanson on her recommendation or suggestion, to ‘agreeing’ there should be a review, to finally being ‘involved’. The various descriptions she has used throughout are inherently inconsistent.

The documentary evidence on this topic supports the conclusion that Ms Hanson commissioned the review:

- An internal memorandum from Dr Groves to the Chief Executive of SA Health dated 17 February 2017, which states that “an external independent review was sought by the Chief Executive Officer of the Northern Adelaide Local Health Network” (being Ms Hanson).⁴²¹
- That same memorandum states that after the review commenced a number of issues required referral to the CEO of NALHN, ‘who commissioned the Review’.
- The preliminary report of Dr Groves, which is annexed to that internal memorandum uses the same language. It says the review was commissioned by the CEO of NALHN.
- The letter from Ms Hanson to Mrs Spriggs dated 16 December 2016 suggests that Mrs Spriggs suggested an external review should occur, Ms Hanson agreed it would be helpful, that Ms Hanson was exploring the best way to commission the review which would be undertaken in early 2017, and that she wanted to share the results and recommendations of the review with Mrs Spriggs when the review report was complete.⁴²²
- An email involving Dr Groves and Ms Hanson suggests discussions about an investigation may have occurred between them as early as 16 December 2016.⁴²³

⁴²⁰ Ibid, [227].

⁴²¹ Statement of Hon Leesa Vlahos, 175; Internal Memorandum from Dr Aaron Groves to Chief Executive SA Health re: Chief Psychiatrist Review into the Provision of care and Treatment at Oakden Campus – Preliminary Report, 17 February 2017, 2017-000535-E0007 (AGroves2) DOC-000000930.

⁴²² Statement of Jacheline Hanson, 10 October 2017, annexure JRH36.

⁴²³ Ibid annexure JRH40.

- An email from Dr Groves to Mr Corcoran and Ms West on 17 January 2017 states that Ms Hanson was copied into the email and that she “commissioned this review”.⁴²⁴
- The Oakden Report itself refers to Ms Hanson as having requested the review. The Report emphasises that Ms Hanson was clear from the outset that she wanted the review to be extensive and look into all matters relevant to clinical care, and that she would take actions immediately to ensure people were safe and change the service.⁴²⁵

In addition the evidence of other witnesses supports a finding that Ms Hanson commissioned the review. Dr Groves said as much in his examination:

- Q. *I want to ask you about the events in December 2016 leading up to you commencing your review. First of all, who commissioned you to undertake the review?*
- A. *Jackie Hanson.*⁴²⁶

Dr Groves said that Ms Hanson met with Mrs Spriggs on 15 December 2016 and that Ms Hanson had called Dr Groves immediately after that meeting to convey her concerns about Oakden and also asked if Dr Groves would be in a position to conduct a review. He spoke to Ms Hanson by telephone on 16 December 2016, in the morning. She cancelled a meeting they were going to have because she felt she needed to take immediate action at Oakden.

Dr Groves was called into a meeting with Mr Richards by Ms Hanson which was more likely on 20 December 2016, during which Dr Groves agreed that he would conduct an investigation into Oakden.

Mr Corcoran’s evidence supports that Ms Hanson commissioned the review:

- A. *My understanding is when we met with and accompanied Barbara Spriggs, Clive and Kerry to the meeting with Maria West and Jackie Hanson, it was at that time that Jackie Hanson agreed to conduct an extensive review.*⁴²⁷

Indeed Mr Corcoran’s evidence suggests that a review was agreed by Ms Hanson on 15 December 2016, during the meeting with Mrs Spriggs, Ms West and Mr Corcoran.

Dr McKellar also gave evidence that his understanding was Ms Hanson conducted the review. His evidence on the telephone conversation he had with Dr Groves when he was asked to form part of the review team for the Oakden investigation was as follows:

THE COMMISSIONER:

- Q. *And he said what to you?*
- A. *He said to me that Jackie Hanson, the CEO of NALHN, had requested that - had had a meeting with a family member and had heard a story that had made her realise that there was a serious problem here, that she was already starting to make changes to the Service and she had requested that he undertake an independent review and wanted that to commence as soon as possible. He said that he was recruiting Professor Nicholas Proctor and Del Thomson to assist with that review and he wanted to know whether I'd*

⁴²⁴ Ibid annexure JRH45.

⁴²⁵ *The Oakden Report*, above n 39, 1.

⁴²⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 86.38-41 (Aaron Groves).

⁴²⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 60.40-43 (Maurice Corcoran).

*be available and would I speak to my line management to see if I could get permission to participate.*⁴²⁸

Ms West's evidence was that Ms Hanson gave assurances to Mrs Spriggs in the meeting of 15 December 2016 that there would be an investigation.

Ms Owen gave evidence that Ms Hanson commissioned the review:

THE COMMISSIONER:

Q. Who commissioned the chief psychiatrist's report into Oakden?

*A. My understanding is it was the chief executive officer of NALHN.*⁴²⁹

Mrs Spriggs' evidence was similarly that Ms Hanson said in the 15 December 2016 meeting that there would be a review.

The evidence overwhelmingly supports the finding that the Oakden Report was a consequence of the initiative of Ms Hanson. She had met with Mrs Spriggs on 15 December 2016 and Mr Corcoran and Mrs Spriggs said Ms Hanson said that there would be a review. Dr Groves and Dr McKellar (forming the review team) said that Ms Hanson commissioned the review. The objective documents also support that finding.

Whether the review could occur without authorisation or imprimatur and whether Mrs Vlahos' agreement was a necessary step in the report being commissioned is not necessary to decide because the Chief Psychiatrist was willing to conduct the review. In any event the Chief Psychiatrist could have carried out the review on his own initiative.

Ms Hanson initiated the review that gave rise to the Oakden Report. She made that decision probably on 15 December 2016 and conveyed that decision to those at the meeting. She approached Dr Groves on 16 December and advised Minister Vlahos most likely on 19 December.

Minister Vlahos agreed to the course that had been determined by Ms Hanson and to a degree by Dr Groves in agreeing to Ms Hanson's initiative.

The composition of the review panel was determined by Ms Hanson and Dr Groves and Minister Vlahos had no input into that decision.

The Terms of Reference were agreed by Ms Hanson and Dr Groves and again the Minister had no input into the fixing of the Terms of Reference.

Minister Vlahos was on leave between 2 and 9 January 2017.

The immediate changes to staffing and staffing funds were initiated by Ms Hanson as would be expected.

Ms Kaminski and Ms Hanson were concerned that nothing they did would cut across any findings or recommendations made by the Chief Psychiatrist and the review team, so they requested a preliminary report. Minister Vlahos had no input into that decision.

Dr Groves provided Ms Hanson and probably Ms Kaminski with a preliminary report on 17 February 2017, which identified serious problems at the Oakden Facility. For reasons that I cannot understand, Minister Vlahos, although knowing that there was a report, did not read it. I reject the reasons she gave.

⁴²⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 23.29-40 (Duncan McKellar).

⁴²⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 46.44-47 (Vanessa Owen).

She was not responsible for any of the initiatives that were taken to address the problems at Oakden. Ms Kaminski, Ms Hanson and Dr Groves drove those matters. She did not see Mrs Spriggs until 20 April 2017. Her reasons for not seeing Mrs Spriggs until then are not believable.

She said she would have been involved in the response document prepared in answer to the Oakden Report.⁴³⁰

She read a draft of SA Health's response when she went to Sydney and at the same time as she read the Oakden Report. She did not articulate what her contribution to the draft document or final document was.

It would be open to find that Mrs Vlahos deliberately overstated her involvement in the bringing about of the Oakden Report and that she claimed more credit than she was entitled to. However I do not need to decide whether her evidence was deliberately false for the same reasons I gave earlier in relation to the second aspect of her evidence. I simply find that her evidence on this aspect must be rejected because it is inconsistent with all of the contemporaneous evidence and the evidence of the witnesses to which I have referred.

Her contribution was no more than providing her agreement to a course that had been already been decided by Ms Hanson.

As I have said above she had limited input in the events that followed.

She did not lead in addressing the crisis. She followed.

Her claims were over-reach.

The Fourth Aspect

The fourth issue arose because in early February 2017, Ms Kaminski⁴³¹ requested Dr Groves prepare a preliminary report. This request was made because since early January, Ms Hanson had been implementing changes at Oakden and Ms Kaminski and Ms Hanson were keen to understand the issues sooner rather than wait upon a final report many months later.⁴³²

Ms Kaminski, Ms Hanson and Mr Don Frater⁴³³ met with Dr Groves who confirmed there were issues with culture, restraints and infrastructure.

Dr Groves said that he prepared a preliminary report at Ms Kaminski's request⁴³⁴ for the reason, he thought, that Ms Hanson was already taking steps to improve the service and for the further reason that the Chief Executive was or had been told that things at Oakden were very bad. He believed the Chief Executive wanted to ensure that Ms Hanson's views and Dr Groves' views coincided.⁴³⁵ He provided the preliminary report to Ms Kaminski on or about 17 February 2017, which he described as a 'heads up'.⁴³⁶

He said that after providing the report he met with Ms Kaminski, Mr Frater and Ms Hanson to go through the findings, and he recalled Ms Kaminski was concerned about the language

⁴³⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 67.7 (Hon. Leesa Vlahos).

⁴³¹ The Chief Executive of SA Health.

⁴³² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 110.25 – 111.2 (Jacheline Hanson).

⁴³³ Deputy Chief Executive of SA Health.

⁴³⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 100.7 – 39 (Aaron Groves).

⁴³⁵ Ibid 100.16 – 24.

⁴³⁶ Ibid 100.41- 46.

that was used in the preliminary report and the nature of the findings.⁴³⁷ He said that Ms Kaminski told him that if he was going to make certain findings he would need very good evidence to support those findings.⁴³⁸

No one asked him to make any changes in respect of his preliminary report.

In her examination Mrs Vlahos was asked the following questions and gave the following answers:

Q. *The chief psychiatrist prepared a preliminary report?*

A. *Which chief psychiatrist - Tyllis?*

Q. *Dr Groves?*

A. *Dr Groves. Did he?*

THE COMMISSIONER: *In relation to his Oakden inquiry.*

MR BESANKO:

Q. *Yes, in relation to the review he was conducting into the Oakden facility.*

A. *What document is that?*

THE COMMISSIONER: *Page 179 or 178 of your statement?*

A. *Of my statement?*

THE COMMISSIONER: *Yes, page 178?*

A. *It can't be 178 of my statement.*

THE COMMISSIONER: *178 of the booklet.*

A. *Which volume?*

MR BESANKO:

Q. *No, page 178 of your statement - page 178 of your statement.*

THE COMMISSIONER: *It's behind document 38.*

THE WITNESS: *Yes. Okay, is this the document you're referring to, Mr Besanko?*

MR BESANKO: *It is.*

THE COMMISSIONER:

Q. *Were you not aware of that document?*

A. *I remember asking - I knew that the department was gearing up for recommendations. I remember talking to Aaron at CEs meetings, because he continued to come to CEs meetings during this time, and I remember saying to him, "How does it go?" And he'd say, "Hard, Minister, very hard. It's hard, grim work." And I've reflected on that earlier today. I don't - are you - I'm not allowed to ask questions. You ask me the question.*

THE COMMISSIONER:

Q. *Okay. Have you ever read this report?*

A. *I was trying very hard to maintain my impartiality and stay away from things before they came to me fully, Commissioner.*

THE COMMISSIONER:

Q. *What's the answer to the question? Have you ever read this report?*

A. *I don't recall seeing this report.*

THE COMMISSIONER:

Q. *You're not aware of it?*

⁴³⁷ Ibid 100.41-101.47.

⁴³⁸ Ibid 102.2-12.

- A. *There was - there may well have been discussion that there was a preliminary report in Health, but I don't recall seeing it. I don't remember seeing it.*

THE COMMISSIONER:

- Q. *Do you remember being told about it?*

- A. *I - there may well have been discussion about it in a broader context at a CEs meeting briefly, but I don't recall seeing this document. I'm not being obtuse. I just literally --*

...

THE COMMISSIONER:

- Q. *Were you told about it, Mrs Vlahos?*

- A. *In the context of the CEs - it's possible it was raised at one of the CEs meetings, that Health was preparing for the recommendations of the Groves' report and we knew that we were already preparing for the Northgate move from probably around February - I'd have to check - but as soon as we were aware - there was a watcher placed on site, and once the watcher started giving us information, that is someone who was watching the site as a nurse, once we became aware of that, there were a number of things that were escalating through Health at any one day that was focused on remedying the situation at Oakden. One of them was, for example, we stopped taking new patients. There were new - staff were being taught not to sash belt people into Princess chairs which is restraint and seclusion. There were a number of things that were - Duncan and the team there, and additional staff were being brought in. There was a huge list of - a variety of action plans which occasionally would come up to me with additional actions that had been taken along the way and would continue to be taken to rectify the care and concern issues at Oakden, but I don't recall seeing the preliminary --*

THE COMMISSIONER:

- Q. *That's not my question. The question is were you told about the preliminary report?*

- A. *It may have come up at one of the CEs meeting, yes, in passing, that they were preparing - that they were preparing a response - the department was preparing a response and getting ready for the report's findings.*

...

THE COMMISSIONER: *Yes, you can answer that question and then I'll adjourn?*

- A. *277, you're correct in refreshing my memory that in the statement that I gave, I do not remember seeing the interim report but I was told about the fact that an interim report had been received and SA Health were taking all due actions to rectify the matter, so that to me fits with my recollection that they were preparing for the recommendations and it would have occurred at probably a CEs meeting, Commissioner.*

THE COMMISSIONER:

- Q. *You've read the preliminary report recently?*

- A. *This preliminary report?*

THE COMMISSIONER:

- Q. *Yes, it's attached to your statement.*

- A. *I'm aware of it as a document we've discovered in the process. I can't say that I read it - I looked at it and looked at it in the context of - it's a document that I didn't recall. I don't recall reading it intimately. I read the first couple of pages and go "I don't remember seeing this." Why, Commissioner?*

THE COMMISSIONER:

Q. Sorry?

A. Sorry, Commissioner I'm not allowed to ask you questions.

THE COMMISSIONER:

Q. You exhibited it to your statement.

A. Yes, because it was something I don't recall seeing before.

THE COMMISSIONER:

Q. Okay. You knew about it, though?

A. I was probably told, as I said --

THE COMMISSIONER:

Q. You said obviously you were told about it?

A. Yeah, at a CEs meeting in the general context that the department was preparing a response, and this document has - look, the Oakden report has six recommendations. Obviously, he would have been talking to the department about the response, but we were already acting and there was already an action spreadsheet that came up from time to time at the CEs meeting. There was such a lot of documentation coming up at this time.

On the second day of her evidence she was again taken to the topic:

Q. You've given evidence that you did not read the chief psychiatrist's preliminary report but that you were aware of it?

A. Well, I knew the department was preparing a response, yes.

Q. You did not request the chief psychiatrist prepare a preliminary report?

A. No, not that I recall. My office might have or the department may have, but I don't recall doing it.

Q. Why did you not read the preliminary report prepared by the chief psychiatrist?

A. Because this briefing wasn't provided to me.

THE COMMISSIONER:

Q. But you were aware of the report.

MR ABBOTT: Commissioner, are you talking about the report or the preliminary report?

THE COMMISSIONER: The preliminary report. That's what the questions are about.

Q. You're aware of the preliminary report?

A. In CEs meetings, as I stated yesterday, the issue of Oakden would come up regularly from the time I became aware of it and the department would reassure me they were taking all appropriate steps to rectify the care and concern issues on that site and preparing and assisting Dr Groves in writing the review.

THE COMMISSIONER:

Q. Why did you not read the preliminary report?

A. Because this was an independent review that needed to be done at arm's distance from the Minister and that I should not get involved on editing the document or being involved in any of the witnesses or any of those things, because I wanted it to be thorough and independent....

THE COMMISSIONER:

Q. How would you get involved by reading it?

A. *Because I potentially could run into some of the people who were mentioned in the document, and I didn't want to be perceived to be involved with --*

THE COMMISSIONER:

Q. *Well, you couldn't know that there were any recommendations in it.*

A. *At meetings they - I knew there would be a number of recommendations, Commissioner, because the report was coming. If you look at this document now that you've shown me, I think there are seven recommendations in this document. I think the final Oakden report only has six.*

THE COMMISSIONER:

Q. *I'm not sure what that point means.*

A. *Well, my office would have liaised with SA Health, and SA Health would have been assisting the chief psychiatrist and I was waiting for the final version of the Oakden report from the chief psychiatrist.*

MR BESANKO:

Q. *Weren't you interested to know what the chief psychiatrist's preliminary observations were?*

A. *He had mentioned at CEs meetings that it was hard going and it was grim work. It was an independent review. I don't think it's appropriate that I speak to the people undertaking an independent review until they come to me with the final report.*

THE COMMISSIONER:

Q. *That's a different point. The question of speaking to him has not been raised. The question is whether you read what he wrote?*

A. *I said I haven't seen this document before and I said that in my statement.*

THE COMMISSIONER:

Q. *Yes, but you're giving it as an explanation as to why you didn't read it, that you didn't want to speak to him. That wasn't the question. The question is why didn't you read it when you knew it existed?*

A. *Because it was my view at the time and a view held in my office that an independent report means that you let it run its course. You don't get involved. But I did know and we were acting on a day-to-day basis to intervene to ensure the care concerns on Clements, Makk and McLeay, but most importantly Makk and McLeay, were improved from January onwards and that's where my focus was on, the actual rectifying of the residents' quality of life, Commissioner.*

THE COMMISSIONER: *Yes. We'll move on from there, Mr Besanko.*

As the questions and answers show, Mrs Vlahos had annexed to her statement the Chief Psychiatrist's Preliminary Report, which was itself attached to an Internal Memorandum from Dr Groves to the Chief Executive.

Mrs Vlahos said in her statement:

275. Document thirty eight is an Internal Memorandum dated 17 February 2017, which annexes the preliminary report of the Chief Psychiatrist.

276. The Internal Memorandum is written by Aaron Groves and bears the date 17 February 2017 and the annexed preliminary report refers to a number of issues at Oakden.

277. This memorandum was not addressed to me and I do not remember seeing the interim report, although obviously I was told about the fact that the interim report had been received, and that SA Health was taking all due action to rectify the matters that had been pointed out in the interim report.

278. I was also told that there was an action plan to remediate the issues identified by Aaron Groves.

The evidence to which I have referred is an example of the manner in which Mrs Vlahos gave evidence. The answers were evasive and non-responsive.

I asked her whether she was aware of the document and her answer addressed a conversation with Dr Groves in which he said the work was hard and grim.

I then asked her whether she had read the report and she did not answer that question. I asked her again and she said 'I don't recall seeing the report'.

I asked her if she was ever told about the report and while she said that there might have been discussion about the report she did not remember seeing the report – an answer which she repeated.

It might be thought in view of her answers that she was not aware that the Chief Psychiatrist had ever prepared a preliminary report. Her answers to the first and second questions asked by Mr Besanko indicate she was surprised to hear that the Chief Psychiatrist had prepared a preliminary report. But as I have said, she said in her statement that she was told that interim report had been received and that SA Health was taking action to rectify the matters that had been pointed out in the report.

The evidence discloses that Mrs Vlahos said that she became aware that a preliminary report had been prepared probably in a meeting of Chief Executives. However, she made a decision not to request a copy because she thought that if she were to read a copy that could in effect jeopardise the investigation or make her uncomfortable if she ran into someone mentioned in the preliminary report.⁴³⁹

She said that the preliminary report was an 'independent review that needed to be done at arms distance from the Minister' and 'that she did not want to get involved because she wanted to be thorough and independent' and she did not want to be perceived as involved if she were to run into someone mentioned in the document.⁴⁴⁰

She said that she did not think it was appropriate to speak to Dr Groves. However, the question was whether she had read the report.

I do not accept Mrs Vlahos' reasons for failing to read the preliminary report and I do not believe her evidence.

She was due to receive the final report when it was complete. If she were to receive and read the preliminary report, that could not in any way impact upon the independence of the review. The proposition that she should not read a report because it might affect the independence of the review is an incredible and unbelievable explanation. Her explanation that she might run into someone mentioned in the report is a nonsense.

In my opinion she had an obligation as a Minister to remain abreast of the review, and to acquaint herself with the preliminary report so that she could be satisfied that the steps that were being taken in respect of Oakden by Ms Hanson and in part by Ms Kaminski were appropriate.

In view of her evidence I do not think she took the trouble to read the report until just before she gave her evidence.

I reject her evidence in relation to this issue.

⁴³⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 155.4-156.23 (Hon. Leesa Vlahos).

⁴⁴⁰ Ibid.

The Fifth Aspect

It was submitted that I should find that Mrs Vlahos refused to accept any level of responsibility for what had occurred at Oakden.

When she was examined on that issue by Mr Besanko she was, regrettably, quite evasive.

Mr Besanko took her through the Oakden Report finding by finding:

MR BESANKO:

Q. *I'll start with page 31. You'll see that the chief psychiatrist identifies a number of failings under the heading "Finding 1"?*

A. *Yes.*

Q. *Who in your view was responsible for those failings?*

A. *Let me just refresh my memory by reading it, if you don't mind.*

Q. *Sure.*

A. *Models of care, in my time as the Minister, were always informed by clinical leads, and clinicians are people who work inside Local Area Health Networks and the Local Area Health Network, as I put forward in my statement, my understanding very early on as a Minister that significant reform had taken place to ensure that Local Area Health Networks governed their areas. Oakden fell within the NALHN purview in that sense. The models of care and the management of Oakden and the clinical leads that would have informed that was something that probably the chief psychiatrist and the CE of that health network over many years many chief psychiatrists would have been involved in.*

Q. *If you turn to page 57, you'll see a number of other failings identified under the heading "Finding 2." I invite you to read what's under that heading. Who in your view is responsible for those failings identified under the heading "Finding 2"?*

A. *Sorry, I read the recommendations. Sorry, I was reading the recommendations.*

Q. *Sure, take your time.*

A. *The maintenance and provision of a fit for purpose facility again lies with the CEs of the Local Area Health Network and the people who were running that facility at the time, the nurse lead and the chief psychiatry person on site. In talking to the people in NALHN and the command chain in NALHN, if the facility was not fit for service [sic], then - the quality of the infrastructure very much lies with the Local Area Health Network and they need to bring that up to the Minister if they wish to see it replaced.*

THE COMMISSIONER:

Q. *Hasn't the government got a responsibility to provide adequate infrastructure for vulnerable people?*

A. *Certainly. When I became aware that the infrastructure was inadequate and not fit for purpose during the discovery process and the fact-finding stage we talked about from October to December, we then, with the report, went to Cabinet, accepted the recommendations and we now know in a subsequent budget have allocated significant funds for a rebuild and we have established a model of care committee which is undertaking the oversight of the six recommendations in the chief psychiatrist's review.*

So, in my time, we have moved forward on this issue to ensure that those recommendations were addressed and that these things were rectified. The fact that we were moving residents to the Northgate facility and spent considerable time and effort ensuring that anyone who didn't move to Northgate was supported in their transition to the private health care sector

shows that when I became aware of it, I acted. These issues are longstanding and that the Local Area Health Network needed to take ownership. If it was a rundown facility and infrastructure, they should have put a bid through the normal bid processes for budget.

THE COMMISSIONER:

Q. *There is no responsibility on government, then, for the conditions that existed at Oakden at the time of the chief psychiatrist's report?*

A. *The government has issued an unconditional apology to families --*

MR ABBOTT: *Commissioner, that assumes that the government - and it's not clear from your question - I object to the question, because it's not clear who you mean in government. If you mean, Commissioner, my client --*

THE COMMISSIONER: *I would have said "the Minister".*

MR ABBOTT: *If you mean --*

THE COMMISSIONER: *"Government" includes all the Ministers..*

MR ABBOTT: *If it includes the Local Area Health Network as part of government, that's one thing, but I think using the phrase "the government", obviously someone should be responsible for it, but the question you put is, "Shouldn't the government be responsible for it?" Obviously the government should be responsible for it. It depends who you mean by the use of the term "government", and that depends on when people in the government knew about it and were able to do something about it.*

THE COMMISSIONER: *Maybe.*

THE WITNESS: *Budget bids are the responsibility of SA Health with the Local Area Health Networks. If there were concerns about the facility, budget bids should have been brought up through the normal budget preparation process is my understanding.*

THE COMMISSIONER:

Q. *Did any of the Ministers of the government have any responsibility in relation to the infrastructure at Oakden at the time - as it was when the chief psychiatrist found it in his report on 10 April?*

A. *Oakden is part of NALHN and that falls under the Health Act.*

THE COMMISSIONER:

Q. *So no Ministers had any responsibility?*

A. *I didn't say that.*

MR ABBOTT: *She hasn't said that.*

THE WITNESS: *I didn't say that, Commissioner.*

THE COMMISSIONER: *That was my question.*

MR ABBOTT: *She hasn't said that.*

THE COMMISSIONER: *I'll ask the question again.*

Q. *Did any of Ministers of the government have any responsibility for the state of the infrastructure as the chief psychiatrist found it as at 10 April?*

A. *The Minister for Health --*

THE COMMISSIONER:

Q. *Could you answer the question?*

MR ABBOTT: *She just answered it, Commissioner. She just said "the Minister for Health".*

THE WITNESS: *He oversees the bulk of infrastructure and maintenance programs by the CE. The CE of Health makes recommendations to the Minister for Health.*

MR ABBOTT: Oakden has been declared a hospital under the Health Act as well. So it follows.

THE COMMISSIONER: Please, Mr Abbott, let your client give the evidence.

MR ABBOTT: I am. I am.

THE WITNESS: I was about to try and do that.

THE COMMISSIONER: Please don't shout at me, Mrs Vlahos.

THE WITNESS: I'm not. I'm trying to raise --

THE COMMISSIONER: You are.

THE WITNESS: -- my voice over both of you, Commissioner, so I could finish --

THE COMMISSIONER: Don't speak over me, please. I want to hear your evidence. I don't want to hear Mr Abbott providing me with facts which you might adopt. Please go ahead.

A. Commissioner, if I had been allowed to continue my statement, I was about to say that, that my understanding is that it had been a longstanding practice that Oakden was a Health facility that was under NALHN. NALHN looks after hospitals, and the infrastructure of those facilities go through a budget bid process under the standard preparation for any budget and they would have to bring that up to the CE for Health and it would go through the standard budgetary bid association of any money that we have to put up.

THE COMMISSIONER:

Q. I'll ask the question again. Do you say that no Minister of government had any responsibility for the conditions of Oakden as at 10 April when the chief psychiatrist reported?

A. The department brings to Ministers information that allows us to make decisions. Now, when information was brought to me about what was going on at Oakden and its condition, and the care and concern issues in relation to people who were living there, past and present, I acted.

THE COMMISSIONER: I take it that you won't answer the question.

MR ABBOTT: I object to that. I object to that. She's doing her best to assist you in answering --

THE COMMISSIONER: She hasn't answered the question. I've asked her three times. We'll move on.

MR ABBOTT: She did answer it. She said the Minister of Health --

THE COMMISSIONER: No, she didn't.

MR ABBOTT: -- when you first asked the question.

THE WITNESS: I did. I did say that.

THE COMMISSIONER:

Q. So Mr Snelling was responsible?

A. He, with myself, I would have been responsible for the clinical care of those people, but under the jurisdiction of and assistance of the CE of Health and the chief psychiatrist and relying on the CE of NALHN to provide that information to me in the standard reporting process through SA Health.

THE COMMISSIONER:

Q. What's the answer to that question?

A. That was an answer.

THE COMMISSIONER:

Q. It wasn't. I asked the question was Minister Snelling responsible?

A. Plus me as - that's what I said.

THE COMMISSIONER:

Q. The two of you were responsible, is that what you're saying?

A. He oversees the buildings, by and large, and I had to look after the clinical setting - the clinical - the model of care - that is all brought up to me as a Minister.

THE COMMISSIONER: I'm only addressing the conditions of the building. Anyhow, move on, Mr Besanko.

MR BESANKO:

Q. Mrs Vlahos, could you turn to page 65 in the report. I invite you to read the bullet points under the heading "Finding 3". They continue over on to page 66. Please stop at the heading "Recommendation 3".

A. Could you repeat your question?

Q. Who in your view is responsible for the failings identified by the chief psychiatrist under the heading "Finding 3"?

A. The chief psychiatrist was responsible for providing quality and safe care environments across the State under his Act, and Ms Hanson would be responsible for the day-to-day ensuring that there was adequate nursing and the right amount of allied health support and the right mix of nurses on that site and doctors to assist them.

Q. So the chief psychiatrist and Ms Hanson are responsible for those failings?

A. They're, on a day-to-day basis, tasked with that. I never been asked to get involved in rostering on a site.

Q. Do you bear any responsibility for those failings, in your view?

A. My view is when information was brought to me, I acted.

THE COMMISSIONER: Yes, move on, Mr Besanko.

MR BESANKO:

Q. Could you turn to page 89 and read the bullet points under the heading "Finding 4". Those bullet points continue over on to page 90. Once again, I invite you to stop at the heading "Recommendation 4". Who in your view is responsible for the failings identified by the chief psychiatrist in those bullet points?

A. Again, the chief psychiatrist is responsible for ensuring that standards and quality frameworks are met across the State and learning systems, training systems, rostering and reporting should have been done at that site, and the people giving supervision to that site would have been the NALHN senior management.

Q. Could you turn to page 100 of the report and read the text appearing under the heading "Finding 5". Who in your view is responsible for the failings identified under that heading?

A. Culture and management of staff falls to the Local Area Health Network and the people on that site who are not showing leadership and allowing - I think there were people on that site that were trying to do the right thing, but there had been such a longstanding culture that some people were intimidated and we now know that to be the case, but, again, I believe the day-to-day people on that site who failed to show leadership in clinical roles - it upset me when I read the report, and it still upsets me now.

THE COMMISSIONER: Yes.

A. And that no-one in NALHN - and these people escaped adequate oversight from NALHN for the time that it's been looking after this site and I suspect even previous to NALHN having it, in previous health networks, it relies on the CEs of those networks to be adequately governing all of its sites, not just

the main hospitals that they may be working in on a day-to-day basis. It was one of the reasons - it was important that we shut Oakden and implement the recommendations, because in moving some people to Northgate there was at least additional scrutiny with people with disability being on the same site. There would be more people with eyes and ears looking to make sure that the culture didn't continue, and we were intent on making sure the culture didn't continue, and that people who had done the wrong thing, the miscreants were prosecuted in every way possible, and I took a lot of time on that at the beginning of the year and supported Jackie to make sure all disciplinary actions could be expedited as fast as possible and I wrote to AHPRA and asked them to do that. If I had my way at the beginning of February, I would have sacked the lot of them, but I couldn't because of industrial relations. I may well have sacked some good people along the way, but as the time came out, we've tried to establish who has got good true hearts.

MR BESANKO:

- Q. *Lastly, Mrs Vlahos, could I ask you to turn to page 213 and read the text under the heading "Finding 6". Who in your view is responsible for the failings identified under that heading?*
- A. *I know that the chief psychiatrist undertook training in restraint and seclusion last year, I've given you evidence to that effect. I know now that people on that site were in fact given that training during that time but failed to enact it. The management of that site allowed these practices to continue and managed to continue to not comply with policy directives, standards, State policy and procedures. Again, it is the people on the actual site of those two wards and then the Local Area Health Network that would have been responsible for ensuring that those operational and policy directives were overseen on a day-to-day basis and were robust.*
- Q. *Just two final questions, Commissioner. Do you accept any responsibility for any of the failings identified in the six sections that I've just taken you to in the chief psychiatrist's report?*

MR ABBOTT: *I object to that. Does that mean now, or at the time? I think it needs to have a time limit on it.*

MR BESANKO: *The question is directed to now.*

THE COMMISSIONER:

Q. *Do you now accept any responsibility --*

MR ABBOTT: *When she's not a Minister.*

THE COMMISSIONER:

- Q. *Do you now accept any responsibilities whilst you were a Minister for the findings that have been identified in the six findings made by the chief psychiatrist?*
- A. *When I became aware of the situation I acted, and I took the responsibility and I showed the leadership to move forward and rectify the situation. I took responsibility to try and fix this situation up, not conceal it.*

The evidence speaks for itself. Mrs Vlahos' was evasive and she refused to accept responsibility for what occurred at Oakden.

Mrs Vlahos said that the Minister (Mr Snelling) was the person responsible under the MHA and while she was Parliamentary Secretary she had no 'discretion' over complaints.⁴⁴¹

⁴⁴¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 47.10 – 27 (Hon. Leesa Vlahos).

She said that she had no statutory power to do anything or power to execute but rather she simply assisted the Minister.⁴⁴² Mrs Vlahos had no power to deal with issues involving Mr Corcoran as her responsibilities were simply to 'take the meetings'.

Mrs Vlahos said that in relation to the meeting with Dr McKellar in 2016, that if Dr McKellar raised the restraint issue then she would have 'automatically' said that Dr Groves was responsible for that matter and that she would have 'automatically' gone to him and looked at him.⁴⁴³

In summary, Mrs Vlahos' evidence was that she had no responsibility while she was Parliamentary Secretary because she was simply assisting Mr Snelling. In response to each of the six findings made by the Chief Psychiatrist she blamed others and took no responsibility. She did not directly answer the question near the end of her examination whether she accepted any responsibility for the six findings made, but instead answered that she acted to rectify the situation. At one point she said she had responsibility for clinical care but later blamed the Chief Psychiatrist and Ms Hanson for failings in that area. To the very limited extent that she accepted any responsibility, it was significantly qualified by what information was escalated to the Minister by the Chief Psychiatrist and SA Health.

In answer to the criticism that Mrs Vlahos was not prepared to take responsibility for the matters raised in the Oakden Report over the period when she was Minister, Mr Abbott pointed to her statement made on 9 May 2017, in which she said 'I reiterate the unconditional apology myself and the Premier have made on behalf of the South Australian Government to residents, their families and loved ones'; and a further statement 16 May 2017 in which she said 'what occurred at Oakden over a protracted period of time is unacceptable and that I reiterate mine and the governments apology to the residents and families of Oakden'. Of course, apologising for what occurred is a different thing to accepting responsibility for it.

Mr Abbott also pointed to her answer to the question 'so Mr Snelling was responsible' – and her answer 'he, with myself, I would be responsible for the clinical care of those people'.

Her counsel contended therefore that there was evidence that Mrs Vlahos had accepted Ministerial responsibility for patient care.

In her further submissions she relied upon the evidence of Ms Hanson which she said was not materially different to her own.

There is a significant difference between the manner in which Ms Hanson gave evidence and the manner in which Mrs Vlahos gave evidence and the content of their evidence.

A reading of Mrs Vlahos' evidence as a whole shows that she took every opportunity available to deflect any possible criticism of her onto others.

The evidence I have set out above indicates in my opinion a refusal to accept any responsibility as Minister for the conditions at the Oakden Facility and the sub-optimal care that was offered.

Her evidence can be contrasted to that of Mr Hill and Mr Snelling who both accepted some measure of responsibility for the conditions at the Oakden Facility during their time as Ministers.

It can also be contrasted with Ms Hanson's evidence when, unprompted, she accepted responsibility as CEO of NALHN for the findings in the Oakden Report. Specifically, Ms Hanson gave the following evidence:

⁴⁴² Ibid 53.8-38.

⁴⁴³ Ibid 140.40-141.10.

MR BESANKO:

- Q. *In your view, does responsibility for the facility and what happened there stop at the level of Dr Draper, Mr Skelton and Ms Harrison, or does the executive director of Mental Health also have a degree of responsibility?*
- A. *From a governance perspective, to answer your question, that actually stops with my position as the chief executive officer for NALHN but, yes, there would have been a responsibility of the clinical director for Mental Health Services and the operations director, which had a number of titles over time. That was the Leonie Nowland and Eli Rafalowicz positions. So they were accountable and responsible for all of the Mental Health Services of which there were a number of different service units.*
- Q. *Do I take it, then, from the evidence you've just given that from a governance perspective at least, everyone within the Mental Health executive and, indeed, yourself at a NALHN executive level, shared some responsibility for what happened at Oakden?*
- A. Yes.

The contrast between this evidence and the evidence given by Mrs Vlahos on the topic of responsibility for the failings could not be more stark.

In my opinion the evidence to which I have referred further establishes a refusal by Mrs Vlahos to take responsibility while she was Minister.

Conclusion

By reason of these matters, I accept Mrs Vlahos' evidence only when it is supported by some other witness or is corroborated by documentary evidence. I reject her evidence where it is contradicted by another witness or any documentary evidence.

CHAPTER 8: THE FIRST TERM OF REFERENCE

- 1) ***Whether appropriate mechanisms were in place from 2007 to receive complaints and reports about the quality of care provided to patients at the Oakden Older Persons Mental Health facility (the facility).***

8.1 COMPLAINT MECHANISMS

I have first considered what complaint mechanisms were in place to receive complaints and reports about sub-optimal care at Oakden during the relevant period. I have largely relied upon Mr Besanko's submissions of those mechanisms.⁴⁴⁴ No one who has reviewed those submissions has suggested they were incomplete or inaccurate.

Mr Besanko identified five different mechanisms:

- (1) ministerial
- (2) statutory
- (3) organisational
- (4) facility
- (5) other external mechanisms.

Secondly, I have considered whether those mechanisms were appropriate.

This section draws heavily from Mr Besanko's submissions and the written witness statements, in particular the written statement of Ms Hanson, which was of considerable assistance and which I accept.⁴⁴⁵

Over the course of the investigation I was provided with evidence showing complaints made between 2007 and 2017. Appendix 10 is a schedule of such complaints.

The evidence received from witnesses and those interviewed demonstrated that many more complaints were made. Many complaints were oral and/or the person who made the complaint could not particularise the dates of the complaints and those complaints are not included in the schedule. That supports a finding that there were many more complaints received with respect to Oakden beyond those referenced in the schedule.

The schedule does not purport to be exhaustive.

The schedule does not include many complaints that were considered at the lower end of the spectrum in terms of seriousness. Those included complaints with respect to laundry, missing clothing, food and drink and other such matters. The schedule includes the more significant complaints without of course diminishing the validity of complaints about these other matters.

The schedule also omits the CVS reports as these are referred to elsewhere in this report.

The schedule draws a distinction between complaints that were registered (such as on the SLS) and those which were not. Not all complaints that were included on the SLS are included in the schedule (e.g. the less serious complaints) and the description of a complaint that was included on the SLS may not have exactly lined up with the subject matter of the

⁴⁴⁴ His submissions in that regard were non-controversial.

⁴⁴⁵ Statement of Jacheline Hanson, 10 October 2017.

complaint which might mean that the complaint is on the SLS but described in different terms. The schedule illustrates many complaints were not logged onto the SLS.

Of significant concern is that over the reference period some 100 different persons complained about Oakden. It is a matter of great concern that so many persons were so concerned about issues at Oakden that they felt a need to make a complaint. The schedule lists some 400 serious complaints which over the reference period is about one serious complaint every week which is by itself an underestimate because many less serious complaints were also made but not included in the schedule and also that witnesses and interviewees discussed other complaints which could not be sufficiently particularised so as to be included in the schedule.

8.2 MINISTERIAL MECHANISMS

The relevant Ministers have statutory functions under the Acts falling within their remit. The Minister for Mental Health and Substance Abuse had and has functions, powers and obligations under relevantly the MHA 1993 and subsequently the MHA, as well as the functions, powers and obligations of the Minister for Health under the *South Australian Health Commission Act 1976* (SA) (SAHC Act) and then the HCA⁴⁴⁶ pursuant to delegations dated 9 January 2006 and 3 July 2008.⁴⁴⁷

In particular s 86 of the MHA provides that the Minister has the following functions:

- (a) *to encourage and facilitate the involvement of persons who currently have, or have previously had, a mental illness, their carers and the community in the development of mental health policies and services;*
- (b) *to develop or promote a strong and viable system of treatment and care, and a full range of services and facilities, for persons with mental illness;*
- (c) *to develop or promote ongoing programmes for optimising the mental health of children and young persons who are or have been under the guardianship or in the custody of the Minister pursuant to the Children's Protection Act 1993;*
- (d) *to develop or promote services that aim to prevent mental illness and intervene early when mental illness is evident;*
- (e) *to ensure that information about mental health and mental illness is made available to the community and to promote public awareness about mental health and mental illness;*
- (f) *to develop or promote appropriate education and training programmes, and effective systems of accountability, for persons delivering mental health services;*
- (g) *to promote services in the non-government sector that are designed to assist persons with mental illness;*
- (h) *to develop or promote programmes to reduce the adverse impact of mental illness on family and community life;*
- (i) *any other functions assigned to the Minister by this Act.*

⁴⁴⁶ See, eg, *Health Care Act 2008* (SA) s 6 ('HCA').

⁴⁴⁷ Statement of Hon Gail Gago, 20 October 2017, [9], [34].

Mr Besanko submitted that whilst those Acts do not expressly provide that the Minister was responsible for managing, addressing or resolving complaints or specific incidents, the Minister certainly had the power to do so, and arguably was subject to an implied statutory obligation to ensure the appropriate care and treatment of persons with a mental illness, having regard to the Minister's statutory functions.

I do not need to decide that question. I think it is a matter which is best addressed by a court if it is asserted in litigation that the Minister had such a duty.

In any event, the Minister was and is at one level accountable for any failure by any member of the public sector who is responsible for the provision of care and treatment to those with mental illnesses. This includes those responsible for the handling of complaints and reports of sub-optimal care at Oakden, pursuant to the principles of responsible government. The fact that others may have had statutory responsibilities in respect of such persons does not absolve the Minister from any level of responsibility – a conferral of responsibility on a statutory office holder does not, in this case at least, confer exclusive responsibility in all respects on that office holder, and does not exclude the principles of responsible government, or render them nugatory, to the extent that they are still respected and adhered to by Ministers.⁴⁴⁸ The principles of responsible government are addressed below.

Although there was and is no obligation or policy on, or guide to, how the Minister is and was to address complaints or reports of sub-optimal care brought to their attention, each relevant Minister seems to have adopted a similar practice, to which they generally adhered, throughout the period covered by the Terms of Reference. That practice was to the following effect.

- (1) A complaint or report would be received by the office or staff of the relevant Minister.
- (2) The complaint at first instance was usually managed by a member of the Minister's staff, such as a Ministerial Liaison Officer who might manage the complaint without escalating it to the Minister at all.⁴⁴⁹
- (3) Often (regardless of who within the Minister's office managed the complaint) a request would be issued to the Department, usually the Chief Executive or Chief Executive Officer, for a briefing about matters pertaining to the complaint or report.⁴⁵⁰
- (5) NALHN and other Local Health Networks would then provide a briefing to the Minister, and often provide a draft response, through the Department of Health and Ageing.⁴⁵¹ Sometimes these briefings came directly from the Department of Health and Ageing but more frequently they came from NALHN or its predecessors and were endorsed by relevant person in the Department, usually the Chief Executive or Deputy Chief Executive.
- (6) The Minister would then send or otherwise provide a response to the person who made the report or complaint.

⁴⁴⁹ Statement of Hon John James Snelling, 29 September 2017, [23] – [29]; Statement of Hon Gail Gago, 20 October 2017, [37] – [47]; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 23.35–21.18 (John James Snelling).

⁴⁵⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 18.42–19.46 (John James Snelling); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 8 November 2017, 13.46–14.14 (Hon. Gail Gago); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 47.29–44 (Hon. Leesa Vlahos).

⁴⁵¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 18.42–19.46 (John James Snelling).

- (7) The Minister (or Minister's Office) would almost invariably rely upon the information and draft response provided by the Department, without conducting any independent inquiry.⁴⁵² If a response had been drafted by the Department or NALHN, the Minister would usually sign it without making any or any substantial changes. Of course there are instances where a Minister was more proactive but the usual approach was to rely on the information and response from the Department.
- (8) It was not uncommon for the Minister to respond to the complaint simply by quoting directly or paraphrasing the explanation that was given by the Department to the Minister.

Whilst Mrs Vlahos was Parliamentary Secretary (first to the Premier and then to Mr Snelling whilst he was Minister for Health), she responded on occasions to complaints on behalf of Mr Snelling.

The general practice outlined above was principally adopted in respect of complaints or reports made by members of the public directly to the office of the relevant Minister. However, the evidence before me supports the conclusion that a similar practice was adopted in respect of complaints or reports that came to the attention of the relevant Minister by other means. Obviously members of the public could complain directly to the offices of the relevant Ministers, or indeed (and there is some evidence of this having occurred) their local Members of Parliament both at a State and Federal level.⁴⁵³

Some complaints were received by the Minister for Health and, separately, the Premier. Those complaints appear to have been referred to the Minister for Mental Health and Substance Abuse, in most cases quite promptly. This was appropriate given the functions conferred by the MHA 1993 and the MHA; the delegation that was in place; and the principle of responsible government which makes each Minister responsible for the Minister's relevant Department.

The Minister for Ageing does not appear to have had any relevant involvement with or responsibility for Oakden, despite Makk and McLeay being classified as an aged care facility under the *Aged Care Act 1997* (Cth). No relevant functions appear to have been imposed on the Minister for Ageing, either pursuant to the *Office for the Ageing Act 1995* (SA) or otherwise. There is certainly no evidence of the Minister for Ageing having any real involvement in respect of the Oakden Facility during the period covered by the Terms of Reference.

8.3 STATUTORY MECHANISMS

Health and Community Services Complaints Commissioner

The office of the Health and Community Services Complaints Commissioner (HCSCC) was established by the *Health and Community Services Complaints Act 2004* (SA) (HCSC Act)⁴⁵⁴ and commenced in 2005.⁴⁵⁵

The functions of the HCSCC are relevantly to:

- prepare and review a Charter of Health and Community Services Rights

⁴⁵² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 60.15–34, 63.19–22 (Hon. Leesa Vlahos).

⁴⁵³ An example is the complaint Ms Baff made to Mr Tony Zappia MP in December 2014.

⁴⁵⁴ *Health and Community Services Complaints Act 2004* (SA) s 5 ('HCSC Act').

⁴⁵⁵ Steve Tully has been the Health and Community Services Complaints Commissioner (Health Commissioner) since 2012.

- identify and review issues arising out of complaints and make recommendations for improving health and community services and preserving and increasing the rights of people who use those services
- review and identify the causes of complaints and recommend ways to remove, resolve or minimise those causes and detect and review trends in the delivery of health or community services
- provide information, education and advice
- receive, address and resolve complaints
- encourage users to resolve complaints directly with providers
- assist providers to develop and improve procedures to resolve complaints, and
- inquire into, advise and report to the Minister on relevant issues.⁴⁵⁶

The HCSCC may receive complaints from a health or community service user; a parent or legal guardian of a child who is a service user; a donee of a power of attorney from a service user or a substitute decision-maker appointed under an advance care directive; a person acting on behalf of a service user by law or Court Order; a Member of Parliament; a person approved by the HCSCC to act on behalf of a service user; a health or community service provider; a person who can demonstrate an enduring relationship with or personal representative of a deceased service user; the Minister; the Chief Executive of the Department; or any other person as appropriate.⁴⁵⁷

The grounds on which the HCSCC may receive complaints are:⁴⁵⁸

- (1) A health or community service provider has acted unreasonably by not providing or discontinuing a health or community service provided to a particular person.
- (2) The provision of a health or community service was unnecessary or inappropriate.
- (3) The service provider acted unreasonably in the manner of providing the service.
- (4) The service provider has failed to exercise due skill.
- (5) The service provider has failed to treat a service user in an appropriate, professional manner.
- (6) The service provider failed to respect a user's privacy or dignity.
- (7) The service provider has acted unreasonably by failing to provide the user with sufficient information in a form understandable to the user to make an informed decision; a reasonable opportunity to make an informed choice of the treatment or services available; adequate information on the availability of further advice; or adequate information on the treatment or services received with a prognosis that would have been reasonable to provide.
- (8) The service provider acted unreasonably by denying access to or restricting access to records relating to the user; not making information available to a user about the user's condition.
- (9) The service provider acted unreasonably in disclosing information to a third person.

⁴⁵⁶ HCSC Act s 9.

⁴⁵⁷ Ibid s 24.

⁴⁵⁸ Ibid s 25.

- (10) The service provider has acted unreasonably by not taking proper action in relation to a complaint made by the user about the service provider's actions.
- (11) The service provider acted inconsistently with the Charter.
- (12) The service provider acted in a manner that did not conform with the generally accepted standard of service delivery expected of a provider of the relevant kind.

The HCSCC must conduct an assessment of the complaint within 45 days and determine whether to: refer the complaint to conciliation; investigate the complaint; refer the complaint to a registration authority; refer the complaint to another person or body; or take no action.⁴⁵⁹

An investigation by the HCSCC is to be conducted in such manner as the Health Commissioner thinks fit and in particular the Health Commissioner may obtain expert advice or assistance as deemed appropriate.⁴⁶⁰

The HCSCC has significant coercive investigative powers including being able to require any person to produce documents or information or attend before a person to give evidence.⁴⁶¹ The Health Commissioner may require any person to be examined under oath or affirmation or verify information by statement,⁴⁶² or obtain a warrant to enter and search any premises.⁴⁶³

The Health Commissioner may prepare a report with appropriate findings or recommendations.⁴⁶⁴

The HCSCC also has the power to investigate the conduct of unregistered health practitioners.⁴⁶⁵ This would largely include those not subject to regulation by AHPRA (discussed below).

Of particular note in the context of this investigation is that if the Health Commissioner is of the opinion that a complaint relates to a matter that falls within the functions conferred on another person or body, and it is appropriate to make a referral to that body or person, then the Health Commissioner may refer the complaint to that person or body.⁴⁶⁶

Further, if the complaint involves an approved provider under the Aged Care Act (as was the case for Makk and McLeay Houses) the Health Commissioner must consult with the complaint resolution bodies under that Act, and may refer the complaint to such an authority and provide information about the complaint to that body.⁴⁶⁷

Australian Health Practitioner Regulation Agency (2010 to Present)

AHPRA is established by largely uniform legislation enacted throughout the States and Territories of Australia. In South Australia the relevant legislation is the *Health Practitioner Regulation National Law (South Australia) Act 2010* (SA) (AHPRA Act).

⁴⁵⁹ Ibid s 29.

⁴⁶⁰ Ibid s 45.

⁴⁶¹ Ibid s 47.

⁴⁶² Ibid s 48.

⁴⁶³ Ibid s 49.

⁴⁶⁴ Ibid ss 54-55.

⁴⁶⁵ Ibid ss 56A-F.

⁴⁶⁶ Ibid s 29(2)(d).

⁴⁶⁷ Ibid s 29(3).

AHPRA commenced on 1 July 2010. It consists of 14 National Boards, each governing the conduct of a health profession.⁴⁶⁸

The AHPRA Act requires that certain 'notifiable conduct' be reported to AHPRA, such as where a practitioner has:

- practised while intoxicated
- engaged in sexual misconduct in connection with the profession
- placed the public at risk of substantial harm because the practitioner has an impairment
- placed the public at risk of harm because the practitioner has practiced in a way that constitutes a significant departure from accepted professional standards.⁴⁶⁹

Registered health practitioners and employers have a statutory obligation to report such 'notifiable conduct'.⁴⁷⁰

In addition to mandatory notifications there are voluntary notifications that may be made. These could include notifications where a registered health practitioner's conduct is of a lesser standard than reasonably expected; the knowledge, skill, judgment or care of a practitioner is below the standard reasonably expected; the practitioner is not suitable to hold registration; the practitioner has an impairment; the practitioner has contravened the AHPRA Act; the practitioner has contravened a registration condition; or registration has been improperly obtained.⁴⁷¹

AHPRA may receive complaints by phone or in writing.⁴⁷²

A Board may investigate a complaint received through appointed investigators.⁴⁷³

The investigations conducted by AHPRA and its associated Boards are directed to the conduct of an individual health professional, rather than system, governance or institutional issues, or underlying issues affecting the conduct of multiple health professionals.

State Nursing and Medical Boards (2007 to 2010)

Prior to the establishment of AHPRA regulation of the conduct of many health professionals was the subject of review by various State-based boards.⁴⁷⁴ I have received little evidence about such boards and the manner in which they operated which suggests that they had little to do with Oakden. In any event those mechanisms are historical and need not be further addressed.

The South Australian Community Visitor Scheme (2011 to Present)

The Community Visitor Scheme (CVS) was established by the MHA⁴⁷⁵ and commenced on 1 July 2011.⁴⁷⁶

It has been provided additional responsibilities specifically with respect to disability services by the *Disability Services (Community Visitor Scheme) Regulations 2013* (SA).

⁴⁶⁸ AHPRA Act sch 2 cl 31.

⁴⁶⁹ Ibid sch 2 cl 140.

⁴⁷⁰ Ibid sch 2 cl 141-142.

⁴⁷¹ Ibid sch 2 cl 144.

⁴⁷² Ibid sch 2 cl 146.

⁴⁷³ Ibid sch 2 cl 160.

⁴⁷⁴ See, eg Medical Practice Act 2004 (SA); Nursing and Midwifery Practice Act 2008 (SA).

⁴⁷⁵ Mental Health Act 2009 (SA) ss 50-54 ('MHA').

⁴⁷⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 7.19-33 (Maurice Corcoran).

The relevant statutory functions of the CVS, and specifically community visitors, are to:

- conduct visits and inspections of treatment centres and mental health facilities
- refer matters of concern relating to care, treatment or control of patients to the Minister, Chief Psychiatrist or other appropriate person
- act as an advocate for patients to promote proper resolution of issues relating to care, treatment or control.⁴⁷⁷

Whilst not expressly stated, those functions must extend to complaints and reports about sub-optimal care that come to the attention of the Principal Community Visitor or community visitors.

The functions are performed by the Principal Community Visitor and community visitors.⁴⁷⁸ The Principal Community Visitor and each community visitor is a statutory office-holder with statutory powers. However, community visitors are volunteers who come from all walks of life and who do not require any particular training (other than the short training provided by the CVS).⁴⁷⁹

Principal Community Visitor

The function of the PCV is to oversee and co-ordinate the CVS, advise and assist community visitors in their performance of their statutory functions including by referring matters of concern to the Minister, Chief Psychiatrist or other appropriate person.⁴⁸⁰

Maurice Corcoran was appointed as the inaugural PCV on 1 July 2011 and remains the current PCV.⁴⁸¹

Community visitors (and the PCV) have significant coercive investigative powers which include the powers of an inspector under the HCA.⁴⁸² A community visitor may at any reasonable time enter a hospital to inspect the premises or any equipment or thing on the premises, require the production of documents and records, examine any documents or records and take extracts from or make copies of them.⁴⁸³ A community visitor may visit without previous notice and at any time of the day or night.⁴⁸⁴

A community visitor visiting a facility must provide a report to the PCV.⁴⁸⁵ In respect of the Oakden Facility those internal reports were provided to members at the facility who were responsible for the management of the various units,⁴⁸⁶ and in some instances were forwarded to members of NALHN management.⁴⁸⁷

A patient, guardian, medical agent, relative, carer, friend of a patient, or any person who is providing support to a patient may request to see a community visitor and if such a request is made then the director of the facility must notify a community visitor of that request.⁴⁸⁸

The PCV may refer matters of concern relating to the organisation or delivery of mental health services in South Australia, or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body.⁴⁸⁹

⁴⁷⁷ MHA s 51.

⁴⁷⁸ Ibid ss 50-51A.

⁴⁷⁹ They are entitled to an honorarium of \$100 per month.

⁴⁸⁰ MHA s 51.

⁴⁸¹ Ibid.

⁴⁸² Ibid.

⁴⁸³ Ibid s 88.

⁴⁸⁴ Ibid ss 52(5), 53(5).

⁴⁸⁵ Ibid s 52(4).

⁴⁸⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 37:24-30 (Maurice Corcoran).

⁴⁸⁷ Ibid 13:40-14:9.

⁴⁸⁸ MHA s 53.

The PCV also has an obligation to prepare an annual report in which issues or concerns can be raised, which must be provided to the Minister and which the Minister must lay before both Houses of Parliament within six sitting days after receiving such a report.⁴⁹⁰ The PCV also has the power at any time to issue a special report to the Minister relating to matters arising out of the performance of the functions of the community visitors, and the Minister must lay such a special report before both Houses of Parliament within two weeks of receipt.⁴⁹¹

South Australian Office of the Chief Psychiatrist (2011 to Present)

The Office of the Chief Psychiatrist was created by the MHA.⁴⁹²

The MHA provides the Chief Psychiatrist with the following functions:

- to promote continuous improvement in the organisation and delivery of mental health services in South Australia
- to monitor the treatment of voluntary inpatients and involuntary inpatients and the use of restrictive practices in relation to such patients
- to monitor the administration of the MHA and standards of mental health care in South Australia
- to advise the Minister on issues relating to mental health and report to the Minister any matters of concern relating to the care or treatment of patients
- any other functions assigned to the Chief Psychiatrist by this Act or by any other Act or by the Minister.⁴⁹³

Medical practitioners and other persons have the responsibility of notifying the Chief Psychiatrist of Level 1 and 2 Community Treatment Orders and Level 1 to 3 Inpatient Treatment Orders. Those notifications impose further responsibilities on the Chief Psychiatrist.⁴⁹⁴

The Chief Psychiatrist is taken to be an inspector for the purpose of the HCA and has coercive investigative powers to inspect hospitals or any equipment or things on the premises; and require the production of, copy and examine, documents and records.⁴⁹⁵

The Chief Psychiatrist may issue standards that must be observed in the care and treatment of patients.⁴⁹⁶

Although the Chief Psychiatrist does not have express powers or obligations with respect to the handling, addressing or resolving of complaints, it is clear that his or her functions extend to dealing with relevant complaints and reports of sub-optimal care. The Chief Psychiatrist has the statutory function to 'monitor the administration of this Act and the standard of mental health care provided in South Australia' (s 90(1)(c)), and to 'advise the Minister on issues relating to mental health, and to report to the Minister any matters of concern relating to the care or treatment of patients' (s 90(1)(d)).

Indeed Dr Groves was asked by Ms West to investigate the complaint made by Mrs Spriggs.⁴⁹⁷ He could have exercised that power on his own initiative when Mr Corcoran brought the complaint to his attention.

⁴⁸⁹ Ibid s 51(1)(b).

⁴⁹⁰ Ibid s 54.

⁴⁹¹ Ibid s 54(3)-(4).

⁴⁹² Ibid s 82.

⁴⁹³ Ibid s 90.

⁴⁹⁴ Ibid ss 11, 14, 17, 19, 22, 26, 30.

⁴⁹⁵ Ibid s 90.

⁴⁹⁶ Ibid s 90(2).

⁴⁹⁷ See, eg Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 33.18-31 (Maria West).

The Chief Psychiatrist also has an obligation to prepare an annual report by 30 September each year, addressing the matters referred to in s 92 of the MHA, which must be provided to the Minister and which the Minister must lay before both Houses of Parliament within 12 sitting days after receipt of the report.⁴⁹⁸

South Australian Office of the Chief Advisor in Psychiatry (Prior to 2009)

The MHA 1993 established the position of Chief Advisor in Psychiatry.⁴⁹⁹ The position of Chief Advisor in Psychiatry was not recognised in the MHA which repealed the MHA 1993 and accordingly the position of Chief Advisor in Psychiatry ceased to exist from 2009. The powers and functions of the Chief Advisor were not as extensive as those conferred on the Chief Psychiatrist; the Chief Advisor only had the power to advise the Minister on matters relating to psychiatry and any other functions assigned by the Minister or an Act.⁵⁰⁰ Very little evidence was discovered on this investigation in relation to the Chief Advisor and no more needs to be said about that office.

The Office for Public Integrity and ICAC (2013 to Present)

As mentioned earlier the OPI was established by the ICAC Act and has the power to receive and assess complaints and reports with respect to potential issues of corruption, misconduct and maladministration in public administration. The ICAC has the power to investigate or refer complaints and reports.

Office of the Aged Care Complaints Commissioner

The Aged Care Complaints Commissioner is established by the Aged Care Act. The Aged Care Complaints Commissioner operates at the Commonwealth level.

The authorised complaints officers connected with the Aged Care Complaints Commissioner are entitled to exercise investigative powers which include: searching premises; taking photographs or recordings; inspecting, examining or taking samples of things; inspecting any document or record at a premises; taking extracts or making copies of any document or record at a premises; and using any equipment necessary to exercise the powers.⁵⁰¹

An authorised complaints officer may also require a response to be provided to questions or for the production of any documents or records requested by the complaints officer.⁵⁰²

It appears that the Aged Care Complaints Commissioner adopts an approach that seeks early resolution through informal processes. The Aged Care Complaints Commissioner may require a service provider to resolve a complaint within a set timeframe. Alternatively he or she could assist through conciliation or conduct an investigation into the complaint.⁵⁰³

An equivalent of the Aged Care Complaints Commissioner has largely existed since the beginning of the period covered by the Terms of Reference. However, the office of the Aged Care Complaints Commissioner operates at a federal level whilst the Terms of Reference are framed around investigating whether public officers within the meaning of the ICAC Act have engaged in maladministration in public administration. For that reason it is not necessary to consider or address in detail the federal mechanisms and it is only relevant to the extent that it puts other mechanisms in context.

⁴⁹⁸ MHA s 92.

⁴⁹⁹ Ibid s 6.

⁵⁰⁰ Ibid s 7.

⁵⁰¹ Aged Care Act 1997 (Cth) ss 94B.1-94B.5.

⁵⁰² Ibid s 94B.4.

⁵⁰³ Complaint Principles 2015 (Cth) s 12.

The Aged Care Complaints Commissioner is different to the Australian Aged Care Quality Agency (AACQA). The Aged Care Complaints Commissioner focusses on complaints while the AACQA is responsible for accreditation matters.

8.4 ORGANISATIONAL MECHANISMS

Safety Learning System (2010 to present)

The Safety Learning System (SLS) was introduced throughout SA Health in 2010.⁵⁰⁴ The SLS is a system that is accessible to all employees on the SA Health Intranet.⁵⁰⁵ The SLS has five relevant modules for reporting:⁵⁰⁶

- (1) Consumer feedback Module.
- (2) Notifications Module.
- (3) Patient Incident Module.
- (4) Worker Incident Module.
- (5) Security Incident Module.

The Consumer Feedback Module relates to complaints and commendations from consumers and carers; the Notifications Module relates to formal notifications to bodies such as SA Police, AHPRA and the Coroner; the Patient Incident Module relates to incidents affecting the safety and quality of care delivered to patients; the Worker Incident Module relates to occupational health and safety incidents with respect to workers; and the Security Incident Module relates to incidents affecting security during the delivery of health services.⁵⁰⁷

The Patient Incident Module, Consumer Feedback Module and Notifications Module are the most relevant to this investigation.

PATIENT INCIDENT MODULE ON THE SLS

All SA Health employees (including those who worked at Oakden and within NALHN) were and are required to use the SLS for reporting patient/consumer incidents and near misses.⁵⁰⁸

Since 14 July 2016 this obligation has been set out in the Patient Incident Management and Open Disclosure Policy Directive.⁵⁰⁹

The Patient Incident Management and Open Disclosure Policy Directive:

- (1) defines a patient incident as ‘any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a patient, that occurs during an episode of health care’

⁵⁰⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 12.13-18, 12.28-29 (Arthur Moutakis).

⁵⁰⁵ Statement of Jacheline Hanson, 10 October 2017, [31].

⁵⁰⁶ Ibid [32].

⁵⁰⁷ Ibid.

⁵⁰⁸ Ibid [34].

⁵⁰⁹ Ibid. There was a similar policy directive before July 2016.

- (2) prescribes an open disclosure process of providing an open, consistent approach to communicating with patients/consumer, their family, carers and support persons
- (3) requires acknowledgment of the issue, reporting onto the SLS, a review of the incident within two working days, a manager to finalise the review and feedback given to staff
- (4) encourages expressions of regret and saying sorry.⁵¹⁰

The Patient Incident Management and Open Disclosure Policy Directive does not appear to apply with respect to incidents reported under the Consumer Feedback Module, Security Incident Module, Notifications Module or Worker Incident Module. It appears to be limited to the Patient Incident Module.

The SLS provides for various severity ratings ranging from SAC1 to SAC4. A SAC1 incident is the most severe while SAC4 incident is the least severe.⁵¹¹

Issues such as seclusion, restraint, falls and medication errors must be recorded on the SLS.⁵¹² These issues would likely fall within the scope of the Patient Incident Module on the SLS.

Once an employee has entered the incident into the SLS an email is automatically sent to a Patient Incident Manager at NALHN and, depending on the SAC rating, others within management are notified.

As an example, the CEO of NALHN would be notified of all SAC1 incidents, the Chief Operating Officer of NALHN would be notified of SAC1 and SAC2 incidents, and the Divisional Director of Mental Health Services, the Risk Manager and local managers at facilities notified of relevant incidents from SAC1 to SAC4.⁵¹³

The Patient Incident Manager is responsible for implementing changes to reduce the risk by referring any recommendations to committees and recording recommendations in the SLS.

The concept of a SLS is an appropriate mechanism for the identification, recording and notification of reports, incidents and complaints.

However, its effectiveness relies upon employees understanding when and how to use it. It relies upon employees actually using it when appropriate and using it properly.

Critically, it relies upon managers taking appropriate action upon the receipt of an SLS report.

The system is rendered ineffectual if appropriate action is not taken on a report.

CONSUMER FEEDBACK MODULE ON THE SLS

The governance framework established at the Oakden facility and other such facilities is intended to provide for the appropriate management of complaints about quality of care locally at first instance (i.e. at the facility-level).⁵¹⁴

⁵¹⁰ Ibid annexure JRH-7.

⁵¹¹ Ibid [35]. The acronym 'SAC' refers to Safety Assessment Code. There is also reference in the evidence before me to 'SAM' which I understand to refer to a Seriousness Assessment Matrix. However Ms Hanson uses the acronym SAC throughout her statement to refer to the different modules in the SLS. I will use the acronym SAC.

⁵¹² Ibid [36].

⁵¹³ Ibid [37].

⁵¹⁴ Ibid [43].

At first instance consumers, families, carers and members of the community are encouraged to raise their concerns or provide feedback directly to staff members located at the facility.⁵¹⁵

NALHN encourages managers to deal with complaints at the facility level.⁵¹⁶ At Oakden those managers were the Clinical Services Coordinators (CSC) and Clinical Practice Consultants (CPC)⁵¹⁷ and may also include the higher line of managers such as Service Manager, Nursing Director or Clinical Director.

If a more formal complaint process was required in respect of a particular complaint or it could not be resolved at a local level the Consumer Liaison Officer (also known as the Consumer Adviser) could become involved. The role of the Consumer Liaison Officer was to receive, register, manage and close the complaints.⁵¹⁸

The management of complaints was subject to the SA Health Consumer Feedback Management Policy Directive and the Consumer Feedback Management Guideline and Toolkit.⁵¹⁹

Ordinarily the Consumer Liaison Officer would receive complaints in person or in writing. The expectation was that the Consumer Liaison Officer would review the complaint and would register it on the SLS. The Consumer Liaison Officer would ordinarily refer the complaint to the relevant Divisional Director to investigate locally and the Director would usually draft a written response.⁵²⁰ The response might be signed by the CEO of NALHN if the complaint was particularly serious.⁵²¹

NALHN was required to resolve and close a complaint within 35 days. If the complaint was not resolved within that timeframe then the Consumer Liaison Officer was required to refer it to the Department and explain the delay.⁵²²

SAC1 reports in the Consumer Feedback Module were not notified to the CEO of NALHN.⁵²³ Instead these reports were tabled at Divisional Clinical Governance Committee meetings.⁵²⁴ The usual approach for escalation of complaints recorded in this module is therefore considered in the Clinical Governance Committees section below.

The Consumer Feedback Management Policy Directive relevantly provides that, in summary:⁵²⁵

- The Policy Directive applies to all SA Health employees.
- The purpose of the Policy Directive is, inter alia, to ensure an approach that is consistent with the HCSCC Charter of guiding principles.
- The responsibility of the Chief Executive of SA Health is to ensure the management of consumer feedback across SA Health in accordance with the Policy Directive.
- The responsibilities of the Local Health Networks are to ensure sufficient resources are in place to enable effective systems for the management of feedback; encourage an environment where consumer feedback is handled seriously and thoroughly; ensure there are controls to receive, investigate and

⁵¹⁵ Ibid [44].

⁵¹⁶ Ibid [45].

⁵¹⁷ Ibid.

⁵¹⁸ Ibid [46].

⁵¹⁹ Ibid [46]-[47], annexures JRH-8, JRH-9.

⁵²⁰ Ibid [47].

⁵²¹ Ibid.

⁵²² Ibid [48].

⁵²³ Ibid [50].

⁵²⁴ Ibid.

⁵²⁵ Ibid annexure JRH-8.

respond to complaints and to implement the actions necessary to reduce the likelihood of complaints; ensure recommendations derived from investigations are appropriately addressed; ensure all complaints with potential for substantial liability or media attention are escalated to the Chief Executive of SA Health; and ensure day-to-day responsibility is delegated to relevant managers.

- The responsibilities of the General Managers, Executive Directors, Directors, Heads of Departments and other senior managers are to manage consumer feedback; develop, implement and monitor local processes, and ensure timely investigation of complaints.
- The responsibilities of the Consumer Advisers are to ensure all feedback is recorded in the Consumer Feedback Module on the SLS; ensure the effective management of consumer feedback referred by staff, managers and consumers; provide support, advice and education to staff managing consumer-related feedback.
- The responsibilities of all SA Health employees are to adhere to the policy; respond to feedback and refer to line managers; and ensure feedback is reported.

The Consumer Feedback Management Policy Guideline and Toolkit relevantly states, in summary:⁵²⁶

- The guiding principles are: commitment to consumers and quality improvement; accessibility; responsiveness; effective assessment; appropriate resolution; privacy and open disclosure; gathering and using information; and making improvements.
- All consumer feedback should be recorded in the SLS.
- A person making a complaint in connection with residential aged care (such as Makk and McLeay Houses) should be advised of the Aged Care Complaints Schemes.
- Consumer feedback should be dealt with by the unit involved with support from a supervisor, line manager or Consumer Adviser. Where the matter is more serious or has broader implications, senior management and executives are to be notified.
- The complaint management process is relevantly to receive the feedback; register and acknowledge the feedback; conduct an initial assessment of the issue; investigate the matter through the collection of information, analysis and review; respond to the feedback provided; seek a resolution to the issue; and follow-up preventative action.

Once again, at a practical level the complaint mechanism was reliant upon employees at lower levels being aware of the relevant policy and adhering to it and indeed managers ensuring compliance with it.

⁵²⁶ Ibid annexure JRH-9.

The Notification Module of the SLS essentially connects with external notification obligations such as to SA Police and AHPRA. Whilst there is little evidence before me with respect to this module it is clearly contingent on the mandatory reporting mechanisms that exist external to SA Health (e.g. the Coroner, SA Police, AHPRA and OPI).

Clinical Governance Committees

The evidence before me shows that the CEO of NALHN was not automatically notified of complaints logged in the Consumer Feedback Module regardless of whether such complaints were logged as SAC1 to SAC4.⁵²⁷

The usual process was that reports were generated for Divisional Clinical Governance meetings.⁵²⁸ There were four committees identified of escalating authority – the OPMHS Clinical Governance Committee, the NALHN Mental Health Divisional Governance Committee, the NALHN Clinical Governance Committee and the NALHN Senior Executive Team Performance and Risk Committee.

The Terms of Reference of the OPMHS Clinical Governance Committee relevantly state, in summary:⁵²⁹

- The purposes of the committee includes providing overall leadership and direction to OPMHS; ensuring effective clinical governance for OPMHS; ensuring consumer safety and quality of care; ensure compliance to legislation, professional standards and SA Health directives; and overseeing the divisional budget and activity for OPMHS.
- The membership of the committee include the Director of Mental Health Strategy and Operations; Director of Medical Services for Northern Mental Health; Service Manager; Clinical Director; Nursing Director; Clinical Services Coordinators; Clinical Practice Coordinators; Consumer Liaison Officers and other relevant staff.
- Meetings are expected to occur on a monthly basis.
- A quorum is required at the meeting of at least 50% of the membership of the committee.⁵³⁰

The OPMHS Clinical Governance Committee reported to the NALHN Mental Health Divisional Governance Committee.

The Terms of Reference of the NALHN Mental Health Divisional Governance Committee state that:⁵³¹

- The purposes of the committee include providing overall leadership and direction; ensuring effective clinical governance; ensuring consumer safety and quality of care; and providing reports as requested to the Executive.
- Membership of the Committee include the Service Manager for OPMHS and Clinical Director for OPMHS in addition to a number of other staff who are

⁵²⁷ Ibid [50].

⁵²⁸ Ibid. This committee went by various names including the Older Persons Mental Health Service Clinical Governance Committee, whose remit included but was not limited to Oakden.

⁵²⁹ Ibid annexure JRH-13.

⁵³⁰ In circumstances where the membership consisted of approximately 19 individuals, the necessary quorum at most times would have been 10 staff members.

⁵³¹ Statement of Jacheline Hanson, 10 October 2017, annexure JRH-12.

also on the OPMHS Clinical Governance Committee as well as a number of staff not on that Committee.

- Meetings are scheduled to occur monthly.
- A quorum is required of at least 50% which may have been as many as 10 persons.

The NALHN Mental Health Divisional Governance Committee reported to the NALHN Clinical Governance Committee.⁵³²

The Terms of Reference for the NALHN Clinical Governance Committee relevantly state that:⁵³³

- The purposes of the Committee include assisting the CEO of NALHN to discharge responsibilities with respect to the provision of safe and high-quality care; providing direction to the other NALHN clinical governance committees; monitoring and evaluating clinical audit programs; ensure compliance with NALHN policies and procedures; monitoring accreditation status of all services within NALHN; and initiating, monitoring and supporting processes for investigations.
- Meetings are scheduled on a monthly basis.
- Membership includes the CEO of NALHN and COO of NALHN.
- A quorum is 50% of the membership which would require about 8 staff members.
- The Committee does not appear to include any persons who were members of the NALHN Mental Health Divisional Governance Committee or alternatively the OPMHS Clinical Governance Committee.

The NALHN Clinical Governance Committee reports to the NALHN Senior Executive Team Performance and Risk Committee.⁵³⁴

The Terms of Reference for the NALHN Senior Executive Team Performance and Risk Committee relevantly state that:⁵³⁵

- The purposes of the Committee include ensuring that consumer safety and quality of care is protected by using risk management approaches; and that there are appropriate mechanisms for the workforce including work health and safety.
- The committee meet on a monthly basis.
- A quorum is 50% which would be approximately 12 staff members.
- It does not appear that the Committee reports to any other Committee.

⁵³² Ibid.

⁵³³ Ibid annexure JRH-10.

⁵³⁴ Ibid [63].

⁵³⁵ Ibid annexure JRH-11.

This complaint mechanism includes a series of meetings where matters could be escalated depending on whether the lower committee reporting to the higher committee had determined to escalate the complaint.

Obviously the effectiveness of this mechanism is dependent on the effectiveness of the lower committees.

If they are ineffective, complaints and reports will not get properly addressed or resolved; underlying issues will not be identified or fixed; and serious issues or underlying issues or trends will not be escalated to higher committees or persons within the organisation who are in a position to take meaningful action and effect meaningful change.

NALHN Relatives and Representatives Committee Meeting

A NALHN Relatives and Representatives Committee Meeting provided a forum for complaints to be raised by families of consumers and also those interested in raising concerns.⁵³⁶

The committee meetings were not regular but were *ad hoc*.⁵³⁷ It is unclear whether this committee was in place for the duration of the period covered by the Terms of Reference.

Consumer Liaison Officer (2007 to present)

The position of Consumer Liaison Officer/Consumer Adviser was important in respect of the management and resolution of complaints.

The Consumer Liaison Officer had the role of receiving complaints and providing oversight into the investigation and management of complaints by staff working at the relevant facility. It would appear that the Consumer Liaison Officer did not actually conduct the investigation but rather managed the complaint, leaving the investigation to be conducted by someone else at the facility.⁵³⁸

The Consumer Liaison Officer had some responsibility for updating the SLS.⁵³⁹

The Consumer Liaison Officer was also a member of the OPMHS Clinical Governance Committee and the NALHN Mental Health Divisional Governance Committee. The Consumer Liaison Officer was not a member of the two most senior committees.

I received evidence of Consumer Liaison Reports prepared by the Consumer Liaison Officer.

Those reports appear to have been provided to members of the committees of which the Consumer Liaison Officer was a member and it appears that the Consumer Liaison Officer was permitted to address the committee, although the evidence appears to be to the effect that little time was allocated to the Consumer Liaison Officer at those meetings.⁵⁴⁰

Importantly the Consumer Liaison Reports did not go into specific detail about individual complaints. Rather, they were focused on trends, statistics and broader summaries of complaints.

⁵³⁶ Ibid [54]-[55].

⁵³⁷ Ibid.

⁵³⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 22.18-27 (Maria West).

⁵³⁹ Statement of Jacheline Hanson, 10 October 2017, [47].

⁵⁴⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 38.34-39.14 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 27 October 2017, 41.31-38 (Stephen Simon).

It does not appear as though specific complaints were raised by the Consumer Liaison Officer, or otherwise generally discussed, at meetings of the relevant committees.

AIMS (Prior to 2010)

Prior to the introduction of the SLS an incident management system called AIMS was used.⁵⁴¹ The AIMS database did not capture complaints but rather incidents.⁵⁴²

The records of complaints at this time would usually be kept in folders that included the relevant information documents such as drafts, briefings and correspondence.⁵⁴³

There is otherwise little evidence about AIMS.

8.5 FACILITY MECHANISMS

Informally raised with staff at the Facility

The primary mechanism through which complaints were made and received was by making the complaint directly to the staff who were based at the Oakden facility.

The evidence suggests that many staff understood this to be the primary process.⁵⁴⁴ Indeed some staff gave evidence that they would raise complaints with the most senior nurse or whoever was seen as most senior at the time. At times this would have included the Clinical Services Coordinator, Clinical Practice Coordinator, Service Manager, Nursing Director or Clinical Director (if they were present). When these persons were not present, and indeed at other times when one or other of them was present, complaints or indeed incidents or reports were raised with nurses.

The process mandated by the SLS and the policies and procedures surrounding the SLS require that complaints are received by such staff and dealt with locally to the extent possible.⁵⁴⁵

Accordingly, the primary 'mechanism' by which complaints could be made at the facility was to lower level staff.

Complaint forms and suggestion box

Evidence was given that there was a standard complaint form which was used at the Oakden Facility and that there was a suggestion box in which complaints could be placed. The suggestion box was apparently cleared, and suggestions in it forwarded to the Quality Officer, who noted the contents and then directed the issues to wherever was appropriate for further consideration.⁵⁴⁶

Little action appears to have been taken in response to any complaints or suggestions placed in the suggestion box at the Oakden Facility.

⁵⁴¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 16.33-37 (Arthur Moutakis).

⁵⁴² Ibid.

⁵⁴³ Ibid 17.16-22.

⁵⁴⁴ Record of interview, Adelaide, 22 August 2017, 55 (Sangeeta Dhanorkar); Record of interview, Adelaide, 28 July 2017, 19, 25, 34 (Christine Hillingdon); Record of interview, Adelaide, 28 July 2017, 15 (Steven Cleland and Catherine Pirie).

⁵⁴⁵ Statement of Jacheline Hanson, 10 October 2017, annexure JRH-9.

⁵⁴⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 16.43-17.9 (Merrilyn Penery).

Administration book

I received evidence which suggested there was an administration book at the facility in which complaints could be recorded for action by other staff members.⁵⁴⁷ It is unclear on the evidence whether this is a reference to the case notes or other diaries used for recording matters.

In any event I did not receive an administration book fitting the description.

8.6 OTHER EXTERNAL MECHANISMS

Unions

Various unions received complaints about the Oakden Facility from members who worked at the Oakden Facility. In many cases those unions raised the complaints with employees of NALHN.

The South Australian Salaried Medical Officers Association (SASMOA) was particularly vocal in raising the concerns and complaints made to it by various members who worked at the Oakden Facility.⁵⁴⁸

Despite this, little action appears to have been taken by NALHN in response to the concerns and complaints made by SASMOA.

South Australian Office of the Public Advocate

The South Australian Office of the Public Advocate (OPA) was established by s 21 of the *Guardianship and Administration Act 1993* (SA) (GA Act).

The functions of the OPA include:

- reviewing programs relating to mentally incapacitated persons
- identifying areas of unmet needs and recommending programs to the Minister to meet such needs
- speaking for and promoting the rights and interests of mentally incapacitated persons
- speaking for and negotiating on behalf of mentally incapacitated persons in the resolution of problems faced by that person
- giving support to and promoting the interests of carers of mentally incapacitated persons
- advising on the powers that may be exercised in relation to mentally incapacitated persons and appropriate alternatives to taking action
- monitoring the administration of the GA Act and recommending changes to the Minister
- performing any other functions assigned to the OPA.⁵⁴⁹

⁵⁴⁷ Ibid 17.16-24.

⁵⁴⁸ Memorandum from Dr Sally Rischbieth to Margot Mains re: Medical risks at Oakden Campus, dated 7 July 2014, 2017-000535-E0027 (SASMOA1) DOC-000000076; document entitled 'Oakden campus – inadequate medical staff numbers', 17 July 2014, 2017-000535-E0004 (LVlahos1) DOC-000000139; see generally Record of interview, Adelaide, 8 September 2017, 37.24-30 (Bernadette Mulholland).

⁵⁴⁹ *Guardianship and Administration Act 1993* (SA) s 21 ('GA Act').

The OPA has the power to investigate matters upon the direction of the South Australian Civil and Administrative Tribunal.⁵⁵⁰ Although the GA Act does not appear to provide an express broader power to investigate complaints, the functions of the OPA permit it to do so.

8.7 APPROPRIATENESS OF THE MECHANISMS IN PLACE

Prior to 2010/2011 the mechanisms then in place, whilst not inappropriate, did not provide an adequate overall framework for the handling of complaints and reports of sub-optimal care for a facility such as Oakden, which was a specialist mental health facility for older persons.

Whilst there were adequate mechanisms in place for the handling of complaints relating to persons in aged care facilities and for persons in health institutions generally, the framework for the handling of complaints or reports for persons with a mental illness or severe behavioural disorder, such as those at Oakden was inadequate.

The AIMS appears to have been deficient because it was a hardcopy system without adequate mechanisms in place for its proper use and its monitoring, particularly given the absence of information about it.

That was rectified in 2010 and 2011 with the introduction of the CVS and the establishment of the position of Chief Psychiatrist.

The SLS was also introduced in 2010. I accept the submission that it improved the framework around the reporting of incidents and complaints generally.

After 2010/2011, when the SLS and both the CVS and the office of the Chief Psychiatrist had been established the mechanisms in place to receive and address complaints and reports about the quality of care provided to consumers at the Oakden Facility were on their face appropriate, although what happened at the Oakden Facility indicates that improvement is required. The following is a summary of the mechanisms that were in place at Oakden or were applicable to Oakden:

- (1) A Consumer Liaison Officer/Consumer Advisor who was almost entirely devoted to the receipt, management and resolution of complaints.
- (2) A reporting system (the SLS) which provided for registering incidents and complaints.
- (3) A series of governance committees at various levels which had the separate functions of considering and escalating complaints.
- (4) Two complaints bodies (the HCSCC at the state level and Aged Care Complaints Commissioner at the federal level) that were equipped with coercive investigative powers.
- (5) The CVS, which consisted of statutory office-holders and which had an extensive array of relevant functions and powers, as mentioned above.
- (6) The Chief Psychiatrist, another statutory office-holder, with broad oversight over mental health issues, and extensive statutory powers to enable the performance of that function.
- (7) Scope for committee meetings involving stakeholders such as families of consumers.

⁵⁵⁰ Ibid s 28.

- (8) The ability to raise complaints at the facility level although little meaningful action in fact appears to have been taken by staff at the facility in response.
- (9) The ability to bring complaints directly to the attention of a Minister.
- (10) External agencies who could receive complaints and reports about the conduct of SA Health staff (OPI, AHPRA, HCSCC, SA Police).
- (11) External bodies who represented the interests of employees (unions) and consumers (eg OPA).

The evidence establishes that members of senior management were unaware of a number of the serious issues at the Oakden Facility which were identified in the Oakden Report.⁵⁵¹

This was the case throughout the period covered by the Terms of Reference aside from late 2007/early 2008, when persons up to the level of the Minister became aware of serious issues at the facility after it failed the Commonwealth accreditation audit in December 2007, and again late in 2016/early 2017, when persons up to the level of the Minister again became aware of serious issues at the facility as a consequence of the complaint made by Mrs Spriggs.

There is little point in examining the position before 2010/2011 when the CVS, the position of Chief Psychiatrist and the SLS were all introduced. However the reasons for the failure of these mechanisms after that time should be explored.

8.8 HIGH RELIANCE ON LOWER-LEVEL EMPLOYEES

Many of the complaint mechanisms relied heavily on lower-level employees complying with their reporting obligations in order to be effective.

The majority of complaints and reports of sub-optimal care appear to have been made to nursing staff on the wards.

Sometimes but not always these complaints were escalated.

The effectiveness of this particular 'mechanism' depended upon the particular staff member to whom the complaint was made and whether the staff member had been well trained and complied with the training.

In many instances this 'mechanism' was completely ineffective.

The Consumer Liaison Officer, while performing an important role, largely operated as a conduit through which complaints were received and then directed to lower-level employees for investigation.⁵⁵² He did not appear to investigate matters independently but rather simply referred to and relied upon on what lower level employees told him.

The Consumer Liaison Officer does not appear to have exercised any real level of independent scrutiny or analysis over any of the many complaints that came to his attention, and he does not appear to have appreciated the seriousness of many of those complaints or the underlying issues that caused them to be made.

⁵⁵¹ The physical state of the building and grounds and the shortage of staff, particularly medical staff and allied health staff, stand in a different category.

⁵⁵² Statement of Jacheline Hanson, 10 October 2017, [46].

Whilst some attempts were made to identify trends in complaints, no detailed analysis of the issues which might have caused such trends took place, and they were certainly not given any detailed consideration by the committees to whom the Consumer Liaison Reports were provided.⁵⁵³

I find that the Consumer Liaison Officer was a largely ineffective mechanism for the handling and resolution of complaints and reports of sub-optimal care.

This may have been because the particular person who occupied the position apparently lacked the capacity to appreciate the seriousness of some of the incidents and complaints, or trends, and the causes of those trends, as shown by his handling of the complaint made by Mrs Spriggs.

His draft response to Mrs Spriggs' complaint was entirely inadequate which was demonstrated by Dr Elaine Pretorius' refusing to sign the response.

The Consumer Liaison Officer's usual practice was to simply rely upon what he was told by lower-level employees. That may be because the role itself was not clearly defined and indeed may not have been intended to be more than simply a liaison between staff at the facility and the complainant. It is likely both matters contributed to the ineffectiveness of the position as a relevant mechanism.

Although some matters were referred to the Service Manager, Nursing Director or Clinical Director at the facility, they each had responsibilities that extended beyond Oakden, and, in any event, whilst having offices at the Oakden Facility, they do not appear to have been present in the wards themselves very often.⁵⁵⁴ In fact Dr Draper was rarely on the wards.⁵⁵⁵

The majority of complaints were about the conduct of nursing staff which were usually referred to Mr Skelton who appears to have adopted, for the most part, an attitude of simply accepting what he was told by lower-level staff and not finding the incident or substance of the complaint 'proved beyond reasonable doubt' where the staff in question disputed the occurrence or the manner in which it occurred.

He also sought to 'handle' the complaint or incident 'in house' (ie. not inform anyone outside of the facility about it), which usually involved dealing with, or instructing lower-level employees (like the CSCs and CPCs) to deal with the particular complaint or report to the extent necessary to placate the complainant.⁵⁵⁶

The Ministers had to rely upon the information provided to them by the Department or NALHN, which in turn usually relied upon the information emanating from the staff at the facility.

⁵⁵³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 38.34-39.14 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 27 October 2017, 41.31-38 (Stephen Simon).

⁵⁵⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 14.8-42 (Merrilyn Penery); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 15.43-16.2, 16.34-47, 18.23-38 (Karim Goel).

⁵⁵⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 26.10-11 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 14.30-15.42 (Merrilyn Penery); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 18.23-38 (Karim Goel).

⁵⁵⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 75.4-77.26 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 21.19-32 (Maria West); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 128.27-129.14 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 56.8-45 (Russell Draper).

Usually no independent investigation or challenging of information provided was conducted by the Minister or the Minister's staff. This is not surprising.⁵⁵⁷ The Ministers, and their staff, cannot have been expected to independently investigate any complaints or reports that came to their attention.⁵⁵⁸ That is not the Minister's function and would not be appropriate. Moreover, the Minister was entitled to expect the Department and NALHN to handle complaints and reports of sub-optimal care appropriately.

However, the fact that the Ministers did not conduct any independent investigation of complaints and reports of sub-optimal care at the Oakden Facility that came to their attention, and simply relied upon the information that was given to them, means that it is not possible to describe complaints to the Minister as a 'mechanism' for the handling of complaints.

Moreover, the majority of complaints and reports appear to have come to the Ministers' attention through complaints being made directly to Ministers or the Premier by complainants themselves, independent bodies (such as the RANZCP) and other members of Parliament. The Minister was not being advised by the Department, NALHN, the Chief Psychiatrist or PCV of complaints or reports that had been brought to their attention. Accordingly, Ministers were only being advised of a small portion of the complaints actually made about the Oakden Facility.

Of course, the Ministers could have visited the Oakden Facility. Indeed Mr Snelling and Mrs Vlahos were invited to visit the Oakden Facility in July 2014 but the visit never eventuated.

Apart from one visit by Mr Hill to Makk and McLeay in 2010 and a further visit to Howard House, which by then had closed, no Minister visited the facility between March 2008, when Ms Gago visited, and February 2017, when Mrs Vlahos visited.

It follows that the Ministers over the relevant period offered little oversight in respect of complaints and reports about the Oakden Facility.

The consumers at Oakden were part of the most vulnerable people in the South Australian community. They lacked any voice themselves. They were entirely dependent upon others for their care and their safety.

Having regard to the vulnerability of the consumers at the Oakden facility and the responsibility therefore imposed upon the Minister it is surprising that the Ministers did not satisfy themselves that Oakden was fit for purpose and that the standard of care provided to those consumers was appropriate.

The SLS would not operate as an effective oversight mechanism for the handling of complaints or reports about sub-optimal care unless staff understood how to and did in fact use it properly.

The evidence is that staff at the facility had a poor knowledge of the SLS and in any event did not use it at all at times or use it appropriately.

Management at the facility do not appear to have taken any serious steps to ensure that staff knew how to and did in fact use the SLS properly.

⁵⁵⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 18.42 -19.46 (John James Snelling); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 9 November 2017, 60.15-34, 63.19-22 (Hon. Leesa Vlahos).

⁵⁵⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017 (John James Snelling): Mr Snelling said he questioned or challenged information at briefings (27.21-28.17). He had his Chief of Staff satisfy himself that allegations were being dealt with appropriately (29.17-29.30). He had a practice of placing matters on the agenda of the Chief Executive's meeting if he felt that a matter was not being dealt with appropriately (29.32-29.41); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017 (John Hill): Mr Hill said that he visited Oakden but nobody raised concerns with him (20.14-21.17) and he raised the state of the facility with the Chief Executive (21.12-21.27). He described instances where he had his staff further obtain information in relation to a complaint (16.26-17.40) and (17.42-16.19).

The SLS and its related policies and procedures mandated that all issues were to be resolved at the unit level which potentially had the effect of making lower-level employees the arbiter of the complaint mechanisms that were formally adopted by the Department.⁵⁵⁹

That was a significant weakness.

It allowed complaints to be dealt with inappropriately and this 'mechanism' does not appear to have been effective in practice.

The best evidence of the failure of these mechanisms in practice was uncovered and identified in the Oakden Report.

Whilst the particular 'mechanisms' to which I have referred might have appeared on paper as appropriate, the oversight functions performed by the Minister, the Consumer Liaison Officer, and the SLS meant that the mechanisms were largely ineffective in practice.

These were significant failings.

8.9 DEFENSIVE COMPLAINT RESOLUTION PRACTICES

Inappropriate practices were adopted in relation to the investigation of complaints.⁵⁶⁰

Mr Skelton for example adopted a 'beyond reasonable doubt' test when investigating complaints involving staff members.⁵⁶¹ If the complaint could not be proved to a criminal standard Mr Skelton would dismiss the complaint as unsubstantiated.

The criminal standard of proof is not the appropriate standard to use in a misconduct investigation. Mr Skelton said that was the standard he was aware of at the time and it was only later that he became aware of the balance of probabilities test and understood it to be the appropriate approach. In any event the adoption of that standard led to numerous complaints being inappropriately dismissed.

Responses to complaints were at times dismissive. Those investigating complaints arrived at findings in a way that suggested poor reasoning.⁵⁶² The Consumer Liaison Officer's role became too closely tied to the interests of those persons working within the Oakden Facility.⁵⁶³

Many complainants felt that their complaints were not taken seriously by those at the facility or within OPMHS, and were not dealt with adequately.⁵⁶⁴

From what I have seen and heard that is a view that those complainants could reasonably have held.

⁵⁵⁹ Statement of Jacheline Hanson, 10 October 2017, annexure JRH-9.

⁵⁶⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 75.4-77.26 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 21.19-32 (Maria West); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 128.27-129.14 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 56.8-45 (Russell Draper).

⁵⁶¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 76.23-78.6 (Kerim Skelton).

⁵⁶² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 21.19-23.13 (Maria West).

⁵⁶³ A view shared by Ms West: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 22.11-27 (Maria West).

⁵⁶⁴ Record of interview, Adelaide, 3 November 2017, 72.17-26 (Lorraine Baff); Record of interview, Adelaide, 12 July 2017, 28.23-28, 50.6-23 (Alma Krecu, Caterina Serpo, Ervino Serpo); Record of interview, Adelaide, 22 August 2017, 46.2-11 (Sharon Olsson); Record of interview, Adelaide, 13 July 2017, 33.8-11 (Dianne Mack); Letter from the Makk & McLeay Support Group to Hon Gail Gago and Hon Justine Elliot, 30 May 2008, 2017-000535-E0004 (LVlahos1) DOC-000001124.

Complaints and reports of sub-optimal care amongst some staff at the facility were often dealt with defensively, which contributed to the ineffectiveness of the 'mechanisms' which were reliant upon staff at the facility.

The culture that pervaded the complaints reports handling system was a culture that I experienced more broadly in the public sector and indeed in local government when I was first appointed as the ICAC.

In the early years of my office, I often thought that an investigation had been carried out for the purposes of exculpating the public authority that was the subject of investigation. I aired those views publicly on a number of occasions.

That attitude has largely changed in many parts of public administration but obviously did not change in respect of the Oakden Facility.

It also seems that the persons who had the responsibility for handling complaints and reports largely did not understand their own reporting obligations to the OPI.

All public officers are obliged to report to the OPI any conduct that the public officer reasonably suspects raises a potential issue of corruption or serious or systemic misconduct or maladministration in public administration.

8.10 CULTURAL ISSUES FACED BY WORKERS

As I have mentioned, the effectiveness of the SLS was dependent in large part upon low-level staff members.

There was a culture of secrecy at the Oakden Facility which the Oakden Report identified, the finding of which I agree. I will refer to this culture later in this report. It meant that complaints and incidents were either not entered or not entered appropriately into the SLS.⁵⁶⁵

There is also evidence which suggests that staff sought to avoid the 'inconvenience' of making reports on the SLS.⁵⁶⁶

Many staff thought that Oakden was a dumping-ground for those staff needing performance management.⁵⁶⁷ Some staff claimed that if they raised complaints then it was unlikely that they would be able to be moved to another facility.⁵⁶⁸

Those perceptions undoubtedly discouraged some staff from raising complaints with their superiors.

Some staff may have reported incidents at a lower SAC level than would have been expected given the seriousness of the complaint.⁵⁶⁹

Some took the view that an allegation of abuse was not reportable until proven.⁵⁷⁰

⁵⁶⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 97.17-26 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 113.17-113-27 (Aaron Groves).

⁵⁶⁶ This was particularly evident in relation to the use of restraints: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 26.37-27.24 (Merrilyn Penery).

⁵⁶⁷ Record of interview, Adelaide, 28 July 2017, 42 (Christine Hillingdon); Record of interview, Adelaide, 28 July 2017, 15-17 (Steven Cleland and Catherine Pirie); Record of interview, Adelaide, 22 August 2017, 15 (Sharon Olsson).

⁵⁶⁸ Record of interview, Adelaide, 22 August 2017, 24 (Sharon Olsson).

⁵⁶⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 63.11-29 (Jacheline Hanson).

⁵⁷⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 45.13-41 (Karim Goel).

That conduct and that attitude had the effect that serious complaints and incidents would not come to the attention, at least through the SLS, to more senior staff. Other evidence suggests that there were poor induction processes around the use of the SLS.⁵⁷¹

These cultural issues amongst staff (and managers) at Oakden clearly undermined the effectiveness of mechanisms which were dependent, directly or indirectly upon staff at the Oakden Facility.

8.11 LACK OF EXERCISE OF STATUTORY POWERS

The Chief Psychiatrist, the PCV and the community visitors all had the powers of a health inspector under the HCA. Those powers are extensive.⁵⁷² They also had the power to conduct announced and unannounced visits or inspections of the facility.

The community visitors were required to conduct periodic visits and inspections.⁵⁷³

The Chief Psychiatrist had the power to issue standards.⁵⁷⁴

Those powers do not appear to have been utilised specifically in respect of the Oakden Facility prior to late 2016 although the Chief Psychiatrist appears to have exercised the power to issue standards which touched on the Oakden Facility. The community visitors conducted announced visits and inspections as required by the MHA.

Whilst in theory the powers and functions of the CVS and the Chief Psychiatrist were appropriate and were important mechanisms for the addressing of complaints and reports of sub-optimal care, in practice they were less than effective, in part because the statutory powers conferred on the relevant statutory office-holders were not exercised to the extent that they could have been.

I will address this issue further below.

8.12 ESCALATION THROUGH GOVERNANCE COMMITTEES

The Policy Directive⁵⁷⁵ relating to governance committee meetings required at least 50% of members to be present before a meeting was held (at times requiring at least 10 employees to be present). The obligation to have a quorum with that number may have meant that meetings were not held and many complaints or reports did not come to the attention of governance committee meetings which were vital in the context of the complaint mechanisms that were put in place for the escalation of issues.

Moreover, the multi-layered nature of the governance committee structure resulted in an untimely approach to dealing with complaints.

As an example, each of the four committees met on a monthly basis. Depending on when each committee met, it took some months before matters were escalated from the lower committees to the higher governance committees.

The Consumer Liaison Officer (who was integral to the complaints management process) was not a member of the two higher committees.⁵⁷⁶ This is likely to have inhibited the ability

⁵⁷¹ Record of interview, Adelaide, 22 August 2017, 63 (Sangeeta Dhanorkar).

⁵⁷² MHA s 90(4)-(5).

⁵⁷³ See, eg. Ibid s 90(1)(b)-(c).

⁵⁷⁴ Ibid s 90(2).

⁵⁷⁵ Statement of Jacheline Hanson, 10 October 2017, annexures JRH-10 - JRH-13.

⁵⁷⁶ Ibid.

of the higher committees to hear details and gain a proper appreciation of the complaints that were received.

If a lower-level committee was unable to establish a quorum, the flow of information from lower committees to the higher committee could not occur since the higher committees were dependent upon information being escalated to them from the lower committees.

In addition, it seems that individual complaints did not tend to be raised at these committees. Rather, the Consumer Liaison Reports were provided to members of the committee and the Consumer Liaison Officer (sometimes) was given an opportunity to speak briefly to those reports.⁵⁷⁷ But of course he was not a member of the higher committees.

The committee structure was dependent upon the effectiveness of the person chairing the committee.

Dr Draper chaired the OPMHS Clinical Governance Committee from early 2016 onward, while Ms Harrison chaired the OPMHS Clinical Governance Committee.⁵⁷⁸ There is evidence to suggest that both Dr Draper and Ms Harrison were ineffective in these roles.⁵⁷⁹ The fact that the committees themselves operated ineffectively reflects poorly upon Dr Draper and Ms Harrison as the chairs of those committees.

The committee process was too cumbersome to be effective and suffered from all of the shortcomings to which I have already referred but it also suffered from the further defect that complaints and reports were not the core business of the committees but were matters that were incidental to their business.

Whilst the committees that were in place were in theory appropriate, in practice they were ineffective.

To be effective there needed to be one committee to which the Consumer Liaison Officer reported and which comprised not only officers who were at Oakden but senior officers at NALHN who were in a position then to advise the Chief Executive Officer of NALHN of any individual complaint or report which was so serious that it ought to be brought to the Chief Executive Officer's attention or of trends that were identified by the complaints and reports.

8.13 QUALIFICATIONS AND EXPERIENCE OF COMMUNITY VISITORS

As I have already mentioned, the community visitors are volunteers from all walks of life who must be commended for their willingness to perform the important functions assigned to them under the MHA.

However, it cannot be disputed that the CVS did not lead to identify most of the issues at Oakden, at least until Mrs Spriggs met with Mr Corcoran in June 2016. There are a number

⁵⁷⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 36.17-38.18 (Arthur Moutakis).

⁵⁷⁸ It went by various names over time, from about 2008 to 2016: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 21.40-22.3 (Russell Draper); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 34.33-35.4 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 73.30-37 (Julie Harrison).

⁵⁷⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 22.17-21, RD-3, RD-5 (Russell Draper); see generally Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 27 October 2017, 30.12-34 (Stephen Simon); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 48.27-49.1, 57.9-16 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 49.38-50.10 (Jacheline Hanson).

of possible reasons for this, including that the community visitors were not trained or qualified in a way which would have enabled them to identify such issues.⁵⁸⁰

Whilst in theory the CVS is an appropriate mechanism for the protection of persons suffering from a mental illness I find that in practice it was ineffective and for that reason I have made a recommendation that the scheme be reviewed.

8.14 DEFERRAL BY HCSCC TO THE COMMONWEALTH

The HCSCC has significant coercive investigative powers but it appears that it may have adopted a practice of referring complaints made to it about Oakden to the Aged Care Complaints Commissioner, on the basis that Makk and McLeay were 'aged care' facilities under the Aged Care Act. Such a practice seems to be envisaged by the HCSCC Act.⁵⁸¹ In circumstances where the Oakden Facility was not exclusively an aged care facility, the effectiveness of this particular mechanism may have been impaired. But it is not necessary for me to decide whether it did in fact act as an impairment.

8.15 THE COMMONWEALTH AGED CARE SCHEME REVIEW

While it is not my intention to scrutinise the conduct of various bodies at the federal level, it is worth observing that the review by Ms Carnell and Professor Paterson into the aged care quality regulatory processes found that the Commonwealth systems failed to pick up many issues at the Oakden Facility. In particular the report refers to a lack of oversight at the Federal level, an apparent lack of reporting, a need to look deeper into services, and that services may be preparing for accreditation processes.

8.16 CONCLUSION

The mechanisms in place from 2010 / 2011 for the receipt and handling of complaints or reports of sub-optimal care at the Oakden Facility should have been collectively appropriate but they clearly failed for the reasons I have mentioned and for the further reasons mentioned later.

⁵⁸⁰ I will address that when I consider the recommendations that I think ought to be conducted by the Minister.

⁵⁸¹ HCSC Act s 29(3).

CHAPTER 9: THE SECOND TERM OF REFERENCE

- 2) ***Whether since 2007, information (including by way of complaints or reports) concerning sub-optimal care of patients at the facility (relevant information) was brought to the attention of senior staff at the facility, staff of the Northern Adelaide Local Health Network (or its predecessors), executive staff of the Department for Health and Ageing, a statutory office holder or any Minister of the Crown and, if so:***
- a. when that relevant information was communicated;***
 - b. to whom the relevant information was communicated;***
 - c. what action was taken by whom as a result of the receipt of the relevant information; and***
 - d. if action was taken;***
 - i. when that action was taken;***
 - ii. who took the action;***
 - iii. whether the action was taken in a timely and appropriate manner; or***
 - e. if no action was taken:***
 - i. the person or persons who decided not to take action;***
 - ii. the reason or reasons for that decision;***
 - iii. the reasonableness of the decision.***

Term of Reference 2 is concerned only with the passing on of 'relevant information', which is information by way of complaints or reports concerning suboptimal care of patients at the Oakden Facility. Whether other information should or should not have been brought to the attention of persons mentioned in ToR 2 is irrelevant.

The sub-optimal care referred to in ToR 2 is not limited to nursing care but would include the physical state of the premises and any other factor that operated on or caused sub-optimal care to be provided to the consumers at Oakden.

The inquiry is whether relevant information was brought to the attention of senior staff at the facility, staff of the NALHN and the executive staff of SA Health, any statutory office holder including the Chief Psychiatrist, the PCV, Community Visitor or any Minister of the Crown.

If that relevant information were brought to the attention of any of those persons then the inquiry requires an examination of the matters in paragraphs (a) to (e) of ToR 2.

The investigation could not consider every piece of relevant information over the period of the ToR and decide whether that piece of relevant information was brought to the attention of the persons mentioned and when and by whom the relevant information was communicated.

The volume of relevant information that was available to the investigation made such an inquiry impossible.

Mr Besanko submitted that I should deal with this ToR in more general terms by having regard to broad topics, which he identified.

I agree that not only is that the better way to proceed, it is the only way.

I will therefore follow his submissions in that regard and have regard to the following broad topics in considering this ToR, although I will deal with the topics in a slightly different order:

1. The physical state of the facility
2. The state of the equipment at the facility
3. The level of funding for the facility
4. The level of nursing staff at the facility
5. The quality of nursing staff at the facility
6. Poor nursing practices
7. The level of allied health staff at the facility
8. The use of seclusion and restraints at the facility
9. The culture that existed amongst staff at the facility
10. The level of medical staff at the facility
11. The management structure at the facility
12. The state of the clinical documentation at the facility
13. The existence of medication errors and over medication at the facility
14. Physical and sexual assaults on consumers at the facility
15. The availability of activities at the facility
16. The availability of treatment to consumers at the facility

9.1 THE PHYSICAL STATE OF THE FACILITY

As I have said in Chapter 3.2, I visited the Oakden Facility but only after all consumers had departed Makk and McLeay houses.

I agree with the witnesses in this investigation, almost all of whom criticised the Oakden Facility as being not fit for purpose.

The Oakden Report included a number of photographs indicating the poor condition of the facility. The findings in the Oakden Report were highly critical of the facility.

The Oakden Facility was contrasted with the facilities in New South Wales, Victoria and Western Australia.

The principal finding in the Oakden Report was that the Oakden Facility was like a mental institution from the middle of the last century rather than a modern older persons mental health facility. That meant:

- The Oakden Facility was not well designed or modern for the time it was built and is now entirely unsuitable for its current purpose. It meets none of the expectations of a modern mental health service for older consumers with severe and incapacitating mental illnesses.
- The sub-standard quality of the infrastructure is likely to have led to considerable difficulty providing appropriate management of the most severe challenging behaviours of dementia. Further, the infrastructure has led to low morale and frustration amongst staff and led to some visitors becoming distressed by the environment in which their loved one has to reside.⁵⁸²

Almost all of the witnesses agreed with the Oakden Report in relation to those findings. Dr Draper said that he thought it was probably the worst facility in the country; it was old fashioned and it was no longer fit for purpose.⁵⁸³

Ms Harrison said that Makk was malodorous, gloomy and uninviting. She said that the facility was old, outdated, overcrowded and not appropriate for modern day treatment and that a new facility needed to be built.⁵⁸⁴

Mr Skelton said that the facility was very run down and not homely, that the grounds were forgotten, that the physical state of the facility was sub-optimal and that in his view the facility was never accredited for more than three years because of its physical state.⁵⁸⁵

Those three witnesses of course spent most of their time at the Oakden Facility and were in a position to give a first-hand account of the physical problems associated with the facility.

Mr Goel described the Oakden Facility as old, bleak and unattractive. He said that major physical maintenance was required but only the bare minimum was ever done.⁵⁸⁶

Mr Torzyn said that the building was archaic and was not purpose built and the accommodation was sub-standard⁵⁸⁷ and the overall environment was depressing, bordering on custodial.⁵⁸⁸

Ms Penery said the facility was inadequate.⁵⁸⁹

Mr Sexton said the facility was tired and cluttered and far from ideal for the 21st century. He said it needed to close or have significant investment.⁵⁹⁰

Dr Rafalowicz described the facility as old and in need of replacement.⁵⁹¹

⁵⁸² *The Oakden Report*, above n 39, 57.

⁵⁸³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 27.4-44, 28.44 (Russell Draper).

⁵⁸⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 50.10-27 (Julie Harrison).

⁵⁸⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 81.3-82.2 (Kerim Skelton).

⁵⁸⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 25.7-25.27 (Karim Goel).

⁵⁸⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 77.14-17 (Daniel Torzyn).

⁵⁸⁸ *Ibid* 34.3-4.

⁵⁸⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 36.2-4 (Merrilyn Penery).

⁵⁹⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 17.18-19 (Chris Sexton).

Ms Hanson said the building was old, tired and needed to be replaced some time in the future.⁵⁹²

The former Minister Mr Hill said that the facility looked tired, old fashioned and not contemporary.⁵⁹³

Ms Nowland agreed that the physical state was depressing and that it was self-evident that the facility was not going to last much longer.⁵⁹⁴

Ms Mains said that the buildings were old, radiated age and were not fit for time. She said the physical state was not suitable for the client group and it needed to change.⁵⁹⁵

Ms West said that the physical environment was unfit for purpose; the space was poorly used; it was evident no money had been spent on it for a long time; the building was painted yellow; it was neglected; the layout was inappropriate and did not meet best standards.⁵⁹⁶

Mr Moutakis said the facility was antiquated and agreed that it was depressing.⁵⁹⁷

Mr Leggett said the Oakden Facility was tired and needed work.⁵⁹⁸

Mr Corcoran said the conditions of the facility were poor, the furniture was unfriendly, Clements ward was cold and the environment stark. He described the facility as quite depressing.⁵⁹⁹

Mr Simon said that the gutters would leak, lawns were dry, there were issues with possums and the facility was generally not well looked after. He said that NALHN did the bare minimum to maintain the facility.⁶⁰⁰

Ms Owen said that the building was more run down than she initially anticipated and the building was old, stark and unwelcoming and the outside area was not well maintained.⁶⁰¹

Dr McKellar was of the opinion that the Oakden Facility was not fit for purpose in 2014.⁶⁰²

The Oakden Facility can only be described as a disgrace and should not have been used to house anyone let alone frail and vulnerable consumers.

⁵⁹¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 15.22-34 (Elias Rafalowicz).

⁵⁹² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 23.25-32 (Jacheline Hanson).

⁵⁹³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 13.38-44, 20.30-39 (John Hill).

⁵⁹⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 17.26-42 (Leonie Nowland).

⁵⁹⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 21.3-24, 30.19-34 (Margot Mains).

⁵⁹⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 17.17-47 (Maria West).

⁵⁹⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 49.26-37 (Arthur Moutakis).

⁵⁹⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 18 October 2017, 32.21-33 (Mark Leggett).

⁵⁹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 32.3-28, 33.20-26, 33.28-34 (Maurice Corcoran).

⁶⁰⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 27 October 2017, 18.30-19.4, 21.36-21.46 (Stephen Simon).

⁶⁰¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 35.40-36.1, 51.23-24, 55.4-7, 55.9-10 (Vanessa Owen).

⁶⁰² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 6.29-38 (Duncan McKellar).

NALHN must have known of the state of the Oakden Facility. Its officers visited the Oakden Facility often enough to know that the facility was substandard. NALHN was always on notice that this facility was not fit for the purpose for which it was being used.

9.2 THE STATE OF THE EQUIPMENT AT THE FACILITY

The equipment at the Oakden Facility was generally in poor condition, often outdated and in many instances rundown. The chairs in which the consumers were obliged to sit were in very poor condition. The Oakden Report speaks of the poor state of the equipment at the Oakden Facility. As I have already mentioned, I visited the Oakden Facility and noted the poor condition of the equipment.

The air conditioning at the Oakden Facility was inadequate but Ms Harrison said a replacement was deferred due to the intention to privatise the Oakden Facility.⁶⁰³ Dr Rafalowicz said that the air conditioning issues were repeatedly raised but not addressed.⁶⁰⁴ Mr Skelton said that the air conditioning was inadequate.⁶⁰⁵

Ms Harrison, Mr Skelton and Mr Goel all said that it was difficult to obtain equipment to replace old and dilapidated equipment.⁶⁰⁶

A number of family members who were interviewed by Mr McGrath and Mr Healey supported the evidence given at the hearings that the equipment at the Oakden Facility was generally in a poor condition and that there was a shortage of necessary equipment.

9.3 THE LEVEL OF FUNDING FOR THE FACILITY

The profit and loss statements for the financial years 2009-10 to 2016-17 are included as Appendix 11.

The figures indicate that the operating expenditure did not vary much over the whole of that period. In particular the operating expenditure of Makk and McLeay over that period reduced which is somewhat surprising over such a period. There was a significant decrease in supplies and service expenses because of a significant reduction in agency staffing from \$833,081 in 2009-10 to \$245,451 in 2016-17.

Over the same period of time the Commonwealth grants reduced from \$1,804,989 to \$1,333,923.

A number of the witnesses made complaints about the level of funding that was offered by NALHN to the Oakden Facility. Mr Goel said that he was told that the Oakden Facility was significantly over budget and the service needed to tighten its belt.⁶⁰⁷ Dr Rafalowicz said that he understood there were insufficient funds to maintain the facility and there was no interest

⁶⁰³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 47.28-17-31 (Julie Harrison).

⁶⁰⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 14.19-26 (Elias Rafalowicz).

⁶⁰⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 33.31-34.8, 81.28-82.2 (Kerim Skelton).

⁶⁰⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 29.10-37 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 81.28-82.2 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 23.11-35 (Karim Goel).

⁶⁰⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 26.29-45 (Karim Goel).

in further funding. He said it was rare when additional funds were available.⁶⁰⁸ Mr Torzyn's evidence was that there were no funds for Adelaide health staff.⁶⁰⁹

Ms Nowland said no funding was available for repairs and she prepared business cases for improvements which were declined due to funding reasons.⁶¹⁰ She said that Ms Harrison and Mr Skelton complained to her about the underfunding at the Oakden Facility a complaint with which she agreed. Ultimately she resigned due to her belief she was unable to operate within the budget that had been provided.

9.4 THE LEVEL OF NURSING STAFF AT THE FACILITY

It is clear on the evidence that the level of nursing staff at the facility was inadequate during the period addressed by the ToR. That was the conclusion at which the Oakden Report arrived and those who were employed at the facility during the relevant time did not disagree with the Oakden Report in that regard.

Ms Harrison said that the Makk and McLeay nursing levels were consistent with the levels prescribed in the Enterprise Agreement but she viewed the one to four ratio as too low and she rostered above this level until she resigned.⁶¹¹

Mr Skelton said that the nurse to consumer ratio of one to four was not acceptable and that if all beds were occupied then the shortfall in staffing could have been as high as 44 full time equivalents (FTE).⁶¹²

He said that for Makk and McLeay the nursing staff had the assistance of personal carers so they had the right number of persons but the nursing staff ratios were quite low.⁶¹³

Mr Goel on the other hand said they had the right amount of nursing per patient in the technical sense but there was an absence of allied health staff.⁶¹⁴ There was not always a mental health nurse rostered on.⁶¹⁵

Ms Penery raised concerns about nursing levels with Mr Skelton the Nursing Director.⁶¹⁶ She said that the number of registered nurses began to outbalance the mental health nurses and there were insufficient aged care nurses at the facility.⁶¹⁷

Mr Torzyn said that the nursing levels at the Oakden Facility were insufficient and there was a lack of senior nurses who could act as role models.⁶¹⁸

Ms Owen said that staff raised the need for more nursing staff at open forums and numbers were increased in 2015.⁶¹⁹

⁶⁰⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 18.4-12, 21.11-13 (Elias Rafalowicz).

⁶⁰⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 29.1-21 (Daniel Torzyn).

⁶¹⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 16.36-17.17 (Leonie Nowland).

⁶¹¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 47.19-48.19 (Julie Harrison).

⁶¹² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 96.5-28 (Kerim Skelton).

⁶¹³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 23.24-37, 88.3-18 (Kerim Skelton).

⁶¹⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 39.1-18 (Karim Goel).

⁶¹⁵ Ibid 51.4-5.

⁶¹⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 31.4-10 (Merrilyn Penery).

⁶¹⁷ Ibid 33.10-16, 33.29-34.

⁶¹⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 50.20-22, 55.19-24 (Daniel Torzyn).

The best evidence as I have said is that contained in the Oakden Report. Adherence to the Enterprise Agreement would not necessarily have meant that the facility was adequately staffed. NALHN needed to determine for itself based upon the expert evidence of doctor, nurses and administrator what level of staffing were needed to provide a safe and adequate level of care.

9.5 THE QUALITY OF NURSING STAFF AT THE FACILITY

It was Mr Corcoran's view that the Oakden Facility was inadequately staffed which affected the care provided to patients at the facility.⁶²⁰ In particular he said that the community visitor had raised concerns about the staff to patient ratios during the nightshift.⁶²¹

The majority of the nursing staff at the facility performed their duties poorly. There was as the Oakden Report found a minority of nursing staff who discharged their duties appropriately but as the Oakden Report shows they were the exception and not the norm.

Ms Harrison said that as early as 2007 she had grave concerns for the quality of nursing.⁶²² She said the quality improved but then declined again in 2012/13 when budgets became tight.⁶²³ She said that a significant number of overseas registered nurses were working at Oakden many of whom were difficult to understand.⁶²⁴ They were able to obtain employment at the Oakden Facility because it was the only mental health facility that employed non mental health staff.

Dr Draper said that the lack of skilled psychiatrically trained nursing staff impacted on the level of care.⁶²⁵ He said it was difficult to attract and retain staff because there was a view that the Oakden Facility was the least attractive place to work.⁶²⁶ He said that two nursing staff were reported for abuse.⁶²⁷ Over sedation frequently occurred at the Oakden Facility.⁶²⁸

Mr Skelton said that he was satisfied with some nursing staff⁶²⁹ but there were always difficulties in recruiting mental health nurses as aged care was not necessarily an area where mental health nurses wished to work.⁶³⁰

He said it would have been preferable to have a higher number of mental health nurses rather than general or geriatric nurses.⁶³¹

He said there was systemic under resourcing in mental health⁶³² and as a consequence more personal care attendants were employed rather than nurses.⁶³³ Some of the overseas trained nurses had narrowly defined practices, skills and knowledge.⁶³⁴

⁶¹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 33.5-34.2 (Vanessa Owen).

⁶²⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 43.5-44.2 (Maurice Corcoran).

⁶²¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 43.5-44.2 (Julie Harrison).

⁶²² Ibid 28.8-22.

⁶²³ Ibid 29.4-13.

⁶²⁴ Ibid 20.25-34.

⁶²⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 52.1-3, 29.22-23, 73.9-13 (Russell Draper).

⁶²⁶ Ibid 91.2-10, 90.41-47.

⁶²⁷ Ibid 42.7-26.

⁶²⁸ Ibid 56.13-26.

⁶²⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 78.35-79.8 (Kerim Skelton).

⁶³⁰ Ibid 65.6-9, 66.1-17; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 21.11-22.2 (Kerim Skelton).

⁶³¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 78.1-2, 117.33-118.5 (Kerim Skelton).

⁶³² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 24.21-31 (Kerim Skelton).

Mr Goel said quality of care depended upon the particular staff member.⁶³⁵ He said that 35% of nurses at the facility were outright poor.⁶³⁶ He said that of the 40 staff, approximately five were mental health nurses.⁶³⁷

Mr Torzyn agreed that the quality of nursing was sub-optimal at times⁶³⁸ and the quality of care provided by some of the foreign trained nursing staff was not as good.⁶³⁹

Ms Owen said that in 2013 and 2016 less than 50% of the nurses were mental health nurses.⁶⁴⁰ That evidence can be contrasted with Ms Nowland's evidence which was that Oakden had highly trained mental health nurses, aged care nurses, along with registered nurses (varying levels), enrolled nurses allied health professionals and psychiatrists.⁶⁴¹

However she admitted that because many of the staff were on sick leave, NALHN was not in a position to make positions permanent and therefore could not attract staff.⁶⁴²

Ms Mains said that the staff turnover was high which meant training and retraining staff was a significant challenge for the facility.⁶⁴³

Mr Moutakis said that there were competency issues amongst nursing staff with nurses providing very basic nursing care.⁶⁴⁴ Nursing staff generally stayed within their quarters and rarely interacted with consumers.⁶⁴⁵

He claimed the majority of complaints received by him about the Oakden Facility related to nursing staff.⁶⁴⁶ He said that he raised issues with nursing staff seeking employment elsewhere leaving them with agency staff and some nursing staff requiring a lot of clinical supervision.⁶⁴⁷

Mr Corcoran said he observed permanent nursing staff being under pressure because a number of tasks and roles could not be performed by agency nurses.⁶⁴⁸

9.6 POOR NURSING PRACTICES

The Oakden Report includes a finding that there were poor nursing practices at the facility throughout the period covered by the ToR.

That finding was supported by the evidence adduced in this investigation.

Mr Sexton said that a report was prepared in 2008 by Ms Buob, which found that there was a lack of knowledge about nurses ability on how to best interact and communicate with

⁶³³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 79.16-29 (Kerim Skelton).

⁶³⁴ Ibid 119.19-30.

⁶³⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 53.42-54.10 (Karim Goel).

⁶³⁶ Ibid 54.31-37.

⁶³⁷ Ibid 50.36-39.

⁶³⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 23.32-34 (Daniel Torzyn).

⁶³⁹ Ibid 54.45-55.13.

⁶⁴⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 68.28-33 (Vanessa Owen).

⁶⁴¹ Ibid 27.4-12.

⁶⁴² Ibid 31.15-26.

⁶⁴³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 29.28-30.17 (Margot Mains).

⁶⁴⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 61.1-8 (Arthur Moutakis).

⁶⁴⁵ Ibid 56.28-37.

⁶⁴⁶ Ibid 106.8-18.

⁶⁴⁷ Ibid 62.18-21.

⁶⁴⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 34.23-32 (Maurice Corcoran).

consumers and recommended a need for training staff on how to safely manage consumers.⁶⁴⁹

Mr Torzyn said that the quality of nursing care was sub-optimal and that he suspected there was a small core group who mistreated consumers.⁶⁵⁰ He observed staff using restraints as first line treatment.⁶⁵¹

Mr Goel said that nursing staff would allow consumers to lie on the floor.⁶⁵² He said staff used physical restraints as a falls prevention mechanism.⁶⁵³ He said a nurse locked himself in the nursing quarters for the duration of a shift and refused to go onto the floor and interact with the consumers.⁶⁵⁴

Mr Moutakis also said that nursing staff failed to interact with the consumers and some nurses failed to leave the nursing quarters.⁶⁵⁵

Ms Harrison agreed that some senior nurses were not present as much as they ought to have been on the wards.⁶⁵⁶

Ms Hanson's evidence was that the nursing staff adopted a custodial prison-like approach to care which meant that nurses left consumers for hours at a time.⁶⁵⁷

There is evidence that certain staff physically abused consumers and exhibited violence towards them. One staff member who has died but who I will not name, was particularly violent towards consumers. Notwithstanding that that was known to the Nursing Director he was not reported and no steps were taken by the Nursing Director to prevent the poor treatment he meted out to consumers.

9.7 THE LEVEL OF ALLIED HEALTH STAFF AT THE FACILITY

The evidence establishes that the level of allied health staff at the facility was frequently too low, and at times non-existent and for that reason the care provided to consumers at the facility was adversely affected and can be described as sub-optimal.

The absence of a social worker at times meant that the consumers who should not have remained at the Oakden Facility were not transitioned out of the facility.⁶⁵⁸

The empirical evidence shows that after the Oakden Facility was closed, consumers who had been at the facility were transitioned to mainstream nursing homes.

Ms Harrison said there was no allied health staff in 2015 and business cases submitted requesting allied health care were not approved due to funding.⁶⁵⁹ She said the number of assessments decreased due to not having enough social workers.⁶⁶⁰

⁶⁴⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 32.42-33.10 (Chris Sexton).

⁶⁵⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 23.23-34 (Daniel Torzyn).

⁶⁵¹ Ibid 54.4-34.

⁶⁵² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 58.33-59.22 (Karim Goel).

⁶⁵³ Ibid 59.24-29.

⁶⁵⁴ Ibid 68.40-45.

⁶⁵⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 56.28-57.8 (Arthur Moutakis).

⁶⁵⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, pt 2 T12.24-29 (Julie Harrison).

⁶⁵⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 11.8-23, 13.25-38 (Jacheline Hanson).

⁶⁵⁸ *The Oakden Report*, above n 39.

⁶⁵⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 49.11-36 (Julie Harrison).

Dr Draper said there was a lack of robust, diversional activity programs and occupational therapy input.⁶⁶¹ He said the shortage of allied health staff affected the quality of care.⁶⁶² He provided an example of a medication error that occurred due to there being an absence of oversight by a clinical pharmacist.⁶⁶³

Mr Skelton wrote a business case seeking the employment of a social worker. He said the Oakden Facility needed a social worker, dietician and physiotherapist.⁶⁶⁴ He said that the Oakden Facility was unsafe because there was no clinical pharmacist on the premises.⁶⁶⁵

Mr Goel thought there was a shortage of allied health staff at the Oakden Facility because there was an absence of social workers who played a pivotal role in transferring consumers out of the facility.⁶⁶⁶ He said the social worker roles were removed due to a lack of funding.⁶⁶⁷

Mr Torzyn and Ms Penery also raised concerns about the lack of allied health staff at the Oakden Facility.⁶⁶⁸

Ms West said that allied health staff from another facility were provided to cover the Oakden Facility. She said she met with the Executive Director of Allied Health on a number of occasions to discuss how they could generate additional allied health support for the Oakden Facility.⁶⁶⁹

Dr Rafalowicz spoke of a shortage of allied health staff across the whole service, but although he sought to have some social workers from the Queen Elizabeth Hospital move to the Oakden Facility, the staffing level remained inadequate.⁶⁷⁰ He said he spoke to the Director of Finance about the shortage of allied health staff.⁶⁷¹

Ms Hanson said that the allied health staff at the Oakden Facility reduced over a long period of time until there was only leisure and lifestyle workers remaining and the occasional visiting allied health practitioner.⁶⁷²

She said that concerns were raised with her that a 0.5 FTE social worker was insufficient for the needs at the Oakden Facility⁶⁷³ and as a consequence in October 2016 gave approval for a social worker and clinical pharmacist.⁶⁷⁴

Mr Moutakis said that the facility was chronically underfunded in relation to allied health and medical support staff.⁶⁷⁵

⁶⁶⁰ Ibid 69.19-27.

⁶⁶¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 34.4-23 (Russell Draper).

⁶⁶² Ibid 60.5-27.

⁶⁶³ Ibid 60.43-61.24.

⁶⁶⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 73.31-74.10 (Kerim Skelton).

⁶⁶⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 69.16-36 (Kerim Skelton).

⁶⁶⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 35.38-36.41 (Karim Goel).

⁶⁶⁷ Ibid 34.18-35.9.

⁶⁶⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 20.4-7, 28.21-31, 29.2-13, 31.30-47 (Daniel Torzyn); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 34.10-17 (Merrilyn Penery).

⁶⁶⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 14.12-44 (Maria West).

⁶⁷⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 20.18-35 (Elias Rafalowicz).

⁶⁷¹ Ibid 21.38-43, 22.13-16.

⁶⁷² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 31.21-31 (Jacheline Hanson).

⁶⁷³ Ibid 32.18-30.

⁶⁷⁴ Ibid 31.38-46.

Mr Corcoran said that he reported on the lack of allied health staff on a number of occasions. He agreed that the removal of a social worker further compromised the care at the facility and the temporary social worker position was unsatisfactory. The absence of allied health at Clements remained on the risk register for some time.⁶⁷⁶

I accept that Mr Corcoran reported on the lack of allied health staff on a number of occasions. He said that the removal of the social worker further compromised the care at the facility and the temporary social worker position was unsatisfactory.

Dr McKellar said that the allied health staffing was at the barest minimum and was continually being cut back.⁶⁷⁷

9.8 THE USE OF SECLUSION AND RESTRAINT AT THE FACILITY

Seclusion and restraints were applied throughout the period covered by the ToR but more particularly recently were applied inappropriately and in some respects amounted to abuse. The Oakden Report made damning findings in relation to the overuse of seclusion and restraint which I have already mentioned.

Ms Harrison said that nursing staff did not understand that when they put a person in a room alone that amounted to seclusion.⁶⁷⁸ She said that in 2008 Mr Skelton and the then CPC removed all restraints in all units.⁶⁷⁹

Dr Draper said that in 2015 there was a restraint minimisation group that tried to gradually implement better practices.⁶⁸⁰ Dr Draper conceded there was an occasion when he and the staff did not realise that moving a consumer into a separate room without nursing staff supervision constituted seclusion.⁶⁸¹ He agreed that there are better practice models that do not rely on restraints but they were unable to implement those practices without further funding.⁶⁸²

Mr Skelton said that he was not aware of staff using restraint as a management tool.⁶⁸³ That evidence is in direct contradiction to the findings of the Oakden Report. He said there were mixed messages around reporting because different views were held as to what actually constituted a restraint.⁶⁸⁴ Mr Skelton said that Oakden's use of restraints appeared high because they reported all incidents.⁶⁸⁵ He agreed that consumers in McLeay were left in chairs, restrained but said that they were attended to for toileting, feeding and leisure activities.⁶⁸⁶ He said that some consumers had tray tables placed in front of them at

⁶⁷⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 66.9-16 (Arthur Moutakis).

⁶⁷⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 27 October 2017, 54.3-7 (Stephen Simon).

⁶⁷⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 7.31-45 (Duncan McKellar).

⁶⁷⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, pt 2 13.26-35 (Julie Harrison).

⁶⁷⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 45.24-46.7 (Julie Harrison).

⁶⁸⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 57.22-36 (Russell Draper).

⁶⁸¹ Ibid 65.5-66.44.

⁶⁸² Ibid 31.41-47.

⁶⁸³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 111.23-112.16 (Kerim Skelton).

⁶⁸⁴ Ibid 114.28-115.19, 123.7-8.

⁶⁸⁵ Ibid 114.28-115.19.

⁶⁸⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 60.13-17 (Kerim Skelton).

mealtimes which meant that they were unable to walk away.⁶⁸⁷ Mr Skelton said that housing a consumer in the corridor did not constitute a seclusion.⁶⁸⁸

Mr Goel said that he instructed staff to remove restraints if he saw a consumer was unnecessarily restrained.⁶⁸⁹ He said staff members were uncertain about when it was appropriate to use seclusion and restraint.⁶⁹⁰ He said that Makk nearly eradicated physical restraint at around the time of the Chief Psychiatrist's visit on 30 June 2016.⁶⁹¹

Mr Torzyn said certain members of staff over used restraints and they had to be reminded to use less restrictive options.⁶⁹² He did not agree with the Oakden Report in that he said restraint and seclusion were used openly and the practice was transparent.⁶⁹³

Ms Penery said that restrictive practices decreased between 2007 and 2017.⁶⁹⁴ She said restraints were rarely used at Makk because if restraints were used there was an obligation to report on the SLS.⁶⁹⁵

Ms Hanson said that she was told by Dr Groves that staff did not know their obligations around restraints and seclusion.⁶⁹⁶ She said 'cloud' and 'princess' chairs were used to restrain consumers. They acted as a restraint because a consumer could not get out of the chair without assistance.⁶⁹⁷

Ms Nowland said that the use of restraints was over reported because bed trays were recorded as being a restraint.⁶⁹⁸

Mr Moutakis said that restraint levels diminished over time.⁶⁹⁹

Mr Corcoran said that concerns about the over use of restraints were expressed in a number of community visitor reports.⁷⁰⁰

Dr Tyllis said that he was concerned with high restraint numbers at the Oakden Facility whilst he was Chief Psychiatrist and he raised his concerns during his handover to Dr Groves who was his successor.⁷⁰¹

Mr Simon said that restraint numbers were high and restraints appeared to be imposed by the same members of staff.⁷⁰² He thought there was an excessive use of pelvic restraints

⁶⁸⁷ Ibid 57.28-58.2.

⁶⁸⁸ Ibid 68.22-34.

⁶⁸⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 59.31-37 (Karim Goel).

⁶⁹⁰ Ibid 73.32-35.

⁶⁹¹ Ibid 72.31-39.

⁶⁹² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 51.44-52.14, 52.27-34 (Daniel Torzyn).

⁶⁹³ Ibid 50.32-51.8.

⁶⁹⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 26.41-45, 26.29-45 (Merrilyn Penery).

⁶⁹⁵ Ibid 27.12-24.

⁶⁹⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 58.41-47 (Jacheline Hanson).

⁶⁹⁷ Ibid 59.34-41.

⁶⁹⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 28.28-29.6 (Leonie Nowland).

⁶⁹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 56.21-27 (Arthur Moutakis).

⁷⁰⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 52.2-10 (Maurice Corcoran).

⁷⁰¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 8 November 2017, 10.12-23, 20.31-42, 26.42-47, 11.33-37 (Peter Tyllis).

⁷⁰² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 27 October 2017, 12.25-38 (Stephen Simon).

within Older Persons Mental Health Service.⁷⁰³ Mr Simon said reporting increased when the Chief Psychiatrist told staff to report restraints which were being used to prevent falls.⁷⁰⁴

Dr McKellar said that he told Minister Vlahos and others that there was a regime of illegal seclusion and restraint at the Oakden Facility.⁷⁰⁵ He said in 2016 there were more incidents of mechanical restraint at McLeay than the rest of mental health services in the adult sector across the rest of country.⁷⁰⁶

Dr Groves said there were differing opinions on what constituted seclusion⁷⁰⁷ and during his visit on 30 June 2016 it became evident that one of the uses of restraint was to prevent falls⁷⁰⁸ and consumers were inappropriately placed in princess chairs and pelvic restraints for that reason.⁷⁰⁹

Dr Groves requested Ms Hanson to put together an action plan to reduce restrictive practices.⁷¹⁰

The evidence of Dr McKellar and Dr Groves establishes the overuse of restraints at Makk and McLeay to the point where as Dr Groves says the total annual rate of mechanical restraint at the Oakden Facility was greater than the total rate of mechanical restraint at all acute mental health services in the rest of Australia combined.⁷¹¹ That is an indictment by itself.

There is some evidence inconsistent with Dr McKellar and Dr Groves' evidence but that only indicates in my opinion that there was a lack of proper understanding as to what constituted a restraint and when it was appropriate to use restraints. The use of restraints for the safety of consumers or to prevent falls indicates a lack of understanding of the proper use of restraints.

It may be that restraints were used to an even higher degree than Dr McKellar and Dr Groves thought because other evidence suggests that the SLS was not as well used as it should have been.

9.9 THE CULTURE THAT EXISTED AMONGST STAFF AT THE FACILITY

The general thrust of the evidence that was given was that morale at the Oakden Facility was low. It was affected by the proposal that had first been made in the Stepping Up Report to effectively privatise the Oakden Facility and close the facility. Morale was also impacted by a lack of funding and resources. The attitude of many staff was poor. The majority of the nursing staff did not provide adequate care for the consumers. Many of the nursing staff were disinterested in and disrespectful to consumers.

There was bickering and bullying amongst staff. There were instances of verbal abuse, physical and sexual abuse.

The Oakden Report addresses those matters, which I of course accept.

⁷⁰³ Ibid 43.19-21.

⁷⁰⁴ Ibid 25.42-26.4.

⁷⁰⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 4.20-34, 12.25-38 (Duncan McKellar).

⁷⁰⁶ Ibid 25.34-44.

⁷⁰⁷ Ibid 7.5-23.

⁷⁰⁸ Ibid 81.5-15.

⁷⁰⁹ Ibid 75.5-23.

⁷¹⁰ Ibid 39.6-13.

⁷¹¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 80.1-11 (Aaron Groves).

Ms Harrison said that staff morale was adversely affected by the proposed closure of Oakden which prior to the Oakden Report never came about.⁷¹² She said that there was a culture of negativity because the staff felt undervalued and she said were burning out.⁷¹³ She told of an assault by one worker upon another at Oakden.⁷¹⁴

Mr Skelton said that nurses were moved when personal conflict or bullying claims arose.⁷¹⁵

Mr Goel said that Mr Skelton and Ms Harrison preferred to deal with some matters in-house and thereby fostered a culture of secrecy.⁷¹⁶

Mr Goel said that on one occasion he was advised by Mr Skelton not to report a matter to AHPRA and on another occasion a junior nurse was advised by Mr Skelton not to contact AHPRA.⁷¹⁷ The first of those matters is mentioned in the Oakden Report.⁷¹⁸ Mr Goel said there was bickering, infighting and bullying between staff members.⁷¹⁹ He said Oakden was viewed by some as a dumping ground for staff who were a problem at other institutions.⁷²⁰

Mr Torzyn said that the staff that came from Glenside on the closure of the ward at Glenside brought their culture to the facility, which adversely affected the culture at Oakden.⁷²¹

Ms Penery said that consumers were treated disrespectfully because some staff had a custodial power approach.⁷²² She also said that morale was affected by the belief amongst the staff that Oakden would close.⁷²³ She agreed with Mr Torzyn that the Glenside staff brought their old culture with them which influenced staff.⁷²⁴

She also agreed with the other witnesses that there was conflict between the staff and had been since before 2007.⁷²⁵

Mr Sexton on the other hand said he did not think there was a culture of hiding information but I think he is one of the few witnesses to hold that view.⁷²⁶

Dr Rafalowicz said that nursing staff put their own interests ahead of the interests of consumers.⁷²⁷

A number of other witnesses said that the introduction of the Glenside staff had an adverse affect on morale and culture generally.⁷²⁸

⁷¹² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 32.30-37 (Julie Harrison).

⁷¹³ Ibid 52.1-9, 33.1-6.

⁷¹⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, pt 2 46.36-47.21 (Julie Harrison).

⁷¹⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 118.32-119.2 (Kerim Skelton).

⁷¹⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 32.14-37 (Karim Goel).

⁷¹⁷ Ibid 32.14-33.12.

⁷¹⁸ *The Oakden Report*, above n 39, 97.

⁷¹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 57.19-32, 57.19-32 (Karim Goel).

⁷²⁰ Ibid 65.22-24.

⁷²¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 30.27-38 (Daniel Torzyn).

⁷²² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 24.28-25.17 (Merrilyn Penery).

⁷²³ Ibid 36.26-41.

⁷²⁴ Ibid 23.29-24.26.

⁷²⁵ Ibid 25.29-44.

⁷²⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 56.19-34 (Chris Sexton).

⁷²⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 23.21-39 (Elias Rafalowicz).

⁷²⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 13.25-14.11 (Jacheline Hanson); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 55.18-55.34 (Arthur Moutakis).

Ms Hanson said there was a custodial approach to the management of consumers, which probably came with employees who moved to Oakden from Hillcrest and Glenside.⁷²⁹

Ms Hanson agreed that there was a level of subterfuge to try to keep things close to prevent anyone from knowing.⁷³⁰

Ms Nowland said there was a poor nursing culture at Oakden.⁷³¹ She had to suspend four nurses for abuse of a consumer in May/June 2012.⁷³² She said that staff were deliberately placed at Oakden to change the culture.⁷³³

Mr Moutakis said that Mr Skelton deliberately withheld information.⁷³⁴

Dr McKellar and Dr Groves both were of the opinion that matters including misconduct were swept under the carpet while Dr Groves said that nursing staff and Mr Skelton had an old school attitude of how to operate mental health services which gave rise to the culture to cover things up.

9.10 THE LEVEL OF MEDICAL STAFF AT THE FACILITY

The level of medical staffing at the Oakden Facility was inadequate which compromised the care offered at the facility. So much is clear from the findings in the Oakden Report which were supported by the oral evidence.

Ms Harrison said that a 0.3 FTE consultant psychiatrist was not sufficient for the facility and a further medical officer was required.⁷³⁵ She said that Dr Flynn who was a medical officer regularly came in on weekends or stayed late or came in on extra days because of the pressure of work.⁷³⁶

Dr Draper said there was no onsite medical officer after hours.⁷³⁷ There was inadequate medical staff but not enough to make it medically unsafe.⁷³⁸ He said he presented a business case in 2014 to increase the time spent at the Oakden Facility by a consultant psychiatrist.⁷³⁹

He said when medical officers were on leave a crisis situation would arise because there were problems with the juniors engaged to cover at the Oakden Facility.⁷⁴⁰

Mr Skelton said in his opinion the Oakden Facility was medically unsafe because of the inadequate medical staffing.⁷⁴¹

Dr Rischbieth entered a statement in the risk register that the Oakden Facility was medically unsafe due to inadequate medical staff and lack of clinical pharmacists.⁷⁴² Mr Torzyn agreed that the Oakden Facility was medically unsafe due to inadequate staffing levels.⁷⁴³

⁷²⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 11.8-23, 13.40-14.11 (Jacheline Hanson).

⁷³⁰ Ibid 14.25-32, 13.25-38.

⁷³¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 24.27-31 (Leonie Nowland).

⁷³² Ibid 16.7-20.

⁷³³ Ibid 22.7-35.

⁷³⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 97.8-26 (Arthur Moutakis).

⁷³⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 43.16-18, 44.1-8 (Julie Harrison).

⁷³⁶ Ibid 45.3-7.

⁷³⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 9.14-27 (Russell Draper).

⁷³⁸ Ibid 63.26-64.8, 64.14-36.

⁷³⁹ Ibid 67.29-43.

⁷⁴⁰ Ibid 77.1-6.

⁷⁴¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 69.16-29 (Kerim Skelton).

Ms Hanson said that Dr Rafalowicz had reported that there was a shortage of medical staff across mental health and as a result a medical officer who was an 0.8 FTE was raised to a 1.0 FTE.⁷⁴⁴

A number of other witnesses said that the Oakden Facility was medically unsafe or that there was a chronic shortage of medical staff.⁷⁴⁵

The oral evidence and the documentary evidence, including the entry in the risk register, all support a finding that the level of medical staff was inadequate and that the absence of a proper level of medical staff affected the care that was offered in the facility.

9.11 MANAGEMENT STRUCTURE

The management structure at the Oakden Facility was inappropriate and I have commented on that previously. The responsibility for the Oakden Facility was shared between the Service Manager, the Clinical Director and the Nursing Director with no one of them having control over the others. All three who occupied that position over the relevant time recognise that the structure was inappropriate. Each of them reported to a different officer within NALHN which meant that there was no single person in NALHN who became informed of issues at the Oakden Facility.

I have made a recommendation to improve the management structure.

9.12 THE STATE OF CLINICAL DOCUMENTATION AT THE FACILITY

The findings in the Oakden Report were that the state of clinical documentation at the facility was poor throughout the relevant period.

That finding was inevitable and nobody who was in a position to know disagreed.

Mr Moutakis said that when he had occasion to review medical notes he formed the view that the notes were poorly expressed and that by and large nursing staff fell short when it came to documentation.⁷⁴⁶

Ms Penery said there were two sets of clinical notes apparently because standard clinical records by themselves would not have satisfied Commonwealth standards.⁷⁴⁷

Ms Harrison, who was in a position to know, said that the state of clinical records was manifestly deficient which had the potential to affect the quality of care.⁷⁴⁸

⁷⁴² Document entitled 'Oakden Campus – inadequate medical staff numbers', 17 July 2014, 2017-000535-E0004 (LVlahos1) DOC-000000139.

⁷⁴³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 59.45-60.1 (Daniel Torzyn).

⁷⁴⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 38.1-9, 40.32-37 (Jacheline Hanson).

⁷⁴⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 34.2-4 (Leonie Nowland); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 63.20-26 (Margot Mains); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 64.21-65.26 (Arthur Moutakis); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 7.31-45 (Duncan McKellar).

⁷⁴⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 125.27-30, 125.27-126.15 (Arthur Moutakis).

⁷⁴⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 38.3-39.10 (Merrilyn Penery).

⁷⁴⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, pt 2 60.26-28 (Julie Harrison).

Mr Skelton said there was not a reasonable system for recording clinical matters and the notes were often not specific enough. An attempt was made in about 2010 to provide additional training to staff to improve the state of the clinical documentation.⁷⁴⁹

Dr Draper commenced by defending the state of the clinical notes but ultimately said that the clinical notes were inadequate and of poor quality and insufficiently reviewed⁷⁵⁰ and that they were not useful.⁷⁵¹

9.13 THE EXISTENCE OF MEDICATION ERRORS AND OVER MEDICATION AT THE FACILITY

There were frequent medication errors at the facility which obviously affected the care provided. The findings from the Oakden Report support that proposition.

The evidence rather supports the finding that there was a regime of over medication. That finding is supported by Ms Hanson's evidence that when she met with about 10 families of consumers they all claimed that there was over medication at the Oakden Facility.⁷⁵² She said that after Dr McKellar became involved in the Oakden Facility the medical management changed and the consumers' health significantly improved.⁷⁵³

There was also an under reporting of medication errors and Ms Hanson gave an example where on one occasion 10 times the amount of a strong anti-psychotic sedative drug was administered. It was interesting to note when that error was reported on the SLS it was reported as a SAC4, which is the lowest severity of a reported incident.⁷⁵⁴

Ms Harrison and Mr Skelton were not sure whether there were a significant number of medication errors.⁷⁵⁵

Mr Corcoran said that he raised with Dr Tyllis when he was Chief Psychiatrist his concerns that the consumers were being over medicated.⁷⁵⁶

Dr Draper agreed that there was over sedation but it was not deliberate. Rather it was due to the fact that working out medication levels involved 'fine tuning'.⁷⁵⁷

Of course Mr Spriggs was the victim of a medication error which was a genuine error rather than deliberate over medication.

⁷⁴⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 50.3-51.25 (Kerim Skelton).

⁷⁵⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 46.21-30 (Russell Draper).

⁷⁵¹ Ibid 47.14-23.

⁷⁵² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 11.43-12.29 (Jacheline Hanson).

⁷⁵³ Ibid 25.34-45.

⁷⁵⁴ Ibid 63.3-64.18.

⁷⁵⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 74.15-35 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 92.8-19 (Kerim Skelton).

⁷⁵⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 56.38-47 (Maurice Corcoran).

⁷⁵⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 56.21-26 (Russell Draper).

9.14 PHYSICAL AND SEXUAL ASSAULTS ON CONSUMERS AT THE FACILITY

There is evidence in the documentation of physical and sexual assaults that occurred at the facility during the period addressed by the ToR. The Oakden Report addresses the topic as do the consumer liaison reports which were tendered in the investigation.

A number of reports have been made to the OPI and SA Police is investigating some of those reports. I do not intend to pre-empt SA Police's investigations.

Mr Torzyn described physical abuse as a long term problem in Clements House about which he complained to Mr Skelton and Ms Harrison on about six occasions.⁷⁵⁸

Mr Goel claimed the complaints about elder abuse did not usually come to his attention⁷⁵⁹ but that in any event an allegation of assault on a consumer was not required to be logged on the SLS. He claimed rather surprisingly that unless the assault could be proven it was not required to be registered.⁷⁶⁰

That evidence stands in stark contrast to Mr Moutakis' evidence, which was that a claim of an assault upon a consumer was a SAC1 level complaint on the SLS, the most severe rating possible.⁷⁶¹

Ms Harrison gave evidence of a sexual assault in Makk House.⁷⁶² Mr Leggett remembered that an alleged assault had been reported to him but wasn't sure if it was sexual or physical.⁷⁶³

Dr Draper said that two staff were reported for serious abuse allegations.⁷⁶⁴

9.15 AVAILABILITY OF ACTIVITIES AT THE FACILITY

There was a lack of meaningful leisure and lifestyle programs for the consumers at the facility during the period addressed by the ToR.

Mr Sexton admitted that there was a lack of activities in 2008 but he said that was addressed by 2012.⁷⁶⁵

Mr Torzyn's evidence was that some consumers often became involved in activities but other consumers who were not involved effectively lived in a corridor.⁷⁶⁶ Mr Moutakis' evidence was that many consumers spent the whole of their time watching television in a corridor.⁷⁶⁷ Ms Harrison agreed that there were consumers at the Oakden Facility whose

⁷⁵⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 27.9-46 (Daniel Torzyn).

⁷⁵⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 44.25-35 (Karim Goel).

⁷⁶⁰ Ibid 45.13-46.2.

⁷⁶¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 23.19-27 (Arthur Moutakis).

⁷⁶² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, p t 2 66.3-12 (Julie Harrison).

⁷⁶³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 18 October 2017, 67.23-26 (Mark Leggett).

⁷⁶⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 42.7-13 (Russell Draper).

⁷⁶⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 33.12-18, 45.43-46.3, 46.26-36 (Chris Sexton).

⁷⁶⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 34.17-30 (Daniel Torzyn).

⁷⁶⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 69.17-70.4 (Arthur Moutakis).

days consisted solely of eating, watching television and taking medication and admitted that this did not constitute proper care.⁷⁶⁸

I accept that evidence. My observations of the Oakden Facility was that most of the consumers must have lived their waking life in a corridor. There was nowhere else for them to be.

Mr Goel said that 'the team' did a good job dealing with leisure and lifestyle matters considering the resources.⁷⁶⁹ Leisure and lifestyle was more apparent in Makk and McLeay because of the availability of Commonwealth funding.⁷⁷⁰ The program involved playing games, concerts, dogs visiting the facility and a dolphin cruise.⁷⁷¹

Mr Skelton said that 50% of the consumers at the Oakden Facility engaged with the leisure and lifestyle program which was available on Mondays through Fridays but not on weekends.⁷⁷²

Ms Penery said that the leisure and lifestyle program improved greatly after the accreditation fail in 2008.⁷⁷³

It can be seen from the evidence to which I have referred that the evidence shows that few of the issues which I have addressed were raised with persons above the executive level within NALHN, especially after the failed accreditation audit in 2007 and not until the complaint by Mrs Spriggs.

However, Mr Skelton, Ms Harrison and Dr Draper who were the senior SA Health employees at the Oakden Facility were aware of most of the issues identified above which they admitted in their own evidence. They did not appear to take any significant action in respect of most of these issues.

It would appear that the action taken in response to the issues raised was generally inadequate and was not escalated appropriately to senior levels within NALHN.

Mr Skelton, Ms Harrison and Dr Draper were responsible for that omission. However NALHN of course was responsible for the funding of the facility which was inadequate.

9.16 THE AVAILABILITY OF TREATMENT TO CONSUMERS AT THE FACILITY

The consumers at Oakden had poor access to any meaningful treatment and were managed on the basis that they would remain as consumers at Oakden until they died. Mr Skelton confirmed that the consumers would be managed until they died.

A number of witnesses gave evidence that consumers at the Oakden Facility had a bed for life and were effectively managed until they died without any significant attempt to treat them.⁷⁷⁴

⁷⁶⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 38.18-27 (Julie Harrison).

⁷⁶⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 60.8-12 (Karim Goel).

⁷⁷⁰ Ibid 60.37-61.10.

⁷⁷¹ Ibid 61.12-31.

⁷⁷² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 65.27-36 (Kerim Skelton).

⁷⁷³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 29.22-39 (Merrilyn Penery).

⁷⁷⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 30.27-38 (Daniel Torzyn); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 36.3-37.12 (Russell Draper); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 84.3-37 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2

As already indicated, there was a shortage of allied health staff as well as a shortage of medical and nursing staff, and there was a lack of leisure and lifestyle program.

Ms Hanson said that she believed there were a number of consumers who were denied the appropriate care and treatment that they should have received.⁷⁷⁵ She said there was a culture at the Oakden Facility that consumers would remain until they died and there was no point therefore in providing any active therapy or treatment.⁷⁷⁶

Dr McKellar was seconded to the Oakden Facility in early 2017 and he undertook a review of each consumer as a result of which, the therapy and intervention plans for consumers changed, the medication management was changed, all of which resulted in immediate improvements.

Ms Harrison said that it was self-evident that the Oakden Facility was not appropriate for modern day treatment.⁷⁷⁷

9.17 SUMMARY

As I said at the start of this Chapter, the investigation could not consider every piece of relevant information brought to the attention of persons mentioned in this ToR because the volume of the relevant information that was available would make that inquiry impossible.

When I embarked on this investigation I was not expecting that there would be such a flood of information and evidence relating to the issues at the Oakden Facility over the period of the ToR.

The volume of complaints mentioned in Appendix 10 meant that to investigate each of those complaints would have resulted in a protracted investigation as to when and to whom each individual complaint and piece of information was made and the action that was taken with respect to the issues raised in the complaint. Such inquiry would not in my view have materially influenced the findings and recommendations I have made.

It is for that reason that the discussion in this Chapter has concentrated on the particular issues at the Oakden Facility.

ToR 2(a) and (b) address when relevant information was communicated and to whom. In this regard there ought to be seen to be 6 tiers of relevant persons in this investigation:

- **Tier One** - the nurses and staff working at the facility including the CSCs and CPC.
- **Tier Two** - the senior management based at the Oakden Facility, being the Service Manager (Ms Harrison), Clinical Director (Dr Draper) and Nursing Director (Mr Skelton).
- **Tier Three** - the executive directors with responsibility for Oakden, including persons such as Ms Nowland and Ms Owen. I also include Mr Moutakis within this tier.
- **Tier Four** - the CEO of NALHN, being Ms Mains and Ms Hanson at different times.
- **Tier Five** - the CE of the Department, which was Mr Swan for much of the period.

November 2017, 38.1-9, 26.13-21, 29.13-28 (Jacheline Hanson); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 3 November 2017, 12.44-45 (Chris Sexton).

⁷⁷⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 38.1-9, 12.11-22 (Jacheline Hanson).

⁷⁷⁶ Ibid 29.17-28.

⁷⁷⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, p t 2 34.12-28 (Julie Harrison).

- **Tier Six** - the relevant Ministers for Mental Health and Substance Abuse.

The evidence before me is that some persons within the Tier One communicated issues of sub-optimal care to the Tier Two although some of those within the Tier One contributed to the culture of secrecy which would have affected to some degree the level and extent of communications.

But in any event the standard of care was, without staff in Tier One raising concerns, clear to the persons in Tier Two. Those three persons were based at the Oakden Facility for most of the relevant period and witnessed the conduct first-hand.

The investigation found that there were instances where persons within Tier Two communicated matters of concern to persons in Tier Three, however, much of the evidence is that they simply communicated concerns between themselves (i.e. to persons within the same tier of management).

I have also found later in this report that the persons in Tier Two were involved in promoting a culture of secrecy which affected communications from them to Tier Three staff.

Mr Moutakis' role as Consumer Advisor and Consumer Liaison Officer was to be aware of the issues within the facility (as will be discussed later in this report). He was acutely aware of the issues with the facility because he received and was tasked with managing most of the complaints that were made to NALHN.

His evidence was that he mainly communicated the concerns raised with him about the Oakden Facility to the persons within Tier Two. In other words he communicated most of his concerns down the chain instead of up. In some instances that would be appropriate as those three persons were based at the Oakden Facility. However the nature of his role was to provide advice and recommendations which required him at the very least to communicate with those within Tier Three and possibly also Tier Four. There is very limited evidence that he did inform persons within his own tier (Tier Three) and escalate the concerns to those above.

There were some instances where the other staff within Tier Three (such as Ms Owen and Ms Nowland) received complaints that came to their attention. There is some evidence these were escalated however most of the evidence suggests many issues were not escalated above that tier.

It is appropriate to comment on Tier Four and Tier Five together. Ms Hanson said she was not aware of many of the issues at the Oakden Facility and I accept that. That suggests most of the issues were not escalated beyond Tier Three although there seemed to be a bottle-neck at Tier Two. If matters were not escalated to Ms Hanson as CEO of NALHN then unsurprisingly they were not also escalated to Mr Swan as CE of SA Health. The evidence suggests most matters did not come to their attention.

The Ministers received several complaints with respect to the Oakden Facility and there is some evidence matters were raised to Tier Six. Those instances are however few and far between. The Ministers would seek responses from SA Health and NALHN which meant that staff within Tiers Three, Four and Five inevitably became aware of additional issues that came to them from Tier Six. However as I mentioned and will discuss in this report there were relatively few matters raised to Tier Six.

In summary then the evidence is that the issues as to the communication of complaints and information concerning sub-optimal care largely was contained within Tier Two, being with the Service Manager (Ms Harrison), Clinical Director (Dr Draper) and Nursing Director (Mr Skelton).

ToR(2)(c), (d) and (e) are directed towards the action taken in response to any information relating to sub-optimal care that was communicated. Naturally if limited information was reaching Tiers Three, Four, Five and Six then little could have been expected to have been done by persons at those levels.

The evidence suggests that the persons at Tier Two were in the best position to take action. There is of course some evidence that they took some steps to improve the Oakden Facility however when one considers that the issues in 2007 that caused the failed accreditation largely seem to have also existed in 2017 it is clear that the action that was taken in response to complaints or the identification of issues by the persons at Tier Two was simply insufficient to address the relevant issues.

There is some evidence of inaction at Tier Three because of a lack of funding but as I have said elsewhere in this report in my view that is because of a lack of understanding of the severity of issues.

There was overlap between ToR 2 and ToR 3. ToR 3 is directed to the question of when relevant information was not escalated, the persons who failed to communicate, the reasons it was not communicated and the reasonableness of that decision. There was a clear failure to communicate on most issues by the members within Tier Two. The reasons for that are addressed elsewhere but generally it was because 1) there was an understanding that because of Recommendation 31 in the Stepping Up Report, the Oakden Facility would become the responsibility of the private sector and no long term planning occurred and 2) because of the culture of secrecy that had developed.

The failure to escalate and have action taken was of course inexcusable given the sub-optimal care that was provided at the Oakden Facility.

CHAPTER 10: THE THIRD TERM OF REFERENCE

- 3) *If relevant information was not brought to the attention of any person mentioned above:*
- a. *the person or persons who failed to communicate the relevant information;*
 - b. *the reason or reasons why the relevant information was not communicated;*
 - c. *the reasonableness of the decision.*

Mr Besanko contended and I agree that the third term of reference could be dealt with by reference to the matters contained in the second term.

It is not possible to address every instance of sub-optimal care that was identified.

The matters raised in the third term of reference have been dealt with elsewhere and need not be considered again separately.

CHAPTER 11: THE FOURTH TERM OF REFERENCE

- 4) ***Whether any person took steps to actively disguise and/or amend relevant information to protect individuals or government entities from reputational harm and/or to avoid or delay the timely and accurate disclosure of relevant information about the facility to senior staff, staff of the Northern Adelaide Local Health Network (or its predecessors), executive staff of the Department for Health and Ageing, a statutory office holder or any Minister of the Crown;***

with a view to determining whether any public officer as defined in the Independent Commissioner Against Corruption Act 2012 engaged in conduct which involved substantial mismanagement in or in relation to the performance of official functions, thereby constituting maladministration in public administration.

The fourth ToR raises different issues and required investigation into whether there were deliberate acts to disguise and/or amend relevant information about the facility to senior staff; staff of NALHN; the executive staff of SA Health and any statutory office holder or Minister of the Crown. The ToR only speaks of a failure to inform public officers and public authorities in the South Australian public sector. It does not address Commonwealth agencies.

A volume of information was generated and available relating to the Oakden Facility over the period mentioned in the ToR. However it was impossible to determine all of the information that was available over a period of 10 years and whether each particular piece of information was disguised or amended and not provided to a person senior in NALHN or SA Health or the Minister.

Such an inquiry would take years.

Mr Besanko has identified some particular circumstances and some general circumstances which might suggest an attempt to disguise, conceal or amend information, which he has made submissions on. I will address those issues.

I should proceed upon the basis that I first decide whether the event occurred before determining whether, if the event occurred, steps were taken to actively disguise and/or amend information relating to the event for any of the reasons mentioned in the fourth term of reference. I will deal with the circumstances in the same order that Mr Besanko has.

He identified the following issues:

1. *A failure by Ms Penery to report to AHPRA, to notify the Office [for Public Integrity] or SAPOL, or to lodge a report on NALHN's Safety Learning System, an incident that occurred on 13 May 2016 where a nurse, in the presence of another nurse, unsuccessfully attempted a catheterisation procedure on a consumer at the facility in circumstances where the nurse had not obtained consent and where the attempted procedure was continued despite it causing the consumer considerable distress.*
2. *A person at the facility deliberately altering the clinical notes for the consumers the subject of the attempted catheterisation procedure on 13 May 2016 to record that the employee who performed the procedure did not listen to her supervisor when performing the procedure, and further that there were attempts to obtain*

consent from the next of kin of the consumer retrospectively after the procedure had already been attempted.

- 3. Ms Harrison or another person at the facility removing from or not placing on the relevant file the behavioural assessment authored by Ms Meredith and dated 31 January 2008 for the consumer who allegedly killed Mr Rollbusch after Mr Rollbusch died on 28 February 2008 with the intent of concealing the behavioural assessment from investigating authorities.*
- 4. Mr Skelton informing Mr Torzyn, then the CSC at Clements House, not to report a staff member to AHPRA in 2016.*
- 5. A general practice on the part of Mr Skelton, throughout the relevant period, not to report staff members to AHPRA in circumstances where he was obliged to report those staff members.*
- 6. A general failure by staff at the facility to report incidents that should have been reported on the AIMS and, from mid-2010,⁷⁷⁸ the SLS, including the inappropriate use of restraints.*
- 7. Deliberate attempts by staff at the facility to conceal the true physical state of the facility and the care being provided at it from the Community Visitors when they visited each month from about July 2011.⁷⁷⁹*
- 8. Deliberate attempts by staff at the facility to conceal the true physical state of the facility and the care being provided at it from the Commonwealth agency responsible for auditing facilities designated aged care facilities under the Aged Care Act 1997 (Cth), the AACQA.*
- 9. A practice of maintaining two sets of clinical documentation for consumers at Makk and McLeay, only one of which was made available to AACQA because it was recognised that the other set was deficient and would not satisfied the standards maintained by AACQA.*
- 10. Instances where senior staff at the facility moved nursing staff who did not satisfy the standards maintained by AACQA away from Makk and McLeay for audits conducted by AACQA and then moved those staff members back to Makk and McLeay after the relevant audit had been completed by AACQA.*
- 11. A deliberate attempt to privatise the services provided at Oakden in order to shift responsibility for the poor care being provided at the facility to a private organization.*
- 12. A general culture of secrecy at the facility throughout the period 2007 to 2017.*

ISSUE ONE

On 13 May 2016 a nurse in the company of another nurse unsuccessfully attempted a catheterisation procedure on a consumer at Oakden, in circumstances where the nurse had failed to obtain the consent of the consumer to the insertion of the catheter, and where the

⁷⁷⁸ The evidence discloses that the SLS replaced the AIMS at the facility in around mid-2010: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 13.29-14.2, 16.33-17.10 (Arthur Moutakis); Statement of Jacheline Hanson, 10 October 2017; cf document entitled 'Makk and McLeay Nursing Home Complaints/Compliments Register', 24 June 2011, 2017-000535-E0016 (JHanson5)(JRichter5) DOC-000002049.

⁷⁷⁹ It is suggested that the first CVS visit was in July 2011: document entitled 'Community Visitors report on visit to treatment Centre', 29 July 2011, 2017-000535-E0003 (MCorcoran1) DOC-000000710.

attempted procedure was continued despite the consumer being caused considerable distress.

Ms Penery said that an enrolled nurse approached her and said 'Can you come and stop these bloody idiots from doing what they're doing'.⁷⁸⁰ She went in the consumer's room and found two registered nurses, one being a clinical nurse, attempting to catheterise a consumer. One attempt had already been made and failed.⁷⁸¹ Ms Penery asked them to stop and asked if they had obtained the consumer's consent.⁷⁸² The two nurses said 'no', then 'yes',⁷⁸³ and Ms Penery found it was 'really hard to work out what the truth was'.⁷⁸⁴

She then told them to stop the procedure. No further attempts to catheterise the consumer were made.⁷⁸⁵

One of the nurses involved, Ms Sangeeta Dhanorkar, said that she was directed by Ms Mariah Cid, a more senior nurse, to perform a catheterisation on the consumer, but during the attempt the consumer retracted and so Ms Dhanorkar abandoned the procedure. She said the consumer did not show any signs of discomfort. She said that Ms Penery told her after the procedure to ring the next of kin to obtain consent to the procedure.⁷⁸⁶

The incident was not reported on the SLS as it should have been.⁷⁸⁷ Ms Penery accepted that it should have been logged on the SLS by either her, the level two nurse or the level two nurse who was the team leader on the shift.⁷⁸⁸

Ms Penery could not offer any explanation as to why she did not report the incident on the SLS but she did say that it was not a deliberate decision.⁷⁸⁹

I think that evidence has to be accepted because there is no evidence to the contrary.

There is also no reason why Ms Penery would want to disguise the particular incident by concealing it.

In those circumstances I cannot make a finding that Ms Penery deliberately failed to log the incident onto the SLS or failed to report the incident to AHPRA.

ISSUE TWO

There is evidence that an addition was made to the clinical notes sometime after the event to the effect that Ms Dhanorkar did not listen to the 'CN' which probably is a reference to Ms Mariah Cid, but no reference to the fact that consent was or was not obtained.

Ms Penery said that she knew nothing about the clinical notes being altered or amended.⁷⁹⁰ Her evidence in that regard should be accepted because there was no evidence to the contrary.

⁷⁸⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 44.2-10 (Merrilyn Penery).

⁷⁸¹ Ibid 44.9-14.

⁷⁸² Ibid 44.16-19.

⁷⁸³ Ibid 44.21-24.

⁷⁸⁴ Ibid.

⁷⁸⁵ Ibid 44.26-28.

⁷⁸⁶ Record of interview, Adelaide, 22 August 2017, 34.1-35.37 (Sangeeta Dhanorkar).

⁷⁸⁷ 'Incident (patient incident) means: any event or circumstance which could have (near miss) or did lead to unintended and/or unnecessary psychological or physical harm to a consumer/patient that occurs during an episode of health care. Incident types are harmful incident, cluster incident, near miss, no harm incident and adverse incidents'; document entitled 'Policy Directive: compliance is mandatory – Patient Incident Management and Open Disclosure Policy Directive', 14 July 2016, Statement of Jacheline Hanson, 10 October 2017, annexure JRH7.

⁷⁸⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 44.39-42 (Merrilyn Penery).

⁷⁸⁹ Ibid 43.25-34.

It is probable that the amendment was made by Ms Cid but there is no evidence as to why she made the later note.

There is no evidence that if it was Ms Cid who made the later note that she did so with the intention of avoiding disclosure of relevant information about the delivery of nursing care at the Oakden Facility.

ISSUE THREE

The third issue relates to a behaviour assessment report prepared by Ms Meredith on 31 January 2008 for Mr Palmer the consumer who allegedly killed a fellow consumer Mr Rollbusch. Ms Meredith was a clinical psychologist who was engaged by Ms Harrison in January 2008 in order to conduct behaviour assessments of consumers at the Oakden Facility.⁷⁹¹

Ms Meredith appears to have been engaged because of the failed Commonwealth accreditation in December 2007.

The evidence would appear to support a finding that the report was not provided to SA Police or anyone outside the facility by Ms Harrison or any staff employed at the facility.

On 23 January 2008 Ms Meredith conducted a behaviour assessment on Mr Palmer⁷⁹² and on 31 January she prepared a report setting out observations and opinions as a consequence of that assessment.⁷⁹³

On 28 February 2008 Mr Palmer allegedly killed Mr Rollbusch.⁷⁹⁴

On 11 March 2009 Ms Harrison provided a statement to Senior Constable Craig Foster-Lynam.⁷⁹⁵

On 8 April 2009 Senior Constable Foster-Lynam emailed Ms Harrison requesting a copy of Ms Meredith's behavioural assessment reports for the persons she examined at the Oakden Facility in January 2008.⁷⁹⁶

On 9 April 2009 Ms Harrison emailed a number of persons employed by the OPMHS in which she stated: after referring to Senior Constable Foster-Lynam's email of 8 April 2009 '...as you are aware the assessment cannot be located. I am surprised they do not have the ABC charts as I believe everything was sent. Unfortunately the admin person who sent it said everything is away. We will try and locate it. Any feedback from Joanne re the interview?'.⁷⁹⁷

Senior Constable Foster-Lynam received a copy of Ms Meredith's report from Ms Harrison some time after 8 April 2009.⁷⁹⁸ SA Police had not previously seen that report.⁷⁹⁹

⁷⁹⁰ Ibid 40.22-33.

⁷⁹¹ Record of interview, Adelaide, 7 September 2017, 2.27-3.5, 4.2-4 (Fiona Meredith).

⁷⁹² Behavioural Assessment of Mr Peter Palmer, prepared by Fiona Meredith, dated 31 January 2008.

⁷⁹³ Ibid.

⁷⁹⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 23.34-24.13 (Julie Harrison).

⁷⁹⁵ Unsigned statement of Julie Harrison provided to Senior Constable Foster-Lynam, 11 March 2009, exhibit JH-2, 2017-000535-E0016 (JHanson5)(JRichter5) DOC-000004780; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 27.23-28 (Julie Harrison).

⁷⁹⁶ Ms Harrison did not recall being asked to provide a copy of the report to SA Police: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 27.29-33 (Julie Harrison); email from Craig Foster-Lynam to Julie Harrison re: Makk and McLeay Report, 8 April 2009, exhibit JH-2, 2017-000535-E0016 (JHanson5)(JRichter5) DOC-000000944.

⁷⁹⁷ Email chain between Julie Harrison, Lee Harris, Annette Jones, Alison Fitzgerald, and Craig Foster-Lynam re: Makk and McLeay Report, 8-9 April 2009, 2017-000535-E0014 (JHanson1)(JRichter1) DOC-000000010.

⁷⁹⁸ Record of interview, Adelaide, 7 September 2017, 59.2-7 (Fiona Meredith); Email chain, above n 797.

It would appear that Ms Meredith provided her completed report to Ms Harrison prior to Mr Rollbusch's death.⁸⁰⁰ On 1 March 2008 Ms Meredith informed Mr Wright, Director of Mental Health Operations, that she had prepared a report about Mr Palmer and she was concerned the report did not appear in Mr Palmer's case notes. She told Mr Wright that she was concerned that Ms Harrison had asked her to give the reports she had prepared to Ms Harrison rather than place them in the clinical files.⁸⁰¹

Mr Wright has not been interviewed. I understand that he now resides overseas and despite a number of attempts my staff were unable to make contact with him.

Ms Harrison's evidence was that she did not recall receiving or reading Ms Meredith's report and she did not know whether it was placed on Mr Rollbusch's clinical file and that she was not aware whether someone had deliberately removed the report from the clinical files.⁸⁰²

She said in her evidence that she did not recall getting the report or any conversation about where they should be placed. She said that if she received the report and that it would have been given to the clinical team.⁸⁰³

She said that the Crown in their investigations found an email that she had sent to the risk manager and the Attorney-General's Department (AGD), which said that she had given the report to one of 'our nurse advisor clinical people who were working on the unit to incorporate into the individual client plan for the consumer'.⁸⁰⁴

That might suggest that Ms Harrison did not place Ms Meredith's report on Mr Palmer's clinical file at any time. There is no evidence otherwise. If that is the case then no finding could be made that Ms Harrison placed the report on the file and then removed it after Mr Rollbusch was killed.

Of course someone else might have placed Ms Meredith's report on Mr Palmer's clinical file and the report could have been removed at some time after Mr Rollbusch's death.

Ms Meredith's evidence was that she prepared a report with respect to Mr Palmer and 11 other consumers⁸⁰⁵ and asked Ms Harrison to put the 12 behavioural assessment reports on the respective clinical files, but Ms Harrison declined and said she wanted the reports delivered to her.⁸⁰⁶ Ms Meredith said that she considered that request unusual as the reports would ordinarily go onto the files of the relevant consumers.⁸⁰⁷ Ms Meredith became concerned that her report on Mr Palmer might not have been placed on the relevant file.⁸⁰⁸

She did however as requested provide copies of reports including the report on Mr Palmer to the personal assistant to Ms Harrison.⁸⁰⁹ After hearing that Mr Palmer had attacked Mr Rollbusch she approached Mr Wright because she was concerned that the report she had completed on Mr Palmer might not be on his clinical file.⁸¹⁰ She said Mr Wright told her that he would ensure it was on the file.⁸¹¹ She said she was contacted by SA Police around April 2009 to give a statement which she did and informed SA Police that she had prepared the

⁷⁹⁹ Email chain, above n 797.

⁸⁰⁰ Behavioural assessment, above n 792; Record of interview, Adelaide, 7 September 2017, 54.31-55.30 (Fiona Meredith); Witness statement of Fiona Meredith relative to the death of Graham Rollbusch, 23 May 2017, 2017-000535-E0004 (LVlahos1) DOC-000000980.

⁸⁰¹ Record of interview, Adelaide, 7 September 2017, 53.19-57.30 (Fiona Meredith).

⁸⁰² Ms Harrison was not asked whether the report had been placed on Mr Palmer's clinical file: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 33.16-34.13 (Julie Harrison).

⁸⁰³ Ibid.

⁸⁰⁴ Ibid 33.28-34.9.

⁸⁰⁵ Record of interview, Adelaide, 7 September 2017, 54.17-21 (Fiona Meredith).

⁸⁰⁶ Ibid 55.23-30.

⁸⁰⁷ Ibid 57.7-21.

⁸⁰⁸ Ibid 56.5-9.

⁸⁰⁹ Ibid 55.29-30.

⁸¹⁰ Ibid 55.32-56.13.

⁸¹¹ Ibid 56.11-13.

behavioural assessment report.⁸¹² She was later told by Senior Constable Foster-Lynam Ms Harrison had provided a copy of the report to SA Police.⁸¹³

The evidence supports a finding that Ms Meredith's behavioural assessment reports were provided to Ms Harrison shortly after they had been completed but in the case of Mr Palmer at least not placed upon his file at that time.

SA Police was unaware of the existence of the report until such time as Ms Meredith was interviewed in April 2009.⁸¹⁴ After she was interviewed Senior Constable Foster-Lynam emailed Ms Harrison seeking a copy of the report which was provided to SA Police in April 2009.⁸¹⁵

There is no evidence as to where the behavioural assessment reports were kept or who kept them, nor who retrieved the behavioural assessment report for Mr Palmer after the request was made to Ms Harrison.

I cannot find that the behavioural assessment report was ever placed upon Mr Palmer's file because there is no evidence to that effect. In those circumstances I cannot find that the behavioural assessment report was ever removed from Mr Palmer's file or even if it was by whom.

It is suspicious that the behavioural assessment report was not provided to SA Police immediately after Mr Rollbusch died, but there is not sufficient evidence before me to make a finding that anyone, including Ms Harrison, deliberately failed to produce the report to SA Police in March 2008.

Clearly the report was not destroyed because it was provided to SA Police immediately after it was requested from Ms Harrison.

For all those reasons I cannot find that anyone, in particular Ms Harrison, took steps to actively disguise relevant information to protect anyone else, or NALHN, or the Oakden Facility from reputational harm.

ISSUE FOUR

The fourth incident addressed by Mr Besanko in his submissions relates to Mr Skelton.

A finding was made at page 97 of the Oakden Report:

The second aspect was secrecy and inaction. The review was told that a former Nursing Director (who was in place in 2016) had instructed a junior staff member to not report an allegation of professional misconduct of a nurse working at Oakden to the Australian Health Practitioner Regulation Agency (AHPRA). The message given to staff by the nursing director was "We will handle all this in house". The consequence was a feeling among staff that anyone can get away with things they should not, and why would you bother letting people know it is not good enough, no one will do anything about it.

Mr Skelton was asked by Mr Besanko whether he is the Nursing Director referred to in that finding. He denied that he was⁸¹⁶ and denied that he ever told or directed a staff member not to report an allegation of misconduct to AHPRA.⁸¹⁷

⁸¹² Ibid 58.2-6.

⁸¹³ Ibid 59.2-7.

⁸¹⁴ Ibid 59.9-16.

⁸¹⁵ Email chain, above n 797.

⁸¹⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 120.3-12 (Kerim Skelton).

On the other hand Mr Torzyn who later gave evidence said that he was the junior staff member referred to in the finding and that Mr Skelton was the nursing director who gave him the instruction.⁸¹⁸

Mr Skelton was an unimpressive witness and I do not believe his evidence in relation to this issue. I prefer Mr Torzyn's evidence. I find that Mr Skelton was the Nursing Director referred to in the Oakden Report and that he gave the instruction to Mr Torzyn to which the Oakden Report refers.

I also find that Mr Skelton assumed that it should have been reported because otherwise he would not have needed to give Mr Torzyn the instruction not to do so.

On other occasions he had given similar instructions to Mr Goel.⁸¹⁹

ISSUE FIVE

Dr McKellar provided evidence in which he said that the review team that was responsible for the Oakden Report found evidence that Mr Skelton had a history of sweeping serious misconduct issues under the carpet.⁸²⁰

Mr Skelton also proceeded on the basis that he would not find allegations of misconduct made out, unless they were proved beyond reasonable doubt.⁸²¹

I think it is likely that Mr Skelton fostered the culture of secrecy to which the Oakden Report referred, which I think existed at the Oakden Facility during the relevant period.

I think that Mr Skelton dealt with complaints in house to avoid the scrutiny of regulators such as AHPRA.

I do not think I can go as far as finding that it was a general practice for him not to report staff members to AHPRA, because I only have evidence of two cases in which he gave that instruction.

However, I think I can find that his conduct assisted to foster the culture of secrecy.

ISSUE SIX

Was there a general failure by staff to report incidents that should have been reported before about mid 2010 on the AIMS and, after that time, the SLS?

I have not been provided with sufficient evidence to make any finding in relation to the failure to report incidents on the AIMS prior to mid 2010.

The Oakden Report found that there had been significant under-reporting of restraint and seclusion incidents, notwithstanding the direction of the Chief Psychiatrist issued under s 90(2) of the MHA, which operated after 1 July 2013.⁸²²

⁸¹⁷ Ibid 120.21-24.

⁸¹⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 25 October 2017, 20.41-21.46 (Daniel Torzyn).

⁸¹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 32.23-30 (Karim Goel).

⁸²⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 19.45-20.6 (Duncan McKellar).

⁸²¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 76.32-36 (Kerim Skelton).

There does not appear to be any dispute that there was significant under-reporting of the use of restraints at the Oakden Facility over the relevant period, and since the SLS became the medium through which such reports should have been made.

There is not sufficient evidence however to find that the under-reporting was a conscious decision not to report an incident because the person who had the obligation to report was anxious to hide or conceal the particular incident.

There are a number of inferences that could be drawn to explain the under-reporting. It may have been laziness, error or a misunderstanding on the part of the staff at Oakden as to their obligations to report, possibly as a result of poor instruction.

I cannot therefore find that the under-reporting of the use of restraints on the SLS was a consequence of the employees at the Oakden Facility deliberately attempting to conceal the fact of the restraint.

Indeed there were sufficient reports of mechanical restraints for Dr Groves to observe that the total rate of mechanical restraint in Oakden in 2015 was greater than the total rate of mechanical restraint in all acute mental health units in Australia combined.⁸²³ Dr Groves acknowledged he was not comparing like with like because Oakden was a unit for persons suffering chronic mental health illness, but the 2015 rates were still a standout to him.⁸²⁴

If that were the case, and I accept that of course it was, there would be no reason not to report restraints or seclusion on the SLS to avoid it coming to the attention of the authorities.

It may be that at particular times, staff deliberately did not enter the use of a restraint on the SLS so as to avoid it being known that such a restraint had been used on a particular consumer at a particular time. I have not enquired into each and every failure to log the use of a restraint onto the SLS. That would be an impossible task because it would require an investigation into the absence of evidence.

ISSUE SEVEN

This relates to the visits by the PCV and the community visitors. The majority of visits were announced.⁸²⁵ On those visits the community visitors were usually escorted around the facility by staff at the facility,⁸²⁶ which would have meant that it was more likely that the PCV or the community visitors would be less likely to observe anything untoward. They would be likely to be shown those areas and those consumers that did not indicate any irregularity. However, the PCV and community visitors received full access to the facility.⁸²⁷

A number of witnesses who worked at the Oakden Facility were asked whether a practice existed to disguise information or evidence from the community visitors. Those witnesses

⁸²² *The Oakden Report*, above n 39,106.

⁸²³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 48.21-25 (Aaron Groves).

⁸²⁴ *Ibid* 48.30-39.

⁸²⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 24.16-18 (Maurice Corcoran); Record of interview, Adelaide, 13 October 2017, 15.17-20 (Maurice Corcoran); Mr Corcoran gave evidence that he carried out an unannounced visit in late 2016 and in early 2017: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 24.39-25.5 (Maurice Corcoran).

⁸²⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 62.33-42 (Karim Goel); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 64.34-65.7 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 40.35-41.18 (Merrilyn Penery).

⁸²⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 62.44-47 (Karim Goel); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 86.30-34 (Kerim Skelton).

denied any such practice.⁸²⁸ There is no evidence to the contrary so in my opinion a finding cannot be made that there was a practice of that kind.

I do think, however, it is undesirable that the PCV and the community visitors frequently announce the visits that were to be undertaken. They are more likely to see the particular institution that is being inspected in its raw light if they carry out a visit unannounced.

ISSUE EIGHT

This relates to evidence that the physical state of the facility was “spruced up” prior to announced audits conducted by AACQA.

The purpose of AACQA attending on an inspection was to satisfy itself that the Oakden Facility was maintaining the standards required to continue to be accredited. Accreditation was important to the Oakden Facility because if the inspection resulted in the Commonwealth imposing sanctions that might mean the withdrawal of Commonwealth funding.

I think if management were aware that the AACQA was intending to carry out an inspection for the purpose of deciding on accreditation management would be derelict in its duty if it did not ensure that the Oakden Facility looked as good as possible especially in circumstances where the facility had such a poor appearance. I do not think that management could be criticised for ‘sprucing up’ the Oakden Facility for the AACQA or indeed for an inspection by the PCV or the community visitors. I think it would be appropriate behaviour. Indeed I could not think that anyone would not do that.

In any event the fourth term of reference does not identify the AACQA as one of the public authorities that was misled became disguised or amended information.

In those circumstances I agree with Mr Besanko that even if I was wrong about the factual findings I have made, this inquiry may well be outside the ToR.

ISSUE NINE

This relates to the allegation that a practice existed of maintaining two sets of clinical documentation for consumers at Makk and McLeay. The purpose of the two sets was to provide a particular set to AACQA because it was recognised that the second set was insufficient and would not conform to the standards maintained by AACQA.

I have found this allegation surprising.

If a set of clinical documentation was kept for each consumer that was considered satisfactory to satisfy accreditation for AACQA's purpose, I cannot see the point in keeping another set of clinical documentation which was insufficient.

The sufficient clinical documentation would appear to include all of the insufficient clinical documentation. It frankly does not make sense to me.

Ms Penery explained why in her opinion there were two different sets of clinical documents. She said the assessments that were NALHN assessments had to be kept in a separate file because otherwise they would be removed because they did not have the requisite ‘MR’

⁸²⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 42.12-15 (Merrilyn Penery); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 70.11-15 (Karim Goel); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 68.2-17 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 81.18-21, 87.3-22 (Kerim Skelton).

number which would mean that on an AACQA inspection not all of the documents would be available.⁸²⁹

I still have difficulty understanding the reason for there being two sets of clinical documents.

Ms Penery said the files which contained the assessments were not hidden or concealed from AACQA.⁸³⁰ That rather suggests that the clinical documentation that was provided to the AACQA was from the deficient files, that is, the files that contained less information.

There is no doubt in my opinion there should not have been two sets of files unless the obligation to keep a separate file was imposed upon the facility by the AACQA and that is not the case.

It was also the case that all of the information that was kept on a consumer and which was relevant for the AACQA's accreditation assessment should have been provided to AACQA. If the assessments were not relevant for AACQA's accreditation process then it cannot be said that there has been any withholding from AACQA of relevant information.

The evidence is unclear in this regard.

I do not think there is sufficient evidence to make a finding that any person took steps to actively disguise and/or amend relevant information to protect the Oakden facility from reputational harm. In any event I think that the failure to provide relevant information or more particularly to disguise relevant information from AACQA is probably outside the ToR. There is insufficient evidence to make a finding as to who failed to provide the information to AACQA.

ISSUE 10

Dr Draper said that a staff member who did not satisfy the Commonwealth accreditation requirements by having a current police check was moved from Makk and McLeay to Clements House whilst an audit was conducted by the AACQA.⁸³¹

However, there is no evidence as to who moved that staff member and in those circumstances a finding cannot be made that a particular person took the steps identified in the fourth term of reference.

ISSUE 11

The evidence does not in my opinion support the kind of finding that is postulated in the eleventh matter mentioned. There was a desire at different levels to privatise the services at Oakden but not in order to shift responsibility for the poor care being provided at the facility to a private organisation.

The proposal to privatise the Oakden facility by involving a Non-Government Organisation (NGO) to provide the care that was being provided at Oakden arose out of Recommendation 31 of the Stepping Up Report.⁸³²

After the publication of that report a number of efforts were made by the Chief Executive Officers of NALHN (Ms Mains and Ms Hanson in particular) and its predecessors to move

⁸²⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 38.3-24 (Merrilyn Penery).

⁸³⁰ Ibid 38.33-35.

⁸³¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 93.43-94.6 (Russell Draper).

⁸³² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 25.2-6 (Margot Mains).

Oakden and its consumers away from the government's responsibility and to an NGO.⁸³³ It was considered that the Oakden Facility and the services provided were not part of the public health services core business and it was also perceived that the private sector could do a better job providing the services that were being provided at Oakden and in a better physical environment.⁸³⁴

It was always thought that there would be efficiencies and cost savings if such a measure were adopted.⁸³⁵

In my opinion the moves to privatise the Oakden Facility were for the right reasons and not for the reasons mentioned in the ToR.

This is confirmed by the briefing notes to the Ministers between 2013 and 2016 and the evidence of Ms Mains and Ms Hanson both of whom attempted to bring about the result for the appropriate reasons to which I have referred.

Mr Alan Bottrill who was the Manager of State-Wide Services which was part of OPMHS said that in about 2009/10 because he realised that a privatisation proposal was going to be a "financial disaster" due to the costs associated with staff and that he was not being provided with the financial information necessary to make decisions about the proposal, he approached Mr Wright to resign from responsibilities for the proposal.⁸³⁶ He had a significant role in progressing the proposal.

He worked with Mr Skelton in preparing spreadsheets on nursing costs for the proposal.⁸³⁷

Mr Wright and Mr Bottrill met with the CEO of CNAHS where Mr Bottrill raised his concerns, and ultimately this resulted in the 'PKF Report' being commissioned.⁸³⁸

Mr Bottrill gave evidence that he and Mr Wright commissioned the PKF Report.⁸³⁹

He recalls meeting with CEOs of well-respected NGOs some of whom showed a lot of interest in the Oakden Facility, they were in his words 'very interested' and/or had prepared detailed analysis reports.⁸⁴⁰

Mr Bottrill was assisted by a contractor who drafted the paperwork for the EOI.⁸⁴¹

In his view all the paperwork was ready and there were interested NGOs but then a comment was made that the Government did not want it to proceed as it was getting too close to an election.⁸⁴²

Ms Hakesley was the Director of Mental Health, Adelaide Health Service from 1 November 2010 to 30 June 2011 and Director of Adelaide Metropolitan Mental Health Directorate until 28 October 2012.⁸⁴³

She was advised throughout her employment by Mr Wright that there was an intention for a new facility at Oakden, which was likely to be governed by an NGO. However, she was not

⁸³³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 28.25-33 (Margot Mains); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 117.1-35 (Jacheline Hanson).

⁸³⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 11.19-37 (Margot Mains); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 15.26-29 (Jacheline Hanson).

⁸³⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 22.13-19 (Jacheline Hanson).

⁸³⁶ Record of interview, Adelaide, 21 November 2017, 32.3-33.34 (Alan Bottrill).

⁸³⁷ Ibid 34.32-35.4.

⁸³⁸ Ibid 36.25-39.3.

⁸³⁹ Ibid 29.1-8.

⁸⁴⁰ Ibid 27.10-28.25.

⁸⁴¹ Ibid 43.16.

⁸⁴² Ibid 44.34-45.29.

⁸⁴³ Statement of Paula Hakesley, 30 October 2017, [2].

directly involved in outsourcing planning discussions as these all occurred above her level.⁸⁴⁴

Ms Hakesley gave evidence that the outsourcing plan affecting planning for the Oakden Facility was known in the mental health service. It therefore made it difficult to recruit and retain permanent medical staff at the Oakden Facility and resulted in an increased reliance on agency staff.⁸⁴⁵

From February 2012 Ms Hakesley was a member of the Older Persons Mental Health Service Reform Executive Leadership Group.⁸⁴⁶ The Reform Group discussed the Oakden Facility transition proposal and endorsed the business case developed by PKF that there be an EOI and then tender request process.⁸⁴⁷ The Group discussed the process of providing a briefing to the Chief Executive and the Minister for Mental Health and Substance Abuse on the outsourcing proposal.⁸⁴⁸

Ms Mains said that she was aware when she commenced as CEO of NALHN that outsourcing of the Oakden Facility had been considered but not progressed to a formal EOI.⁸⁴⁹

She requested copies of background documents, and was provided with the PKF Report from July 2012 and also received briefings from executives within the Department.⁸⁵⁰

Ms Mains requested a meeting with Mr Kyffin Thompson of BDO who has been involved in the PKF Report (it is unclear whether this meeting occurred).⁸⁵¹

Ms Mains said that the fate of the facility had been under scrutiny since 2007/08 when the Stepping Up Report was released, and that nobody was prepared to make strategic and lasting decisions because there was a belief that outsourcing may occur.⁸⁵²

Ms Mains said that she thought a better service could be achieved by outsourcing as there would be a more suitable environment with specialist operators.⁸⁵³

Ms Mains and Ms Nowland determined that a recommendation should be made to the Minister to progress an EOI to source the service to the private sector. There was some discussion between Ms Mains and Ms Nowland about whether it should be a Request for Tender, Request for Quote or an EOI. Ultimately they considered that an EOI was the most appropriate.⁸⁵⁴

On 27 June 2013 Ms Mains requested a meeting with Ms Nowland and the Chief Executive to discuss outsourcing of the Oakden facility.⁸⁵⁵

On 26 July 2013 Ms Mains prepared a memorandum to the Chief Executive.⁸⁵⁶

Ms Mains says that the memorandum was predicated on there being \$5.5 million savings realised from the closure of the Jacaranda and Acacia wards at Glenside.⁸⁵⁷

⁸⁴⁴ Ibid [71].

⁸⁴⁵ Ibid [71]-[73].

⁸⁴⁶ Ibid [74].

⁸⁴⁷ Ibid [75].

⁸⁴⁸ Ibid.

⁸⁴⁹ Statement of Margot Mains, 26 October 2017, [50].

⁸⁵⁰ Ibid [51].

⁸⁵¹ Ibid.

⁸⁵² Ibid [52].

⁸⁵³ Ibid [55]-[57].

⁸⁵⁴ Ibid [59].

⁸⁵⁵ Ibid [63].

⁸⁵⁶ Ibid [64], annexure MKM11.

⁸⁵⁷ Ibid [65].

The Chief Executive signed the memorandum on 19 August 2013 confirming that the outsourcing project could be commenced subject to a communications plan, union consultation and providing details of anticipated savings.⁸⁵⁸

On 22 August 2013 Ms Mains discussed the requirements for outsourcing with Ms Nowland, Mr Whinnen and Mr Picton.⁸⁵⁹

Ms Richter said that she discussed the outsourcing proposal with Ms Mains, and that Ms Mains had prepared a business case but was concerned about how the industrial bodies would react to privatisation and also how families of residents would feel about a change in service delivery.⁸⁶⁰

She agreed that a proposal to privatise should be progressed expeditiously because uncertainty has the potential to compromise people's performance and in turn the services provided.⁸⁶¹

On 16 September 2013 Ms Mains signed two minutes to (1) the Chief Executive and (2) the Minister for Mental Health and Substance Abuse, seeking approval for the implementation process.⁸⁶² The memorandums noted that the unions had expressed 'in principle opposition' to outsourcing.⁸⁶³

While Mr Swan authorised the minute on 18 September 2013 Ms Mains is unsure whether the Minister also received the minute.⁸⁶⁴

On 17 October 2013 Ms Mains met with Ms Mulholland (of SASMOA), Mr Johnson (of ANMF), Ms Gordon (of PSA) and Mr Boyle (of United Voice) to discuss proceeding with an EOI.⁸⁶⁵ Although the unions were opposed to the transfer they were prepared to work with NALHN.⁸⁶⁶

On 17 October 2013 Ms Mains signed a minute to the Minister for Health and Ageing regarding the transfer of OPMHS which included that the unions had indicated their intention to launch a campaign against the proposed outsourcing at the time that the EOI was to be published, that a communications and project plan had been drafted and that there was an intention to develop an acquisition plan.⁸⁶⁷ The Minister noted the contents of the briefing on 21 October 2013.⁸⁶⁸

On 7 November 2013 Ms Mains signed a minute to the Minister for Mental Health and Substance Abuse providing an update which relevantly included that there would be a consultation session with OPMHS staff and a separate presentation to families and carers on 8 November 2013.⁸⁶⁹ The Chief Executive authorised the minute of 7 November 2013 on that same day, and the Minister noted the contents on 20 November 2013.⁸⁷⁰

The staff consultation and meeting with relatives took place on 8 November 2013.⁸⁷¹

On 5 May 2014 Ms Mains signed a minute to the Minister for Mental Health and Substance Abuse regarding timelines for the publication of the EOI.⁸⁷² Ms Mains explains that an

⁸⁵⁸ Ibid [67].

⁸⁵⁹ Ibid [68].

⁸⁶⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 1 November 2017, 9.43-10.15 (Jenny Richter).

⁸⁶¹ Ibid 19.7-31.

⁸⁶² Statement of Margot Mains, 26 October 2017, [69]-[70], annexures MKM13-14.

⁸⁶³ Ibid [69]-[70].

⁸⁶⁴ Ibid.

⁸⁶⁵ Ibid [71].

⁸⁶⁶ Ibid [72].

⁸⁶⁷ Ibid [73], annexure MKM15.

⁸⁶⁸ Ibid.

⁸⁶⁹ Ibid [74], annexure MKM16.

⁸⁷⁰ Ibid.

⁸⁷¹ Ibid [75], annexure MKM17.

acquisition plan had been drafted by May 2014 but there had been some delays in decision-making due to elections.⁸⁷³

Ms Mains said that from her perspective everything was in place for the project to proceed to EOI.⁸⁷⁴ At some point after 5 May 2014 Ms Mains became aware that the minute had been 'superseded by Cabinet note' and was informed by either Mr Swan or Ms Richter that the project was not a priority and so she was not provided with the approval to proceed or information on a change in direction.⁸⁷⁵ Ms Mains resigned from her position effective 10 October 2014.⁸⁷⁶

Ms Mains said that between about January and May 2013, Oakden fell under the operational management of the Department because Mr Bottrill was managing the EOI process however after May 2013 it fell under the management of NALHN.⁸⁷⁷

She said that she formed the view when she became CEO of NALHN that there had been a delay in progressing towards an EOI and she considered that it was necessary to accelerate the process.⁸⁷⁸

Ms Mains contacted Mr Kyffin Thompson to discuss the business case and also arranged a tour of the Oakden Facility in about May 2013 so she could form a view about progressing the proposal.⁸⁷⁹

Ms Mains was requested in about May 2014 to focus on an electronic patient administration system and so did not have an opportunity to consider a plan B for Oakden.⁸⁸⁰

Ms Hanson said that when she commenced as CEO of NALHN she had a briefing meeting with NALHN managers including Dr Rafalowicz and Ms Harrison where she was informed that one of the key areas for consideration was progressing towards a possible outsourcing of the Oakden Facility.⁸⁸¹ Ms Hanson said that she was informed when she started in the position of CEO of NALHN that the privatisation of the Oakden Facility had been dragging on, that there had been a plan to test the market but it was stalled because of the election, and that a decision needed to be made one way or another.⁸⁸²

Ms Hanson gave an undertaking to Mental Health Services to recommence the process.⁸⁸³

Ms Hanson recalled a meeting with Mr Swan where she raised the prolonged process for privatisation and in which it was agreed that NALHN should resubmit a request to Mr Snelling.⁸⁸⁴

On 27 August 2015 Ms Hanson sent a memorandum to the Minister for Mental Health and Substance Abuse seeking approval to assess market interest and capability to take over Oakden management.⁸⁸⁵

⁸⁷² Ibid [77].

⁸⁷³ Ibid.

⁸⁷⁴ Ibid [77], annexure MKM19.

⁸⁷⁵ Ibid [78].

⁸⁷⁶ Ibid [2].

⁸⁷⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 14.29-15.16 (Margot Mains).

⁸⁷⁸ Ibid 19.42-20.19.

⁸⁷⁹ Ibid 20.21-21.1.

⁸⁸⁰ Ibid 44.25-47.

⁸⁸¹ Statement of Jacheline Hanson, 10 October 2017, [167].

⁸⁸² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 20.17-44 (Jacheline Hanson).

⁸⁸³ Statement of Jacheline Hanson, 10 October 2017, [169].

⁸⁸⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 42.1-14 (Jacheline Hanson).

⁸⁸⁵ Statement of Jacheline Hanson, 10 October 2017, [170], annexure JRH57.

Between August 2015 and January 2016, a memorandum was sent to Minister Snelling for approval and that approval was received in about December 2015, but then the portfolio changed over to Mrs Vlahos and so NALHN considered it necessary to obtain Mrs Vlahos' approval rather than rely on the authorisation of a previous minister.⁸⁸⁶

The briefing was approved by Minister Snelling in December 2015 but no action taken as the Mental Health portfolio was being handed over to Mrs Vlahos as of January 2016.⁸⁸⁷

Ms Hanson had meetings with Mrs Vlahos as Minister where the issue did not progress and so Ms Hanson considered it necessary (and on the advice of Mr Len Richards, the Deputy Chief Executive of SA Health) to send a further minute in November 2016 in order to formalise the request.⁸⁸⁸

On 17 November 2016 Ms Hanson sent a minute to the Minister for Mental Health and Substance Abuse (Mrs Vlahos at this time), requesting that she note NALHN's intention to publish two expressions of interest to assess market interest.⁸⁸⁹ Ms Hanson understands the minute was received by Minister Vlahos but not progressed by her.⁸⁹⁰

At a meeting in December 2016 Minister Vlahos told Ms Hanson that she did not have enough confidence in NALHN or information as to how the process would be managed in the public arena and so Minister Vlahos requested a comprehensive action plan.⁸⁹¹

Mr Swan said that he had no involvement in the commissioning or drafting of the Stepping Up Report, however he was involved in meetings with Monsignor Cappelletti of the Social Inclusion Board.⁸⁹²

By the time he became Chief Executive of SA Health, the report had been endorsed by the Government as policy and was being implemented for three or so years.⁸⁹³

Mr Swan said that his view is that Recommendation 31 was intentionally vague so as to stop industrial unrest with the unions.⁸⁹⁴ There was opposition to the Stepping Up Report based on those who felt there should be an acute/institutional approach to care (i.e. those needing care come to the relevant institution) as opposed to a community approach to care (i.e. the services are located where the people need the care).⁸⁹⁵

He said that he was not sure that the Minister agreed to put a submission to Cabinet to outsource the facility, and that Ministers generally were concerned about timing of matters.⁸⁹⁶

Industrial bodies had concerns about any government service going to a non-government provider.⁸⁹⁷ Mr Swan said that the Government at election times was signing off on a 'no outsourcing policy' so as to get the support of the unions for the next terms of government.⁸⁹⁸

⁸⁸⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 117.20-118.9 (Jacheline Hanson).

⁸⁸⁷ Statement of Jacheline Hanson, 10 October 2017, [170].

⁸⁸⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 120.31-122.5 (Jacheline Hanson).

⁸⁸⁹ Statement of Jacheline Hanson, 10 October 2017, [171], annexure JRH58.

⁸⁹⁰ Ibid [172].

⁸⁹¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 120.14-29 (Jacheline Hanson).

⁸⁹² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 7.3-23 (David Swan).

⁸⁹³ Ibid 7.42-8.13.

⁸⁹⁴ Ibid 23.41-24.18.

⁸⁹⁵ Ibid 24.39-25.16.

⁸⁹⁶ Ibid 27.12-22.

⁸⁹⁷ Ibid 27.34-45.

⁸⁹⁸ Ibid 32.28-36.

Ms Gago was appointed as Minister for Mental Health and Substance Abuse on 23 March 2006.⁸⁹⁹ On 1 April 2008 Ms Gago issued a News Release announcing that arrangements were being negotiated to form a management partnership for Makk and McLeay.⁹⁰⁰ Ms Gago resigned as Minister for Mental Health and Substance Abuse on 24 July 2008.⁹⁰¹ Ms Gago refers to an established long term plan for Oakden which included the involvement of an NGO (she did not see this plan).⁹⁰²

Mr Hill was appointed Minister for Health on 4 November 2005, and appointed Minister for Mental Health and Substance Abuse on 25 March 2010 and he resigned from both portfolios on 21 January 2013.⁹⁰³

Mr Hill said there was strong union cohesion and the union was difficult to take on but that another reason was there were other priorities to implement or battles to fight.⁹⁰⁴

Mr Hill did not have any direct role in commissioning the report but he was aware of it during the process.⁹⁰⁵ He gave evidence he 'possibly' reviewed a draft report as a member of Cabinet, but cannot recall.⁹⁰⁶

Mr Hill said that his understanding was that ACH did not want to renew the contract after it expired, but he was not certain of this.⁹⁰⁷

He did not recall anyone saying that the intention behind the outsourcing proposal was to deal with the inadequacy of care at the facility, but rather there was a view that not-for-profit organisations would do it better than the government.⁹⁰⁸

Mr Snelling said that he had difficulties with the Stepping Up Report as he did not believe that clinicians had been adequately engaged and there were significant flaws with the assumptions.⁹⁰⁹ He said that he spent time unwinding the recommendations in the Stepping Up Report and that he was not a fan of the recommendations.⁹¹⁰

He said that his first recollection of outsourcing was during a conversation with Mr Swan (which preceded the minute issued by Ms Mains in October 2013) in which he was told that the Department wanted a non-government operator as aged care was not core business.⁹¹¹

Mr Snelling said that he attended a meeting with RANZCP on 6 September 2013 at which the agenda included an item to discuss the proposed transfer of management to the private sector.⁹¹²

Mr Snelling saw and signed the following minutes:⁹¹³ (1) minute from Ms Mains dated 17 October 2013 which was approved on 21 October 2013; (2) minute from Ms Hanson dated 27 August 2015 which was approved sometime after 31 August 2015; and (3) minute from Ms Hanson dated 17 November 2015 which was approved on 30 November 2015.

⁸⁹⁹ Statement of Hon Gail Gago, 20 October 2017, [9].

⁹⁰⁰ Ibid [102], annexure PRE.001.001.1931.

⁹⁰¹ Ibid [22].

⁹⁰² Ibid [51]: The annexure is a summary document which simply refers to a plan.

⁹⁰³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 1-12 (John Hill).

⁹⁰⁴ Ibid 8.6-36.

⁹⁰⁵ Ibid 9.25-29.

⁹⁰⁶ Ibid 9.31-38.

⁹⁰⁷ Ibid 18.46-20.12.

⁹⁰⁸ Ibid 26.11-18.

⁹⁰⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 32.12-32 (John James Snelling).

⁹¹⁰ Ibid 32.21-33.2.

⁹¹¹ Ibid 36.7-37.5.

⁹¹² Statement of Hon John James Snelling, 29 September 2017, [42]-[43], annexure JJS2.

⁹¹³ Ibid [71], annexures JJS20-22.

Mr Snelling said that when he was first briefed about the Oakden Facility he was informed that the Department was keen to get out of the Facility as it was not core business.⁹¹⁴

He understood that while privatisation was a government priority, it was not a priority for him and that his main concern was industrial disruption and that he did not want to have an 'industrial war' as he understood the unions would oppose privatisation.⁹¹⁵

Mr Snelling said that during his three years as Minister there was no political will to change the model so as to avoid an argument with the unions.⁹¹⁶

Ms Nowland said that she met monthly with the unions and they discussed the outsourcing proposal.⁹¹⁷ The unions were strongly opposed to the proposal (particularly the ANMF) as the proposal would have resulted in loss of public service jobs.⁹¹⁸

She said that she was told that the proposal was not progressed because it was not a priority.⁹¹⁹

Mr Snelling said that he did not want to take on the unions three months before an election (in March 2014) and this was likely the reason why nothing was done towards the end of 2013.⁹²⁰

A further minute was sent to Mr Snelling in May 2014, however, he did not recall reading it.⁹²¹

There is a handwritten note on the May 2014 minute from Ms Joan Atkinson, an advisor to Mr Snelling, which states that the minute is 'superseded by Cabinet note'.⁹²²

Mr Snelling declined to answer questions about what was meant by the note that was found on the minute or Cabinet discussions.⁹²³

Mrs Vlahos was appointed the Minister for Mental Health and Substance Abuse on 19 January 2016 and resigned from that appointment on 18 September 2017.⁹²⁴

Mrs Vlahos said that she received a number of briefings from SA Health in relation to placing the Oakden Facility under alternate management.⁹²⁵

On 16 November 2016 Minister Vlahos' office received a ministerial briefing that refers to an EOI being under development to explore options for a private or NGO provider to take over Oakden.⁹²⁶

On 24 November 2016 Minister Vlahos received an email that contained a briefing from Ms Hanson and a draft communication plan regarding the handover of Makk and McLeay to the private sector (Mrs Vlahos received these on 1 December 2016).⁹²⁷ The briefing was noted

⁹¹⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 15.30-16.22 (John James Snelling).

⁹¹⁵ Ibid 15.36-16.44.

⁹¹⁶ Ibid 16.46-17.10.

⁹¹⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017, 20.25-21.24 (Leonie Nowland).

⁹¹⁸ Ibid 20.25-21.24.

⁹¹⁹ Ibid 30.37-40.

⁹²⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 40.19-37 (John James Snelling).

⁹²¹ Ibid 40.39-41.33.

⁹²² Minute from Margot Mains to the Office of the Minister for Mental Health and Substance Abuse re: Options for the Transfer of Older Persons Mental Health Services – Non Acute Inpatient Services to a Private Provider/Non-Government Organisation, 5 May 2014, 2017-000535-E0005 (JWeatherill1) DOC-000000285.

⁹²³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 42.36-44.13 (John James Snelling).

⁹²⁴ Statement of Hon Leesa Vlahos, [16]-[17].

⁹²⁵ Ibid [81].

⁹²⁶ Ibid [192]-[197], document 19.

⁹²⁷ Ibid [211]-[214], document 24, 25.

by Minister Vlahos on 8 January 2017, and the same minute which was sent to Minister Snelling was noted on 8 December 2016.⁹²⁸

The reason why nothing happened between 2008 and 2017 is because there was no perceived urgency to bring the change about. Moreover the unions had opposed the suggested privatisation of the Oakden Facility.⁹²⁹ As Mr Snelling said there was no political will to bring it about, at least while he was Minister for Health and Minister for Mental Health and Substance Abuse, because he did not wish to engage in an industrial dispute with the relevant unions about the plan to privatise the services at the Oakden Facility.⁹³⁰

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The last issue identified as being relevant to the fourth term of reference is the general culture of secrecy at the facility throughout the period of the terms of reference.

The finding in the Oakden Report was that such a culture existed and that finding is supported by a volume of evidence given to my investigation.

Dr Groves said there was such a culture and Ms Hanson gave like evidence.⁹³¹

Mr Goel said that Mr Skelton and Ms Harrison fostered a culture of secrecy and he particularised that by saying that Ms Harrison reprimanded him on one occasion when he sought to raise his concerns about the physical state of the facility with Ms Nowland.⁹³²

The non-use or under use of the SLS supports the existence of such a culture.

Further, the manner in which the freedom of information request made by the Sunday Mail in March 2010 further supports the existence of this culture.⁹³³

However, the most important evidence of the existence of such a culture is the absence of information flowing out of the Oakden facility to the senior executives at NALHN.

The senior executives at NALHN were mainly not aware that the standard of care that was being offered to the consumers at the Oakden Facility was sub-optimal. They must have known about the state of the facility if they visited the Oakden Facility but it would appear from all of the evidence that I have received they did not know that the care that was being offered at Oakden was as bad as the Oakden Report found it to be. That rather indicates there was a culture of secrecy of the kind that was found in the Oakden Report.

I am satisfied that during the relevant period there was such a culture and, as a consequence of the existence of such a culture, the sub-optimal standard of care that was being offered to consumers at the Oakden Facility was disguised to protect the Oakden Facility from reputational harm by not providing information to senior staff of NALHN, or executive staff of the Department of Health and Ageing and the Chief Psychiatrist and the relevant Ministers.

⁹²⁸ Ibid [214]-[219], document 24, 25.

⁹²⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 30 October 2017, 36.16-30 (Margot Mains).

⁹³⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 18.13-30, 40.23-33 (John James Snelling).

⁹³¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 113.9-27, 119.24-41 (Aaron Groves); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 2 November 2017, 11.8-19, 29.13-40 (Jacheline Hanson).

⁹³² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 24 October 2017, 32.32-37, 27.24-36 (Karim Goel).

⁹³³ Email from Arthur Moutakis to Tracey Ellmers re: Please review 'Sunday Mail Freedom of information Application 150310', 17 March 2010, 2017-000535-E0012 (JHanson2)(JRichter2) DOC-000001816, AM-2; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 93.30-97.16 (Arthur Moutakis).

That finding is made notwithstanding the contrary evidence that was offered by Dr Draper, Mr Skelton and Ms Harrison, which I reject. I reject that evidence because it cannot be right. If the facility and standard of care was as bad as the Oakden Report has found then that could have only been maintained by a culture of secrecy, unless it could be said that the executives of NALHN or the senior executives of SA Health were aware of the sub-optimal facility and sub-optimal standard of care and did nothing about it. There is no evidence to that effect. Ms Hanson's evidence, which I accept, would not allow me to make such a finding.

CHAPTER 12: MALADMINISTRATION

This brief chapter describes how maladministration on the part of a public authority or public officer can occur, and the proof required to substantiate such findings. I also clarify my jurisdiction in making such determinations.

The definition of 'maladministration' contained in the ICAC Act is set out in Chapter 2 of this report and need not be repeated: s 5(4).

When considering whether any public authority or public officer has engaged in maladministration I do not need to be satisfied that the maladministration is serious or systemic. At the assessment stage the jurisdiction to investigate maladministration depends upon an assessment that the maladministration is serious or systemic: s 24(2)(b) of the ICAC Act. However, once I have jurisdiction I could find that a public authority or public officer engaged in maladministration without needing to find whether the particular conduct was serious or systemic.

A public authority can only engage in maladministration if a practice, policy or procedure of that public authority results in an irregular and unauthorised use of public money or substantial mismanagement of public resources.

Therefore there are only two circumstances in which a public authority can engage in maladministration and they both relate to the practice, policy or procedure of the public authority. It must be a consequence of a practice, policy or procedure of a public authority that results in the irregular and unauthorised use of public money or alternatively a substantial mismanagement of public resources.

A public officer can engage in maladministration if the conduct of a public officer results in an irregular and unauthorised use of public money or the conduct of that public officer results in substantial mismanagement of public resources.

A public officer could also engage in maladministration if that public officer's conduct involves substantial mismanagement in or in relation to the performance of official functions.

Therefore there are four ways in which a public officer can engage in maladministration.

The first requires proof that the conduct has resulted in an irregular and unauthorised use of public money.

The second requires proof that the conduct has resulted in substantial mismanagement of public resources.

The third involves an investigation and determination into whether the conduct of the public officer involves substantial mismanagement in the performance of official functions.

The fourth involves an investigation and determination into whether the public officer's conduct involves substantial management in relation to the performance of official functions.

There need not be a consequence relating to public money or public resources in the third and fourth types of conduct.

The ICAC Act specifies that the conduct need not be intentional or reckless because it includes conduct resulting from impropriety, incompetence or negligence: s 5(4)(b).

In all cases the conduct must be assessed having regard to relevant statutory provisions and administrative instructions and directions: s 5(4)(c).

Maladministration can also arise where a public officer has failed to act so I should consider whether a public officer acted or failed to act in considering whether that public officer has engaged in maladministration: s 5(5)(c).

The ICAC Act commenced in two stages. A very limited number of provisions commenced on 20 December 2012 but the bulk of the Act did not commence until 2 September 2013 (which was the day my office and the OPI commenced operations). Some of the conduct under consideration occurred prior to the commencement of the ICAC Act.

However the ICAC Act operates retrospectively because of the provisions of s 5(5)(a), which provides that the ICAC Act applies to conduct that occurred before the commencement of the Act. Therefore my jurisdiction extends back to the commencement of the period mentioned in the terms of reference.

The Act also reaches out to persons who were public officers but are no longer public officers: s 5(5)(d).

It is therefore irrelevant for the purposes of this investigation whether the person whose conduct is under consideration is no longer a public officer.

CHAPTER 13: FINDINGS OF MALADMINISTRATION

13.1 SUB-OPTIMAL CARE

Dr Draper and Ms Harrison contended that the meaning of 'sub-optimal' was not specifically addressed in Mr Besanko's submissions and it is not possible to make findings without understanding what the term means.

I do not think it can be disputed that the Oakden Report found that consumers at the Oakden Facility were provided with sub-optimal care in every respect.

My view as to what amounts to sub-optimal care is informed by the opinions expressed in the Oakden Report; the opinions expressed by the witnesses interviewed and examined (in particular Dr Groves and Dr McKellar), many of whom clearly had the expertise to express views about whether certain matters were 'sub-optimal' (for example, nursing practices); the relevant policies and procedures in place at various levels at the various points in time; and the views expressed in the contemporaneous documents.

It is self-evident that the matters identified in the Oakden Report were 'sub-optimal'.

For the purposes of this report, 'sub-optimal care' means care that is adjudged not to meet a standard considered reasonably appropriate in the circumstances and includes:

- delays in diagnosis, treatment or referral
- inadequate or inappropriate management of a consumer's needs
- a facility not fit for purpose
- lack of medical, nursing or allied health staff
- poor or inadequate assessment of needs
- poor quality nursing including poor culture and poor morale
- lack of appropriate approvals for support staffing
- abusing consumers
- inadequate or inappropriate management of staff

A number of the points referred to above may of themselves not have amounted to sub-optimal care but rather were the cause of sub-optimal care.

13.2 PUBLIC OFFICERS AND PUBLIC AUTHORITIES

One of the purposes of this investigation was to determine who was responsible for the sub-optimal facility and the standard of care that was being offered at the facility. I wanted to determine who knew what and when and who failed to act to ensure that consumers at the Oakden Facility were provided with proper care in a fit for purpose institution.

It is possible that some people will find the findings that follow surprising, but as I said in the Executive Summary all findings must be determined by the facts and only the facts.

I shall deal with the public officers involved from the top down and I shall deal with the relevant public authority.

Before I do I shall say something about who a public officer is and who or what may be a public authority.

The ICAC Act defines public authorities and public officers in Schedule 1 to the Act: s 4 ICAC Act.

Schedule 1 addresses public officers, public authorities and responsible ministers in tabular form and lists public officers, the public authorities responsible for the public officers and the Ministers responsible for the public authorities.

A minister is a person appointed to an office by the Governor and is therefore a public officer for whom the Governor or Attorney-General have responsibility.

The Chief Executive of an administrative unit of the public service is a public officer.

Thus at the relevant time Mr Swan and later Ms Kaminski were public officers for the purposes of the ICAC Act. The public authority who is responsible for the Chief Executive is the Minister responsible for the administrative unit, which in this case is the Minister for Health.

A list of the Ministers for Health and the Ministers for Mental Health and Substance Abuse is included in Appendix 4.

Ms Hanson is and was a public officer because she is and was a public sector employee, employed by the Chief Executive of the Department under the HCA. The Chief Executive of the Department is the public authority in respect of Ms Hanson.

A public sector employee is a public officer and the public authority who has responsibility for that public officer is the relevant public sector agency, which in this case is the Chief Executive of the Department as the relevant employing authority.

It follows that all of those who are employed by the Chief Executive of SA Health, the Chief Executive Officer of NALHN and therefore all those employed in NALHN and at the Oakden Facility were public officers.

A statutory office holder, such as the Chief Psychiatrist and the PCV, is a public officer and the public authority responsible for that public officer is the Minister responsible for the administration of the Act under which the statutory authority is constituted or the statutory officer is appointed.

In my opinion it would be appropriate to proceed upon the basis that all of the persons to whom I have referred who were Ministers, statutory office holders, chief executives, chief executive officers or employees of SA Health or NALHN were public officers.

Both Mr Besanko and the State of South Australia contended that NALHN is a public authority for the purposes of the ICAC Act.

I accept that NALHN is a public authority.

As I have said, a public authority is defined by reference to Schedule 1 of the ICAC Act and includes a statutory authority which has the responsibility for officers or employees of the statutory authority.

A 'statutory authority' is not defined in the ICAC Act. In my opinion it should not be given a narrow interpretation but a broad interpretation which would capture bodies or persons entrusted by statute to perform functions in the public interest or for a public purpose, whether incorporated by, or merely under, an Act.

NALHN is an incorporated hospital established by the Governor by proclamation under s 29 of the HCA to provide specified health service and facilities under that Act.

NALHN is a body corporate⁹³⁴ capable of holding property,⁹³⁵ of suing and being sued⁹³⁶ and has the functions, rights, powers, authorities, duties and obligations conferred, composed or prescribed under the HCA or any other Act.⁹³⁷

⁹³⁴ *Health Care Act 2008* (SA) s 31(1) ('HCA').

⁹³⁵ *Ibid* s 31(1)(a).

⁹³⁶ *Ibid* s 31(1)(d).

⁹³⁷ *Ibid* s 31(1)(g).

It is an instrumentality of the Crown.⁹³⁸ It is empowered to make its own by-laws in relation to the hospital.⁹³⁹

The State contended that the ICAC Act evinces an intention that 'statutory authority' should have a broad meaning and capture bodies such as NALHN, which as I have said is established under statute with specific statutory functions and powers. Incorporated hospitals are the vehicles through which public healthcare is administered in this State. The Local Health Networks have been incorporated as hospitals for that purpose.

The State contended that the ICAC Act has evinced an intention to capture incorporated hospitals as statutory authorities because otherwise ICAC could not conduct evaluations of their practices, policies and procedures, and its principal aim under s 7(1)(d) of the ICAC Act, to advance comprehensive and effective systems for preventing or minimising corruption, misconduct and maladministration in public administration, might be frustrated.

I agree that NALHN is a public authority⁹⁴⁰ and I agree that I can make findings of maladministration against it as a public authority but only if satisfied that a practice, policy or procedure of a NALHN has resulted in an unauthorised use of public money or substantial mismanagement of public resources. The rest of the definition in s 5(4) does not apply to a public authority and therefore does not apply to NALHN as an entity.

13.3 MINISTERS

The Ministers are responsible for their departments while they are Ministers. They had and have the political responsibility for the Oakden Facility. I will return to that.

The evidence does not permit a finding that any Minister engaged in maladministration within the meaning of s 5(4)(a)(i) of the ICAC Act.

The Ministers could only have engaged in conduct that amounted to maladministration if their conduct involved substantial mismanagement in or in relation to the performance of official functions: s 5(4)(a)(ii).

The Ministers' official functions include the Ministers' statutory responsibilities.

It seems to me that if a Minister failed to discharge his or her statutory obligations that might amount to mismanagement in or in relation to the performance of the Minister's official functions and constitute maladministration within the meaning of the ICAC Act, if in fact the mismanagement was 'substantial'.

The statutory responsibilities that were imposed upon the Ministers differed depending upon when they held office, because different legislation was in place at different times.

13.3.1 Ms Gago

When Ms Gago held office as Minister for Mental Health and Substance Abuse between 23 March 2006 and 24 July 2008 her statutory obligations were imposed by s 15 of the SAHC Act.

⁹³⁸ Ibid s 31(3).

⁹³⁹ Ibid s 42.

⁹⁴⁰ It might also be said that NALHN is a public authority because it is a public sector agency as defined in the *Public Sector Act 2009* (SA).

Section 15 of that Act required the Minister to promote the health and wellbeing of the people of the State and provided the Minister with a discretion to adopt the functions mentioned in s 15(1).

She also had functions given to her by the MHA 1993.

During her time as Minister, Oakden failed the Commonwealth accreditation audit conducted by AACQA in December 2007.

It is clear from the contemporaneous evidence and from evidence that was provided to my investigation that the facility was at that time in a very poor state and the standard of care that was being offered was also very poor.

Although Minister Gago had the overall statutory responsibility as Minister she could not be held responsible for the state of the Oakden Facility unless she was aware of it or that she should have been aware.

In determining whether a person in authority should have been aware of a particular matter, regard must be had to the processes whereby information was to be provided by one person to another and in particular to the person in authority. In other words, it is relevant to know whether there were reporting obligations on employees such that a person in a higher position should have become aware of particular matters.

The other factor to take into account is whether the person had been provided with information of a kind that ought to have put the person on notice to obtain the further information that would have made the person aware of the matter.

There is no evidence that Ms Gago was aware of the state of the Oakden Facility before she was told that Oakden had failed the AACQA accreditation process. Nor is there any evidence that she ought to have known of the state of the facility before that time.

In those circumstances it cannot be said that she has engaged in maladministration prior to the accreditation process.

Ms Gago visited Oakden on 28 March 2008. She described the physical state of the building as 'quite old' but 'pretty typical of our aged care mental health facilities'. There is no evidence that she had any appreciation of the serious issues that were uncovered by AACQA's audit in December 2007.

After becoming aware of the accreditation issues clearly Ms Gago had a better appreciation of the Oakden Facility. She received a number of briefing notes about the failure of the audit to which she referred in her statement.⁹⁴¹

I am mindful of the fact that the conduct that is referred to in s 5(4)(a)(ii) of the ICAC Act can include conduct resulting from impropriety, incompetence or negligence: s 5(4)(b). However, a Minister could not be deemed incompetent or negligent where the Minister had not been made aware of a particular fact or where the circumstances do not indicate that the Minister should have been aware of that fact.

Ms Gago said that after she became aware that the Oakden Facility had failed the AACQA accreditation process she took appropriate steps to bring the facility up to a standard that met accreditation. The objective evidence supports a finding to that effect. It would appear that as Minister she put in place appropriate arrangements by increasing and changing staff where necessary to ensure that the Oakden Facility was raised to a standard where it would pass AACQA's accreditation process.

Reaccreditation occurred before she resigned as Minister on 24 July 2008.

⁹⁴¹ Statement of Hon Gail Gago, 20 October 2017, [67]-[8], [70], [75]-[6].

In those circumstances it is not possible to say that she conducted herself in a way that involved substantial mismanagement in relation to the performance of official functions.

I think at that stage it was thought that if the Oakden Facility remained accredited and continued to satisfy AACQA's accreditation process then the facility and the standard of care that was being offered at the facility must have been at least adequate, if not appropriate.

With the benefit of hindsight that was not necessarily so. It assumed that AACQA's accreditation process was itself rigorous and appropriate and that the accreditation process set appropriate standards for consumers of the kind that were resident at the Oakden Facility. Those consumers were not merely older people who required nursing home accommodation but were people who suffered from chronic and sometimes acute mental illness.

The accreditation process adopted by AACQA was not concerned with the kind of person who was resident at the Oakden Facility but more particularly concerned with persons who were older and required nursing home facilities.

I think that is something that was never addressed at any level up until the time that the Oakden Facility closed. There was a continuing assumption through that whole period that a successful accreditation meant an appropriate facility with an appropriate standard of care.

It was an assumption that should not have been made at any level.

However, for the reasons I have mentioned I do not find that Ms Gago engaged in conduct that amounted to maladministration.

13.3.2 Dr Lomax-Smith

Dr Lomax-Smith followed Ms Gago as Minister for Health and Substance Abuse. She was appointed on 27 July 2008 and remained the Minister until 25 March 2010.

The HCA repealed the SAHC and commenced mainly between 13 March 2008 and 1 July 2008. Dr Lomax-Smith's statutory obligations and functions arose under the HCA, the delegation by the Minister for Health to the Minister for Mental Health and Substance Abuse dated 3 July 2008 and the MHA 1993 until 1 July 2009 when the MHA 1993 was repealed and replaced by the MHA.

The relevant functions under the HCA are set out in s 6 and need not be particularised. The functions under the MHA are contained in s 86 of the MHA and are identified earlier in this report.

Dr Lomax-Smith did not visit Oakden at any time while she was Minister for Mental Health and Substance Abuse.

Dr Lomax-Smith denied that she was aware of the previous failed accreditation in December 2007 prior to assuming the portfolio, although a briefing note shows that she was aware that the Oakden Facility had failed the accreditation audit carried out by AACQA in December 2007.⁹⁴²

She also said that it was not raised with her in any context as a matter of concern in her meeting with executives in the Department.

⁹⁴² Minute from Leanne Durrington to the Minister for Mental Health and Substance Abuse re: Makk and McLeay Nursing Home – Update 20 August 2008, 20 August 2008, 2017-000535-E0004 (LVlahos1) DOC-000001152; Minute from Eli Rafalowicz to the Minister for Mental Health and Substance Abuse re: Makk and McLeay Nursing Home – Accreditation Update 15 October 2008, 15 October 2008, 2017-000535-E0004 (LVlahos1) DOC-000001154.

In October 2009 she became aware of a serious issue because of a complaint made by Maria Portolesi, whose father was a consumer at Clements, to Mr Hill the then Minister for Health, which was passed on to Dr Lomax-Smith's office.

The complaint raised concerns about Ms Portolesi's father's physical safety, staffing levels at Clements which were claimed to be 'inadequate to properly care and ensure a safe environment for the clients', the absence of a 'dedicated manager at Oakden' and the suitability of some of the consumers to be at the facility.

Dr Lomax-Smith agreed that she was aware of the complaint made by Ms Portolesi relating to her father and she dealt with it appropriately and quickly. I think that is so. She said that that one complaint was not enough to alert her to any systemic failures at the Oakden Facility.

In my opinion the evidence does not support a finding that Dr Lomax-Smith was aware of the state of the Oakden Facility or the standard of care that was being offered by the facility during her time as Minister.

Nor does the evidence support a finding that she should have been aware of both of those matters. I think on balance I cannot find, on the evidence that was presented to Dr Lomax-Smith during her time as Minister, that she should have carried out some further investigations for herself.

13.3.3 Mr Hill

Mr Hill was Minister for Mental Health and Substance Abuse between 25 March 2010 and 21 January 2013 in addition to being the Minister for Health and later the Minister for Health and Ageing.

His statutory obligations arose by virtue of s 86 of the MHA.

Mr Hill visited Makk and McLeay and Clements shortly after becoming Minister in July 2010. He said that no issues of concern were raised with him when he visited the Oakden Facility.

Mr Hill visited Oakden and it might be said that he ought to have noticed the poor physical state of the facility. He gave the following evidence:

- Q. *Do you recall discussing with anyone the physical state of the Oakden facility whilst you were Minister for Mental Health?*
- A. *I don't recall discussing it, but I'm pretty certain I would have, because after I visited it, I thought the facilities weren't – you know, they weren't like the other Mental Health facilities that we were opening, they weren't modern, they looked old-fashioned to me, and I'm certain I would have discussed it with the CEO, but I can't recall beyond that.*⁹⁴³

He was also aware of some incidents that occurred at Makk and McLeay during his time as Minister.

Specifically he was aware of the inappropriate restraint of Mr John Cartwright on 28 April 2010;⁹⁴⁴ a complaint made on 8 January 2011 by Ms Denton in respect of the care provided

⁹⁴³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017 13.35-44 (John Hill).

⁹⁴⁴ Minute from Lesley Dwyer to the Office of the Minister for Mental Health and Substance Abuse re: John Cartwright: Allegation by Nursing Staff of Elder Abuse, 9 June 2010, 2017-000535-E0004 (LVlahos1) DOC-000001170.

to her brother-in-law;⁹⁴⁵ the contents of an email sent by a person claiming to be Denzel Washington on 23 June 2011; and an alleged assault by a consumer on 1 August 2011.

I have read the briefing note with which he was provided in relation to all four complaints and there is nothing in those briefing notes that would have alerted him to think that there was a serious or systemic failure to deliver an appropriate standard of care at the Oakden Facility.

He accepted, or appears to have accepted, the information provided to him by the persons who had the responsibility of briefing him in respect of all of those complaints.

It is possible that he also received an email from Ms Meredith in which she voiced concerns about the Oakden Facility but if he did he was not the relevant Minister at the time and he could not have taken any action other than to send it on to the appropriate Minister. However there is no evidence that he received it.

His Ministerial Advisor Leah Manuel requested an 'update on the Makk and McLeay Nursing Home particularly regarding their adherence to standards' in 2011.⁹⁴⁶ The evidence is unclear as to whether Mr Hill requested Ms Manuel to obtain an update or whether Ms Manuel acted on her own initiative.⁹⁴⁷

In any event he received an update but that document did not bring to his attention any failings at the Oakden Facility nor is anything contained in the document that should have made him aware that there were any failings at Oakden.

There is no evidence that Mr Hill was made aware of systemic failings in relation to the provision of adequate care at Oakden nor any evidence to support a finding that he should have been aware of those failings.

In those circumstances a finding of maladministration cannot be made with respect to Mr Hill.

13.3.4 Mr Snelling

Mr Snelling became Minister for Mental Health and Substance Abuse on 21 January 2013 and remained Minister until 19 January 2016.

By the time Mr Snelling became Minister it would appear that the facility was under funded and under staffed. The Oakden Report supports that finding as does the other documentary evidence which points to the shortage of medical staff and allied health staff throughout the period when Mr Snelling was Minister.

Mr Snelling never visited Oakden, although at one stage in a meeting on 2 July 2014 with representatives of the RANZCP, which was also attended by Mrs Vlahos, he indicated that he would.

Dr McKellar attended that meeting as one of the representatives of the RANZCP. He said that he informed Mr Snelling and Mrs Vlahos in general terms that the Oakden Facility was neglected; that there were vulnerable people at the facility; and that someone from the Minister's office needed to visit the facility. The evidence is that Mr Snelling responded by

⁹⁴⁵ Letter from Mrs Betty Denton to Hon. John Hill, 2 January 2011, 2017-000535-E0004 (LVlahos1) DOC-000001164.

⁹⁴⁶ Minute from Paula Hakesley to the Office of the Minister for Mental Health and Substance Abuse re: Makk and McLeay Nursing Home Update, 17 May 2011, 2017-000535-E0004 (LVlahos1) DOC-000001171.

⁹⁴⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 10 November 2017 17.42-18.19 (John Hill).

looking at Mrs Vlahos and acknowledged that visiting the facility sounded like something the Minister's office should do.⁹⁴⁸

Mr Snelling did not have a memory of this meeting but he did not deny that he might have said what Dr McKellar claimed he said. However, Mr Snelling said that he did not believe serious issues about the quality of care being provided at the Oakden Facility were raised by Dr McKellar at that meeting or indeed, as he said, at any other time while he was Minister, otherwise he would have directed an investigation take place immediately.⁹⁴⁹

There is no reason to doubt Mr Snelling's evidence in that regard because it is not inconsistent with Dr McKellar's evidence.

Mr Snelling never visited the facility and Mrs Vlahos did not visit the facility until 10 February 2017. There is no evidence that anyone else from the Minister's office visited the facility at the direction of either of those Ministers. The end result is that neither Minister took up Dr McKellar's suggestion in the meeting of 2 July 2014.

The evidence does not disclose why the Ministers did not visit Oakden after 2 July 2014.

In my opinion the information provided at the 2 July 2014 meeting was not sufficient to put either Mr Snelling or Mrs Vlahos on notice that the facility was not fit for purpose or that the standard of care being offered to consumers was sub-optimal. Therefore, a finding of maladministration cannot be made relying solely on what was said at that meeting.

Mr Snelling later became aware of complaints about the standard of care at the Oakden Facility. Ms Anne Franklin, who was then a consumer at Clements, wrote to his office pointing out the dreariness of daily life for many consumers.⁹⁵⁰ Ms Baff made a complaint to Mr Tony Zappia MHR, which Mr Zappia in turn passed on to Mr Snelling. That complaint raised a concern about the adequacy of staffing levels; inappropriateness of consumers sharing rooms in particular sharing with those who exhibited violent behaviour; the high risk of severe injury or death; and a particular incident involving Ms Baff's husband. Mr Snelling may have also become aware of a further complaint made by Ms Baff in 2014 which was to the same effect.

I cannot make a finding that he did become aware of the second letter because it cannot be located. Ms Baff says she is sure, however, that she sent it but she does not have a copy of it.

I accept of course Ms Baff's account that she sent such a letter, but I cannot make a finding that Mr Snelling ever received it.

Although matters about which Ms Baff complained were important and of course accurate as we now know, I cannot find that the receipt of that complaint was enough to inform Mr Snelling of the conditions at the Oakden Facility prior to his resignation as Minister on 19 January 2016.

The evidence does not go far enough to find that Mr Snelling was aware of the sub-optimal care that was being delivered at the Oakden Facility at any time whilst he was Minister and the evidence does not support a finding that he should have been aware.

For that reason I cannot make a finding of maladministration in relation to him.

⁹⁴⁸ Dr McKellar was interviewed by Mr McGrath and in that interview used the term neglected. When he gave evidence he said he could not remember whether he did use that term: Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 10.47-11.1 (Duncan McKellar).

⁹⁴⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 7 November 2017, 57.37-44 (John James Snelling).

⁹⁵⁰ Letter from Anne Franklin to Hon. Jay Weatherill, 16 January 2014, 2017-000535 (JWeatherill1) DOC-000000283.

13.3.5 Mrs Vlahos

Mrs Vlahos was aware of the information that had been provided to Mr Snelling by Mr Zappia because she in fact attended to that complaint.

However, there is no evidence that Mrs Vlahos was any better informed about the condition of the Oakden Facility or the care that was being offered than Mr Snelling, prior to receipt of the PCV's annual report on 30 September 2016. That report contained the information previously described and would have brought to her attention some concerning matters.

Mrs Vlahos said that she read the PCV's annual report in October 2016, the contents of which caused her to have concerns.

She also received Mr Corcoran's letter on 14 October 2016, which brought to her attention Mrs Spriggs complaint which had been made on 1 June 2016, so by then Mrs Vlahos had an awareness of allegations of sub-optimal care at the Oakden Facility.

After receipt of the PCV's report and Mr Corcoran's letter she sought a briefing from the Department.⁹⁵¹

She also met with Dr McKellar and other members of the RANZCP on 17 November 2016 and at that meeting was told by Dr McKellar that the consumers at the Oakden Facility were vulnerable and neglected and there was evidence of 'illegal seclusion and restraint occurring in the campus'. Dr McKellar said Mrs Vlahos raised her hand and looked at Dr Groves and said she would address that issue through Dr Groves' office. Dr McKellar also asked Mrs Vlahos to visit the facility to which she responded by stating 'okay, let me come and learn'.⁹⁵² I accept Dr McKellar's evidence in relation to that meeting.

Notwithstanding the content of the PCV's annual report, Mr Corcoran's letter of 14 October 2016 and Dr McKellar's advice of 17 November 2016, Mrs Vlahos took no active steps to investigate the condition of the facility or obtain evidence as to the standard of care at the facility.

During that period, her staff did however attempt to obtain information and have Mrs Spriggs' complaint addressed.

On 18 October 2016, Mr Josh Abbott, who was a Ministerial Liaison Officer for Mrs Vlahos, requested a meeting with NALHN in relation to Mr Corcoran's letter.

On 24 October 2016, Rebecca Horgan who was the correspondence officer at the office of the Chief Executive of the Department, emailed Ms West and Mr Moutakis seeking the preparation of a brief and draft Ministerial response to the PCV about OPMHS.

Those requests do not seem to have resulted in a briefing or meeting and on 7 November 2016 Mr Abbott made a record that his request was overdue.

Nothing much seems to have happened until 7 December 2016 when Mr Abbott submitted a second request to NALHN for an urgent updated briefing.

On 6 December 2016, Mr Corcoran sent a further email to the Minister's office, following a phone call he had made on the same day in which he had complained about the lack of response to his letter of 14 October.

⁹⁵¹ Document entitled 'Oakden timeline', 2017-000535-E0005 (JWeatherill1) DOC-000000329.

⁹⁵² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 November 2017, 13.15-23 (Duncan McKellar).

In that email, Mr Corcoran wrote:⁹⁵³

Just confirming our phone call related to the complaints and to the care of Mr Robert (Bob) Spriggs While He Was a Patient at Oakden Older Persons' Mental Health Services and the lack of response to this matter in over six months by NALHN.

On 7 December 2016, Mr Josh Abbott emailed the Minster's Chief of Staff, Sam Runnel, and said:⁹⁵⁴

Hey Sam, what's the best way to approach this?

Aaron advised that he discussed this with Jackie last night. She's going to ask her staff to clarify a couple of issues and then NALHN will determine whether they want him to be involved any further or not. He will lead with Jackie to progress this. So to answer your question about what the likely outcome of OCP looking into it... it's not clear they are looking into it.

Now Zora (see below) wants me to call Maurice – which I'm happy to do. What should I tell them?

Cheers

Josh Abbott

Ms Hanson agreed that Josh Abbott spoke to her on that day and directed her to have an immediate meeting with the Spriggs' family, as a result of which Ms Hanson instructed Ms West to make arrangements for the meeting, which occurred on 15 December 2016.

Ms Hanson's evidence is consistent with an email her Acting Executive Assistant sent to Ms Migliore, Mr Corcoran and Ms West on 8 December 2016 in which she said:⁹⁵⁵

Good afternoon Maurice and Connie

Jackie Hanson would like to extend an invitation to you both and to Mrs Spriggs to discuss her concerns raised re her husband Mr Spriggs.

Thank you for your time in assisting with making these arrangements with Maria West.

Maria will make contact with you shortly to discuss the final arrangements for this meeting and the extension of this invitation to Mrs Spriggs and her support persons.

I have attached below a map to assist you in locating the CEO meeting Room located on Level 2 at the LMH.

If I can be of any further assistance, please don't hesitate to contact me

Later, Mr Josh Abbott emailed Ms Hanson, who responded:⁹⁵⁶

Yes Josh that is being arranged ASAP. I will update the brief as well.

⁹⁵³ Email from Maurice Corcoran to Zora Doukas, John Luke, re: Response to complaints into the care of Mr Robert (Bob) Spriggs while he was a patient at Oakden Older Persons Mental Health Services, 6 December 2016, 2017-000535-E0003 (MCorcoran1) DOC-000000349.

⁹⁵⁴ Email from Josh Abbot to Sam Runnel, re: FW: Response to complaints into the care of Mr Robert (Bob) Spriggs while he was a patient at Oakden Older Persons Mental Health Services, 7 December 2016, 2017-000535-E0004 (LVlahos1) DOC-000000061.

⁹⁵⁵ Email from Jackie Hanson to Maurice Corcoran, Connie Migliore, Maria West, re: Meeting with Mrs Spriggs and NALHN CEO re the care of Mr Spriggs, 8 December 2016, 2017-000535-E0011 (MWest1) DOC-000000084.

⁹⁵⁶ Email from Jackie Hanson to Josh Abbott, 7 December 2016, 2017-000535-E0004 (LVlahos1) DOC-000000067.

It cannot be said that Mrs Vlahos did not act between 14 October 2016 and 15 December 2016 when Ms Hanson met with Mrs Spriggs.

Between 30 September 2016 and 6 December 2016, her staff sought a briefing from the Department. She did not know that NALHN had delayed investigating Mrs Spriggs' complaint until 6 December and her staff addressed that issue.

For that reason I cannot find that during the period between 30 September 2016 and 19 December 2016, which was the relevant time, Mrs Vlahos' conduct in respect of the Oakden Facility resulted in substantial mismanagement in or in relation to the performance of her official functions.

Mrs Vlahos became aware of the meeting between Mrs Spriggs and her two children and Ms Hanson, Ms West and Mr Corcoran on 15 December 2016 most likely on 19 December 2016. As I have found, she agreed with Ms Hanson's decision to commission a report.

She took no part in the appointing of the review panel or the terms of reference governing the review.

It would seem that the review panel was identified as early as 10:00am on 20 December. Dr Groves emailed Ms Hanson at 10:01am and said:⁹⁵⁷

I have the following people who have confirmed they can do the review:

1. Prof Nicholas Proctor UniSA
2. Dr Duncan McKellar CALHN
3. Ms Del Thompson (OCP clinical risk manager, Senior MH Nurse by background)
4. Me.

Nicholas had commenced a project with nursing at Oakden to try to reduce restrictive practices (as part of his contract with me) as we had identified the problem. He will pause this whilst the review is on.

Duncan is very well respected within the Faculty and brings a new and fresh approach to Psychogeriatrics.

Del did the visit with me to Oakden previously and assist with all my investigations.

I will start on some terms of reference. I think I should at least make some reference to Mr S, are you happy about that.

In addition, I will do this under the MH Act as well and will appoint the oethers [sic] as investigators under section 90 which gives some additional powers.

I will also start on the briefing for Min asap.

Ms Hanson replied to that email and suggested the terms of reference could fit around the complaint from a family.

On 12 January 2017 all mental health staff in NALHN were sent a bulletin outlining the review and the review panel. The bulletin advised staff of staffing changes at the Oakden Facility.

Although she was aware that Dr Groves and the review panel had been asked to provide a preliminary report and a report was provided on 17 February 2017, Mrs Vlahos did not read that report for reasons which I have found to be unsatisfactory.

⁹⁵⁷ Email from Aaron Groves to Jackie Hanson, re Oakden, 20 December 2016, 2017-000535-E0007 (AGroves2) DOC-000000765.

She received the Oakden Report and, I assume, presented it to Cabinet and thereafter made the announcement on 20 April 2017.

She met with Mrs Spriggs for the first time on that day but excluded Mr Corcoran from the meeting.

She was not a leader in righting the conditions at Oakden. The leadership for that was shown by Ms Hanson and possibly Ms Kaminski. Mrs Vlahos was a follower.

I think she did very little after receiving the PCV's report on 30 September 2016 and before 19 December 2016 and very little thereafter.

Inactivity can be evidence of maladministration because it amounts to a failure to act: s 5(5)(c) of the ICAC Act.

Did her failure to act amount to a substantial mismanagement in, or in relation to, the performance of official functions?

During that time, substantial changes were made at the Oakden Facility, although not at her instigation, and the Chief Psychiatrist and the review panel wrote the Oakden Report, again not at her instigation.

However, it cannot be said that her inactivity or her failure to act amounted to substantial mismanagement in, or in relation to, the performance of official functions.

I think if Ms Hanson had not done what she did following the meeting with Mrs Spriggs on 15 December 2016 it would have been likely that conditions at the Oakden Facility would have continued for a further and unknown period of time.

This would have meant that a finding of maladministration might have been able to be made against Mrs Vlahos due to her inactivity.

However I think Mrs Vlahos has been saved from a finding of maladministration by Ms Hanson's actions. Ms Hanson put in place the review and made the radical staffing changes at the Oakden Facility. Ms Hanson thereafter kept a close eye on the facility.

I agree with Mr Besanko that whilst her failure to act was unsatisfactory it does not give rise to a conclusion that engaged in conduct that amounts to maladministration in s 5(4)(a)(ii) of the ICAC Act.

I therefore do not find that Mrs Vlahos engaged in maladministration in public administration.

13.3.6 Ministerial Responsibility

I have said elsewhere that the Ministers had the responsibility for the Oakden Facility.

In *Egan v Willis*⁹⁵⁸ Gaudron, Gummow and Hayne JJ stated at [42], [43] and [45]:

[42] A system of responsible government traditionally has been considered to encompass 'the means by which Parliament brings the Executive to account' so that 'the Executive's primary responsibility in its prosecution of government is owed to Parliament'. The point was made by Mill, writing in 1861, who spoke of the task of the legislature 'to watch and control the government; to throw the light of publicity on its acts'. It has been said of the contemporary position in Australia that, whilst 'the primary role of Parliament is to pass laws, it also has important functions to question and criticise government on behalf of the people' and that 'to secure accountability of government activity is the very essence of responsible government'.

⁹⁵⁸ (1998) 195 CLR 424.

In Lange v Australian Broadcasting Corporation, reference was made to those provisions of the Commonwealth Constitution which prescribed the system of responsible government as necessarily implying 'a limitation on legislative and executive power to deny the electors and their representatives information concerning the conduct of the executive branch of government through the life of a federal Parliament. The Court added:

"Moreover the conduct of the executive branch is not confined to Ministers and the public service. It includes the affairs of statutory authorities and public utilities which are obliged to report to the legislature or to a Minister who is responsible to the legislature."

In Australia, section 75(v) of the Constitution and judicial review of administrative action under federal and State law, together with freedom of information legislation, supplement the operation of responsible government in this respect.

[43] *In the United Kingdom*, the responsibility or accountability of individual Ministers recently was identified in a publication by the Cabinet Office as a guide to Ministers as including:

"Each Minister is responsible to Parliament for the conduct of his or her own Department, and for the actions carried out by the Department in pursuit of Government policies or in the discharge of responsibilities laid upon him or her as a Minister. Ministers are accountable to Parliament, in the sense they have a duty to explain in Parliament the exercise of their powers and duties and to give an account to Parliament of what is done by them in their capacity as Ministers or by their Departments."

On the other hand, the Court recently affirmed that the confidentiality of Cabinet deliberations reflects the principle of collective responsibility which 'remains an important element in our system of government'

...

[45] One aspect of responsible government is that Ministers may be members of either House of a bicameral legislature and liable to the scrutiny of that chamber in respect of the conduct of the executive branch of government. Another aspect of responsible government, perhaps the best known, is that the ministry must command the support of the lower House of a bicameral legislature upon confidence motions. The circumstance that Ministers are not members of a chamber in which the fate of administration is determined in this way does not have the consequence that the first aspect of responsible government mentioned above does not apply to them. Nor is it a determinative consideration that the political party or parties, from members of which the administration has been formed, 'controls' the lower but not the upper chamber. Rather, there may be much to be said for the view that it is such a state of affairs which assists the attainment of the object of responsible government of which Mill spoke in 1861.

In *FAI Insurances Limited Ltd v Winneke*⁹⁵⁹ Mason J identified the two aspects of Ministerial responsibility. First the individual responsibility on the Minister for the administration of his or her Department, and secondly the collective responsibility of Cabinet to Parliament and the public for the whole conduct of its administration.

Ministers are held to be responsible to Parliament by the use of question time or by electing to make ministerial statements.

There is no way that the Minister can be required to be responsible to Parliament by any action outside of Parliament.

⁹⁵⁹ (1982) 151 CLR 342.

The extent of Ministerial responsibility was addressed in the *Royal Commission on Australian Government Administration* (1976) in which it was stated at 4.2.1:⁹⁶⁰

It is through ministers that the whole of the administration – departments, statutory bodies and agencies of one kind and another – is responsible to the Parliament and thus, ultimately, to the people. ... In recent times the vitality of some of the traditional conceptions of ministerial responsibility has been called into question, and there is little evidence that a minister's responsibility is now seen as requiring him (sic) to bear the blame for all the faults and shortcomings of his (sic) public service subordinates, regardless of his (sic) own involvement, or to tender his (sic) resignation in every case where fault is found.

Professor Mulgan has written⁹⁶¹ in Keith Dowding and Chris Lewis, *Ministerial Careers and Accountability in the Australian Commonwealth Parliament* (Australian University Press, 2012) at page 178:

It includes collective ministerial responsibility, which obliges ministers to give public support to cabinet colleagues, especially the Prime Minister [and the Premier at a State level]. It also covers individual ministerial responsibility, the subject of this chapter, which requires ministers to take responsibility for their portfolios, answering to parliament for the conduct of their departments and resigning in the case of failure or impropriety. In practice, this means that ministers are obliged to inform parliament and the public about any action taken by themselves or their officials and to impose remedies when failures have come to light. Resignation becomes an issue when the minister can be said to be personally responsible, particularly for matters of individual impropriety, illegality, negligence or incompetence. Whether ministers do resign depends on a range of factors, including the seriousness of the alleged failure, the extent of the minister's personal responsibility and political calculation (ultimately by the prime minister [or the premier]) about the consequences for the government's standing of either accepting or rejecting the resignation (Mulgan 2002; page 1990; Thompson and Tillotsen 1999; Weeller 1999).

It would seem on all of the material before me that a Minister need not resign unless there is some form of personal fault or impropriety on the part of the Minister and that a Minister does not need to resign for failings which occurred within the Minister's department or portfolio without the Minister's knowledge.

Some may find that to be at odds with their own view as to Ministerial responsibility.

In the case of the Oakden Facility only Ms Gago and Mrs Vlahos were questioned in Parliament. In the case of Ms Gago she was questioned in relation to the failed accreditation audit in December 2007 and in the case of Mrs Vlahos following upon an ABC report about Oakden in January 2017.

All Ministers said that if they had known of what was contained in the Oakden Report during their time as Minister or, as in Mrs Vlahos' case before 10 April 2017, they would have taken action to remedy the situation immediately.

There is no reason to doubt any of them in relation to that because that would have been their clear duty as Minister.

While the evidence does not permit a finding of maladministration against any of the Ministers, it remains the fact that they were, as Ministers, responsible for the Oakden Facility and for the care provided there during the time that they were Ministers.

⁹⁶⁰ Commonwealth, Royal Commission on Australian Government Administration, *Royal Commission on Australian Government Administration: report* (1976) 4.2.1.

⁹⁶¹ Richard Mulgan, 'Assessing Ministerial Responsibility in Australia' in Keith Dowding and Chris Lewis (eds) *Ministerial Careers and Accountability in the Australian Commonwealth Government* (Australian National University Press, 2012) 177, 178.

That, however, seems to me to be a matter between the Minister and Parliament.

As I have mentioned above there are two aspects to ministerial responsibility. The second aspect relates to the collective responsibility of individual ministers for a Cabinet decision.

I have not considered whether Cabinet has engaged in maladministration because the Cabinet is not a public officer or a public authority and is therefore not amenable to my jurisdiction.

13.4 STATUTORY OFFICE HOLDERS

13.4.1 Chief Psychiatrist

There were three Chief Psychiatrists over the period covered by the ToR.⁹⁶² Only Dr Groves visited the Oakden Facility and then only on one occasion prior to Mrs Spriggs' meeting with Ms Hanson on 15 December 2016.

DR HONEYMAN AND DR TYLLIS

The failure of Dr Margaret Honeyman and Dr Peter Tyllis to visit the Oakden Facility at any time cannot by itself give rise to a finding of maladministration. I am surprised that the previous occupants of the position of Chief Psychiatrist did not visit the Oakden Facility during the time that they occupied the position of Chief Psychiatrist. They had the power to conduct an unannounced visit but did not do so.

I would have thought it would be necessary on appointment to the office of Chief Psychiatrist to visit all of the facilities in the State that provide care to persons who are suffering from mental health issues or at least those institutions that operate solely for that purpose (which was the case at the Oakden Facility), because the consumers at Oakden had to have had some chronic form of mental health issue.

I do not make any criticism of Dr Honeyman because she was not a witness and was not available to be interviewed on this issue.

Dr Tyllis said that he was not aware at any relevant time of any information that would give rise to sufficient cause to exercise the power to conduct an announced or unannounced visit to Oakden. I accept that. He then said that he disputed the suggestion that notwithstanding that he was not aware of any relevant information that he could be criticised for not visiting the Oakden Facility.

He said there must be some reason to conduct an announced or unannounced visit to a facility, 'whether it be a concern about some aspect of a particular facility or whether it be pursuant to some terms of reference regarding carrying out inspections of facilities.'

Dr Tyllis said that he had a threshold which needed be met to justify conducting an unannounced visit to a facility. That threshold, he said, was that there must be some 'good reason' to conduct an unplanned visit.

I disagree with that contention.

The purpose of investing the Chief Psychiatrist with the power to carry out an unannounced visit is to provide the Chief Psychiatrist with the means whereby he or she can satisfy himself or herself that the standard of care at any particular institution is appropriate.

⁹⁶² Chief Psychiatrists are identified at Appendix 4.

If there has to be good reason before an unannounced visit is undertaken then the Chief Psychiatrist will be always reacting to a crisis rather than acting to avert a crisis.

However, I cannot find that Dr Tyllis has engaged in substantial mismanagement in or in relation to the performance of official functions because he had no knowledge that the facility and the standard of care at the facility were sub-optimal.

DR GROVES

Dr Groves' position is somewhat different to that of Dr Honeyman and Dr Tyllis.

Dr Groves emailed Ms Hanson on 3 June 2016 seeking to visit the Oakden Facility because of evidence that the use of restraints at the facility was 'extraordinary'. On 9 June 2016 Ms Hanson agreed. On the same day Mr Corcoran reported Mrs Spriggs' complaint to Dr Groves. Dr Groves accepted that that complaint was serious.

On 30 June 2016 Dr Groves visited Oakden. He told Mr McGrath in interview that when he entered Oakden he was concerned with the institutional nature of the facility. He said it resembled walking into a 1950s style psychiatric facility. He also said to Mr McGrath that the inside matched the outside. He said: 'you can go to places where the inside is actually really good and very functional and the outside looks terrible but this was a match. So that was the first thing that struck me.'⁹⁶³

In his evidence, in answer to what observations he made on his visit, Dr Groves said that⁹⁶⁴:

the wards were in better upkeep than the outside, but they had that – they had a very sterile old-fashioned 1980s approach to being wards. So they weren't really fit for Older Persons Mental Health Services, but by the same token, they weren't – completely falling apart.

He said however that the purpose of the visit was to focus on restrictive practices.

On 11 July 2016 he emailed Dr Sujeeve Sanmuganatham (Dr Sujeeve):⁹⁶⁵

Thank you for facilitating the visit to Oakden Campus for Del and myself, we appreciated both the opportunity and the time from all of you in helping us to have a better understanding of the obstacles staff face in providing care to people in difficult circumstances.

While the long term goal for older persons services at Oakden is to improve the physical environment and enable the use of trauma informed care and sensory modulation we have given some thought to possible immediate and short term actions you could consider. This includes:

- asking for a full OT assessment and sensory assessment on any person who is being transferred from 1H, SE or Ward 18 before accepting the transfer;*
- looking at education for all staff on an understanding of sensory modulation and importance;*
- choosing a mental health nurse as a champion who can do a sensory modulation course / spend some time with an OT somewhere for experience, which they could then bring back to Oakden;*
- considering if the allocation you have for psychologist time can be converted to OT position as an interim measure and;*
- reviewing the data collected to see what may be useful in demonstrating your need for an improved environment, appropriate staffing and upskilling and training. For*

⁹⁶³ Record of interview, Adelaide, 27 September 2017, 55.14-26 (Aaron Groves).

⁹⁶⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 28 November 2017, 74.12-23 (Aaron Groves).

⁹⁶⁵ Email from Aaron Groves to Sanmuganatham Sujeeve re Visit to Oakden, 11 July 2016, 2017-000535-E0007 (AGroves2) DOC-000000655.

example, is there a difference in the restraint use on people who are recent transfers from 1H, SE or Ward 18, can you compare PRN and restraint pre and post transfer, and whether some restraints are used more on certain days?

I would also encourage ongoing attendance by Beccy and Dan on the state-wide Trauma Informed Practice Working Group (this has replaced the Minimising Restrictive Practice Working Group), their input is welcomed and I would have they may get ideas from other that they can use in their current environments even if changing that environment remains difficult.

Dr Groves' evidence was that notwithstanding Mr Corcoran had brought Mrs Spriggs complaint to his attention he did not think that anyone expected him to take any steps in relation to the complaint.

That evidence is very difficult to accept in light of the email from Mr Corcoran to Dr Groves on 20 July 2016 in which Mr Corcoran said:⁹⁶⁶

When we raised the matter with you, there were elements that you or your office was going to follow up such as the insistence on cash payments for his care at Oakden, the medication errors and severe bruising. Can you advise whether this was investigated by your office?

The email shows that Mr Corcoran expected Dr Groves' office to at least follow up the complaint. Dr Groves did not reply to Mr Corcoran's email.

If Dr Groves thought no one expected him to take any steps in relation to Mrs Spriggs' complaint, it is difficult to understand why he did not tell Mr Corcoran that Mr Corcoran was mistaken.

In my view it would rather suggest that as at that date Dr Groves had not made up his mind as to whether to investigate the matter or, if he had, that he was open to changing his mind.

On 15 August 2016 Ms West telephoned Dr Groves about Mrs Spriggs' complaint. Dr Groves told Ms West that he was happy to receive material from her concerning the matter in order to assess whether it was appropriate for him to investigate. It is difficult to understand why he would have said that if in fact he was to play no part in dealing with Mrs Spriggs' complaint.

On 19 August 2016 he received an email that included a draft letter addressed to Mr Corcoran in response to Mrs Spriggs' complaint which had been approved by Mr West but disapproved by Dr Pretorius.

Dr Groves formed the view that the draft letter to Mr Corcoran was unsatisfactory because it did not seem to acknowledge much of Mrs Spriggs' complaint. He said that he decided to discuss the matter with Ms Hanson.

On 23 August 2016 Dr Groves said he spoke to Dr Sujeeve at a meeting of clinical directors about Mrs Spriggs' complaint. He told Dr Sujeeve that he was concerned that Dr Sujeeve had not become involved and advised Dr Sujeeve that he had responsibility to finalise the investigation. He said that he told Dr Sujeeve that Mrs Spriggs' complaint did not raise issues that warranted a separate investigation by him as the Chief Psychiatrist.

Dr Groves said he spoke to Ms Hanson on 25 August 2016 expressing his concern that NALHN had not responded quickly enough or appropriately to Mr Corcoran. He said he also told her that there was no need for his office to separately investigate the matter. His evidence was that she said she would have NALHN take action in relation to the matter.

In view of the conversations he had with Dr Sujeeve and Ms Hanson, Dr Groves had concluded at that stage that there was no need for him to investigate Mrs Spriggs' complaint.

⁹⁶⁶ Email from Maurice Corcoran to Aaron Groves re: Complaint and incidents that occurred at Oakden Older Persons involving Mr Bob Spriggs as raised by his wife Barbara, 20 July 2016, 2017-000535-E0003 (MCorcoran1) DOC-000000287.

Ms Hanson could not remember that conversation but she did not deny that it occurred. Dr Groves was copied in on an email from Mr Corcoran to Ms West. Dr Groves contended that that email indicated that NALHN was completing its investigation in order to address Mrs Spriggs' concerns.

It is not so much to the point that NALHN was investigating Mrs Spriggs' complaint. That was always intended to be the case. NALHN had been slow but NALHN's investigation did not absolve Dr Groves from considering whether he should separately or independently investigate Mrs Spriggs' complaint.

On 2 September 2016 Mr Corcoran emailed Dr Groves advising him that Ms West had told him that Dr Groves had agreed to review the draft response and that the material had been sent to Dr Groves two weeks previously.

Dr Groves had received the material on 19 August 2016 and had discussed it with Dr Sujeeve and Ms Hanson following receipt of that information.

Dr Groves said that he thought NALHN was handling the matter and that was what he told Mr Corcoran.

Mr Moutakis contacted Dr Groves' office to obtain information but it was Dr Groves' evidence that he did not become aware of that contact until late January 2017.

Dr Groves did nothing between 25 August 2016 and 6 December 2016 when he became aware that Mrs Spriggs' complaint had become the subject of a briefing minute to the Minister about which he had not been consulted and which he said contained an error.

The briefing note said that the CEO of NALHN had sought advice from the Office of the Chief Psychiatrist and was waiting on advice.

Ms Hanson's evidence was that the briefing note was correct.

The question is whether Dr Groves should have done more to address Mrs Spriggs' complaint.

In my opinion he should have.

Mrs Spriggs' complaint was serious and raised three serious issues which Dr Groves himself identified:

- (a) unexplained bruising (with the implication that it was as a result of use of mechanical restraint)
- (b) an overdose of prescribed medication
- (c) an inappropriate request about payment (Mr Spriggs' daughter was told by Oakden staff that a payment of \$400 bill for Mr Spriggs' care at Oakden could only be done by cash and bank card payments were not accepted).

Only the first two issues should have concerned Dr Groves.

It was clear to Dr Groves by 19 August 2016 that the investigation into what he described as a serious complaint was not progressing expeditiously or appropriately.

Between 19 August 2016 and 6 December 2016 he did nothing to ensure that the investigation was being progressed.

I think Dr Groves should have intervened, at least by raising the matter with the Minister or CEO of NALHN, to ensure that the investigation was carried out in an appropriate way at the very least shortly after 19 August 2016 and even possibly before that.

Even when he read the briefing note on 6 December 2016 he did not do anything except to require Ms Hanson to correct statements about the conduct of his office.

He did not take any steps to ensure that the investigation proceeded appropriately even though by then he knew that the complaint had been escalated to the attention of the Minister's office.

Whilst he failed to involve himself in the investigation or to ensure that the investigation proceeded appropriately that does not, in my opinion, amount to substantial mismanagement in or in relation to performance of official function.

I find accordingly.

It was submitted that Dr Groves ought to be criticised for not performing any unannounced visits prior to 15 December 2016.

Dr Groves has addressed that submission by pointing to the fact that he did not have significantly more information than his predecessors. Dr Groves was not aware that the Oakden Facility had failed its Commonwealth accreditation audit in 2007 and Dr Tyllis was aware of rates of restricted practices in 2014 which he addressed in a draft letter to the former CEO of NALHN.

Dr Groves said that the Oakden Facility was subject to unannounced visits from the AACQA and the Australian Council of Health Care Standards, an external accreditation body that accredits all South Australian LHNs against mandatory national safety and quality standards and that those unannounced visits by those bodies did not unearth any difficulties at Oakden.

As I understand Dr Groves' contention he suggests that because other agencies had carried out unannounced visits and had not unearthed any concerns that it was unlikely any unannounced visits carried out by him would have been more fruitful.

In my opinion that contention should be rejected.

The Chief Psychiatrist had to discharge his own statutory responsibilities. He was not entitled to rely upon some other body discharging its responsibilities and therefore allowing him not to perform his own statutory responsibilities.

He was responsible under s 90(1) to perform the function of monitoring the treatment of voluntary and involuntary inpatients and the use of restrictive practices in relation to such patients and monitoring the administration of the MHA and the standard of mental health care provided in South Australia.

He could not discharge those statutory obligations by relying on AACQA or the Australian Council of Health Care Standards.

However again I do not think his failure to conduct unannounced visits can amount to substantial mismanagement in or in relation to performance of official functions. It would have been better if he had but he is not obliged by statute to carry out unannounced visits.

It was also contended by Dr Groves that he had not been guilty of maladministration by not taking action in 2015 and 2016 concerning the high rates of restrictive practices at Oakden.

I do not think that Dr Groves can be criticised for not taking action in relation to the unacceptable use of restraints at the Oakden Facility.

His evidence was that he monitored the data on restrictive practices from Oakden and other facilities and, as a consequence, visited Oakden on 30 June 2016.

He said that he provided staff at the Oakden Facility with instruction and education in relation to the use of restraints⁹⁶⁷ although I think his email of 11 July 2016 provided very little instruction or education.

He said that in March 2015 he had written to the CEO of NALHN asking NALHN to put together an action plan to reduce the use of restrictive practices.

He said that he met with Mr Corcoran to state his concerns about restrictive practices and the rate of restrictive practices at Oakden, which was also a concern of Mr Corcoran.

He attended and chaired meetings of the Statewide Restrictive Practices Working Group, which met every two months and included attendees from Oakden, where they discussed rates of restraint and seclusion, including benchmarks measured against other states.

He arranged for an expert from the National Centre for Trauma-Informed Care in the United States to visit South Australia for one week in May 2016, with the specific intention of training people across the mental health sector in how to reduce seclusion and restraint.

He said that he discussed the use of restrictive practices at Oakden with the CEO of NALHN between February 2015 and November 2016. He expressed concerns at the State-wide Mental Health Safety and Quality Meetings, which were attended by Mr Skelton, about Oakden's use of restrictive practices.

Sometime, probably in the first half of 2015, he asked Professor Procter to become more involved with James Nash House because of its use of restrictive practices.

He encouraged and promoted NALHN's target zero restraint use.

After the visit on 30 June 2016, he instructed Ms Thompson, Clinical Risk Manager within his office, to continue work with follow-up with the Restrictive Practices Group, including Dr Wheatley, and reported back to the Restrictive Practices Working Group and State-wide Meeting about Oakden's progress.

In or about August 2016, he arranged for Professor Procter and Ms Thompson to undertake a new education initiative for Oakden staff, specifically targeting the use of restrictive practices.

I think Dr Groves took adequate steps to address that part of his statutory responsibilities.

13.4.2 Principal Community Visitor

There has only been one PCV since the commencement of the MHA and that is Mr Corcoran.

Mr Corcoran maintained in his evidence, and also in his submissions in response to Mr Besanko's submissions, that neither he nor the CVS could be criticised for his or its conduct over the period covered by the ToR.

Mr Besanko criticised the PCV and CVS in three ways in his submissions: first, that Mr Corcoran and the community visitors did not conduct unannounced inspections of Oakden prior to late 2016; secondly, Mr Corcoran did not do enough to raise concerns he held with the higher echelons of NALHN, SA Health and the Minister in respect to conditions at

⁹⁶⁷ Email from Aaron Groves to Sanmuganatham Sujeeve re Visit to Oakden, 11 July 2016, 2017-000535-E0007 (AGroves2) DOC-000000655.

Oakden; and thirdly for failing to identify most of the issues identified in the Oakden Report prior to Mrs Spriggs' complaint.

The PCV and the community visitors were entitled to make unannounced visits to the Oakden Facility for the purpose of determining whether they should refer matters of concern relating to the organisational delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body.

They could also act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient, or any person who was providing support to a patient under the MHA.

There is no dispute that no unannounced visits were made by the PCV under the CVS prior to 15 December 2016.

In my opinion, the PCV and the community visitors should have made random, unannounced visits. It can be expected on any announced visit that the institution under inspection will present itself as best it can. The purpose of an unannounced visit is to see how an institution operates without the glare of an announced visit.

It would have been better if the PCV had conducted unannounced visits, but his failure to do so does not mean, in my opinion, that there should be a finding of maladministration because it could not be said that that failure involves substantial mismanagement in, or in relation to, the performance of official functions.

I have been provided with the PCV's annual reports and the community visitors reports (CVRs) over a period 2011 to 2017.

I have had a review of the CVRs conducted and that review is Appendix 12 to this report.

The CVRs bear no relationship to the findings made in the Oakden Report, at least before about March 2015.

Up until that time, the community visitor reports suggest an exceptional facility with exceptional staff. The reports are quite inconsistent with the findings made by the Chief Psychiatrist.

There is, however, a change in the matters reported on after January 2015.

I do not know whether that was a result of a change in the community visitors who were visiting Oakden, or a change in the standard of care that was being offered after about the end of 2014.

I suspect it might be the former.

The observations made under the heading 'Comments Suggesting Issues Not Identified' having regard to the Oakden Report are extraordinary and the description of the facility is nothing like the facility that I saw.

Even after December 2014, the description of the facility as 'atmosphere was conducive to quality care' is inconsistent with the Oakden Report and inconsistent with my own observations.

It was not until an inspection on 19 September 2016 that the community visitors disagreed that the atmosphere was conducive to quality care. It is interesting to note that one of the

community visitors who visited on that day had previously not visited the institution, at least in her role as a community visitor.

The issues of sub-optimal care identified seem to have changed after early 2015 and there were more criticisms identified than had been previously identified in the whole of the period of the reporting.

I am told that the forms which the community visitors filled out changed sometime in October 2015, which might account perhaps for some of the change of language, especially in relation to 'Comments Suggesting Issues Not Identified.'

The PCV's annual report of 30 September 2016 brought to the Minister's attention problems at the Oakden Facility.

The CVRs on NALHN Mental Health Treatment Centres were commonly emailed from Ms Migliore (DCSI) to Ms West.⁹⁶⁸ Ms Migliore's emails seek a response to the issue identified by the community visitor.

However, Ms West's evidence shows one occasion where Ms Migliore emailed Ms Gilligan⁹⁶⁹ and Mr Brunton⁹⁷⁰ instead of Ms West. The other community visitor reports were provided by Ms Migliore (DCSI) to Ms West.

Ms West's statement includes CVRs from June 2016 to April 2017.⁹⁷¹

Once Ms West, Ms Gilligan or Ms Brunton received a report, it appears an email was sent to a number of parties, including: Ms Smith-Sparrow, Mr Torzyn, Dr Sujeeve, Dr Draper and others requesting responses to the issues raised. Once feedback was received, a response was drafted for Ms West which was then sent by Ms West to Ms Migliore.⁹⁷²

I think the CVRs show the problems with announced visits and for that reason I intend to make recommendations in relation to the CVS.

Mr Besanko in his submissions said that it could not be disputed that the CVS did not identify the vast majority of the issues at the Oakden Facility (at least until Mrs Spriggs met with Mr Corcoran in June 2016). Mr Corcoran said in his reply that he disputed this strongly. In my opinion, Mr Besanko's submission must be accepted. The CVRs did not identify the issues that the Oakden Report found.

Even after Mr Spriggs had been a consumer at the Oakden Facility and after Mrs Spriggs had made her serious complaint to Mr Corcoran, the community visitors were continuing to describe Oakden as an atmosphere that was conducive to quality care.

Those observations are inconsistent with the findings in the Oakden Report. Mr Besanko's submissions must be accepted in that regard.

However, I do not intend to find that the PCV or any particular community visitors engaged in conduct that amounted to maladministration. They were not responsible for the institution or the care that was provided.

⁹⁶⁸ Statement of Maria West, 24 October 2017, annexure MLW81.

⁹⁶⁹ Ibid annexure MLW82.

⁹⁷⁰ Ibid annexure MLW82.

⁹⁷¹ Ibid [82]–[104].

⁹⁷² Ibid annexure MLW82.

13.5 CHIEF EXECUTIVE AND DEPUTY CHIEF EXECUTIVE OF SA HEALTH

13.5.1 Mr Swan

Mr Swan who was the former Chief Executive of the Department of Health and Ageing and was, as I have said, an impressive witness.

His evidence was that he did not know of the serious or systemic issues identified in the Oakden Report. There is no reason to doubt Mr Swan's evidence in that regard because it is consistent with the documents and the other oral evidence. In particular, the documents do not contain information to show that Mr Swan was alerted to any problems at the Oakden Facility.

Some isolated incidents and complaints came to his attention after having been brought to the attention of the Minister (by way of a complaint made to the Minister) and he would see briefing notes or minutes to the Minister in answer to those complaints.

As I have said, there is no evidence that Mr Swan was aware of any of the serious or systemic issues identified in the Oakden Report. Nor is there any evidence that he should have known.

There is no evidence that he received sufficient information that would put him on notice as to the unsuitability of the facility or the poor care that was being provided. Any information that he received was in the form of the briefing notes to the Minister, of which there were four, and any report that he would receive from Ms Mains or Ms Hanson when they were the CEO of NALHN. Because they were unaware of the serious and systemic problems, so also was Mr Swan.

The Department, of course, was responsible for the Oakden Facility and the sub-optimal care that was provided. Mr Swan was responsible as the Chief Executive of the Department during his time as Chief Executive and he readily accepted that he was accountable for the conduct of staff at the facility.

But the evidence does not support a finding that he knew, or that he ought to have known, of the matters found in the Oakden Report during his time as Chief Executive. In those circumstance a finding of maladministration cannot be made.

Nevertheless, the Oakden Facility was not fit for purpose and the care provided at Oakden was suboptimal. As the Chief Executive of the Department he was responsible for that state of affairs.

13.5.2 Ms Richter

The Deputy Chief Executive at the relevant time was Ms Richter, who was also an impressive witness.

She stands in the same position as Mr Swan. There is simply no evidence that she was aware of serious and systemic problems at Oakden or that she should have been aware.

13.6 CHIEF EXECUTIVE OFFICERS AT NALHN

The two CEOs who gave evidence were Ms Mains, who was chief executive officer between 15 August 2011 and 10 October 2014 and Ms Hanson, who was appointed chief executive officer on 19 January 2015 and who has remained in that position until the date of this report.

Both of those persons provided me with statements that had been prepared with the assistance of the CSO. Those statements were very helpful, as was the evidence they subsequently gave.

They were both impressive witnesses.

Ms Hanson readily accepted responsibility as the CEO of NALHN for the condition of the facility and the standard of care at Oakden. I have referred to that evidence when discussing Ms Hanson's evidence.⁹⁷³ Ms Mains was not asked that question.

Ms Hanson was right to accept that responsibility because, as the CEO of NALHN, she was ultimately responsible for the failings within NALHN and, in particular, at the Oakden Facility while she held the position of CEO.

The Oakden Report shows that the facility was in a very poor physical condition and it was under-funded and under-staffed, and the standard of care that was offered was not appropriate.

NALHN was therefore responsible for those matters and Ms Mains and Ms Hanson were responsible as the CEOs of NALHN.

However, the documentary evidence does not establish that Ms Hanson or Ms Mains were aware of the matters that were subsequently found in the Oakden Report.

They were both aware, of course, of the state of the facility as were a number of persons within NALHN.

I rather think everyone became immune to the state of the facility because so little was done about it.

However, there was no evidence that they were aware of serious or systemic problems within the Oakden Facility of the kind that was contained in the Oakden Report.

NALHN had in place proper mechanisms for reporting but, as I have previously said, those mechanisms failed at a number of levels and as a consequence, those who should have known about the systemic problems at the Oakden Facility were not told.

In my view the evidence does not support a finding of maladministration against the former CEOs of NALHN.

However, the evidence supports a finding that they were responsible when they were in the position of CEO of NALHN for the poor condition of the facility and, even though they were unaware of it, the poor standard of care that was provided within the facility.

⁹⁷³ See Chapter 2.

13.7 EXECUTIVES AT NALHN

Mr Besanko submitted that the evidence does not support a finding of maladministration against any of the relevant executives at NALHN or its predecessors.

He said that the evidence does not permit a finding that any of them knew of the specific problems at the Oakden Facility, as identified in the Oakden Report, and which evidently existed at the facility for much of the period covered by the ToR.

13.7.1 Mr Sexton

Mr Sexton was employed when the facility failed accreditation in December 2007 and was then aware of the significant issues at the facility that were identified. His evidence was that he believed that the issues, of which he was aware, were being adequately addressed and he said that he relied upon Ms Harrison, Mr Skelton and Dr Draper for his knowledge of the manner in which the facility functioned, and whether the issues of which he was aware were being adequately addressed.

The documents in evidence do not permit a finding that he was aware, or engaged in positive conduct, or failed to engage in conduct, to justify a finding that he engaged in maladministration in public administration.

13.7.2 Ms Nowland

Ms Nowland⁹⁷⁴ knew of a number of problems at the Oakden Facility. She was aware of its poor physical state and the shortage of staff, including medical staff and allied health staff. She received complaints from staff about those matters. She appears to have raised some of those issues with persons within NALHN and she also sought to address the shortage of mental health staff herself.

In her submissions in response to Mr Besanko's submissions, she said that the evidence supported a finding that while she attempted to address these issues, she was frustrated by a lack of funding. As a consequence of that lack of funding, she said she was unable to employ nursing staff on a permanent basis and requisite additional allied health and medical staff as well as funding for capital works to repair and upgrade the Oakden Facility.

She said she had made numerous submissions, sent emails and attended meetings at which she presented information about the risks of under-funding across the service particularly the Oakden Facility. She said at those meetings, she was continually told she must reduce the costs within her budget and must do so without closing beds, which was an impossible task and, as a result of which, she ultimately resigned.

Ms Nowland said there was nothing more she could have done. She claimed she did as much as she could until she was so frustrated by NALHN's demands that she cut her budget that she resigned.

I think that she was frustrated as a consequence of budget restraints and I think she just gave up, which I can understand.

I accept her evidence. She has not engaged in maladministration in relation to her functions.

⁹⁷⁴ Director of Operational Strategy NALHN.

13.7.3 Ms Owen

Ms Owen met with Ms Jay Christie in November 2016 when Ms Christie told her of concerns that had been raised by students who were required to work at the Oakden Facility. The students had observed rough handling of the consumers, consumers being dragged off to the toilet, staff deliberately allowing consumers to fall by letting go of the consumer, poor hygiene, observations of injuries to consumers, consumers left with faeces in their hair, staff referring to mealtimes as 'feeding time at the zoo' and staff referring to the consumers as a 'group of mindless children.'

Ms Owen was aware as at November 2016 of mistreatment of consumers at the Oakden Facility by staff members or certainly allegations of that kind. Shortly after Ms Owen received that information, Ms Hanson took the steps that she did after meeting with Mrs Spriggs on 15 December 2016.

Ms Owen says that she raised those complaints with the CEO and it was resolved to incorporate those complaints into the broader review of Oakden.

In those circumstances it seems to me that no finding of maladministration could be made against Ms Owen because she escalated the allegations that she had received appropriately.

13.7.4 Dr Rafalowicz

There is no evidence that Dr Rafalowicz was aware of the suboptimal care that was being offered at the Oakden Facility and no evidence which would have put him on inquiry such that he should have been aware.

13.7.5 Ms West

Ms West commenced with NALHN on 15 June 2016. She had the responsibility of coordinating the response to Mrs Spriggs' complaint. She approved the response that had been prepared by Mr Moutakis but which Dr Pretorius refused to sign. I do not think that she can be criticised for approving Mr Moutakis' response. She had only been in the position less than two months.

She was otherwise unaware of the conditions at the Oakden Facility and did not become aware of them until she was present at the meeting on 15 December 2016 with Mrs Spriggs, her two children, Ms Hanson and Mr Corcoran. Thereafter, she assisted in trying to address the issues.

13.7.6 Mr Moutakis

Mr Moutakis was the Consumer Advisor/Consumer Liaison Officer for NALHN, and had been since December 2007. He was the subject of criticism in submissions by counsel assisting.

Mr Moutakis responded by offering further evidence about the role which he had performed and the manner in which he had performed it.

The further evidence that he offered was not inconsistent with the evidence he gave when he was examined by counsel assisting.

No position description for Mr Moutakis is exhibited to the Corporate Affidavit. However, he gave evidence, relevantly, that it was his understanding that:

- The role of Consumer Liaison Officer was to manage consumer feedback.⁹⁷⁵
- He had the responsibility to receive all complaints relating to Oakden and other Adult Mental Health Service institutions.⁹⁷⁶
- It was his responsibility to investigate complaints that came to his attention.⁹⁷⁷
- He was dealing with the presenting issues and how to improve the system and so he would make recommendations as to service improvements.⁹⁷⁸
- He did not have authority to effect change, but it was part of his role to provide advice and recommendations.⁹⁷⁹
- He would conciliate or mediate less serious complaints or provide explanations.⁹⁸⁰
- More serious complaints required an investigation. He would request information from the relevant staff. There were not statements per se but the staff member would respond with their version of events.⁹⁸¹
- He would make recommendations to senior management being the Director, Executive Director, Clinical Director, Service Manager, Nursing Director.⁹⁸²
- He presented at various clinical governance meetings on a monthly basis, and prepared reports identifying trends and issues arising from the feedback and complaints that came to his attention.⁹⁸³ A number of these reports were before me.

Mr Moutakis' evidence is particularly relevant to the question of the scope of his role, and his duties and responsibilities.⁹⁸⁴

Q. *You mentioned before that your responsibility as a Consumer Adviser and then a Consumer Liaison Officer was to manage complaints. What do you mean by 'manage'?*

A. *Well I had a firm belief in what I was doing, in essence, that when we are dealing with people that are obviously very distressed with the system, and have got issues concerned with the system, it was about – yes, dealing with the presenting issues – but more importantly how can we improve the system. We're doing all this work in terms of managing consumer feedback and the complaints – it's important also that we also need to learn from that and also how can we improve the services based on that.*

To that end as time went on and part of my role was also making some recommendations in terms of service improvement based on the issues that were presenting - I would be providing to the various governance committee meetings on a monthly basis - at the Adult Clinical Governance meetings for Mental Health, Forensic Mental Health Governance meetings, the Older Persons' Governance meetings for Mental Health and also the Mental Health Divisional Governance meetings. The report that I'll be providing on a monthly basis gave a quick snap shot in terms of the complaints, the types of complaints that were coming through; the themes; and some suggestions in terms of recommendations. The recommendations were the, in terms of implementation, were as an Adviser or Liaison - it was advice. I could not, I didn't have the responsibility or the authority to drive the changes, these

⁹⁷⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 20 October 2017, 8.35-9.12 (Arthur Moutakis).

⁹⁷⁶ Ibid 9.20-34.

⁹⁷⁷ Ibid 10.8-15.

⁹⁷⁸ Ibid 30.1-35.

⁹⁷⁹ Ibid 30.16-35.

⁹⁸⁰ Ibid 31.18-32.16.

⁹⁸¹ Ibid 32.20-35.

⁹⁸² Ibid 33.14-37.

⁹⁸³ See, eg, ibid 34.7-14.

⁹⁸⁴ Ibid 30.1-31.16.

service changes. That was at the senior management or executive level in order to get that to occur.

Q. *So who had authority to make those changes?*

A. *It was the service managers, the nursing directors, the clinical directors, and the executive directors.*

COMMISSIONER: *Say that again?*

A. *Executive directors.*

MR BESANKO:

Q. *So in the case of Oakden that was Ms Harrison, Mr Skelton and Dr Draper?*

A. *Yes.*

Q. *In addition to the Executive Director for Mental Health?*

A. *That's right. Yes. The Clinical Director – there was a Clinical Director that Mr Draper was also liaising with, which was – I mean there were a number but the one that I'm thinking of that comes to mind is a gentleman by the name of Eli Rafalowicz.*

It is apparent from this evidence that Mr Moutakis accepted that it is part of his role to advise and make recommendations on ways that things could be improved, based upon the complaints that he was 'managing' and the underlying issues that came to his attention by reason of his management of those complaints.

He agreed in his examination that:

- The accommodation at Oakden had significant shortcomings and was restrained.⁹⁸⁵
- There were significant issues with the nursing staff including that nursing staff rarely interacted with the consumers because of the level of turnover of staff, nurses generally stayed within the nursing quarters, there were competency issues with nurses, there was a heavy reliance on agency staff, the staff required a significant amount of clinical supervision, and the bulk of the complaints related to the nursing staff.⁹⁸⁶
- Oakden was underfunded in relation to allied health and medical support staff.⁹⁸⁷
- The nursing director (Mr Skelton) had a culture of withholding information.⁹⁸⁸
- Oakden was medically unsafe as medical staff were stretched.⁹⁸⁹

In addition, Mr Moutakis by the very nature of his role was aware of the majority of the complaints made with respect to the Oakden Facility. Whilst there was no position description for the role he occupied, he accepted that it was part of his role to advise on issues he identified in 'managing' complaints, and to make recommendations although he said he could not take action himself to address them.

However, there is no written record of him raising any serious concerns about the Oakden Facility or the systemic issues he was aware of.

I doubt his evidence that he raised a number of his concerns with various individuals involved in the management of the Oakden Facility orally. That it is not supported by the documents or, in any material way, by the oral evidence of the other witnesses.

His evidence on this topic was given in an unconvincing, self-serving and unsatisfactory way. It was inconsistent with his handling of the FOI request by the Sunday Mail, which

⁹⁸⁵ Ibid 49.26-37.

⁹⁸⁶ Ibid 56.28-37, 57.1-3, 61.1-8, 62.8-15, 62.18-21, 106.8-18.

⁹⁸⁷ Ibid 66.9-16.

⁹⁸⁸ Ibid 97.8-26.

⁹⁸⁹ Ibid 65.14-66.8.

suggests that he, like others at the facility, held the view that it was best to keep information 'in house'.

His handling of Mrs Spriggs' complaint suggests that he did not appreciate the serious nature of issues at the Oakden Facility. If, contrary to his evidence, he did not know of or appreciate the issues at the facility, he should have, given his position and the fact that of all the people with responsibility at the Oakden Facility he was the one best placed to identify serious or systemic issues. He was responsible for 'managing' complaints made about the Oakden Facility and therefore was the one who had knowledge of most of the more serious complaints. It was his responsibility to raise these issues and make recommendations.

He did not do so satisfactorily, even on his own evidence.

He said that his role concerned the gathering of information from various sources, including from relevant senior staff in the respective areas. He said that while he might query or question information, ultimately his role does not have the authority or responsibility to question or scrutinise the information provided. The persons responsible for scrutinising information were the more senior staff and, in the case of information provided by Ms Harrison, Mr Skelton and staff at the facility, the responsibility fell with other levels of upper management, such as the Director, Clinical Director and Senior Executives.

His explanation for his failure to scrutinise the information that was provided to him when considering a complaint or report that had been made to him by a consumer or a consumer's family shows that the submission made by Mr Besanko, that he was ineffective in his role, must be accepted.

Whatever the reason was for the lack of scrutiny of the information being provided, the fact is because of that lack of scrutiny, the role itself was ineffective.

Mr Moutakis discharged his responsibilities by simply accepting information and explanations given to him by staff and passing them onto the complainant or reporter.

While he attended the Governance Committee meetings, at which the monthly consumer feedback data/trends/analysis/recommendation reports were presented, there appears to have been little conversation about those reports.

In particular, he does not appear to have raised issues about the Oakden Facility with many people above him in the organisation.

Mr Moutakis' office was at the Oakden Facility, so he was well aware of the physical condition of the facility.

He often went onto the wards, so he would also have been aware of the conditions in which the consumers were kept. It would be difficult for him not to notice the very poor conditions in which the consumers were kept and the manner in which they were kept.

Mr Moutakis had formal nursing qualifications and he was in a position to judge for himself the appropriate standard of care that should have been delivered at the Oakden Facility. He was in a position to report his own observations on the SLS system or to his superiors but he took no action of that kind. From the evidence, it would appear that he did not raise problems and issues with persons senior to him in the organisation.

In his submissions in response to Mr Besanko's submissions, he said that the evidence shows he had more than a few isolated concerns. In particular, he said he was concerned about:

- local feedback not being captured⁹⁹⁰
- the conduct of nursing staff⁹⁹¹
- inadequate medical staff and lack of clinical pharmacist⁹⁹²
- funding constraints⁹⁹³
- the care provided to Mrs Fox and her seclusion⁹⁹⁴
- the lack of activities for consumers at Clements House⁹⁹⁵
- the few trained mental health nurses at the facility⁹⁹⁶
- the inappropriate restraints applied to Mr Cartright⁹⁹⁷
- the level of nursing care at Oakden⁹⁹⁸
- the concerns raised by nursing students⁹⁹⁹
- the standard of care that was being provided.¹⁰⁰⁰

I accept his evidence that he was concerned about all of those matters.

The difficulty with his evidence is that there is no evidence that he took adequate steps to report those concerns to the appropriate authorities within NALHN, notwithstanding his protestations to the contrary.

There is little or no documentary evidence that would support him raising issues or concerns with people above him in NALHN. So much was recognised by Mr Moutakis in his reply to Mr Besanko's submissions in which he said the dearth of documentation to support his raising issues with senior management was very disappointing.

His failure to escalate complaints and reports to those above him contributed to the culture of secrecy that enveloped the Oakden Facility.

Mr Moutakis said he started preparing Consumer Liaison Reports (CLRs) in May 2013 and that he did so on his own initiative.¹⁰⁰¹

The evidence does not disclose whether he prepared any similar reports between December 2007 (when he started in his role) and May 2013.

A review of the CLRs shows that the reports contained:

- a) statistics as to how many complaint were received within the Mental Health Services at NALHN including whether they were acknowledged within 48 hours and closed within 35 days.
- b) primary categories of complaint which were largely unhelpful because of the breadth of categories such as 'corporate services', 'access', 'treatment' and 'communication'.

⁹⁹⁰ Ibid 42.34–37, 43.

⁹⁹¹ Ibid 57, 58, 61, 62.

⁹⁹² Ibid 64.

⁹⁹³ Ibid 66.

⁹⁹⁴ Ibid 70-71.

⁹⁹⁵ Ibid 70.

⁹⁹⁶ Ibid 83.

⁹⁹⁷ Ibid 87.

⁹⁹⁸ Ibid.

⁹⁹⁹ Ibid 113.

¹⁰⁰⁰ Ibid 115.

¹⁰⁰¹ Ibid 32.20-33.

- c) an 'other' section which appears to be for additional notes relating to complaints. As an example the May 2013 report listed inconsistent categorisation of feedback on SLS and that local feedback continues not to be captured.
- d) graphs showing the number of compliments, complaints, suggestions and advices received for the month and previous months which shows the 'type of feedback' received.
- e) a graph comparing each of the facilities forming part of Mental Health Services, NALHN with respect to the subject matter of complaints received and the primary category of complaint.
- f) in some instances there were some very general and largely unhelpful recommendations.

The CLRs did not however list the specific complaints.

Appendix 10 is a schedule of the complaints relating to Oakden during the review period. The complaints listed in May 2013 indicate that complaints were raised at Oakden with respect to issues with treatment and care; verbal abuse; inappropriate interactions between consumers; a staff member removing drugs from a safe; restraints; and lack of supervision issues but these complaints are not mentioned in the CLRs for May 2013.

The CLRs do not descend into detail about the Oakden Facility but include all facilities forming part of Northern Mental Health. Oakden-specific data was not the focus of the CLRs.

A sample of the CLRs are included in Appendix 13.

The CLRs were of little utility for managing specific individual complaints in relation to Oakden. The CLRs do not disclose the specific complaints, the complainant, the action taken in relation to the complaint and whether or to whom it was escalated.

The CLRs would not provide sufficient information to those at the facility as to the complaint and if the CLRs were forwarded to persons in more senior positions then those persons could hardly be expected to be aware of specific complaints based on the CLR's content.

Mr Moutakis said he provided a copy of the CLRs in advance of committee meetings.¹⁰⁰² He said he was given an opportunity to speak to those CLRs as it was a standing agenda item at meetings. He said that time he spent speaking to a CLR at a committee meeting would vary from five to 15 minutes¹⁰⁰³ which would not have allowed him to address specific individual complaints relating to the Oakden Facility, particularly given the CLRs addressed all mental health services in NALHN.

Mr Moutakis was charged with dealing with Mrs Spriggs' complaint. His conduct in that regard was unsatisfactory. The investigation took considerably longer than it should have and in the end, when he composed a letter for Dr Pretorius to sign, she refused because she did not think it addressed the issues raised by Mrs Spriggs. A reading of the draft shows that she was correct about that.

The draft that was proposed by Mr Moutakis to be sent to Mrs Spriggs was indicative of the defensive way in which he handled complaints and reports.

¹⁰⁰² Ibid 38.34-39.4.

¹⁰⁰³ Ibid 39.5-13.

He seems to have been of the opinion that complaints and reports should be fielded rather than investigated, an attitude which is, of course, of no assistance to complainants, reporters, NALHN or the Department more generally.

It is in the Department's interests that all complaints and reports are investigated thoroughly and objectively so that if issues arise they can be addressed.

That was not an approach adopted by Mr Moutakis.

Mr Moutakis submitted in response to Mr Besanko's submissions that he was not negligent or incompetent in the manner in which he discharged his duties. He said his evidence was 'thick with references to him reporting his concerns up the administrative chain.'

He gave evidence that at one stage he expressed concerns to the Executive Director of Nursing and Midwifery and the manager of the Clinical Governance Service over the last year or two. But that complaint was not specific to the Oakden Facility. It was about the number of complaints with which he was dealing across NALHN. His complaint to those persons was that he was becoming hard-pressed and overwhelmed. He specifically referred to Modbury and Lyell McEwen Hospitals which were causing him a significant case load.

Mr Moutakis did not express his concerns about the Oakden Facility to persons in authority at NALHN.

I have re-read the evidence to which he referred in his submissions. The thrust of his evidence was that he made complaints to Ms Harrison and Mr Skelton about various matters. He said he expressed concerns to Mr Alan Scarborough about the level of nursing care but those concerns were not peculiar to the Oakden Facility but about the level of nursing care at NALHN.

He also said at one stage he expressed his concerns to Ms Nowland but a close reading of his evidence shows that most of his concerns were expressed to Ms Harrison and Mr Skelton.

Whilst he complained to Mr Skelton, he said there was never any improvement. In his submissions, he said:¹⁰⁰⁴

The Consumer Advisor / Consumer Liaison Officer is a nonclinical role which does not have responsibility for clinical practice and or service management in Oakden or any other mental health site for that matter. The role may have been physically based in an office at Oakden however it also managed feedback from across the Northern Mental Health Division including acute, community and forensic mental health service sites which required me to be offsite regularly. In total there were 25 ward / service areas across the Northern Mental Health Division covered by this role and the role was part of and reported to the Northern Adelaide Local Health Network Clinical Governance Service. It was not part of the OPMHS.

I was aware of the clinical documentation issue, poor morale and some of the cultural issues as were many other senior staff throughout the organization [sic] however my role had no responsibility or authority to respond to these issues apart from raising them with senior management including Karim Goel, Clinical Service Consultant, Marilyn Penery, Clinical Practice Consultant, Nursing Director and Service Manager. I was given reassurances that these matters were acknowledged and that there were plans in place to address them. In addition, as the Oakden facility was meeting accreditation requirements there did not appear to be any cause for concern.

¹⁰⁰⁴ Michael Jandy on behalf of Arthur Moutakis, Response submission to the Independent Commissioner Against Corruption, Independent Commissioner Against Corruption Oakden Maladministration Investigation, 22 January 2018, [24].

The role of the Consumer Adviser / Consumer Liaison Officer is to inform complainants about their rights and responsibilities including their right to make a complaint. In addition, they are also made aware of their right to escalate their complaint with the Health and Community Services Complaints Commissioner and or the Aged Care Complaints Commissioners office. Information about these external agencies is provided.

That submission highlights why he should have escalated the complaints about Mr Skelton to more senior officers in NALHN.

One of Mr Moutakis' primary functions was to deal with complaints and reports about conditions at NALHN and, in particular, one of his functions was to deal with complaints about reports about the Oakden Facility.

If, as he said, he became aware of sub-optimal nursing care at Oakden, he had a responsibility to report that to Mr Skelton, a responsibility which he discharged. When he observed that the nursing care had not improved he had the further responsibility to report those matters above Mr Skelton so as to ensure that the consumers at the Oakden Facility were provided with an appropriate standard of care.

He failed to fulfil that function.

For that reason, his conduct involves substantial mismanagement in, or in relation to, the performance of official functions and therefore amounted to maladministration.

I find accordingly.

13.8 STAFF AT OAKDEN

13.8.1 Mr Torzyn and Mr Goel

Counsel assisting has submitted that I should not make any findings of maladministration against Mr Torzyn or Mr Goel.

I accept that submission.

It is true that Mr Goel and Mr Torzyn were aware of a number of the issues identified in the Oakden Report. However, despite their position as CSCs, their evidence that they were not aware of serious incidents of abuse or neglect by nursing staff should be accepted.

The evidence before me, including the documentary evidence, shows that when they were aware of matters of concern they took steps to raise those concerns with those above them, particularly Ms Harrison and Mr Skelton, and that they themselves made attempts to address issues at the Oakden Facility.

Mr Goel raised concerns about nursing staff under his supervision with a number of persons above him.

Mr Torzyn expressed concerns about and sought to change the practice of simply managing consumers at Clements House until they died. He sought to try and improve the treatment and rehabilitation of consumers in Clements so that they could be 'transitioned' out of the facility. He also raised concerns with appropriate persons about the nursing care at the Oakden Facility on a number of occasions.

However, their evidence was, and there is no reason to doubt it, that they were not aware of the serious incidents of abuse and neglect by nursing staff, even though they had suspicions of poor nursing practices which they investigated or raised with Mr Skelton.

I am not satisfied that they engaged in conduct that resulted in substantial mismanagement of public resources or involving substantial mismanagement in or relation to the performance of official functions.

Therefore, I am not satisfied they engaged in maladministration in public administration.

In light of the fact that I have formed the view that the evidence does not support a finding of maladministration against Mr Goel or Mr Torzyn, it is not necessary for me to set out what their official functions were.

13.8.2 Dr Draper, Ms Harrison and Mr Skelton

That leaves for consideration Ms Harrison, Dr Draper and Mr Skelton (whose positions and tenure have been previously described). They shared the immediate responsibility for providing adequate care to the consumers at the Oakden Facility.

Ms Harrison and Dr Draper both made submissions in response to Mr Besanko's submissions to the effect that their formal responsibilities in respect of the Oakden Facility were in material respects limited, such that, whether they knew of issues at the facility or not, they were not required to do anything more than what they did.

Dr Draper in particular appeared to contend that he had very little formal responsibility for the facility at all, despite being the Clinical Director responsible for the Oakden Facility. Mr Skelton did not respond to Mr Besanko's submissions.

In order to address whether Ms Harrison and Dr Draper, and indeed Mr Skelton and Ms Penery, have engaged in conduct amounting to substantial mismanagement of public resources or substantial mismanagement in or in relation to the performance of official functions, it is necessary to set out what their official functions were. I will come to that in due course.

I think the evidence supports a finding that the management structure at Oakden was inappropriate during the whole of the period covered by the ToR.

Ms Harrison, Dr Draper and Mr Skelton had different roles but nobody had overall responsibility for the facility.

They shared that responsibility.¹⁰⁰⁵

The management structure was essentially a triumvirate.

Ms Harrison said the structure was at times cumbersome and not clear. Any one of them could not say to any other of them that they must do something.

Mr Skelton agreed the structure was cumbersome and unclear from the staff's point of view. He agreed that the Oakden Facility needed a person in charge.

Dr Draper agreed that responsibility was shared between the three of them but thought that to be satisfactory.

They also had other roles apart from the particular roles at the Oakden Facility. It meant that they were each part-time, as it were, with nobody having full-time responsibility for the facility.

¹⁰⁰⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 71.30-71.35 (Julie Harrison).

In my opinion there should have been someone who had the ultimate responsibility for the Oakden Facility who was based at Oakden on a full time basis, so that that person would have the responsibility of escalating all of the matters which were subsequently found in the Oakden Report to the executives at NALHN for action.

Dr Draper and Ms Harrison have relied on this poor management structure to reject suggestions that they mismanaged their official functions.

They both have blamed each other. Mr Skelton took a similar line.

The three people who ultimately shared responsibility for the Oakden Facility have each sought to avoid responsibility by pointing the finger at each other.

That is most unsatisfactory.

As I have said there were two cultures operating at the Oakden Facility which did not serve the consumers well.

The first was an expectation that at some stage the Oakden Facility would either close or be run by an NGO. That was the effect of Recommendation 31 made in the Stepping Up Report in 2007 and it was thought by all of those who were associated with the Oakden Facility that at some stage the recommendation would be acted upon and something would happen. Either there would be no further need for the Oakden Facility or it would become the responsibility of an NGO. Ms Penery's evidence shows the impact that had upon the staff.

Unfortunately, as Mr Snelling accepted, there was no political will to bring that about, especially in circumstances where the unions were apparently opposed to privatisation.

The recommendation therefore, although it had been accepted by the Government, was never acted upon. However, it continued to infect the culture at the Oakden Facility because most of the staff at the facility thought that the recommendation would one day be acted upon.

The second culture that operated at the Oakden Facility was a culture of secrecy.

It was referred to in the Oakden Report and I am satisfied that it existed.

That culture was fostered, I think, by Ms Harrison, Dr Draper and Mr Skelton but particularly by Ms Harrison and Mr Skelton.

In my opinion they were concerned to keep everything in-house so that the standard of care that was provided to the consumers at the Oakden Facility did not become known to NALHN, Ministers or indeed the public.

Mr Moutakis, as I have found, played a part in fostering that culture.

Mr Skelton in particular kept things in-house.

He rarely reported conduct to bodies to which he ought to have reported such as AHPRA or the OPI. He rarely took internal disciplinary action or sought to have appropriate action taken, against nurses who were incompetent or who treated consumers poorly. He specifically instructed Mr Torzyn not to report a particular staff member to AHPRA.

It is not clear why they fostered a culture of secrecy. It may have been a desire to avoid investigation and potential criticism of the way in which the Oakden Facility operated.

At the end of the day it does not matter much why they fostered that culture. The fact is the culture existed and as a consequence of that culture issues that ought to have been reported or escalated were not.

As a consequence issues were simply not addressed or resolved. Without intervention they became worse.

Although as I have said they shared responsibility for the provision of services and care at Oakden their conduct must be examined separately.

Mr Harrison sought leave to file an affidavit to accompany her lengthy submissions in response to Mr Besanko's submissions.

In that affidavit she addressed a number of issues and the evidence of a number of witnesses. She also addressed the question of a culture of secrecy.

I have taken into account the matters identified in her affidavit in making the findings both in relation to the fourth ToR and in relation to the question as to whether she has engaged in conduct that amounts to maladministration.

Dr Draper also made lengthy submissions in response to Counsel Assisting's submissions all of which I have taken into account.

I will refer to Ms Harrison's affidavit and her submissions and Dr Draper's submissions when I deal with their conduct.

The position descriptions which were exhibited to the Corporate Affidavit for Mr Skelton record that from 2006 until 2008 his functions, duties and responsibilities included, relevantly:

- Providing leadership as the direct line manager for level 3 nurses.
- Ensuring the selection and appointment of nursing staff to the service met required standards.
- Maintaining an effective and regular performance appraisal system for himself and the service nursing staff.
- Collaborating with the General Manager and Director of Nursing in preparation of the nursing budget submissions and planning and implementing agreed financial budget strategies.
- Collaborating with the General Manager, to determine capital equipment budgets / priorities relating to staff practice within the service.
- Providing reports to the General Manager and Director of Nursing on expenditure, as required.
- Communicating and collaborating with staff on matters of concern associated with the operation of the service.
- Developing and supporting "a standard of excellence in mental health nursing care" by, relevantly:
 - Participating in the local senior management meetings.
 - Ensuring a high standard of nursing practice through the establishment and monitoring of consistent professional work practices that meet professional and legislative requirements.
 - Participating in consumer/carer participation strategies in partnership with consumers/carers, in order to maximise a consumer focus.
 - Establishing and participating in mechanisms for review of client care.
 - Implementing and monitoring policies regarding continuous quality improvement.
 - Working closely with members of the Senior Nurses Group, General Manager and other staff to develop and maintain a comprehensive range of services.
 - Contributing to education and staff development programs as requested.
 - Collaborating with the General Manager to establish goals, objectives, and procedures for the Service.

- Developing and monitoring strategic and annual operating plans for the Service in conjunction with the General Manager.
- Collaborating with the General Manager to establish, implement and evaluate systems which ensure high quality consumer outcomes for the Service.
- Actively participating in the strategic planning processes, which include both evaluation and performance indicators, to enable outcomes to be measured.
- Ensuring that a culture of continuous performance improvement was integrated through all levels of the service; including by adopting a proactive approach to program review, development of new initiatives and research activities.
- Actively participating in the Acute & Early Intervention / Rehabilitation & Recovery / Specialist MHS Quality Improvement process to identify and achieve outcomes as part of a quality improvement program.
- Acting to rectify unsafe nursing practices.
- Delivering non-discriminatory treatment and support that was sensitive to the social and cultural values of the consumer, the consumer's family and carers and the community.
- Contributing to the personal development of himself and others by:
 - Complying with the nursing profession's code of conduct and code of ethics.
 - Providing effective leadership.
 - Promoting effective leadership.
 - Practicing in accordance with common law and legislation affecting practice.
 - Maintaining contemporary professional knowledge and skills through involvement in and at times facilitating ongoing staff development and education.
 - Assisting with training and support for consumers, their families and carers to maximise their participating in Service programs.
 - Collaborating as required with Staff Development providers in educational programmes for staff.

Similar functions were identified in Mr Skelton's 2008 position description. In that document, his duties, functions and responsibilities as Nursing Director were summarised as follows:¹⁰⁰⁶

The nursing director works as a member of the management team and is directly responsible for all aspects of mental health nursing care delivery by ensuring professional standards of nursing care, cost effective and efficient management of nursing resources and the coordination of nursing quality improvement programmes across their span of control.

The Nursing Director uses their clinical knowledge and experience to provide strategic and operational leadership, governance, and direction for mental health nursing services for a specified division. This role balances and integrates strategic and operational perspectives within a specified span of appointment.

The Nursing Director accepts accountability for the governance and practice standards of nursing, the development and effectiveness of systems to support, evaluate and consistently improve nursing practice and health work environments, and the cost effective provision of health services within their span of appointment.

The Nursing Director will provide corporate professional nursing advice, leadership, and management for a specified service division or function by

¹⁰⁰⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, KS-3 (Kerim Skelton)

providing corporate management of nursing services for a specified nursing division in a Health Care Unit.

The 2008 position description listed Mr Skelton's functions, including:

- (1) ensuring the provision of 'professional high quality health care aimed at improving consumer outcomes';
- (2) ensuring the efficient and effective management of nursing services; and
- (3) contributing to the achievement of professional expertise through the maintenance of ongoing personal professional development / continuing education.

Similar functions, duties and responsibilities were set out in the position descriptions created in 2009 and 2011.

Mr Skelton gave evidence about his understanding of his role and responsibilities in relation to Oakden:

- The Service Manager had operational control of the facility prior to 2015. Mr Skelton gained operational control in about 2015.¹⁰⁰⁷
- Prior to about 2015 his role involved providing quality services, looking at complaints management quality, dealing with performance issues, providing advice around nursing performance.¹⁰⁰⁸
- He was to maintain close collaborative working relationships and to work in partnership with the Head of Unit, all Nursing Directors, Senior Managers and Adelaide Health leads.¹⁰⁰⁹
- He was to ensure the provision of professional high quality health care aimed at improving patient client health outcomes.¹⁰¹⁰
- He was to establish and participate in mechanisms for the review of consumer care.¹⁰¹¹
- He was to provide advice on how to best manage difficult clients or clients with difficult needs.¹⁰¹²
- He was to ensure efficient and effective management of nursing and midwifery services, managing workforce and performance of staff (this came within his control in 2015).¹⁰¹³
- Day to day operational control of the facility rested with the Service Manager. When she was not there, control fell to him.¹⁰¹⁴

A number of position descriptions for Ms Harrison are exhibited to the Corporate Affidavit. The first position description, dated 28 April 2010 and signed by Ms Harrison on 7 July 2010, summarises Ms Harrison's functions, duties and responsibilities as follows:

The Service Manager is accountable to the General Manager Statewide Services for the development and delivery of an integrated system of older person's mental health care within the catchment boundaries of the Central Northern Adelaide Health Service – Mental Health Directorate.

¹⁰⁰⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 21.35-23.5 (Kerim Skelton).

¹⁰⁰⁸ Ibid 23.6-18.

¹⁰⁰⁹ Ibid 24.7-15.

¹⁰¹⁰ Ibid 24.21-29.

¹⁰¹¹ Ibid 24.30-25.1.

¹⁰¹² Ibid 25.1-12.

¹⁰¹³ Ibid 25.13-24.

¹⁰¹⁴ Ibid 30.10-22.

The Service Manager is responsible and accountable to the General Manager Statewide Services for achieving a specific range of strategic and operational objectives for inpatient and community care that are consistent with SA Health mental health policies, practices and procedures, the mental health reform agenda and the regional priorities identified for the provision of older persons mental health services within the catchment boundaries of the Central Northern Adelaide Health Service – Mental Health Directorate. The Service Manager is accountable for the cost effective and efficient management of the full range of older persons mental health services located within the catchment boundaries of the Central Northern Adelaide Health Service – Mental Health Directorate including transitional / long stay and extended care services, community mental health terms and acute services.

Specific functions, duties and responsibilities listed in the position description include:

- The Service Manager is accountable to the General Manager Statewide Services for the: coordination, delivery and operational outcomes of Inpatient and Community Mental Health Services and Quality Mental Health Services within OPMHS.
- The Service Manager works collaboratively with the Director of Clinical Services and other discipline seniors within the Older Persons Mental Health Service for the provision of high quality mental health care services which meet both the National Mental Health Standards and all other professional standards.
- The Service Manager will work with the Clinical Director to achieve consistent practice.
- Ensures mental health care and support goals and objectives for consumers, their families and carers are achieved in an effective and time appropriate manner.
- Ensures that the financial and human resources allocated to the Older Persons Mental Health Service are utilised effectively and efficiently within budget.
- As a member of the senior management team, contributes to the pursuit of the strategic direction of SA Health, the Mental Health Unit and Older Persons Mental Health Service to implement mental health reform processes intended to improve mental health outcomes for consumers.
- Contributing to the development of an inspiring, relevant vision for the Service and leading others with these goals to create an effective work environment.
- Contributing to the implementation, monitoring and reviewing of SA Health Mental Health Plan and regional mental health plans.
- Ensuring the efficient and effective human resource management of the service by, amongst other things:
 - Developing the service workforce through empowering effective communication, motivating and creating a work environment that promotes life-long learning, diversity, mutual trust and respect.
 - Contributing to the achievement of best practice across the SA Health (Mental Health) service system and Region and Sector.
 - Leading, motivating and inspiring team members to achieve service excellence and innovation in service provision.
- Ensuring that “consumers’, carers’ and the community’s needs are addressed, and their expertise utilised in the development and operations of the service” by:
 - Facilitating consumer and carer participation in the implementation of policies and the evaluation of services.
 - Ensuring staff practice is consumer centred and recovery orientated.
 - Establishing and maintaining positive working relationships with consumers, employees and families and other key stakeholders through the use of open and transparent consultation and communication approaches.

A subsequent position description for Ms Harrison, dated 17 November 2011 and apparently signed by her on 2 December 2011, contains more extensive and more onerous duties, functions and responsibilities as Service Manager:¹⁰¹⁵

The Service Manager is accountable to the General Manager for the development and delivery of an integrated system of older person's mental health care within the catchment boundaries of the Adelaide Metro Mental Health Directorate (Central & Northern).

The Service Manager is responsible and accountable to the General Manager for achieving a specific range of strategic and operational objectives for inpatient and community care that are consistent with SA Health mental health policies, practices and procedures, the mental health reform agenda and the directorate priorities identified for the provision of older persons mental health services within the catchment boundaries of the Adelaide Metro Mental Health Directorate (Central & Northern). The Service Manager is accountable for the cost effective and efficient management of the full range of older persons mental health services located within the catchment boundaries of the Adelaide Metro Mental Health Directorate (Central & Northern) including transitional / long stay and extended care services, community mental health teams and acute services.

The Service Manager accepts accountability for the governance and practice standards of the multidisciplinary team; the development and effectiveness of systems to support, evaluate and consistently improve clinical practice and health working environments, and the cost effective provision of health services within their span of appointment.

Employees in this role will:

- *Lead a nursing and multi-disciplinary division or stream.*
- *Provide corporate management of nursing services for a specified nursing division/stream with oversight of multiple services.*
- *Provide corporate management of multi-disciplinary services for a specified the Sector [sic].*
- *Initiate and oversee innovations, systemic change processes, and coordination of responses to multi-disciplinary practice and health service needs within span of control.*
- *Integrate contemporary information and research evidence with personal knowledge and experience to support executive level decision making.*

It is worth identifying in some detail the functions, the duties and responsibilities specifically referred to in this position description. The Service Manager:

- Is accountable to the General Manager for the: coordination, delivery and operational outcomes of Inpatient and Community Mental Health Services and Quality Mental Health Services within the older persons mental health service.
- Is responsible for the management of all level 3 and 4 Nurses and Midwives within the span of the position.
- Works collaboratively with the Clinical Director, Nursing Directors and discipline seniors within the Sector for the provision of high quality mental health care services which meet both the National Mental Health Standards and all other professional standards.
- Will work with the Clinical Director to achieve consistent practice.
- Maintains cooperative and productive working relationships with all members of the health care team.

¹⁰¹⁵ Affidavit of Adam Dennis Monkhouse, 21 September 2017, 511.

- Develops strategic relationships with consumers, their families and carers.
- Ensures that the financial and human resources allocated to the Older Persons Mental Health Service are utilised effectively and efficiently within budget.
- As a member of the senior management team, contributes to the pursuit of the strategic direction of SA Health, the Mental Health Unit and the Older Persons Mental Health Service to implement mental health reform processes intended to improve mental health outcomes for consumers.

The following further functions are identified in the position description:¹⁰¹⁶

The Service Manager is responsible for ensuring the provision of professional high quality health care aimed at improving consumer health outcomes by:

- *Providing strategic leadership for innovation, change processes, and coordinated responses to emerging service and workforce needs within community mental health services within the Service.*
- *Contributing to the development of an inspiring, relevant vision for the Service and lead others with these goals to create an effective work environment.*
- *Contribute to and implement the corporate nursing professional practice framework established by the Director of Nursing.*
- *Integrating contemporary information and research evidence with personal knowledge and experience to support decision making.*
- *Contributing to policy development and service improvement initiatives by providing effective strategic leadership within SA Health, Directorate and Service level.*
- *Contributing to the change management approach adopted by the SA Health (Mental Health) service system, Directorate and Service.*
- *Implementing the corporate administrative and risk management frameworks within frame of responsibility.*
- *Ensuring that policies, standards and practices comply with all professional, industrial and legal requirements of the SA Health system.*
- *Contributing to the implementation, monitoring and reviewing of SA Health Mental Health Plan and directorate mental health plans.*
- *Co-managing with the Clinical Director an organisational portfolio which will entail innovation and change process for a specific service.*

Ensures the efficient and effective management of the services by:

- *Provide corporate management of multi-disciplinary services for a Service.*
- *Developing the Older Persons Mental Health Service workforce through empowering effective communication, motivating and creating a work environment that promotes life-long learning, diversity, mutual trust and respect.*
- *Managing human resources, financial, physical, technological and information requirements within a budget framework and culture of due diligence.*
- *Ensuring the skills of the multi disciplinary team are effectively utilised.*
- *Developing and guiding the use of information systems to inform decision making, and manage practice.*
- *Overseeing human resource systems implementation including processes and standards of staff recruitment, performance, development and retention.*
- *Leading, coaching, coordinating and supporting direct reports.*
- *Leading the establishment of healthy working environments, respectful relationships and learning cultures across span of appointment.*
- *Contributing to the achievement of best practice across the SA Health (Mental Health) service system and Directorate and Service.*

¹⁰¹⁶ Ibid 514-515.

- *Leading, motivating and inspiring team members to achieve service excellence and innovation in service provision.*
- *Ensuring recovery orientated practice occurs within all components of the service.*
- *Contributing to the maintenance of employees' rights and responsibilities, including participating in decision making as appropriate.*

Ensure that consumers', carers' and the community's needs are addressed, and their expertise utilised in the development and operations of the service by:-

- *Facilitating consumer and carer participation in the implementation of policies and the evaluation of services.*
- *Ensuring staff practice is consumer centred and recovery orientated.*
- *Establishing and maintaining positive working relationships with consumers, employees, families and other key stakeholders through the use of open and transparent consultation and communication approaches.*

Contributes to the achievement of professional expertise through the maintenance of ongoing personal professional development/continuing education:

- *Holding a contemporary professional practice portfolio containing professional development evidence commensurate with the level of autonomy, authority and influence expected of the role.*

The later positions descriptions, which are unsigned but created in 2015, set out similar functions, duties and responsibilities.

During her examination, Ms Harrison explained her understanding of her functions, roles and responsibilities:

- Mr Skelton had clinical practice responsibility for the nursing division.¹⁰¹⁷
- However, she was involved in rostering prior to mid-2015, and she would approve the roster.¹⁰¹⁸
- She could move staff between facilities within OPMHS.¹⁰¹⁹
- Dr Draper was responsible for clinical outcomes at the facility.¹⁰²⁰
- She had operational control of Oakden.¹⁰²¹
- She had ultimate responsibility for the hotel services, the leisure and lifestyle program and building issues at the facility, with the "buck" stopping with her.¹⁰²²
- Education programs were the joint responsibility of her and Mr Skelton.¹⁰²³
- Day to day responsibility for the facility lay with the Level 3 nurses.¹⁰²⁴
- Responsibility for the clinical quality of nursing fell to the clinical practice consultant (Ms Penery).¹⁰²⁵
- Day to day responsibility for the facility lay with the clinical practice consultant and clinical services coordinators.¹⁰²⁶ However, she conducted performance reviews for the clinical services coordinators.¹⁰²⁷

¹⁰¹⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 2.31-3.2 (Julie Harrison).

¹⁰¹⁸ Ibid 3.14-20.

¹⁰¹⁹ Ibid 5.34-6.3.

¹⁰²⁰ Ibid 6.35-7.2.

¹⁰²¹ Ibid 8.21-23.

¹⁰²² Ibid 9.27-33, 38.31-32.

¹⁰²³ Ibid 9.33-36.

¹⁰²⁴ Ibid 11.12-15.

¹⁰²⁵ Ibid 13.14-32.

¹⁰²⁶ Ibid 13.36-14.4.

- She was not responsible for drafting the restraint policy.¹⁰²⁸
- She saw Mr Skelton as ultimately responsible for ensuring compliance with the restraint policy but that she did not see that as abdicating any responsibility on her part.¹⁰²⁹
- She was not responsible for entering complaints on the SLS.¹⁰³⁰
- She was responsible for calling clinical governance committee meetings.¹⁰³¹
- Initially her primary role and responsibility was to regain accreditation at Oakden, although her role also encompassed all of the aged care services for the Central Northern Adelaide Health Service Mental Health Director.¹⁰³² In this role she had a number of direct reports including: hotel services, leisure and lifestyle team, allied health.¹⁰³³
- She spent the majority of her time at Oakden.¹⁰³⁴
- She said the role of the Service Manager, which she assumed at some point in 2009, 2010 or 2011, was the same as her role as Acting Aged Care Director, but later said there had been some changes to the roles and responsibilities. She could not recall those changes.¹⁰³⁵
- She said her role from mid-2015 was Service Manager and had responsibility for the community components of mental health service, forensics and older persons mental health services. She said the nursing directors took over all of the operational management for inpatient units and her role was then freed up to look at strategic and community matters.¹⁰³⁶ At this point she said she formally ceased to have responsibility for Oakden.
- She said that Mr Skelton had more global responsibilities about the operational components of Oakden, as well as around building, hotel services and allied health staff.¹⁰³⁷ However she conceded that she had at least some control over allied health staffing numbers.¹⁰³⁸
- She chaired the Aged Care management meeting, which later became the Older Persons' Governance meeting,¹⁰³⁹ a management meeting specifically around Makk and McLeay Nursing Home, performance meetings and NALHN corporate services meeting (due to her responsibility for the buildings, hotel services), and occupational health and safety meetings.¹⁰⁴⁰
- She admitted that she was responsible for requesting funding for building maintenance.¹⁰⁴¹
- She asserted that it was Mr Skelton's responsibility to decide if additional nursing was required, and that he would then approach her for her approval.
- She did not have authority to approve nursing resources or medical resources beyond one or two or three extra people and she did not have authority to increase the FTEs.¹⁰⁴²
- She was responsible for hotel services and leisure and lifestyle¹⁰⁴³

¹⁰²⁷ Ibid 19.22-27.

¹⁰²⁸ Ibid 46.9-24.

¹⁰²⁹ Ibid 46.25-31.

¹⁰³⁰ Ibid 57.20-24.

¹⁰³¹ Ibid 73.36-37.

¹⁰³² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 7.31-37 (Julie Harrison).

¹⁰³³ Ibid 8.10-18.

¹⁰³⁴ Ibid 11.21-24.

¹⁰³⁵ Ibid 14.25-34.

¹⁰³⁶ Ibid 22.28-23.4.

¹⁰³⁷ Ibid 27.1-6.

¹⁰³⁸ See ibid 54.5-15.

¹⁰³⁹ Ibid 34.33-37.

¹⁰⁴⁰ Ibid 35.5-29.

¹⁰⁴¹ Ibid 36.22-26.

¹⁰⁴² Ibid 37.18-38.3, 38.10-17.

¹⁰⁴³ Ibid 47.20-34.

- She could write business cases for further resources.¹⁰⁴⁴

In an affidavit she provided after her examination in answer to Mr Besanko's submissions, she said:

- She had day to day responsibility as Service Manager for OPMHS between Christmas Eve 2007 until October 2014.¹⁰⁴⁵
- Between October 2014 and February 2015 she was acting in another position and did not have day to day responsibility for Oakden.¹⁰⁴⁶
- Between March 2015 and June 2015 she was on sick leave.¹⁰⁴⁷
- In mid-2015 there was an organisational restructure and she no longer had operational control of inpatient facilities.¹⁰⁴⁸
- She did not have any duties from January 2016 onwards.¹⁰⁴⁹
- She disagreed that she was the "overall manager" of the facility and said that the management structure was a triumvirate structure.¹⁰⁵⁰
- She did not have generally autonomous control over Oakden, nor control over matters that fell outside her responsibilities.¹⁰⁵¹
- She made improvements to Leisure and Lifestyle Program including recruiting, relocating, arranging specific training sessions and arranging plans.¹⁰⁵²
- The Nursing Director "also" had the responsibility for managing reportable cases of abuse, although she would draft briefings to NALHN.¹⁰⁵³
- She was involved in dealing with complaints with Mr Moutakis.¹⁰⁵⁴
- She agreed that she should have done more whilst Service Manager, specifically by writing a paper outlining the issues at the facility, instead of seeing the tender process as the only means of putting the spotlight onto Oakden.¹⁰⁵⁵

Only one position description setting out Dr Draper's functions, roles and responsibilities was exhibited to the Corporate Affidavit. That is somewhat surprising given it is for the position of 'Director of Psychiatry (Aged Care)' and dated October 2004, not the position of Clinical Director, which Dr Draper occupied for the majority of the period covered by the ToR.

However other correspondence to which I will refer in this chapter from Ms Hanson to Dr Draper suggests that there are no other position descriptions that relate to Dr Draper. In any event, the job description summarised Dr Draper's functions, roles and responsibilities, at least while he held the position of Director of Psychiatry, as follows:¹⁰⁵⁶

The Director of Psychiatry (Aged Care) provides clinical leadership and specialist psychiatrist care for the provision of effective and efficient quality mental health services in the Northern/Western region within the Lyell McEwin Health Service Mental Health Division.

It also set out the responsibilities of the Director of Psychiatry as follows:¹⁰⁵⁷

¹⁰⁴⁴ Ibid 71.1-12.

¹⁰⁴⁵ Affidavit of Julie Harrison, 31 January 2018, [2].

¹⁰⁴⁶ Ibid [3].

¹⁰⁴⁷ Ibid [4].

¹⁰⁴⁸ Ibid [6].

¹⁰⁴⁹ Ibid [7].

¹⁰⁵⁰ Ibid [17].

¹⁰⁵¹ Ibid [17].

¹⁰⁵² Ibid [61].

¹⁰⁵³ Ibid [72].

¹⁰⁵⁴ Ibid [84] – [85].

¹⁰⁵⁵ Ibid [93].

¹⁰⁵⁶ Affidavit of Adam Dennis Monkhouse, 21 September 2017, 115.

¹⁰⁵⁷ Ibid 116.

- *[The Director of Psychiatry] [i]s responsible for:-*
 - *Providing clinical leadership to the Aged Care teams and units, by providing an authoritative forum for discussion and resolution of clinical issues.*
 - *Developing and maintain high clinical standards in both the inpatient and community services in consultation with Team Leaders.*
 - *Reviewing the clinical systems of care in the Aged Care areas of the Lyell McEwin Health Service Mental Health Division.*
 - *Assisting in consultation with Team Leaders the further development of integration of community and inpatient services.*
- *The Director of Psychiatry Aged Care will be required to:*
 - *Serve on Committees as required.*
 - *Supervise Psychiatry Trainees.*
 - *Provide Inservice Staff Development Programs.*
 - *Teach Medical Students.*
 - *Participate in research activities.*
- *Contribute to the ongoing commitment to policies and procedures of the Lyell McEwin Health Service Mental Health Division, by:*
 - *complying with Occupational Health, Safety and Welfare principles and procedures on a daily basis;*
 - *participating in Quality Improvement activities, including the identification of performance standards and increased efficiencies;*
 - *complying with Equal Employment Opportunity principles and procedures on a daily basis;*
 - *participating in Performance Enhancement activities, including annual performance appraisals;*
 - *ensuring the ongoing training and development of all staff supervised;*
 - *understanding and complying with the LMHS Delegations of Authority.*

Dr Draper said the following in respect of his duties at the Oakden Facility:

- His role involved strategy in planning for the development of new services. He said he attended various committees, oversight committees, management-type committees and governance committees, and he had medical staff at Oakden who would report direct to him.¹⁰⁵⁸
- His role was not predominately a clinical one – he was not providing the coalface clinical services.¹⁰⁵⁹
- His clinical psychiatry time at Oakden was limited to when Dr Flynn was on leave and when he was on-call.¹⁰⁶⁰ He was the on-call consultant one in every five or one in every six weeks.¹⁰⁶¹
- He attended Oakden after hours (usually weekends) when required to do the reviews under the MHA (i.e. if someone had been placed on a detention order, inpatient treatment order).¹⁰⁶²
- He used his Oakden office for administrative purposes such as paperwork.¹⁰⁶³
- He would not routinely walk through the wards.¹⁰⁶⁴

¹⁰⁵⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 12.9-36 (Russell Draper).

¹⁰⁵⁹ Ibid 8.28-41.

¹⁰⁶⁰ Ibid 8.46-9.6.

¹⁰⁶¹ Ibid 9.29-35.

¹⁰⁶² Ibid 9.37-44.

¹⁰⁶³ Ibid 10.34-44.

¹⁰⁶⁴ Ibid 10.46-11.8.

- The question as to what his role was a 'complex question'.¹⁰⁶⁵
- He was involved in strategy in terms of planning for the development of new services, medical staff reported to him, involvement in committees.¹⁰⁶⁶
- He was involved in the development of the new model of care but conceded there was no specific model of care for Oakden.¹⁰⁶⁷
- He was, with Mr Skelton and Ms Harrison, in charge of the day to day running of the facility.¹⁰⁶⁸
- He was not responsible for everything that happened at the facility clinically.¹⁰⁶⁹
- He was responsible for the day to day delivery of the clinical services.¹⁰⁷⁰
- He was a member of the OPMHS clinical governance committee in 2016.¹⁰⁷¹
- He chaired the OPMHS clinical governance committee.¹⁰⁷²
- People generally deferred to him as to the consumers who would be admitted to Oakden, but it was supposed to be a 'consensus decision'.¹⁰⁷³
- Dr Flynn made decisions about which consumers left Oakden and Dr Draper was not generally involved.¹⁰⁷⁴
- The site was not his responsibility.¹⁰⁷⁵
- Resource allocation in respect of the facility was not his responsibility.¹⁰⁷⁶
- His clinical time was largely in the Community Mental Health Service in Salisbury.¹⁰⁷⁷
- He also conducted his private practice.¹⁰⁷⁸
- He had to accept some responsibility for what occurred at the facility as Clinical Director.¹⁰⁷⁹

Ms Hanson wrote to Dr Draper on 23 August 2017 and in that letter identified Dr Draper's responsibilities:¹⁰⁸⁰

- C. At all material times your responsibilities [Dr Draper's responsibilities], as set out in your Job and Person Specification dated October 2004 included:
 - i. Providing clinical leadership to the Aged Care teams and units, by providing an authoritative forum for discussion and resolution of clinical issues.
 - ii. Development and maintaining high clinical standards in both the inpatient and community services in consultation with Team Leaders.
- D. At all material times you [Dr Draper] were required to observe the Code of Ethics for the South Australian Public Sector (Code). In particular, you were bound by the following Professional Conduct Standards which are set out in the Code:
 - i. Public sector employees will not at any time act in a manner that a reasonable person would view as bringing them, the agency in which they work, the public sector or Government into disrepute; or that is otherwise improper or disgraceful.

¹⁰⁶⁵ Ibid 12.9-19.

¹⁰⁶⁶ Ibid 12.17-36.

¹⁰⁶⁷ Ibid 12.41-13.24.

¹⁰⁶⁸ Ibid 14.4-6.

¹⁰⁶⁹ Ibid 14.27-29.

¹⁰⁷⁰ Ibid 14.8-36.

¹⁰⁷¹ Ibid 18.32-34.

¹⁰⁷² Ibid 21.40-22.3.

¹⁰⁷³ Ibid 35.28-32.

¹⁰⁷⁴ Ibid 35.34-42.

¹⁰⁷⁵ Ibid 52.20-26.

¹⁰⁷⁶ Ibid 53.18-21.

¹⁰⁷⁷ Ibid 72.6-10.

¹⁰⁷⁸ Ibid 72.13-14.

¹⁰⁷⁹ Ibid 94.3-16.

¹⁰⁸⁰ Letter from Finlaysons Lawyers to Jackie Hanson, 15 September 2017, RD-4.

- ii. Public sector employees will be diligent in the discharge of their role and duties and not act in a way that is negligent.
- iii. Public sector employees will comply with all legislation, industrial instruments, policies and procedures and lawful and reasonable directions relevant to their role as a public sector employee and/or to the performance of their duties.

Ms Hanson's reference to the job and person specification dated October 2004 would suggest that that was the only job and person specification which referred to Dr Draper's responsibilities and would explain why it was the only one provided in the Corporate Affidavit.

In that same letter she wrote of Dr Draper's additional responsibilities:

- He was the Chair or a senior member of the OPMHS Governance Committee.
- He was required to ensure the Governance Committee discussed and resolved clinical issues across OPMHS, with the Terms of Reference for the Governance Committee stating, relevantly, that it would:
 - provide overall leadership and direction for the OPMHS Division;
 - ensure the effective clinical governance of the OPMHS Division;
 - ensure consumer safety and quality of care is protected by using a risk management approach to all decision making;
 - oversee a range of unit level committees;
 - ensure compliance to legislation, professional standards and SA Health Directives are upheld;
 - and that its objectives included:
 - providing a safe, high quality service for consumers/patients, staff and the South Australian community; and
 - providing a culture that supported continuous improvement and patient centred care.
- He had overall responsibility for clinical governance at Oakden and across OPMHS and to ensure the Committee was effective and was achieving its purpose.
- He had overall responsibility for developing and maintaining high clinical standards at Oakden.
- He was to provide strategic leadership, workforce and organisational development to ensure local health systems use least restrictive practices and reduce the use of seclusion and restraint.
- He on behalf of OPMHS was responsible for ensuring staff at Oakden used least restrictive practices and reduced the use of seclusion and restraint.

Dr Draper responded to Ms Hanson's letter in writing on 15 September 2017 in which he denied the allegation that he had engaged in serious misconduct and in particular denied the allegations that he had:

- failed to deliver clinical leadership;
- failed to develop and maintain high clinical standards; and
- failed to meet his responsibilities under the restraint and seclusion guidelines.

He said 'his position is that he has exercised sound clinical judgement at all times and provided appropriate leadership and direction in relation to the Oakden Facility within the constraints of his role and available resources'.

Importantly, however, he did not deny that his responsibilities included the responsibilities identified by Ms Hanson and to which I have referred, although he did maintain that some of those responsibilities were shared with Ms Harrison and Dr Skelton.

Ms Hanson's assertions of Dr Draper's responsibilities are consistent with the evidence that was provided to me during my investigation, other than the evidence given by Dr Draper himself which I reject.

The position descriptions referred to above indicate that each of Mr Skelton, Ms Harrison and Dr Draper had wide ranging responsibilities including in respect of the Oakden Facility.

It was their job to offer appropriate care to the consumers and in that sense, as I have said, they had the immediate responsibility for the delivery of care and to ensure that the quality of care being provided to the consumers at the Oakden Facility was of an appropriate standard.

They were subject to the decisions of senior persons in NALHN in relation to the adequacy of the facility itself but they have no excuse for the failure to deliver adequate care to the consumers.

All three had the responsibility of ensuring that the sub-optimal care that was outlined in the Oakden Report did not occur. That is self-evident from the positions with which they occupied but also is consistent with their position descriptions exhibited to the Corporate Affidavit and the other evidence to which I have referred.

Dr Draper and Mr Skelton occupied their roles at the time that the Oakden Facility failed the AACQA accreditation audit. Ms Harrison was brought into the facility as a consequence of that failure.

Notwithstanding their knowledge of the state of the facility in 2007/2008 they allowed the same issues to develop to the point they had at the time of the Oakden Report or, in Ms Harrison's case, until the time her responsibilities ended.

They agreed that most of those issues were apparent during the nine years between the failure of the accreditation audit and the delivery of the Oakden Report.

If that is the case, and I accept that it was because it is consistent with all of the evidence before me, why did they not take steps to remedy those issues in the meantime?

Dr Draper appeared to have done very little about any of the issues at the Oakden Facility. There was a significant body of evidence to the effect that Dr Draper was very rarely at the facility and even more rarely on the wards.

Dr Draper had responsibility for the medical staff and clinical governance.

Mr Skelton had responsibility for the nursing staff and the delivery of appropriate care.

Both of them failed to provide the oversight and care that was required.

Dr Draper asserted that it was necessary for a finding to be made as to what his official functions were at any relevant time.

He pointed to the Corporate Affidavit which exhibited only one document that identified the extent of Dr Draper's professional responsibility and that was the Job and Person Specification for the position of 'Director Psychiatry (Aged Care)' dated October 2004 and signed by Dr Draper. That is so.

He asserted that SA Health claimed that was the only relevant job and person specification which addressed the duties and responsibilities of Dr Draper as at 2017. On the evidence that is also right.

In that document his role was expressed to be 'accountable to the Service Director. Professionally responsible to the Director of Clinical Services of the Lyell McEwin Health Service Mental Health Division for Clinical Matters'.

He was not responsible for funding, the physical state and layout of the building, allied health input or nursing staff. He asserted that none of those constituted his official functions.

He contended that there was no evidence that the medical staff that he was responsible and accountable for were involved in providing sub-optimal care.

He also contended that the Oakden Report could not be used to make findings that are adverse to Dr Draper because the Oakden Report makes no findings that are specific to Dr Draper. He contended that the Oakden Report could not be used without identifying the source material that underlay the findings made in the Oakden Report. He contended that the Oakden Report does not have the necessary clarity or cogency to support a finding of maladministration against Dr Draper.

Dr Draper addressed Mr Besanko's submissions and contended that the evidence did not support a finding that Dr Draper had engaged in substantial mismanagement in, or in relation to, the performance of his official functions.

He contended that no findings of negligence or incompetence could be made on the evidence that has been adduced and in particular because of the narrow responsibilities Dr Draper had as Clinical Director of OPMHS.

He contended that if a finding were made his career prospects, professional reputation and standing in the community would be ruined.

I have taken into account all of the submissions made by Dr Draper in the course of making these findings.

Dr Draper failed to discharge his responsibilities in respect of the Oakden Facility. According to the position description, it was his responsibility to ensure that there was 'effective and efficient quality mental health services' at the facility, and he was responsible for 'providing clinical leadership' and 'developing and maintaining high clinical standards'. He admitted that he had overall responsibility for the day to day delivery of clinical services, but he said he was not responsible for providing those services himself.

The clinical standards at the facility were sub-optimal and the evidence before me discloses that Dr Draper failed to provide clinical leadership in respect of the Oakden Facility.

He became chair of the OPMHS Clinical Governance Committee after Ms Harrison left in 2016. That committee was largely ineffective. There was a critical shortage of medical staff at the facility, to the point that in 2014 the facility was considered by some at least to be medically unsafe.

Dr Draper was aware that at least one medical practitioner thought that the facility was medically unsafe. He wrote a business case for an increase in psychiatry services but after it was declined he appears to have done very little further.

Whilst his evidence was in many respects inconsistent and unsatisfactory, he did concede at various points, with some qualifications, that:

- Most of the observations made in the Oakden Report were correct.¹⁰⁸¹
- The observations in the Oakden Report about the physical state of the premises were correct,¹⁰⁸² and that the facility was old fashioned and no longer fit for purpose.¹⁰⁸³
- The clinical files were inadequate.¹⁰⁸⁴

¹⁰⁸¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 6 November 2017, 94.22-28 (Russell Draper).

¹⁰⁸² Ibid 42.38-43.4.

¹⁰⁸³ Ibid 27.34-28.18.

¹⁰⁸⁴ Ibid 46.21-46.44.

- There was a lack of Allied Health support and this affected clinical care at the facility.¹⁰⁸⁵
- He had concerns about the quality of nursing at the facility (which he said he raised with Mr Skelton).¹⁰⁸⁶
- He had concerns about the leisure and lifestyle program (which he said he raised with Ms Harrison).¹⁰⁸⁷
- He was of the view that medical staffing at the facility was inadequate, albeit he denied that it was ever medically unsafe due to this.¹⁰⁸⁸

His evidence was that the vast majority of the failings identified in the Oakden Report were not his responsibility but were the responsibility of Mr Skelton or Ms Harrison or someone higher up within NALHN.

He refused to accept responsibility for medical staff and medical staffing levels and said that he did all he could to fix those issues but was stymied by a lack of funding. He denied that there was an inappropriate use of restraint or seclusion.

His responsibilities extended to the standard of the delivery of clinical care at the Oakden Facility which I have found was often poor. The instances of verbal and physical abuse by nursing staff; the poor nursing practices; the lack of staffing across the board, the inappropriate use of seclusion and restraint; the medication errors, the poor state of the clinical documentation; the lack of treatment and the fact that residents were often simply managed at the facility until they died are all matters relevant to the clinical care provided at the facility.

The matters to which I have referred demonstrate that the clinical care was poor. Dr Draper was responsible for the appropriateness of clinical care provided. It was a responsibility which he shared with Mr Skelton and Ms Harrison.

Dr Draper could have and should have done more to address the lack of medical staff at the facility. Because he was the chair he also bears responsibility for the ineffectiveness of the OPMHS Clinical Governance Committee.

I reject his evidence that seclusion and restraints were not used inappropriately. This evidence is inconsistent with the bulk of the evidence before me, and in particular the observations of Dr Groves and Dr McKellar and the matters set out in the Oakden Report, all of which I accept in preference to Dr Draper's evidence.

In light of the evidence of Dr Groves and Dr McKellar, it is difficult to believe that he genuinely believed that restraints and seclusion were not being used inappropriately. If that was his genuine view it was because he did not discharge his responsibilities in relation to the delivery of clinical care.

Mr Skelton was responsible for the nursing staff who overused restraints to the extent mentioned by Dr Groves.

Mr Skelton failed to discharge his responsibilities as Nursing Director and in particular:

- There was an absence of leadership on his part at the facility.
- Many nursing staff failed to meet appropriate standards. One striking example is Mr L (who is now deceased) who frequently abused patients physically and verbally.
- There were shortages of qualified nursing staff.
- The equipment was generally in a poor state.

¹⁰⁸⁵ Ibid 28.38-29.16, 34.3-23, 60.5-23, 60.25-27, 60.43-61.24, 69.2-10.

¹⁰⁸⁶ Ibid 53.13-16, 73.28-32.

¹⁰⁸⁷ Ibid 90.14-26.

¹⁰⁸⁸ Ibid 63.26-64.8, 64.14-36, 67.29-43, 74.43-75.3.

- The standard of nursing care at the facility was not one of ‘excellence in mental health nursing care’.
- On no view could it be said that the care provided at the facility was ‘professional high quality health care aimed at improving consumer outcomes’.
- The culture amongst the vast majority of nursing staff was poor, and unsafe and poor nursing practices were regularly practised.
- Many residents were simply managed at the facility on the basis that they would remain there for the rest of their lives or until the facility closed, as was anticipated.
- Few attempts were made to improve the outcomes for consumers, or attempt to treat or rehabilitate them so that they could be moved to a mainstream facility (which has since happened since the facility closed).
- There was a lack of effective training in a raft of different areas.
- In light of the Oakden Report and the other evidence, nursing services were not provided in an ‘efficient and effective’ way.

Moreover, Mr Skelton was aware of many of the issues pointing to sub-optimal care at the facility which meant that he did not comply with the responsibilities of his role. In his examination, he said:

- That he agreed with Finding 2 made in the Oakden Report, regarding the physical state of the facility and the negative effect that had on staff morale and some visitors to the facility.¹⁰⁸⁹
- That he agreed with Finding 3 made in the Oakden Report, regarding staffing models at the facility, subject to two qualifications (which I reject).¹⁰⁹⁰
- That he agreed with Finding 5 made in the Oakden Report, regarding the poor and secretive culture amongst staff at the facility.¹⁰⁹¹
- The Oakden Report accurately set out the nature of OPMHS nursing.¹⁰⁹²
- There was no model of care developed for OPMHS prior to 2012 and little was done to define a model specific to Oakden.¹⁰⁹³
- Oakden did not meet best practice.¹⁰⁹⁴
- The quality of the clinical documentation was not good.¹⁰⁹⁵
- The physical environment was not contemporary, was very run-down and was not homely.¹⁰⁹⁶
- It was a forgotten facility in terms of the grounds.¹⁰⁹⁷
- The facility did not receive Commonwealth accreditation for more than 3 years because of its physical state.¹⁰⁹⁸
- The physical environment was sub-optimal for patients.¹⁰⁹⁹
- The physical environment was always a topic of discussion.¹¹⁰⁰
- There was a shortfall in staffing levels which might have been as high as 44 FTE and as time went on there was an increasing reliance on personal care workers and enrolled nursing staff rather than highly skilled or trained staff.¹¹⁰¹

¹⁰⁸⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 93.30-94.3 (Kerim Skelton).

¹⁰⁹⁰ Ibid 101.30-102.17.

¹⁰⁹¹ Ibid 120.25-121.4.

¹⁰⁹² Ibid 87.4-87.8.

¹⁰⁹³ Ibid 90.26-90.36, 92.25-92.27.

¹⁰⁹⁴ Ibid 93.15-94.3.

¹⁰⁹⁵ Ibid 105.5-11.

¹⁰⁹⁶ Ibid 60.15-29.

¹⁰⁹⁷ Ibid 72.23-28.

¹⁰⁹⁸ Ibid 81.13-26.

¹⁰⁹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 28.4-29.2 (Kerim Skelton).

¹¹⁰⁰ Ibid 31.18-37.

¹¹⁰¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 96.20-97.9, 96.5-28, 73.21-26 (Kerim Skelton).

- He was only satisfied with some nursing staff and that the facility needed more mental health nurses.¹¹⁰²
- There was systemic under resourcing in mental health generally.¹¹⁰³
- There was a shortage of allied health staff at the facility, in that at times the facility needed a social worker, dietician and physiotherapist. He and Ms Harrison prepared a business case for a social worker.¹¹⁰⁴
- The facility was medically unsafe due to inadequate medical staffing numbers and a lack of a clinical pharmacist.¹¹⁰⁵
- Large numbers of patients were left restrained in chairs for the majority of the day, and some were locked in the corridors. He asserted that locking patients in the corridor was not seclusion. He said at least at times, that the use of restraints were not always a last resort. He said that the use of restraints for the staff's convenience at times was not inappropriate.¹¹⁰⁶
- The air-conditioning was inadequate, the equipment was old, and often the equipment was broken and the amount of equipment was insufficient.¹¹⁰⁷
- The environment at the facility was not set up for aged care related issues and mental health issues.¹¹⁰⁸
- The management structure at the facility was cumbersome and unclear for staff, and meant that the facility did not function as smoothly as it could have.¹¹⁰⁹

The breadth of his functions stated in the 2008 position description, and restated in later position descriptions, meant that he was responsible for all of the issues of which he was aware and failed to ensure the provision of 'professional high quality health care aimed at improving consumer outcomes'.¹¹¹⁰

However, even if some of these issues and failings were not strictly matters for which he was directly responsible, for example inadequate medical staffing levels and inadequate Allied health support, he was responsible for the standard of nursing care at the facility which he knew was not 'efficient and effective'. He also knew that it did not meet 'a standard of excellence in mental health nursing care'; and it was grossly deficient.

As I have mentioned he and Ms Harrison were part of the reason for the culture of secrecy at the facility. The standard of nursing care provided at the facility was ultimately his responsibility and that of Ms Penery. It is clear that he failed to discharge his responsibilities because he knew that the care being provided was inadequate and he did not rectify it.

¹¹⁰² Ibid 78.35-79.11, 78.1-12, 79.16-29, 117.33.118.5.

¹¹⁰³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 24.21-31 (Kerim Skelton).

¹¹⁰⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 73.31-74.10 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 38.12-23, 39.13-27 (Kerim Skelton).

¹¹⁰⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 69.16-36 (Kerim Skelton).

¹¹⁰⁶ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 107.31-108.30, 111.23-112.16, 114.28-115.19, 122.34-123.14 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 56.33-57.17, 57.26-58.14, 59.3-25, 60.13-29, 68.13-34 (Kerim Skelton).

¹¹⁰⁷ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, 60.10-29, 81.28-82.2, 82.22-83.2 (Kerim Skelton); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 33.31-34.8 (Kerim Skelton).

¹¹⁰⁸ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 35.29-36.2 (Kerim Skelton).

¹¹⁰⁹ Ibid 9.3-8, 9.25-10.22, 10.34-11.4, 11.18-26.

¹¹¹⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 October 2017, KS-3 (Kerim Skelton); document entitled 'Job and Persons Specification approval – Nursing Director Clinical Practice – Mental Health', 4 August 2011, 2017-000535-E0007 (AGroves1) DOC-000000076.

The insufficiency of resources does not account for the standard of nursing care, the state of the clinical documentation and the culture of secrecy at the Oakden Facility which could have been rectified without the allocation of further resources.

Ms Harrison failed to discharge her responsibilities as Service Manager and in particular:

- She and the other senior members of OPMHS (Dr Draper and Mr Skelton) did not work collaboratively to provide 'high quality mental health care services which [met] both the National Mental Health Standards and all other professional standards'.
- Ms Harrison and Dr Draper did not work to achieve consistent practice at the facility.
- She did not ensure that the mental health care and support goals and objectives for consumers, their families and carers were achieved in an effective manner. Patients were often mistreated and they were simply managed until they died at the facility.
- In light of the serious staff shortages, and the shortages of particular types of staff, like Allied health staff, trained mental health nurses and medical staff, as well as the culture at the facilities, Ms Harrison did not ensure that the 'financial and human resources allocated to the Older Persons Mental Health Service [were] utilised effectively and efficiently within budget', even though the budget for OPMHS was inadequate.
- There is little evidence that as a member of the senior management team of OPMHS Ms Harrison contributed to the pursuit of the strategic direction of OPMHS 'to implement mental health reform processes intended to improve mental health outcomes for consumers'. The same criticism can be made of Mr Skelton and Dr Draper.
- There is little evidence that Ms Harrison contributed to the development of an 'inspiring, relevant vision for the Service' or that she was 'leading others with these goals to create an effective work environment'. Indeed in light of the poor culture at the facility and the staff issues she did neither of those things.
- Ms Harrison did not ensure 'the efficient and effective human resource management of the service', by developing the service workforce through empowering effective communication, motivating and creating a work environment that promoted life-long learning, diversity, mutual trust and respect, or contributing to the achievement of best practice, or 'leading, motivating and inspiring team members to achieve service excellence', in light of the poor culture that existed at the facility, the poor staff morale and the serious staffing shortages.
- Ms Harrison did not ensure that 'consumers', 'carers' and the community's needs [were] addressed', or that staff practice was consumer centred and recovery orientated, or that positive working relationships with consumers, employees and families were established through the use of open and transparent consultation and communication approaches, in light of the culture of secrecy that existed at the facility, the poor treatment and care received by many consumers and the poor culture among staff at Oakden. The consumers, particularly in Makk and McLeay were simply managed on the basis that they had a bed for the rest of their lives or until the facility closed, as was anticipated, which was inappropriate because on the evidence many consumers who were at Oakden when it closed have been successfully moved to mainstream aged care facilities.
- Ms Harrison did not ensure 'the provision of a professional high quality health care aimed at improving consumer health outcomes', in light of the poor care provided at the facility, the poor culture and staff practices, the poor morale, the staff shortages, the poor state of the equipment and the physical state of the premises.
- She did not ensure the efficient and effective management of the service by 'developing the [OPMHS] workforce through empowering effective communication, motivation and creating a work environment that [promoted] life-long learning, diversity, mutual trust and respect', 'managing human resources, financial, physical, technological and information requirements within a budget framework and culture of

due diligence', 'overseeing human resource systems implementation including processes and standards of staff recruitment, performance, development and retention', 'leading the establishment of health working environments [and] respectful relationships', 'contributing to the achievement of best practice', 'leading, motivating and inspiring team members to achieve service excellence and innovation in service provision' or 'ensuring recovery orientated practice occurs within all components of the service', in view of the way many consumers were managed and treated; the poor culture and staffing practices; the staffing shortages; the poor state of the equipment; and the physical state of the premises.

- She admitted that she was responsible for the building, the leisure and lifestyle program and hotel services, and that she had some responsibility over nursing and Allied Health staffing levels, of which there were significant shortages. The leisure and lifestyle program, particularly for those consumers housed at Clements House, was less than optimal and in so far as Clements' consumers were concerned there was no independent leisure and lifestyle program.
- The building was not fit for purpose.
- By her own admission she said she could have written a paper outlining her concerns about the Oakden Facility, but never did. She admitted that it was part of her role to write business cases, but the evidence before me suggests that she wrote few such cases. For those reasons those superior to her within NALHN and its predecessors were not aware of the physical state of the premises, the staffing shortages and the insufficiency of equipment.

Other evidence shows that Ms Harrison was aware of many of the issues at the Oakden Facility which meant that she did not comply with the responsibilities of her role:

- She agreed with 'most things' set out in the Oakden Report.¹¹¹¹
- She agreed that there was no model of care at the facility.¹¹¹²
- She said that the building was not appropriate for modern day treatment, that it was old, outdated, overcrowded and in a poor condition; that Makk was malodorous, gloomy, cluttered and uninviting; and that there were possums in the building.¹¹¹³ She also said that in 2007 there was no front entrance and a rusty old fence, and that there were always cracks in the ground.¹¹¹⁴
- She felt that the nursing ratio for the facility was too low and as a consequence she rostered above the ratio.¹¹¹⁵
- She accepted that the clinical notes were deficient.¹¹¹⁶
- She had concerns about the quality of nursing staff in 2007. She thought that the quality improved from then until 2013 but then declined again, with good staff leaving the facility as a consequence of the planned closure. Quality replacements did not apply for that same reason.¹¹¹⁷ She was concerned about the significant number of overseas trained nurses, who had minimal clinical education and poor language skills.¹¹¹⁸

¹¹¹¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 76.16-77.6 (Julie Harrison).

¹¹¹² Ibid 25.19-28.

¹¹¹³ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 18.22-19.21 (Julie Harrison).

¹¹¹⁴ Ibid 18.22-19.21, 21.23-26, 50.11-16, (pt 2)16.12-29; Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 32.21-29, 34.11-15 (Julie Harrison).

¹¹¹⁵ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 47.19-48.19 (Julie Harrison).

¹¹¹⁶ Ibid 60.26-60.28.

¹¹¹⁷ Ibid 20.23-34, 28.8-22, 29.4-13, 52.14-23, 61.9-28, 33.1-6, 56.13-28, 65.

¹¹¹⁸ Ibid 20.25-34, 65.

- She admitted that there was a shortage of allied health staff in 2015 but said that business cases were not approved because of a lack of funding.¹¹¹⁹
- She said that there was a culture of negativity at the facility and staff morale was adversely affected by the proposed closure of the facility.¹¹²⁰
- She said that the purchase of certain items of equipment was deferred due to the planned privatisation of the facility, and the air-conditioner was old.¹¹²¹
- She agreed that there was a shortage of medical staff at the facility, and that a further medical officer was required.¹¹²²

On her own evidence, she was aware of most of the issues identified in the Oakden Report, and in any event, the specific issues identified above.

Ms Harrison failed to discharge her responsibilities in respect of the Oakden Facility.

By her own admission she had operational control of the facility, at least until early 2015. She had control over the state of the building and the equipment, as well as the leisure and lifestyle program. She had responsibilities in respect of staffing numbers and resourcing. She had responsibilities in respect of the standard of care being provided at the facility and the culture amongst staff.

Some of these responsibilities in relation to the care being provided were undoubtedly shared with Mr Skelton and Dr Draper, but her position descriptions show that she had responsibilities in respect of the standard of care being provided at the Oakden Facility.

She had the responsibility to ensure 'the provision of professional high quality health care aimed at improving consumer health outcomes', which was 'recovery orientated'.¹¹²³

She was aware of the poor state of the building, the state of staffing, including the lack of allied health staff, the lack of equipment, the culture of negativity amongst staff, and the problems with the leisure and lifestyle program (at times, particularly in relation to Clements).

The evidence is unclear as to precisely what authority she had to incur expenditure and engage resources but it is not necessary to resolve this question because she occupied a position that permitted her to request more resources. Indeed it was part of her role to write business cases for the Oakden Facility.

Ultimately many of the failings at the Oakden Facility were her responsibility, either by her own admission or by reference to her position descriptions.

She did not act appropriately, or in many cases at all in respect of serious issues.

By her own admission she could have done more.

She could have set out the issues at the Oakden Facility that she was aware of in a briefing paper and brought it to the attention of those senior in NALHN. She did not.

¹¹¹⁹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 49.11-36, 53.3-5 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 5.20-7.18, 28.1-8 (Julie Harrison).

¹¹²⁰ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 32.30-37, 33.1-6 (Julie Harrison).

¹¹²¹ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, 36.5-17 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 28.17-31 (Julie Harrison).

¹¹²² Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 19 October 2017, (pt 2) 72.17-29 (Julie Harrison); Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 23 October 2017, 43.16-18, 44.1-8 (Julie Harrison).

¹¹²³ Affidavit of Adam Dennis Monkhouse, 21 September 2017, 755, 832.

FINDINGS IN RESPECT OF DR DRAPER, MS HANSON AND MR SKELTON

Those who had the immediate responsibility at the Oakden Facility blame NALHN for under resourcing the facility and for failing to provide sufficient resources in particular for adequate staffing.

NALHN failed to provide adequate resources to the Oakden Facility but in a sense that is a consequence of NALHN not knowing the extent of the problems at Oakden and the resources necessary to address those problems.

In my opinion Dr Draper, Mr Skelton and Ms Harrison all failed to seek adequate resources and failed to inform NALHN well enough so that NALHN could appreciate the need for the provision of those resources.

They could have complained to the Chief Psychiatrist about the inadequacy of resources.

They could have complained to the PCV and/or the Community Visitors who operated within the CVS.

They could have reported the myriad of issues to the OPI.

They did make sporadic complaints and reports to those to whom they had the responsibility of reporting but they were not sufficient to discharge their duties.

There was no model of care at the Oakden Facility.

The failure to have a model of care must rest with the Service Manager, the Clinical Director and the Nursing Director.

It is impossible to think that the three persons who had the day-to-day responsibility for Oakden could not have known of the matters found in the Oakden Report during the time that they worked at Oakden.

It is inevitable that a finding must be made that they have engaged in conduct that involves substantial mismanagement in, or in relation to, the performance of their official functions.

Their failure to act in the face of the significant issues at the Oakden Facility permits no other finding.

Accordingly, I find that Dr Draper, Ms Harrison and Mr Skelton all engaged in maladministration in public administration, for the reasons identified in this report.

13.8.3 Ms Penery

Ms Penery was at the Oakden Facility throughout the period addressed by the ToR, including after the facility failed the AACQA accreditation audit, and remained there until her employment was terminated on 4 August 2017.

Seven different position description documents relevant to Ms Penery were exhibited to the Corporate Affidavit. Some but not all of these appear to have been signed by Ms Penery.

The position description attached to her contract of employment dated 14 August 2008, and it would seem signed by her on 2 September 2008, identified her responsibilities, relevantly, as follows:

- Personally accountable and responsible for safe, effective, nursing practice.
- Engaging in professional development and maintenance of own clinical competence.
- Consulting and collaborating with other health care professionals both within the health service and the community to ensure optimal consumer outcomes.

- Ensuring “high quality consumer care in the area of clinical specialty aimed at improving consumer health outcomes” through, relevantly:
 - Integrating contemporary information and evidence with personal experience to support the decision making, innovative thinking and objective analysis at this level.
 - Contributing specific expertise to nursing practice through clinical protocol and standards development.
 - Applying and sharing expert clinical knowledge to improve consumer care.
 - Providing expert clinical nursing care and interventions and/or individual care management to a defined population of consumers.
 - Applying nursing expertise to assess consumers, select and implement different therapeutic interventions and/or supporting programs and evaluating consumer progress in a multidisciplinary primary health care setting.
 - Contributing expert nursing assessment and advice to local clinical teams to achieve integrated nursing care within a risk management framework.
- Contributing to clinical leadership and support for the specific area of clinical specialty by:
 - Leading nursing clinical practice within the professional practice framework established by the Director of Nursing.
 - Maintaining productive working relationships and managing conflict resolution.
 - Contributing specific expertise to monitoring and evaluative research activities in order to improve nursing practice and service delivery.
 - Undertaking the nursing care role with a significant degree of independent clinical decision making in the area of personal expertise.
 - Contributing to the development and sustainability of nursing skills for the needs of the specific population group using systems of resource and standards promulgation.
- Contributing to the achievement of professional expertise through personal professional development/continuing education and teaching.
- Providing leadership to and facilitating of a [sic] professional development of nurses within a designated unit/service by:
 - Leading the nursing team within the professional practice framework established by the Director of Nursing.
 - Developing and maintaining a learning environment, taking a coaching approach to team development, individual capability development and performance management.
 - Maintaining productive working relationships and managing conflict resolution.
- Providing and engaging in regular clinical supervision.
- Contributes to and complies with policies, procedures and practices by:
 - Complying with all legislation, Government policies and procedures, the ANMC Code of Professional Conduct for Nurses in Australia and the Code of Conduct for South Australian Public Sector Employees, and in relation to people affected by mental disorders and/or mental health problems,
 - The United Nations Principles on the Protection of People with a Mental Illness and Improvement in Mental Health Care.
 - The Australian Health Ministers’ Mental Health Statement on Rights and Responsibilities.
 - Mental Health, equal opportunity, anti-discrimination and disability services legislation.
 - Complying with all CNAHS/National Mental Health Service policies, procedures and operating practices.

- In consultation with Nursing Director/Service Manager contributes to the development of organisational policy.
- Ensuring practice is consistent with departmental/organisational/unit policies, standards and legal/regulatory compliance.
- Applying standards and benchmarks for consumer care in the practice setting consistent with current evidenced based clinical care.

Similar, but not identical, responsibilities are identified Ms Penery's other position descriptions exhibited to the Corporate Affidavit. The copies that have been exhibited were not signed by Ms Penery.

Relevantly, Ms Penery gave evidence that she was responsible for overseeing clinical practice and implementing best practice across OPMHS, which included the Oakden Facility.¹¹²⁴

She was also responsible for ensuring that policies and procedures that were amended were adopted.¹¹²⁵

She said that she spent the majority of her week at the Oakden Facility and that she toured the wards or units each day, with most of her time being spent on the floor.¹¹²⁶

She said in her examination:

- She agreed with findings 1 to 3 of the Oakden Report.
- She agreed with some but not all of finding 4 of the Oakden Report, which was that there was a failure of the clinical governance framework.¹¹²⁷
- She agreed with finding 5 of the Oakden Report on the basis that there was a poor culture however that was more so in recent times but not necessarily in 2007.¹¹²⁸
- There was a lack of maintenance at the facility,¹¹²⁹ issues with alarm bells,¹¹³⁰ there were issues with the grounds,¹¹³¹ the paving was uneven, there were cracks in the ground, there was a lack of an outdoor area,¹¹³² bathroom facilities were not inviting,¹¹³³ and the facility was inadequate.¹¹³⁴
- There was a lack of nursing staff,¹¹³⁵ the registered nurses outbalanced the mental health nurses,¹¹³⁶ and there was a lack of aged care nurses at the facility.¹¹³⁷
- She had concerns about the lack of allied health staff.¹¹³⁸
- Restraints were used in McLeay on a select number of residents who were high fall risk and sometimes for behaviour management purposes.¹¹³⁹
- Medication issues occurred despite training being provided.¹¹⁴⁰
- The rate of injuries was high notwithstanding the action taken by staff.¹¹⁴¹
- Senior staff needed upskilling and there was no clear leadership.¹¹⁴²

¹¹²⁴ Evidence to the Independent Commissioner Against Corruption Oakden Maladministration Investigation, Adelaide, 17 November 2017, 7.27-32 (Merrilyn Penery).

¹¹²⁵ Ibid 7.27-32.

¹¹²⁶ Ibid 9.29-44.

¹¹²⁷ Ibid 22.30-23.19.

¹¹²⁸ Ibid 23.21-27.

¹¹²⁹ Ibid 29.26-39.

¹¹³⁰ Ibid 34.32-35.5.

¹¹³¹ Ibid 35.7-13.

¹¹³² Ibid 35.15-28.

¹¹³³ Ibid 35.38-47.

¹¹³⁴ Ibid 36.2-4.

¹¹³⁵ Ibid 31.4-10.

¹¹³⁶ Ibid 33.10-16.

¹¹³⁷ Ibid 33.29-34.

¹¹³⁸ Ibid 34.10-17.

¹¹³⁹ Ibid 26.41-45.

¹¹⁴⁰ Ibid 23.6-8.

¹¹⁴¹ Ibid 23.10-19.

¹¹⁴² Ibid 29.43-47.

- Some consumers had been left unattended on the floor.¹¹⁴³
- The standard of care was sub-optimal.¹¹⁴⁴
- Staff were at each other's throats.¹¹⁴⁵
- There were cultural issues including conflict between staff,¹¹⁴⁶ a poor nursing culture,¹¹⁴⁷ consumers were treated disrespectfully and some staff had a custodial power approach,¹¹⁴⁸ and staff from Glenside brought a poor culture with them.¹¹⁴⁹

In her submissions in response to Mr Besanko's submissions she identified in the transcript of her examination her acceptance of her knowledge of the issues at the Oakden Facility. Her evidence shows that:

- her observations of the facility 'mostly' accord with the Oakden Report.
- the facility was poorly maintained, it was not appropriate for the service... it wasn't what was expected in this day and age... the majority of the Oakden Report is reasonable.¹¹⁵⁰
- patients were left unattended on the floor but were left in that state as it was safer than trying to get them up.¹¹⁵¹
- medication errors continued despite the training.¹¹⁵²
- the rate of injuries remained high notwithstanding the action taken.¹¹⁵³
- her observations of the culture, at least in more recent times, accord with the Oakden Report.¹¹⁵⁴
- the culture of some staff was 'disrespectful' and 'custodial'.¹¹⁵⁵
- attempts were made to re-educate wayward staff and Ms Penery made an attempt in that regard herself.¹¹⁵⁶ Restrictive practices were used and in McLeay they were used frequently on a select number of high risk consumers and in Clements they were used sometimes for behavioural management.¹¹⁵⁷
- restraints had been used inappropriately prior to the introduction of the SLS system.¹¹⁵⁸
- the standard of care became sub-optimal.¹¹⁵⁹
- infrastructure/maintenance issues were obvious.¹¹⁶⁰
- equipment was deficient.¹¹⁶¹
- education was deficient.
- senior staff on the wards needed upskilling and there was no clear leadership on the floor.¹¹⁶²
- there was a lack of nursing staff.¹¹⁶³
- there was a dissatisfaction amongst the staff who were at each others' throats.¹¹⁶⁴

¹¹⁴³ Ibid 21.10-26.

¹¹⁴⁴ Ibid 29.5-15.

¹¹⁴⁵ Ibid 31.41-47.

¹¹⁴⁶ Ibid 36.43-37.6.

¹¹⁴⁷ Ibid 31.21-32.6.

¹¹⁴⁸ Ibid 24.28-25.17.

¹¹⁴⁹ Ibid 23.29-24.26.

¹¹⁵⁰ Ibid 20.40-44.

¹¹⁵¹ Ibid 21.10-26.

¹¹⁵² Ibid 23.6-8.

¹¹⁵³ Ibid 23.10.19.

¹¹⁵⁴ Ibid 23.21-27.

¹¹⁵⁵ Ibid 24.22-25.17.

¹¹⁵⁶ Ibid 28-12.

¹¹⁵⁷ Ibid 26.37-45.

¹¹⁵⁸ Ibid 27.21-24.

¹¹⁵⁹ Ibid 29.5-15.

¹¹⁶⁰ Ibid 29, 30, 34.34-36.4.

¹¹⁶¹ Ibid 29.

¹¹⁶² Ibid 29.43-47.

¹¹⁶³ Ibid 31.4-7.

¹¹⁶⁴ Ibid 31.41-47.

- there were concerns about the side stepping of culture issues in relation to certain staff members.¹¹⁶⁵
- registered nurses started to out number the mental health trained nurses which caused problems with behavioural management.¹¹⁶⁶
- there was a shortage of medical staff.¹¹⁶⁷
- there was a shortage of allied health staff.¹¹⁶⁸
- there was an understanding amongst staff that the facility would be closed which affected attitudes, morale and generated conflict.¹¹⁶⁹
- staff were sent to Oakden for poor performance and when they failed to meet mental health qualification standards.¹¹⁷⁰
- clinical documentation was poor but improved in more recent times.¹¹⁷¹
- two sets of files were kept but there was nothing sinister about that practice.¹¹⁷²
- community visitors were generally accompanied or observed while on the wards for safety reasons but were unaccompanied in the leisure and lifestyle area.¹¹⁷³
- work was done in advance of planned visits by AACQA to ensure that standards would be met.¹¹⁷⁴

In her submissions she reinforced the fact that she was aware of all of the matters mentioned above and indeed brought my attention to those matters.

She said that some of those matters were brought to the attention of others including the Nursing Director.

In answer to Mr Besanko's submission she said that she appeared to have done little if anything to prevent the failings which have been identified. She repeated that she was aware of many incidents' of abuse and poor nursing practice. She said that she raised concerns about the culture both with the staff and HR.¹¹⁷⁵ She said she conveyed her concerns about the physical state of the facility to the Quality Officer.

She requested repairs to the building.¹¹⁷⁶ She raised her concerns with the Nursing Director about the lack of nursing staff.¹¹⁷⁷

She spoke to Mr Skelton the Nursing Director about the side stepping culture issues.¹¹⁷⁸ She raised concerns with Dr Draper about the shortage of medical staff.¹¹⁷⁹ She also said that she raised concerns about the lack of allied health staff.¹¹⁸⁰

She said that she raised issues with the CSC in relation to maintenance, the Nursing Director and the PCV in particular about uneven paving, cracks in the ground, the state of the gardens, the lack of a safe outdoor area and the planter box.¹¹⁸¹ She said she was aware of the demoralisation and conflict amongst staff and she was prolifically aware of steps taken to address those issues.¹¹⁸²

¹¹⁶⁵ Ibid 32.1-31.

¹¹⁶⁶ Ibid 33.10-16.

¹¹⁶⁷ Ibid 33.44-34.8.

¹¹⁶⁸ Ibid 34.10-17.

¹¹⁶⁹ Ibid 36.30-37.6.

¹¹⁷⁰ Ibid 37.17-39.

¹¹⁷¹ Ibid 37.41-38.1.

¹¹⁷² Ibid 28.3-39.38.

¹¹⁷³ Ibid 41.1-41.32.

¹¹⁷⁴ Ibid 42.17-24.

¹¹⁷⁵ Ibid 25.13-17, 31.21-44.

¹¹⁷⁶ Ibid 31.1-2.

¹¹⁷⁷ Ibid 31.4-19.

¹¹⁷⁸ Ibid 32.2-31.

¹¹⁷⁹ Ibid 33.44-34.8.

¹¹⁸⁰ Ibid 34.10-13.

¹¹⁸¹ Ibid 35.7-28.

¹¹⁸² Ibid 36.26-37.15.

It was put in her submissions that it might be inferred that she was one of the persons who became demoralised for the reasons that others did. She said in paragraph 55 of her submissions:

55. It might reasonably be inferred that Ms Penery was one of those who, over time, became demoralised for the same reasons that others did, including:

55.1. Staff understood the facility was to be closed. This adversely affected morale and caused a loss of momentum (T36.26-41).

55.2. There was conflict among staff: the environment wasn't very good, shift lengths were not conducive to good staff mental health, and staff were physically and verbally abused by consumers (T36.45-37.6).

55.3. Concerns were routinely brushed aside or, worse, used against the notifier. When Ms Penery raised concerns about Mr Lynch with Mr Skelton she was told:

55.3.1. 'It will just be for a little while and then he'll go back to Clements'; and

55.3.2. '...just to take a step backwards and take a breath before I called their practice into account'.

I have considered her submissions. Nevertheless, the evidence is clear.

She knew most of which the Oakden Report found. However her evidence shows that she failed to bring this to the attention of the authorities except in some respects to Mr Skelton to whom she reported because he was the Nursing Director.

She failed to bring the poor state of affairs to the attention of someone who might do something about it.

I accept that Dr Draper and Mr Skelton did not take any steps in answer to her complaints but that was a reason to escalate her complaints to persons senior at NALHN. She knew that these vulnerable people were being kept in a facility that was not fit for purpose and which was providing them sub-optimal care.

She had responsibility for the nursing care subject to Mr Skelton's directions and if she was not able to improve the standard of that nursing care she had an obligation to bring the poor standard of nursing care to the attention of those who had responsibility for nursing care outside of Oakden but within NALHN.

She failed to do that.

It is difficult to accept her evidence that she was not aware of some of the instances of abuse and poor nursing practices having regard to the fact that she was in the institution for a period of the full ten years covered by the ToR, and in view of her position as CPC (and a nurse at Oakden before that).

As the Clinical Practice Coordinator (CPC) it seems to me that she had an obligation to report conduct of the kind that she agreed occurred to her superiors.

She was aware of the two sets of clinical documentation but took no steps to stop the practice or draw it to the attention of AAQCA.

Her position descriptions imposed very onerous obligations on her in respect of the standard of clinical and nursing care at the Oakden Facility. For example she was personally

accountable and responsible for safe, effective, nursing practice, and responsible for ensuring 'high quality consumer care in the area of clinical specialty aimed at improving consumer health outcomes', as well as being responsible for clinical leadership and ensuring compliance with all codes, standards, policies, procedures and legislation relating to clinical care. She was responsible for preventing or resolving these issues and failings. Despite this, and despite being aware of the issues, and despite being at the facility for nearly the duration of the period covered by the ToR, she took little action.

Her inaction is inexplicable.

Ms Penery was subsequently dismissed because she failed to make a report to AHPRA about a catheterisation incident or report it on the SLS.

She said her failure was not intentional or considered and that she may have been distracted and I have accepted that evidence.

For that reason I do not make a finding of maladministration in relation to the failure to report that incident.

Putting aside that issue, it seems to me that Ms Penery failed in her duty to report conduct that involved serious and systemic poor nursing practices at the Oakden Facility over a period of ten years and in that respect failed in the performance of official functions.

I think because the conduct of which she was aware was so egregious, it must be said that she engaged in conduct that amounted to a substantial mismanagement in, or in relation to, her official functions.

For that reason, I make a finding of maladministration in respect to her conduct.

13.9 NALHN

NALHN is an incorporated hospital. The purpose of its incorporation is to promote the objects of the HCA. Section 4 of the HCA addresses the objects:

The objects of the Act are—

- (a) *to enable the provision of an integrated health system that provides optimal health outcomes for South Australians; and*
- (b) *to facilitate the provision of safe, high-quality health services that are focussed on the prevention and proper management of disease, illness and injury and to facilitate efficiencies through the use of certain facilities for veterinary science; and*
- (c) *to facilitate a scheme for health services to meet recognised standards.*

If NALHN delivers its services in a facility that is not fit for purpose and provides sub-optimal clinical and nursing care to vulnerable people it has manifestly failed to promote all three of the objects of the HCA.

The principles which are to be applied in connection with the operation of the HCA include:

- (a) *the protection of the public and the interests of people in need of care related to their health should be the highest priorities in the provision of health services;*

[...]

- (f) *health services should be provided as part of an integrated system—*

- (i) *that includes all aspects of health promotion and disease, illness and injury prevention so as to maximise community health and well-being; and*
- (ii) *that supports services or programs designed to promote early intervention in detecting and responding to disease, illness or injury; and*
- (iii) *that provides for the effective and safe management and treatment of disease, illness or injury, including through self-management of chronic or other diseases; and*
- (iv) *that supports improved health outcomes for communities with particular health needs; and*
- (v) *that promotes a whole of Government approach to advance and improve health status within the community; and*
- (vi) *that seeks to reduce in-patient hospitalisation and dependence on emergency and out-patient services within hospitals; and*
- (vii) *that promotes the efficient and economic provision of services;*
- (g) *health services should meet the highest levels of quality and safety*

NALHN and its predecessors had the responsibility for the practices, policies and procedures relevant to the operation of the Oakden Facility during the whole of the period relevant to the ToR and had an obligation to ensure that those practices, policies and procedures did not result in an irregular and unauthorised use of public money or substantial mismanagement of public resources. None of the individual public officers who were in a position of authority held office during the whole of that period.

For NALHN, I must be satisfied, as I have said, that NALHN had a practice, policy or procedure that resulted in an irregular and unauthorised use of public money or substantial mismanagement of public resources.

In my opinion, it would be appropriate to make a finding of maladministration against NALHN for having a practice, policy or procedure that failed to provide an adequate facility for those who resided at the Oakden Facility which amounted to, in my opinion, substantial mismanagement of public resources.

It failed to ensure that its policies were adhered to and failed to have in place a reporting procedure that would have ensured that NALHN was aware of the condition of the Oakden Facility and the poor standard of nursing care delivered.

In my opinion, NALHN failed to resource the Oakden Facility adequately and indeed neglected the facility. Moreover it failed to provide the facility with adequate and properly trained staff. It provided a facility which was not fit for purpose and especially not fit for the vulnerable persons that were obliged to reside there. The staffing levels were suboptimal. There were insufficient medical practitioners, mental health nurses and allied health staff. The quality of care delivered by the nursing staff was poor.

It had become the practice or policy of NALHN not to fund the facility adequately.

The practices, policies or procedures adopted by NALHN were apparently not deliberate but where the State accepts the responsibility for caring for its most vulnerable members, the State must ensure that the conditions in which those vulnerable persons are kept, and the level of care which is provided to those persons, are appropriate and adequate.

The State has said that if it had been aware of the under-funding and under-staffing at the Oakden Facility, such that adequate care was not provided to those vulnerable persons, the State would have acted to remedy the situation.

I accept that. It was not aware because NALHNs practices did not ensure that it became aware.

I find that the practices, policies and procedures of NALHN gave rise to a substantial mismanagement of public resources in that the mechanisms that were available for reporting complaints, issues, incidents or concerns were either inadequate or inadequately supervised such that they failed so that matters of concern that ought to have come to the attention of persons at various levels did not do so and, consequently, they were never addressed. This had the effect that the Oakden Facility was mismanaged and resources that ought to have been properly deployed were not. Indeed the Oakden Facility was a public resource itself. For the reasons I have set out in this report, it could not be argued that that resource was appropriately managed.

One issue that was raised by Dr Draper (in the letter sent by his solicitors to Ms Hanson dated 15 September 2017)¹¹⁸³ and Ms Nowland in her submission to me, and separately by SASMOA with NALHN, was an issue surrounding savings of approximately \$5.5m from the closure of Acacia and Jacaranda wards at Glenside in 2009 that was said to have 'disappeared into the ether', and not made its way to the Oakden Facility as had been promised.

The evidence before me as to what happened to the money is unclear. It would appear that the original estimate was overstated; that some of the money was used to fund certain capital works for OPMHS and that the remainder was not able to be accurately tracked or identified.¹¹⁸⁴

However, there is no evidence before me to suggest that the funds were removed from NALHN inappropriately. At its highest, the evidence, limited as it is, suggests that some of this money went into NALHN's overall budget and could not subsequently be tracked.

NALHN should be able to track funds accurately within its budget and if it could not do so it would be troubling. However, the evidence does not permit a finding that any public officer has engaged in conduct that results in an irregular and unauthorised use of public money or substantial mismanagement of public resources, or that there was a practice, policy or procedure of NALHN that had such a result.

Given that the money appears to have been in NALHN's budget or at least the Department's budget, I did not see it as in the interests of my investigation to investigate the issue further because to do so would have required a separate investigation.

Finally I note that the State of South Australia, through the CSO, having had the opportunity to consider the submissions of counsel assisting, accepted that maladministration had occurred at the Oakden Facility. That was an appropriate acknowledgment.

¹¹⁸³ Letter from Finlaysons Lawyers to Jackie Hanson, 15 September 2017, RD-4.

¹¹⁸⁴ The relevant correspondence is most conveniently collected in exhibit RD-4.

CHAPTER 14: RECOMMENDATIONS

Mr Besanko submitted that I should make 13 recommendations in this report to assist in preventing what happened at Oakden from happening again. He said these recommendations could be made in the exercise of powers under s 25(2) of the Ombudsman Act. Upon reflection, I have some doubts whether I can exercise the statutory powers in s 25(2), and I would not want to purport to exercise a power that I do not have. However, I do not have to decide this issue because I do not think that I need any statutory power to make recommendations after carrying out an investigation of this kind.

Any recommendations that I make will not be binding upon anyone. It will be a matter for SA Health or the Minister to consider whether the recommendations should be accepted and acted upon. The State of South Australia has agreed that all 13 recommendations proposed by Mr Besanko should be made but with minor amendments to Recommendations One and Two. In those circumstances I would expect that the State of South Australia through the Minister would in due course advise Parliament of the manner in which the recommendations have been acted upon.

Mr Besanko suggested the following recommendations could be made. He gave detailed reasons for each recommendation:

Recommendation One. The Commissioner should make a recommendation that the Chief Executive of the Department of Health either direct employees of the Department of Health and Ageing to review the management structures in place for all “treatment centres”¹¹⁸⁵ throughout South Australia or direct the Chief Executive Officers of the Local Health Networks to do so for the purpose of determining whether there are any other treatment centres that have a management structure in place whereby two or more persons have direct overall responsibility for a particular centre.

Recommendation Two. The Commissioner should make a recommendation that, in the event that there are any such treatment centres, the Chief Executive of the Department of Health and Ageing should, in conjunction with the Chief Psychiatrist and the Chief Executive Officers of the Local Health Networks, consider changing the management structures at those treatment centres so that only one person has overall responsibility for that particular treatment centre, with this person to be physically based at the treatment centre for which they have responsibility. The Chief Executive, in conjunction with the Chief Executive Officers, should also consider limiting that person’s responsibilities to the particular treatment centre for which they have responsibility. In the event that changes to the management structure at particular treatments centres are made, employees and staff at those centres should be informed of the nature of those changes and who has responsibility for what at the centre.

Recommendation Three. The Commissioner should make a recommendation that the Chief Executive of the Department of Health and Ageing, in conjunction with the Chief Executive Officers of the Local Health Networks, inform or remind the employees and other staff at all treatment centres throughout the State of the management structure in place at the treatment centre at which they work, what they personally have responsibility for and what others at the centre have responsibility for. This recommendation should be made irrespective of whether recommendations one and two are made, and should be acted upon irrespective of whether changes are made to the management structure at any treatment centre. As to how employees and staff at treatment centres are informed or reminded of

¹¹⁸⁵ As that term is used in the MHA.

these matters, this should be left to the Chief Executive and the Chief Executive Officers.

Recommendation Four. The Commissioner should recommend that the Chief Executive direct that all staff at treatment centres throughout the State undergo training in respect of the use of the SLS, with a particular focus on when it should be used, and the other reporting obligations on employees and staff at treatment centres under Commonwealth and State legislation and applicable policies and procedures. The manner and content of this training should be left to the Chief Executive, the Chief Psychiatrist and the Chief Executives Officers of the Local Health Networks to determine in conjunction with each other, although the training should focus on the obligations to report certain matters, and to whom and how they should be reported. Consideration should be given to delivering this training in the least disruptive but most effective manner.

Recommendation Five. The Commissioner should recommend that the Chief Psychiatrist review the use of the statutory power conferred on the Chief Psychiatrist under s 90(4) of the 2009 MHA to conduct inspections, with a view to the Chief Psychiatrist exercising the power to conduct unannounced visits of treatment centres, to the extent that treatment centres are hospitals for the purposes of s 90(4), more frequently than have been conducted to date.

Recommendation Six. The Commissioner should recommend that the Principal Community Visitor review the use of the statutory power conferred on community visitors and the Principal Community Visitor under ss 51(3) and 52 of the 2009 MH Act to conduct visits and inspections, with a view to the Principal Community Visitor and community visitors exercising the power to conduct unannounced visits and inspections of treatment centres more frequently than they have been conducted to date.

Recommendation Seven. The Commissioner should recommend that the community visitor scheme be the subject of an external review to determine whether the scheme should be amended to provide community visitors with training in mental health care, to require persons to possess certain qualifications in mental health care in order to be community visitors and/or to transfer some of their current functions to persons with specialist qualifications in mental health. The review should be conducted with input from the Principal Community Visitor and should report to the Minister for Mental Health.

Recommendation Eight. The Commissioner should recommend that the provisions in the 2009 MH Act be the subject of a review to determine whether a positive obligation should be imposed on the Chief Psychiatrist to ensure that treatment centres comply with their obligations under the 2009 MH Act and/or to ensure, as far as practicable that an adequate standard of care is provided to persons cared for at treatment centres. This reviewer(s) should also consider whether the resources of the Office of the Chief Psychiatrist need to be increased, and if so to what extent, with or without any legislative change, and whether the Chief Psychiatrist's powers would need to be increased to enable the Chief Psychiatrist to perform any such additional functions, subject to oversight by the Minister for Mental Health.

Recommendation Nine. The Commissioner should recommend that a review be conducted of the physical state of all treatment centres in South Australia for the purpose of determining the physical condition of the centres, their grounds and infrastructure, and specifically whether and in what respects the physical condition of any of them is sub-optimal or renders them not fit for the purpose for which they are being used, the latter being a lower threshold (both should be inquired into though).

This report should be provided to the Minister for Mental Health, who should make it publicly available.

Recommendation Ten. The Commissioner should recommend that the six recommendations contained in the Chief Psychiatrist's Report be adopted and implemented, to the extent that they have not already been implemented.

Recommendation Eleven. In my submission the Commissioner should recommend that the role of Consumer Advisor be reviewed by the Chief Executive of the Department of Health and Ageing to determine whether the duties and responsibilities of Consumer Advisors, so far as they relate to treatment centres, are appropriate, whether they require further training to assess the significance of complaints made about treatment centres, whether they should be required to report complaints in respect of treatment centres that concern them to particular persons or committees and whether steps can be taken to increase their independence from particular treatment centres.

Recommendation Twelve. The Commissioner should recommend that the Chief Psychiatrist, in conjunction with the Chief Executive of the Department of Health and Ageing, review the MHA for the purpose of determining whether the provisions relating to the use of restrictive practices should be amended to reduce the circumstances in which restrictive practices can be employed or to reduce the likelihood that restrictive practices are employed in breach of the Act. This review should involve a consideration of, but not be bound by, the provisions in place in other States. The use of restraints and seclusion at Oakden was clearly highly inappropriate. It may be that the provisions of the MHA could be amended to reduce the likelihood of the inappropriate use of seclusion and restraint occurring at other treatment centres. However, the Commissioner is not in a position to determine whether the Act could be amended to reduce the likelihood of the inappropriate use of seclusion and restraint, or what the nature of any such amendments should be. In my submission expert evidence would be required to determine these issues, which is not before the Commissioner. Therefore, the Commissioner should make the recommendation that there be a review of the relevant provisions.

Recommendation Thirteen. The Commissioner should recommend that the Chief Executive of the Department of Health and Ageing should, in conjunction with the Chief Executive Officers of the Local Health Networks, review the level and nature of allied health staff support available to treatment centres throughout the State for the purpose of determining whether there are critical shortages.

A number of the interested parties addressed the proposed recommendations.

As I have mentioned the State of South Australia agreed with Recommendations Three to 13 and suggested minor amendments to Recommendations One and Two.

The Interim Chief Psychiatrist, Dr Brian McKenny, supported Recommendations five to 11 and 13, and one to four with minor amendments, but did not support recommendation 12.

Dr Tyllis, the former Chief Psychiatrist, agreed with Recommendations Five, Six, Eight and Nine to 13, and made a number of submissions in support of those recommendations. He did not make any submissions in respect of the other proposed recommendations.

Mr Corcoran, the Principal Community Visitor, said:

In general terms, the CVS does not support the submission that a more qualified CVS would/may have identified and raised all of the issues identified in the Oakden report. If this was adopted the Commissioner would need to give consideration to why trained staff (medical, nursing and AHP), with requirement to achieve and

maintain national registration supported by senior clinically qualified managers could have allowed such a poor standard of care to be delivered. These clinicians in addition are guided by their professional standards and clinical practice standards.

It is the view of the CVS that staff often become institutionalised in their care and adopt norms that blind them in relation to what would be regarded as contemporary and quality care. It is in most cases family friends and external organisations who are themselves not clinically programmed who question the adopted custom and practice. As further example, the CVS in another clinical setting raised concerns about the lack of specialist communication support for a deaf client. The family contacted CVS and disclosed significant limitations regarding communication and the lack of involvement and understanding the client had about the treatment they were receiving. Untrained CVs are often mystified as to why trained clinicians do not identify such obvious behaviours.

Training of Community Visitors (CVs)

I believe that our intensive training and orientation to the role of CVs is extensive and I would argue is more than many other positions where permanent paid appointments are made in the public sector. It is also ongoing in that we have regular get togethers and reflective practice sessions in a group-work environment and quite often with guest presenters. We can certainly improve and we certainly strive to do so by surveying our CVs on training needs on a regular basis.

In view of the apparent wide acceptance of most recommendations it is not necessary to set out in detail the reasons for the recommendations. I need only consider the suggested amendments made by the State of South Australia, Dr McKenny and Mr Corcoran.

None of the parties disagreed with Recommendations Five, Six, Seven, Eight, Nine, 10, 11 and 13, except Mr Corcoran who disagreed with Recommendation Seven.

I will deal with Mr Corcoran's objection first, which rather assumes that the review will come to the decision to require community visitors to be trained in mental health care and to possess certain qualifications in mental health care in order to be community visitors, or alternatively the review will decide to transfer some of the community visitors' current functions to persons with specialist qualifications in mental health.

That might be the decision at which a review if it were conducted might arrive, but that is no reason not to have the review that has been suggested.

In view of the failings at the Oakden Facility, which apparently went unnoticed by the community visitors over a long period of time, consideration needs to be given as to whether the CVS in its current form is an appropriate safeguard for those suffering mental illness who are housed or treated in treatment centres, limited treatment centres, or authorised community mental health facilities.

Mr Corcoran can in due course put the arguments that he has advanced on the review, and it will be for the reviewer to determine whether he or she accepts his submissions.

Dr McKenny's objection to Recommendation 12 was that the recommendation might mean that a contemporary clinical practice will be prescribed in legislation. He said that clinical best practice is always evolving and to fix a particular practice in legislation might inhibit the evolution of best practice in the future which might give rise to poor practice or unlawful practice.

He suggested that Recommendation 12 should be that the Chief Executive and the Chief Psychiatrist review all SA Health and Chief Psychiatrist's directives, policies and standards relating to restrictive practices to determine if those documents should reduce the

circumstances in which restrictive practices can be used and reduce the likelihood of the inappropriate use of restrictive practice.

I do not read the proposed recommendation as a recommendation that current clinical practice be enshrined in the MHA, and that is not what was submitted by Mr Besanko. The submission was that there should be a review of the MHA for the purpose of determining whether the provisions relating to the use of restrictive practices should be amended to reduce the circumstances in which restrictive practices can be employed, or to reduce the likelihood they are employed in breach of the MHA. The Chief Psychiatrist may conclude that no amendments need be made to the MHA at the conclusion of such a review, for the very reason submitted by Dr McKenny.

In any event, in light of the concern expressed by Dr McKenny I will make a recommendation that there be a review by the Chief Executive and the Chief Psychiatrist of the use of restrictive practices in mental health institutions in South Australia with a view to the Chief Psychiatrist exercising the power under s 90 of the MHA, to issue new standards in relation to the use of restrictive practice, thus making the observance of those standards in the care or treatment of the patients the subject of them mandatory: s 90(3) of the MHA.

Such a recommendation will permit the Chief Psychiatrist to amend the standards over time in accordance with the evolution of clinical practice and thereby address the issue of the inappropriate use of restraints at the facilities.

That deals with Recommendations Five to 13.

Nobody objected to Recommendations One to Four, but the State submitted that Recommendations One and Two could be amended, and Dr McKenny submitted Recommendations One to Four might be amended.

The State of South Australia submitted in paragraph 37 of its submission:

The State agrees that there is merit in reviewing the governance structures through which South Australian mental health services are delivered, along the lines suggested by Counsel Assisting in recommendations 1 and 2. It is suggested that the recommendations might be framed more broadly, to the following effect:

- a) Recommendation One: *The Chief Executive should review the clinical governance/management of mental health services within the overall clinical governance of each Local Health Network, hospital and community service, and review how the management of the requirements of the Mental Health Act 2009 (including approved treatment centres, limited treatment centres and authorised community mental health facilities) fits within the overall health governance structures.*
- b) Recommendation Two: *The Chief Executive of the Department should, with the Chief Psychiatrist and Chief Executive Officers of the Local Health Networks, consider changing the management structures for the administration of the Mental Health Act 2009 to match those of overall mental health clinical governance structures, such that:*
 - i. *the officer responsible for the clinical mental health care at a particular hospital (approved treatment centre or limited treatment centre) or community service (authorised community mental health facility) is also responsible for the administration of the Mental Health Act 2009 within that site; and*
 - ii. *the officer responsible for overseeing all mental health clinical care within a Local Health Network also oversees the*

administration of the Mental Health Act 2009 for the whole of Local Health Network.

Dr McKenny submitted that Recommendations One to Four should be reformulated as follows:

Recommendation One

The Chief Executive should review the clinical governance/management of mental health services within the overall clinical governance of each Local Health Network, hospital and community service, and review how the management of the requirements of the Mental Health Act 2009 (including approved treatment centres, limited treatment centres and authorised community mental health facilities) fit within the overall mental health governance structures.

Recommendation Two

The Chief Executive should, with the Chief Psychiatrist and Chief Executive Officers of the Local Health Networks, consider changing the management structures for the administration of the Mental Health Act 2009 to match those of overall and mental health clinical governance structures, so that the officer responsible for the clinical mental health care at a particular hospital (approved treatment centre or limited treatment centre) or community service (authorised community mental health facility) is also responsible for the management of the Mental Health Act 2009 within that site. In addition, the officer responsible for overseeing all mental health clinical care within a Local Health Network should also oversee the management of the Mental Health Act 2009 for the whole Local Health Network.

Recommendation Three

The Chief Executive and the Chief Executive Officers should remind all staff that clinical governance and Mental Health Act 2009 management structures are the same and remind all staff what those structures are in each Local Health Network, hospital and community service.

Recommendation Four

The Chief Executive should direct that the staff of all Local Health Networks should be trained in their safety and quality responsibilities, their monitoring and reporting responsibilities and the use of SLS, with a focus on Commonwealth and State legislative requirements.

The State contended that Recommendation One should impose an obligation on the Chief Executive rather than allow, as has been suggested, the Chief Executive either to direct employees or the Chief Executive Officers of the Local Health Networks to carry out the review.

The State is of the opinion that the review which has been suggested should be carried out at higher level than that which has been suggested.

If that is the view of the State then I am prepared to make that recommendation, because clearly the State can cause the Chief Executive to do what is suggested.

The State's submission in relation to Recommendation Two would have much the same effect as the recommendation that has been suggested, which is essentially to identify someone who has overall responsibility at a particular hospital.

I am prepared to make the recommendation suggested by the State.

The Interim Chief Psychiatrist made the same submissions in respect of Recommendations One and Two.

That leaves for consideration the interim Chief Psychiatrist's comments in relation to Recommendations Three and Four.

Dr McKenny has suggested that Recommendation Three could be:

"The Chief Executive and the Chief Executive Officers should remind all staff that clinical governance and Mental Health Act 2009 management structures are the same and remind all staff what those structures are and in each local health network hospital and community service."

I am not sure I understand the proposed rewording of Recommendation Three. I prefer Mr Besanko's proposed recommendation on the topic, although I have changed the wording slightly.

In respect to Recommendation Four, Dr McKenny has suggested an alternative recommendation to that submitted by Mr Besanko.

I prefer the recommendation that has been submitted by Mr Besanko. I think the suggested recommendation should be wide enough to ensure that not only are employees reminded of their obligations under the SLS but that they understand their other reporting obligations, for example to AHPRA and the OPI.

Lastly, Mr Besanko indicated in his submissions that I might be assisted by submissions on the question of whether the recommendations should extend to 'approved treatment centres' and/or 'limited treatment centres' for the purposes of the MHA, or to some other identifier of relevant health units. The State took up Mr Besanko's invitation and made helpful submissions about what identifier I should use in the recommendations. Having considered the State's submissions on this point, I will frame my recommendations around the identifier 'Local Health Network'. I am not aware of mental health services being provided by 'public officers' or 'public authorities' outside of the Local Health Networks.

Finally I have taken those recommendations and put them in the language of a direction.

For all those reasons I make the following recommendations:

Recommendation One

The Chief Executive of the Department of Health and Ageing (Chief Executive) review the clinical governance and management of mental health services within the overall clinical governance of each Local Health Network (LHN) to determine whether the management requirements of the *Mental Health Act 2009* (MHA) fit within the overall health governance structures.

Recommendation Two

The Chief Executive should, with the Chief Psychiatrist and the Chief Executive Officers (CEOs) of the LHNs, consider adopting management structures for the administration of the MHA to match those of overall mental health clinical governance structures, such that:

- the officer responsible for the clinical mental health care of a facility within a LHN is also responsible for the administration of the MHA at that facility; and
- the officer responsible for overseeing all clinical mental health care within a LHN has the responsibility for the administration of the MHA in that LHN.

Recommendation Three

The Chief Executive and the CEOs implement a structure to routinely remind staff working at a treatment centre of the management structure in place at the centre; the assignment of responsibilities at the centre; and the expectations and responsibilities imposed upon each member of staff at the centre.

Recommendation Four

The Chief Executive direct all staff at facilities in a LHN where mental health services are being delivered to undergo training, as may be agreed by the Chief Executive, Chief Psychiatrist and CEOs, in the use of the Safety Learning System; the reporting obligations for staff under Commonwealth and State legislation and the relevant SA Health and LHN policies and procedures.

Recommendation Five

The Chief Psychiatrist review the use of the statutory power conferred on the Chief Psychiatrist under s 90(4) of the MHA to conduct inspections of an incorporated hospital, with a view to the Chief Psychiatrist exercising the power to conduct unannounced visits to facilities within LHNs more frequently than in the past.

Recommendation Six

The Principal Community Visitor review the use of the statutory power conferred on community visitors under ss 51(3) and 52 of the MHA to conduct unannounced inspections and visits of facilities within LHNs and treatment centres, with a view to community visitors exercising the power to conduct unannounced inspections and visits more frequently than in the past.

Recommendation Seven

The Minister for Mental Health and Substance Abuse (the Minister) cause a review to be conducted of the community visitor scheme (CVS) to determine whether the CVS should be amended to:

- require community visitors be trained in mental health care;
- require community visitors to possess certain qualifications in mental health care; and
- provide that some of the community visitors' current functions be discharged by persons with specialist qualifications in mental health.

Recommendation Eight

The Minister cause a review to be conducted to determine whether the MHA should be amended to impose positive obligations on the Chief Psychiatrist to ensure:

- that public officers within the LHNs delivering mental health services comply with their obligations under the MHA; and
- as far as practicable that an adequate standard of care is provided to persons with a mental illness who receive such care from a LHN;

and whether in that case the resources of the Office of the Chief Psychiatrist need to be increased; and

- if so to what extent; and
- whether the Chief Psychiatrist should be provided with further statutory powers to enable the Chief Psychiatrist to perform any such additional functions.

Recommendation Nine

The Minister cause a review to be conducted for the purpose of reporting publicly on the physical condition of all facilities at which mental health services are delivered in a LHN:

- for the purpose of determining whether the physical condition of those facilities are fit for the purpose for which they are being used; and
- if not in what respects the physical condition of any facility is not fit for purpose.

Recommendation Ten

The six recommendations contained in the Oakden Report be implemented, to the extent that they have not already been implemented.

Recommendation Eleven

The Chief Executive review the role of Consumer Advisor to determine whether:

- the duties and responsibilities of Consumer Advisors, so far as they relate to facilities at which mental health services are provided, are appropriate;
- Consumer Advisors require further training to assess the significance of complaints made about those facilities or services;
- Consumer Advisors should be required to report complaints in respect of facilities to particular persons or committees; and
- steps can be taken to ensure Consumer Advisors are independent of particular facilities.

Recommendation Twelve

The Chief Psychiatrist and the Chief Executive review the use of restrictive practices within each LHN with a view to the Chief Psychiatrist exercising power under s 90 of the MHA to issue new standards in relation to the use of restrictive practices and making the observance of those standards mandatory.

Recommendation Thirteen

The Chief Executive, in conjunction with the CEOs, review the level and nature of allied health staff support at facilities at which mental health services are provided by a LHN for the purpose of determining whether there are adequate allied health staff to provide the necessary support at such facilities.

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APPENDIX 1

STATEMENT ABOUT AN INVESTIGATION

THE INDEPENDENT COMMISSIONER AGAINST CORRUPTION

THE HON. BRUCE LANDER QC

2 FEBRUARY 2018

1. On the 25th of May 2017 I told the Parliamentary Crime and Public Integrity Committee (the Committee) that I intended to conduct an investigation into maladministration associated with the Oakden Older Persons Mental Health Service.
2. Before giving that evidence I had sought the views of the Ombudsman as required by s36A(1) of the Independent Commissioner Against Corruption Act 2012 (the ICAC Act).
3. At a press conference on the 30th of May I released the Terms of Reference relevant to my investigation.
4. Shortly after I embarked upon the investigation I issued summonses under the Royal Commissions Act 1917 (Royal Commissions Act) directed to various parties seeking the production of a wide range of documents relevant to the investigation. The powers under the Royal Commissions Act are given by s19 of the Ombudsman Act 1972 (Ombudsman Act) and are therefore available to the Ombudsman and the Independent Commissioner Against Corruption (the ICAC) when exercising the Ombudsman's powers.
5. I appointed Mr Tom Besanko as counsel assisting me and solicitors Mr Sam McGrath and Mr Peter Healey, a partner and a senior associate of Cowell Clarke Solicitors in Adelaide, to also assist me.
6. The following months were taken up with gathering evidence.
7. I commenced to take evidence from a number of witnesses on 17 October 2017 and the taking of evidence concluded after hearing 27 witnesses on 28 November 2017.
8. I put in place a process to accord procedural fairness to interested parties and as part of that process I invited Mr Besanko to make submissions to me as to the findings that should be made in relation to the investigation.
9. I caused those submissions to be distributed to those interested parties on 27 December 2017 so they could have the opportunity of commenting upon Mr Besanko's submissions and putting forward alternative submissions. All the interested parties including the three parties to whom I am about to refer received those submissions.
10. As part of the process the parties were also entitled to seek to adduce further evidence or seek to cross-examine any of the witnesses who had given evidence before me.
11. That process concluded on the 25th of January 2018.

12. Mrs Vlahos the former Minister for Mental Health and Substance Abuse sought to cross-examine Ms Hanson who was during part of the relevant time the Chief Executive of the Northern Adelaide Local Health Network (NALHN) and I acceded to that request and that cross-examination took place on Tuesday 30 January.
13. In his most helpful submissions counsel assisting Mr Besanko referred to the interaction between s26(3) of the Ombudsman Act and s42 of the ICAC Act but submitted that I could exercise the power under s26(3) of the Ombudsman Act and publish any report that I prepared in public.
14. However, three parties Mrs Vlahos, Mrs Harrison and Mr Goel,¹ in alternative submissions that they forwarded to me, have contended that section 26(3) of the Ombudsman Act is not a power available to the ICAC in circumstances where the ICAC is carrying out an investigation into potential issues of serious or systemic misconduct or maladministration. I mention that the State of South Australia which was represented by the Crown Solicitor Mr Wait SC did not make any submission that the ICAC could not exercise the power under s26(3) of the Ombudsman Act and publish a report publicly.
15. I do not need to deal separately with Mr Goel's submissions because his submission does not raise any issue not raised in Mrs Vlahos' submission or Mrs Harrison's submission.
16. Mrs Vlahos first responded on this issue on 5 January 2018.
17. Her solicitor Mr Patsouris wrote:

*I do not accept that Counsel Assisting has correctly interpreted the relevant statutory provisions in section 36A, section 42 of the ICAC Act and section 26(3) of the Ombudsmans Act. I make it clear that pursuant to s 42(1a)(b) my client does not consent to the identification of her as having been involved in the particular matter or matters the subject of your investigation. I ask that you undertake not to publish my client's name or any material identifying her in connection with any findings that you may make without 14 days notice to me. Given the potential for reputational damage to be suffered by my client should you make any publication of my client's name or any material identifying her pursuant to section 26(3) of the Ombudsmans Act I ask you to provide this undertaking as soon as practicable and prior to any publication. I ask that you respond in any event by close of business on **10 January 2018**.*

¹ Mrs Leesa Vlahos was:

- Elected as a Member of Parliament on 20 March 2010
- Parliamentary Secretary to the Premier (assisting in the areas of Health, Mental Health, and Substance Abuse) between 26 March 2014 to 3 February 2015
- Parliamentary Secretary to the Minister for Health between 3 February 2015 to 19 January 2016
- Minister for Mental Health and Substance Abuse between 19 January 2016 to 18 September 2017

Ms Julie Harrison was:

- Manager for Strategic Development, CNAHS until December 2007
- Acting Aged Care Director, CNAHS between 24 December 2007 and July 2010
- Service Manager with responsibility for Oakden between July 2010 and January 2013
- Service Manager for OPMHS and FMHS between January 2013 and October 2014
- Acting Director of the Mental Health Directorate between October 2014 and February 2015
- Service Manager between February 2015 and January 2016

Mr Karim Goel was:

- Clinical Services Coordinator for Makk and McLeay wards between May 2013 to February 2017

18. Mr Patsouris was advised that I was not prepared to give the undertaking sought in that letter in a letter written by Mr Rod Jensen, the Director Legal Services of my office on 9 January 2018. Mr Jensen said:

*In respect of the request made in [11] of your letter, I reiterate that the Commissioner has not yet made any decision to exercise any statutory power in respect of the publication of any report. If your client disagrees with the submissions of Counsel Assisting in the manner suggested in [11] of your letter, your client is able to make submissions to the Commissioner about this in writing by **5pm on 25 January 2018**. Those submissions will then be considered by the Commissioner, along with the submissions of Counsel Assisting, when the Commissioner comes to decide, after 25 January 2018, whether he can and/or should exercise any statutory power to publish a report in respect of his investigation.*

19. Mrs Vlahos' solicitor responded in a letter written to me on 11 January 2018 writing:

It would appear that you intend to publish your report without giving my client any notice of which Counsel Assisting's submissions that are adverse to my client will find their way into your report. I reiterate the issue that I raised in correspondence dated 5 February 2018 [sic] namely that Counsel Assisting has incorrectly interpreted ss 36A and s42(1a)(b) of the ICAC Act and section 26(3) of the Ombudsmans Act. I ask that you provide an undertaking in writing not make public your report containing any adverse findings against my client without 7 days notice to my client of your intention to do so. In considering this request for an undertaking I ask that you note that if your report was published and contained adverse findings against my client then this could cause reputational harm to my client. If such publication was made without notice to my client then reputational harm could be incurred without my client being in a position to challenge the jurisdictional basis of such publication.

20. Mr Jensen responded on 12 January 2018.

21. On 15 January 2018 Mrs Vlahos' solicitor wrote again to me seeking an undertaking:

I now ask directly for an undertaking that you not prepare and/or publish a report setting out your findings or recommendations resulting from a completed investigation into a potential issue of misconduct or maladministration in public administration that identifies my client as a person involved in the particular matter or matters the subject of the investigation without 7 days written notice to my client. For the avoidance of doubt my client does not consent to the preparation of any report setting out any such findings or recommendations.

22. Mr Jensen responded again on the 17th of January.

I note that the undertaking you request of the Commissioner in your letter dated 15 January 2018 is considerably wider than the undertakings you sought in your letters of 5 and 11 January 2018.

Specifically, I note that you now seek an undertaking from the Commissioner that he neither prepare nor publish any report setting out his findings or recommendations resulting from a completed investigation into a potential issue of misconduct or maladministration in public administration that identifies your client as a person involved in the particular matter or matters the subject of the investigation without 7 days' written notice to your client. Previously you had sought an undertaking that the Commissioner not publish or make public any report the Commissioner prepares in respect of his investigation into, as I understood the request, the Oakden OPMHS.

In any event, if it was not clear from my letters dated 9 January and 12 January 2018, the Commissioner will not provide an undertaking in the terms you have sought in your letters dated 5, 11 and 15 January 2018.

As I stated in my letters of 9 and 12 January 2018, the Commissioner has not yet made any decision as to whether he can and/or should exercise any statutory power in respect of the publication of any report.

You have stated a number of times that you and your client do not agree with the submissions advanced by Counsel Assisting on this topic. As you are aware, your client has the opportunity to make submissions, in writing, as to why this is so on or before 25 January 2018. The Commissioner will consider any submission that your client makes by this time, along with any submissions received from any other interested parties, about whether he can and/or should publish any report, and then make a decision about whether he has such a power and whether, in the circumstances, he should exercise it (and if so how).

23. On 25 January 2018 in accordance with the timetable that I had laid down Mrs Vlahos provided her submissions in response to counsel assisting's submissions.
24. I shall deal with those submissions on the substantive issues in the course of the report that I intend to prepare.
25. In those submissions she repeated her call for an undertaking from me:

Via Mr Jensen you have asked that the former Minister respond to your Counsel Assisting's submissions in circumstances where your Counsel Assisting invites you to

[REDACTED] Further your Counsel Assisting makes submissions that you have power by reason of section 36A of the ICAC Act and the Ombudsman's Act to prepare a report of your investigation and that you have the power to publish such a report pursuant to section 26(3) of the Ombudsman's Act if you are satisfied that it is in the public interest to do so. The clear inference from your Counsel Assisting's submissions is that such a report would identify and name those persons in respect of whom you made any adverse finding. In those circumstances your invitation to respond to these submissions would be of no utility if you were not minded to consider and/or adopt and implement the recommendations of your Counsel Assisting.

*Accordingly, to make the former Minister's position abundantly clear, having regard to the above, the former Minister seeks **an undertaking from you, that you will not exercise any statutory power in respect of the making of any finding or recommendation, or the publication of any report of your investigation without giving 14 days notice to the former Minister of your intention to do so.** The former Minister seeks such an undertaking by close of business on 29 January 2018.*

In the absence of such an undertaking we can only assume that you intend (after any submissions are made to you on 30 January 2018) to exercise your statutory powers in the manner recommended to you by Counsel Assisting to make findings and recommendations and to publish a report of your investigation without giving notice to the former Minister of your intention to do so.

This must be so because your Counsel Assisting has told you already that you should utilise what he claims is the power conferred on the Ombudsman to prepare and publish an Ombudsman's report. Your Counsel Assisting also said in his submissions to you:

"In my submission, the Commissioner ought utilise the power conferred on the Ombudsman to prepare and publish his report. The reason for this is closely related to the question of whether the Commissioner ought to be satisfied that it is in the public interest to publish the report, as he must be in order to utilise the power. This is because s42(1a)(b) does not permit the Commissioner to prepare a report that identifies any person involved in the particular matter or matters the subject of the investigation unless the person consents. It should be noted that s42(1a)(b) in terms prevents the Commissioner from preparing any report pursuant to s42(1) that identifies a person without their consent; he is not permitted to prepare such a report but not publish it to anyone. This must be because of the obligation on the Commissioner to provide any report he prepares to the persons identified in s42(2). In my submission the Commissioner should utilise the power conferred on the Ombudsman because it is not limited by s42(1a)(b) of the ICAC

Act and he should publish, and thereby make publicly available, the report he is to prepare"

[redaction added and footnotes omitted]

26. In doing so Mrs Vlahos again relied upon s42(1a) of the ICAC Act which she said meant that I could not exercise the power given to the Ombudsman under s26(3) of the Ombudsman Act.
27. I will deal in this statement with the contention Mrs Vlahos has made that I cannot prepare a report setting out findings or recommendations resulting from my completed investigation into a potential issue of maladministration in public administration that identifies Mrs Vlahos unless Mrs Vlahos consents.
28. Mrs Vlahos has informed me a number of times that she does not consent to my preparing a report that identifies her².
29. The same submission has been made by Mrs Harrison³ and Mr Goel⁴ who have also indicated that they do not consent to be identified in any report and that therefore I cannot prepare a report that identifies them.
30. These parties are seeking to rely on what they perceive to be are their legal rights which they are of course entitled to do. The issue that they have raised is important. If their contention is right then that would have a very serious impact on the ability of the ICAC to conduct any investigation into a potential issue of serious or systemic maladministration.
31. Indeed if their contention is upheld I would have to consider suspending this and investigations that I am presently conducting into maladministration because those investigations would be futile.
32. It was for that reasons that I thought I should decide this question immediately.
33. The three parties rely on section 42 of the ICAC Act for that proposition.
34. Mrs Vlahos puts her submission this way:

For the reasons that follow it is contended:

- (a) *That you do not have the statutory power to **prepare** a report setting out findings or recommendations resulting from a completed investigation into a potential issue of misconduct or maladministration in public administration that identifies any person involved in the particular matter or matters the subject of the investigation unless the person consents.*

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- Letter dated 5 January 2018, Patsouris to ICAC, [11] (Directly: "I make it clear that pursuant to s42(1a)(b) my client does not consent to the identification of her as having been involved in the particular matter or matters the subject of your investigation.");
- Letter dated 11 January 2018, Patsouris to ICAC, p3 (Tangentially: "I reiterate the issue that I raised in correspondence dated 5 February (sic) 2017 ... I ask that you note that if your report was published and contained adverse findings against my client then this would cause reputational harm to my client.");
- Letter dated 15 January 2018, Patsouris to ICAC, p1-2 (Directly: p2 "For the avoidance of doubt my client does not consent to the preparation of any report setting out any such findings or recommendations." and the letter also transposes text from letters dated 5 January and 11 January).
- Written submissions from Ms Vlahos dated 25 January 2018, [18], [21].

³ Paragraph 15 of Mrs Harrison's submissions made on 31 January 2018.

⁴ Paragraph 7 of Mr Goel's submissions made on 25 January 2018

- (b) *Indeed you have no specific power to publish any report, rather your power is confined to providing a copy of your report to:*
 - (i) *The public authority responsible for any public officer to whom the report relates; (section 42(2)(a))*
 - (ii) *The Minister responsible for that public authority; (section 42(2)(a))*
 - (iii) *The Attorney-General (section 42(2)(b))*
 - (iv) *The President of the Legislative Council (section 42(2)(b))*
 - (v) *The Speaker of the House of Assembly (section 42(2)(b))*

35. She says in support of that submission:

*One of your functions, inter alia is to **assist** inquiry agencies and public authorities to identify and deal with misconduct and maladministration in public administration. The performance of your other functions is therefore for the end result of assisting inquiry agencies and public authorities. Further, a primary object of the ICAC Act is "to achieve an appropriate balance between the public interest in exposing corruption, misconduct and maladministration in public administration and the public interest in avoiding undue prejudice to a person's reputation." Relevantly, this object supports the proposition outlined further below, namely that the legislative regime that Parliament has by the provisions of the ICAC Act established, determines how these many factors are balanced. Consistently with the requirement in section 22 of the Acts Interpretation Act 1915, this means that regard must be had to this overarching purpose when construing section 42 of the ICAC Act.*

We also note that the Ombudsman Act pre-dates the establishment by Parliament of ICAC and the legislative provisions concerning reporting in the Ombudsman Act. Section 26(3) of the Ombudsman Act provides:

- "(3) The Ombudsman may, if of the opinion that it is in the public interest to do so, cause a report on an investigation, or a statement about an investigation, or a decision not to investigate [sic] or to discontinue an investigation, to be published in such manner as the Ombudsman thinks fit."*

but you are not the Ombudsman, you are the ICAC.

[footnotes omitted]

- 36. She refers to section 36A of the ICAC Act and then section 42 of the ICAC Act.
- 37. She contends that the specific limitations on reporting in respect of an investigation concerning misconduct or maladministration cannot be overcome by reference to the general provisions in the Ombudsman Act concerning publication of reports.
- 38. She contends that section 26(3) of the Ombudsman Act is in general terms only and must give way to section 42 of the ICAC Act.
- 39. She refers to the second reading speech in Parliament when section 42 (1a) was before the House of Assembly.
- 40. She says:

Moreover, as we have said, unlike the provisions of the Ombudsman Act 1972 there is no general power of publication conferred upon you. As the ICAC shows you are answerable to Parliament. Your functions as the ICAC with respect to reports concerning misconduct and maladministration, is to report to those persons identified in section 42(2). It is the function of the President of the Legislative Council and the Speaker of the House of Assembly to, on the first sitting day after

28 days (or such shorter number of days as the Attorney-General approves), to lay any report before their respective Houses.

In short, the "publication" regime that the ICAC Act establishes is that your reports are provided to the Speaker and the president, to be placed before both houses of Parliament. Two matters flow from this:

- (a) *Given, the requirement for the tabling of the reports in Parliament this strengthens the submissions outlined above concerning the confidentiality of findings concerning misconduct and maladministration which is mandated by section 42(1a)(b).*
- (b) *Secondly, Parliament has mandated that "publication" is only via both Houses of parliament. Because your reports are reports to Parliament, there is no general power of publication at large in the ICAC Act.*

[footnotes omitted]

- 41. Essentially her submission is that the effect of section 42 of the ICAC Act is such that the ICAC has to comply with section 42 which means that the ICAC can not prepare a report that identifies any person involved in the particular matter the subject of the investigation unless the person consents.
- 42. During the hearing on 30 January 2018 when Ms Hanson was cross-examined Mrs Vlahos was represented by counsel Mr Abbott QC, Dr Rachael Gray, Mr Chad Jacobi and solicitor Mr Harry Patsouris.
- 43. At the end of that hearing Dr Gray asked me to provide the undertaking contained in Mrs Vlahos' submission.
- 44. She said she wished to have the undertaking so that Mrs Vlahos could 'injoin me' if necessary before any report was published.
- 45. I think she meant Mrs Vlahos sought the undertaking so that Mrs Vlahos could apply to the Supreme Court for an injunction to restrain me from preparing a report that would identify Mrs Vlahos because Mrs Vlahos did not consent to be identified.
- 46. I refused to give the undertaking which would have delayed the preparation of any report.
- 47. I asked her at that hearing whether she wished to put anything further on this question. Dr Gray said that she wished to put an argument which was apparently being played out in New South Wales (NSW) which I think was to the effect that the NSW legislation might amount to a breach of human rights by contravening Australia's obligations under the International Covenant on Civil and Political Rights.
- 48. I gave her leave to present that argument by 5:00pm on 31 January 2018. That argument was put in Mrs Vlahos' submissions of 31 January 2018.
- 49. In the further submission Mrs Vlahos contended that statutory provisions should be interpreted and applied according to the language of the statute to be consistent with the comity of nations and the established rules of international law. She referred to article 14 of the International Covenant on Civil and Political Rights (the Convention) as follows:

[a]ll persons shall be equal before the Courts and Tribunals. In determination of any criminal charge against him, or his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law. The press and the public may be excluded from all or part of a trial for reasons of morals, public order (order public) or national security in a democratic society, or in the interest of the private lives of

the parties so requires, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interest of justice; but any judgment rendered in a criminal case or suit at law shall be made public except where the interests of juvenile persons otherwise requires or the proceedings concern matrimonial disputes or the guardianship of children.

50. She argued:

41. *The interpretation of section 42 of the ICAC Act for which Counsel Assisting contends breaches the provisions contained in Article 14 of the International Covenant on Civil and Political Rights. It is based upon an erroneous interpretation of the statutory provisions contained in section 36A, section 42 of the ICAC Act and section 26(3) of the Ombudsman Act for the reasons outlined in the previous submissions of the former Minister.*

42. *Counsel Assisting invites you to in effect name and shame those who are said to be responsible for failings that occurred at the facility. Such an interpretation results in the persons the subject of such findings suffering reputational harm with limited redress and without being afforded the fundamental protections, such as procedural fairness which are accorded by courts of law. The interpretation for which Counsel Assisting contends would result in a breach of section 14 of the Convention in a similar manner for example to that currently reported as being before the United Nations Human Rights Committee.*

51. Mrs Harrison argued that although the ICAC had all the powers of the inquiry agency to deal with the matter (section 36A of the ICAC Act) the ICAC at all times remains subject to the ICAC Act: section 24(2)(c) and section 24(2)(d) of the ICAC Act.

52. She argued that the ICAC's functions are set out in section 7 of the ICAC Act and that the ICAC's function in respect of serious and systemic misconduct or maladministration in public administration is to assist in inquiry agencies and public authorities to identify and prevent such conduct. She said: "it is not to deal with individual persons other than by way of a section 36 [sic] referral if such referral should be made, or the independent exercise of the Ombudsman's powers to "deal with" a matter under section 25 insofar as that power relates to individual public officers".

53. She contended that publicly identifying former public officers and expressing an opinion as to whether or not they have committed misconduct or maladministration in public administration is not consistent with the statutory task the Commissioner is undertaking.

54. She contended that while section 36A(2)(b)(i) provides the ICAC with all of the powers of the agency that section is limited by section 24(2)(c)(d) in the sense that the powers may only be used in dealing with the matter.

55. She further contended that:

...section 32A(2)(b)(ii) [sic] the Commissioner is bound by any statutory provisions governing the exercise of those powers subject to such modifications as may be prescribed or as may be necessary for the powers, as if the Commissioner constituted the agency. Modification, in our submission, includes a modification of the power by virtue of the fact it is not consistent with the powers in the ICAC Act or the purpose of an inquiry into serious and systemic misconduct or maladministration in public office. "Modification" cuts both ways in the sense that it may restrict or it may enlarge depending on the statutory framework and the purpose of the ICAC Act.

56. She contended that although at 'first blush' there was a potential conflict between section 5 of the Royal Commission Act and section 26(3) of the Ombudsman Act and section 42(1a)(b) of the ICAC Act there is in fact no conflict at all.

57. She contended that no conflict arose because section 42 deals with preparing a report and section 26(3) deals with publishing a report.
58. She contended that there was no power on an administrative decision maker to prepare a report except that given by a statute. She contended that section 42 is an example of the express grant of such power.
59. She also contended that section 26 of the Ombudsman Act is directed to confidentiality and secrecy.
60. She contended that section 26 unlike the provisions in section 54 of the ICAC Act do not permit the Ombudsman to authorise himself to disclose general information he has obtained in the course of administering the Act except as provided for in the exceptions of section 26(2) and 26(3).
61. Therefore she said section 26(3) of the Ombudsman Act creates an exception to the secrecy requirement.
62. She said it is not a power available to the ICAC because the ICAC Act provides its own powers.
63. Moreover she said that even though section 5 of the Royal Commissions Act provides the power for a commission to publish, that power is not available to the ICAC because of the provisions in section 42 of the ICAC Act.
64. She argued that the only power available to the ICAC in relation to publication of reports is that contained in section 42 of the ICAC Act.
65. She contended that on the submissions made by Mr Besanko there was no work for section 42(1a)(b) to do.
66. Next she put that none of the objects of the ICAC Act would be advanced by identifying a public officer who in the ICAC's opinion has engaged in serious or systemic maladministration or misconduct. It is not, it was put, one of the ICAC's functions to prosecute or discipline public officers but the function of the ICAC is to assist inquiry agencies and public authorities to identify and prevent maladministration.
67. She dealt with Mr Besanko's reasons for his submission that the ICAC has the power under section 26(3) of the Ombudsman Act to publish a report if the ICAC considers it in the public interest to do so.
68. She said that the nine reasons advanced by Mr Besanko assume that section 26(3) of the Ombudsman Act confers a power in the relevant sense which she says is not the case. She repeated her submission that section 26(3) was an exception to the general secrecy provisions in section 26(1).
69. She contended that the ICAC must not prepare a report other than in accordance with the restrictions in section 42(1a)(b)(i).
70. In the alternative she submitted that if I do not agree with her principal submission I should not in any event identify Mrs Harrison's particular involvement in the report.
71. I do not intend to deal with that submission at this time but that is a matter for consideration if in due course I write a report in which I identify persons without their consent.

72. The purpose of making this statement is to respond to the submissions made that I cannot prepare a report which will in turn provide Mrs Vlahos, Mrs Harrison and Mr Goel with the opportunity if they wish to apply to the Supreme Court for an injunction to restrain me from preparing a report which identifies them in any way.
73. I have not obtained the consent of any party to be identified in a report that I would write because no one prior to 5 January 2018 had ever suggested that I needed to do so or that I could not prepare a report that identifies them without their consent. Nor have I, or do I, consider that I am obliged to obtain their consent.
74. If I were to accept the three parties' submissions it would be impossible to prepare a report that would in any way be comprehensible and address all of the matters contemplated in the terms of reference.
75. I agree in general with the submissions made by Mr Besanko and the reasons that follow are consistent with those submissions.
76. In my opinion the three parties' submissions should be rejected because I am not constrained by section 42(1a) of the ICAC Act from preparing a report that identifies all persons.
77. The ICAC's jurisdiction to investigate matters that raise a potential issue of serious or systemic maladministration arises under section 24(2)(b) of the ICAC Act.
78. That sub-section provides for three different ways in which a matter that has been assessed as raising a potential issue of misconduct or maladministration must be addressed. One of those ways is for the ICAC to exercise the powers of inquiry agency if satisfied that the matter raises potential issues of serious or systemic maladministration in public administration and it is in the public interest to do so: section 24(2)(b).
79. The matter may be referred to a public authority which would have to carry out its investigation in accordance with any directions and guidance given by the ICAC: s 24(2)(d). The public authority would not ordinarily have any statutory powers to aid in the investigation but it could be required by the directions and guidance to prepare a report for the ICAC.
80. If the matter was referred to the Ombudsman the Ombudsman would carry out the investigation in private and would have available all of the powers under the Royal Commission Act. At the conclusion of the investigation the Ombudsman could publish his report publicly using s26(3) of the Ombudsman Act because it is not said and cannot be said that s42 of the ICAC Act would prevent the Ombudsman doing so.
81. As I have said the matter may be investigated by the ICAC if the threshold requirements in s24(2)(c) are met. It is contended by three parties that, even if I were to conduct such an investigation, s42 of the ICAC Act would curtail the ICAC's ability to rely upon s26(3) of the Ombudsman Act to publish any report.
82. If the ICAC is of the opinion that the ICAC should exercise the powers of an inquiry agency the ICAC must proceed in accordance with section 36A of the ICAC Act.
83. The only inquiry agency is the Ombudsman. No other person has been declared by regulation to be an inquiry agency: section 4 of the ICAC Act.

84. Section 36A provides:

36A—Exercise of powers of inquiry agency

- (1) *The Commissioner must, before deciding (in accordance with section 24(2)(b) or (c)) to exercise the powers of an inquiry agency in respect of a matter raising potential issues of misconduct or maladministration in public administration, take reasonable steps to obtain the views of the agency.*
- (2) *If the Commissioner decides (in accordance with section 24(2)(b) or (c)) to exercise the powers of an inquiry agency in respect of such a matter—*
- (a) *the Commissioner may, by notice in writing to the agency, require that the agency refrain from taking action in respect of the matter or require that the agency only take action of a specified kind in relation to the matter; and*
- (b) *the Commissioner—*
- (i) *has all the powers of the agency; and*
- (ii) *is bound by any statutory provisions governing the exercise of those powers (subject to such modifications as may be prescribed, or as may be necessary for the purpose),*
- as if the Commissioner constituted the agency; and*
- (c) *the Commissioner must inform the agency of the outcome of the matter.*
- (3) *The Commissioner may at any time withdraw from exercising the powers of an inquiry agency, or decide to exercise such powers, as the Commissioner sees fit.*

85. The ICAC must comply with section 36A(1) which as I have said I did prior to giving evidence before the Committee.
86. If the ICAC decides to exercise the powers of an inquiry agency section 36A(2) is engaged.
87. Relevantly if the ICAC makes that decision the ICAC has all (emphasis added) the powers of the agency as if the ICAC constituted the agency: section 36A(2)(b)(i).
88. The particular powers of the Ombudsman that are relevant are those contained in section 19 of the Ombudsman Act which provides that the Ombudsman has the powers of a commission as defined in the Royal Commissions Act and therefore the powers that are given to a commission under the Royal Commissions Act.
89. There are two relevant powers given to a commissioner under the Royal Commissions Act. The first is in section 6 which empowers the commission to take evidence in public or in private.
90. The Ombudsman Act provides that the procedure in an investigation requires every investigation under the Ombudsman Act to be conducted in private: section 18(2).
91. I will deal with this more fully in due course but I am of the opinion that the effect of section 18(2) of the Ombudsman Act means that the Ombudsman must conduct an investigation into maladministration in private and so must the ICAC.
92. The second and more relevant power for present purposes is that the commission may publish such information obtained in the exercise of their functions as they think fit: section 5 of the Royal Commissions Act.

93. Therefore there is an express power given to a commission which is a power given to the Ombudsman or to the ICAC when exercising the powers of the Ombudsman, to publish such information obtained in the exercise of the ICAC's functions as the ICAC thinks fit.
94. That would include in my opinion publication in public.
95. Section 26 of the Ombudsman Act is relevant and it provides:

26—Confidentiality, disclosure of information and publication of reports

- (1) *A person engaged or formerly engaged in the administration of this Act must not disclose information obtained in the course of the administration of this Act except—*
- (a) *for the purposes of the administration of this Act or proceedings under this Act or the Royal Commissions Act 1917; or*
 - (b) *for the purposes of the performance of official functions by an agency to which this Act applies, any agency or instrumentality of this State, the Commonwealth or another State or a Territory of the Commonwealth, or any other statutory authority or statutory office holder; or*
 - (c) *as authorised or required by the Ombudsman.*

Maximum penalty: \$20 000.

- (2) *The Ombudsman is only to authorise or require information to be disclosed if of the opinion that the disclosure is in the public interest (but a person to whom an authorisation or requirement is directed need not inquire into the basis of the authorisation or requirement).*

- (3) *The Ombudsman may, if of the opinion that it is in the public interest to do so, cause a report on an investigation, or a statement about an investigation, or a decision not to investigate or to discontinue an investigation, to be published in such manner as the Ombudsman thinks fit.*

- (4) *Information that has been disclosed under this section for a particular purpose must not be used for any other purpose by—*

- (a) *the person to whom the information was disclosed; or*
- (b) *any other person who gains access to the information (whether properly or improperly and whether directly or indirectly) as a result of that disclosure.*

Maximum penalty: \$20 000.

96. Section 42 of the ICAC Act provides:

42—Reports

- (1) *The Commissioner may prepare a report setting out—*
- (a) *recommendations, formulated in the course of the performance of the Commissioner's functions, for the amendment or repeal of a law; or*

- (b) findings or recommendations resulting from completed investigations by the Commissioner in respect of matters raising potential issues of corruption, misconduct or maladministration in public administration; or
- (c) other matters arising in the course of the performance of the Commissioner's functions that the Commissioner considers to be in the public interest to disclose.

(1a) *The Commissioner must not—*

- (a) prepare a report under this section setting out findings or recommendations resulting from a completed investigation into a potential issue of corruption in public administration unless—
 - (i) all criminal proceedings arising from that investigation are complete; or
 - (ii) the Commissioner is satisfied that no criminal proceedings will be commenced as a result of the investigation, in which case the report must not identify any person involved in the investigation; or
- (b) prepare a report under this section setting out findings or recommendations resulting from a completed investigation into a potential issue of misconduct or maladministration in public administration that identifies any person involved in the particular matter or matters the subject of the investigation unless the person consents.

(2) *A copy of the report must be provided—*

- (a) in the case of a report of a kind referred to in subsection (1)(b)—to the public authority responsible for any public officer to whom the report relates and to the Minister responsible for that public authority; and
- (b) in any case—to the Attorney-General, the President of the Legislative Council and the Speaker of the House of Assembly.

(3) *The President of the Legislative Council and the Speaker of the House of Assembly must, on the first sitting day after 28 days (or such shorter number of days as the Attorney-General approves) have passed after receiving a report, lay it before their respective Houses.*

- 97. As I have said it was contended that the effect of section 42 (1a) means that, notwithstanding section 26(3) of the Ombudsman Act, the ICAC cannot prepare any report setting out findings or recommendations resulting from a completed investigation into a potential issue of misconduct or maladministration in public administration that identifies any persons involved in the particular matter of matters subject to the investigation unless the person consents.
- 98. The three parties who were relying upon section 42 for the argument that the ICAC could not exercise the powers under section 26(3) of the Ombudsman Act all indicated that they did not consent to being identified in any report.
- 99. They contended therefore that I could not prepare a report of any kind that would identify them.
- 100. One of Mrs Vlahos' contentions was that I could not exercise the power under s26(3) because I was not the Ombudsman but the ICAC. That submission misconceives the effect of s36A(2)(b)(i). That placitum provides the ICAC with the powers of the Ombudsman. It expressly recognises that the ICAC can exercise the Ombudsman's powers. That is the whole point of s36A. There is no question that I remain the ICAC, but in this case I am also given the powers of the Ombudsman.

101. Before proceeding further with the arguments it is necessary to analyse s26 of the Ombudsman Act and section 42 of the ICAC Act.
102. Section 26(1) of the Ombudsman Act imposes obligations on a person who is engaged or formally engaged in the administration of the Act not to disclose information obtained in the course of the administration of the Act except in accordance with paragraphs (a), (b) and (c) of that sub-section.
103. Section 26(2) prescribes the circumstances in which the Ombudsman may give the authority in section 26(1)(c).
104. Section 26(1) does not apply to the Ombudsman because it does not say it does. Section 26(2) specifically empowers the Ombudsman not only to authorise information to be disclosed but also to require information to be disclosed. Section 26(2) is much more than simply being an exception to the s26(1) injunction. Section 26(2) empowers the Ombudsman to require persons to disclose information. That power is also available to the ICAC.
105. Insofar as it empowers the ICAC to require a person to disclose information it is one of the powers contemplated in s36A(2)(b)(i) of the ICAC Act.
106. Section 26(3) is not an exception to the section 26(1) injunction. Section 26(3) only applies to the Ombudsman (ICAC⁵). It empowers the Ombudsman (ICAC⁶) to perform three separate functions being to publish a report on an investigation, or a statement about an investigation or a decision not to investigate or discontinue an investigation. These three separate powers are quite different to the section 42 power which is to prepare a report setting out findings or recommendations resulting from completed investigations.
107. Even if section 26(3) of the Ombudsman Act were simply an exception to the confidentiality provisions in section 26(1) which in my opinion it is not, the argument fails to address the power given to the ICAC when exercising the Ombudsman's powers by s5 of the Royal Commissions Act. That section allows the Ombudsman (ICAC⁷) to publish information "as they think fit". That section does not have the threshold requirements in section 26(3).
108. If s26(3) were merely an exception to section 26(1) of the Ombudsman Act secrecy regime what is the purpose of ss 26(1)(a) and (c) and 26(2)? Those sections would appear to be sufficient to permit the Ombudsman to disclose information otherwise the subject of the secrecy requirements which tends to indicate that s 26(3) has a broader and different purpose and confers a separate and distinct power.
109. That purpose is supported by an analysis of its legislative history.
110. Section 26 is in its current form because of amendments made by Schedule 3 of the ICAC Act when it was first enacted. Prior to the enactment of the ICAC Act the Ombudsman Act had two separate sections regarding confidentiality and publication of reports:

22—Secrecy

- (1) Information obtained by or on behalf of the Ombudsman in the course of or for the purpose of an investigation under this Act must not be disclosed except—*
- (a) for the purposes of the investigation and of any report or recommendation to be made under this Act; or*
 - (b) for the purposes of any proceedings under the Royal Commissions Act 1917 or under this Act.*

⁵ Where the ICAC is exercising the powers of the Ombudsman.

⁶ Ibid.

⁷ Ibid.

(2) A person shall not disclose any information referred to in subsection (1) contrary to the provisions of that subsect

26—Publication of report of investigation

If the Ombudsman considers it to be in the public interest or the interests of an agency to which this Act applies to do so, the Ombudsman may have a report on an investigation published in such manner as the Ombudsman thinks fit

- 111. When the Ombudsman Act was first enacted in the Second Reading Speech s26 was referred to by the then Attorney-General as “arm[ing] the Ombudsman with further powers to give appropriate publicity to his reports or recommendations”.
- 112. Clause 54 of Schedule 3 of the ICAC Act repealed ss 22 and 26 and substituted the present s26. The intention appears to be to consolidate matters about confidentiality and publication into one section rather than changing the nature of those powers.
- 113. In the Second Reading Speech of the ICAC Act the purpose of the consolidation of the sections was described:-

The provisions about confidentiality, disclosure of information and publication of reports are brought together and, as a consequence, sections 22 and 26 are repealed.

and it was further said in explanation:

48—Substitution of section 26

These amendments bring together the provisions about confidentiality, disclosure of information and publication of reports. It is an offence for a person engaged in the administration of the measure to disclose information obtained in the course of the administration of the Act except in the circumstances set out in subsection (1). Subsection (2) requires the Ombudsman to be of the opinion that it will be in the public interest to authorise or require information to be disclosed. Subsection (3) enables the Ombudsman to make a public statement or report if of the opinion that to do so would be in the public interest.

- 114. The purpose of section 42 ought to be identified. Section 42(1) identifies the circumstances in which the ICAC may prepare a report which must be provided to the persons in section 42(2) and not to any other persons.
- 115. There are three circumstances identified in section 42(1). The first is where the ICAC makes recommendations for the amendment or repeal of a law. The third circumstance is when matters have arisen that the Commissioner considers to be in the public interest to disclose.
- 116. The second circumstance which is relied upon by Mrs Vlahos, Mrs Harrison and Mr Goel is where the ICAC prepares a report setting out findings or recommendations resulting from completed investigations by the Commissioner in respect of matters raising potential issues of corruption, misconduct or maladministration in public administration.
- 117. It is to that circumstance that section 42(1a) refers when it limits content of a report in the manner provided.
- 118. Section 42(1a) is referring back to section 42 (1)(b) because it talks only about a report ‘under this section’.

119. Section 42(1)(b) does not refer to an individual investigation and does not empower the ICAC to publish a report of an individual investigation either publicly or indeed even to the persons mentioned in section 42(2). It provides a power to the ICAC to prepare a report setting out findings or recommendations resulting from completed investigations.
120. Section 42(1) contemplates a report by the ICAC which addresses more than one investigation. It empowers me, at my discretion, to prepare a report setting out findings or recommendations from completed investigations into corruption, misconduct or maladministration. It is clearly not a power intended to be used to address a particular investigation that would necessarily include a great level of detail as to the investigation, together with any findings and recommendations. Section 42 expressly contemplates a report about more than one investigation and addressing findings and recommendations made.
121. The power to make the report is derived from section 42(1) of the ICAC Act. Section 42(1a) merely informs the ICAC as to how the power must be exercised.
122. As I have said section 42(1) does not address individual investigations or individual matters. It contemplates that the ICAC will be writing a report arising out of matters learned during the course of the discharge by the ICAC of the ICAC's functions. It is an important power because it permits the ICAC to prepare a report for the attention of Parliament and to relevant Ministers and public authorities that might address a range of findings and recommendations that have been made following a number of investigations.
123. The arguments that have been put forward also rather assume that at the conclusion of every investigation the ICAC might prepare a report that the ICAC wishes to publish publicly.
124. In fact I have carried out a number of investigations in relation to maladministration and made findings and recommendations but not published the report containing those findings and recommendations because I did not think it was in the public interest to do so.
125. However the findings and recommendations arising from those investigations could form the subject matter of a report under section 42(1)(b) but if they did and if the ICAC made a report to Parliament in accordance with that section the report could not identify any person involved in the particular matter or matters the subject of the investigation without that person's consent. In most cases that would not present a difficulty because the report would address a range of investigations and be directed towards what has been learned from those investigations, rather than specifically identifying who engaged in misconduct or maladministration.
126. Of course, a report on an investigation is something else entirely.
127. The other thing to notice about section 42 is that it prescribes a code.
128. If the ICAC prepares a report in accordance with section 42(1) that report must be provided to the public authority responsible for any public officer to whom the report relates and to the Minister responsible for the public authority and in any case to the Attorney-General, the President of the Legislative Council and the Speaker of the House of Assembly.
129. There is no power for the ICAC to publish the report publicly.
130. The mechanism that follows is that the President of the Legislative Council and the Speaker of the House of Assembly must on the first sitting day after 28 days have passed lay it before the respective houses (unless the Attorney-General approves a shorter number of days): section 42(3).

131. The intent of that section is not for the ICAC to report publicly about the matters contained in the report but to provide the report to relevant Ministers, public authorities and Parliament which shall receive the report in accordance with section 42(3).
132. It would not be appropriate if a report were provided in accordance with section 42(1) for the ICAC to publish that report before the report were tabled in Parliament in accordance with the section 42(3).
133. The publication of a report prepared in accordance with section 42 of the ICAC Act through the medium of Parliament is quite different to the publication of a report of an individual investigation pursuant to section 26(3) of the Ombudsman Act which is in the discretion of the Ombudsman (or the ICAC⁸) after the Ombudsman (or the ICAC⁹) is first satisfied that it is in the public interest to publish the report.
134. After a report is provided in accordance with section 42(2) the ICAC has no control over its further publication.
135. Section 42 of the ICAC Act is a different power and given for a different purpose to the power given in section 26(3) of the Ombudsman Act.
136. In my opinion section 42 does not have the effect that the ICAC cannot rely upon section 26 (3) of the Ombudsman Act to prepare a report (or indeed publish that report) into maladministration in public administration publicly.
137. I will deal immediately with the submission that the construction contended for by counsel assisting Mr Besanko is inconsistent with article 14 of the Convention.
138. With respect I cannot see what the relevance of article 14 is to the proper construction of section 42 of the ICAC Act.
139. The Convention says all persons should be equal before the courts and tribunals. Mr Besanko did not address that issue and indeed nor has anyone else. Secondly it says everyone shall be entitled to a fair and public hearing by a competent independent and impartial tribunal established by law. Mr Besanko has not suggested otherwise.
140. I certainly have some sympathy for the proposition that a hearing of this kind ought to be in public but that is not a matter addressed in section 42.
141. The Convention next addresses the exclusion of the press but that is not a relevant matter for the purposes of Mr Besanko's submissions.
142. Lastly it talks about a judgment rendered in a criminal case or a suit at law should be made public.
143. I agree with that. That is what I suggest is the purpose of the power in section 26(3) of the Ombudsman Act.
144. The two paragraphs of counsel's submission to which I have referred do not indicate the relevance of the Convention to the issues presently before me.
145. I reject the suggestion that the Convention has any relevance to the construction of section 42 of the ICAC Act or section 26(3) of the Ombudsman Act.

⁸ Where the ICAC is exercising the powers of the Ombudsman.

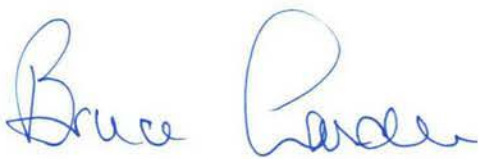
⁹ Ibid.

146. Section 42 of the ICAC Act is a different power to that given in section 26(3) of the Ombudsman Act. The two powers can work together harmoniously if understood as I have explained their functions.
147. There is nothing in s42 that would suggest Parliament intended to limit all the powers given to the ICAC by s36A(2)(b)(i). Any contention to the contrary should be rejected.
148. As I have already mentioned section 36A of the ICAC Act provides the ICAC with "all the powers of the agency": s36(2)(b)(i).
149. To read section 42 as denying the right of the ICAC to exercise one of the three powers under s26(3) of the Ombudsman Act to prepare or cause a report to be published, would be inconsistent with section 36 A(2)(b)(i).
150. To read section 42 of the ICAC Act as meaning that the ICAC cannot exercise the powers under section 26(3) requires a construction of section 36A(2)(a) as meaning that the ICAC has all the powers of the Ombudsman except the powers given to the Ombudsman under section 26(3). There is no reason to read the section that way.
151. Section 36A(2)(b)(ii) imposes upon the ICAC the same statutory provisions governing the exercise of the Ombudsman's powers as are imposed upon the Ombudsman but those statutory provisions are subject to such modifications as may be prescribed or as may be necessary for the purpose.
152. No modifications have been prescribed by the ICAC Act, the Ombudsman Act or the Royal Commissions Act or by any regulation made under those three Acts.
153. 'The purpose' which is addressed in section 36A(2)(b)(ii) is the purpose in section 36A(2)(b)(i).
154. If there are any statutory provisions of that kind these statutory provisions will be found in the three Acts which I have mentioned.
155. The point of the words in parentheses in section 36A(2)(b)(ii) is to consider whether the statutory provisions governing the exercise of the powers in section 36A(2)(b)(ii) in section 36A(2)(b)(i) should be modified when exercising the power in section 36A(2)(b)(i).
156. Section 36A(2)(b)(ii) does not have the effect of imposing further statutory provisions governing the exercise of the Ombudsman's powers.
157. The effect of section 36A(2)(b)(ii) is only to modify where necessary the statutory provisions governing the exercise of those powers.
158. It does not purport to identify the powers in section 42(1) of the ICAC Act as a power that modify the statutory provisions governing the exercise of the powers that are given to the Ombudsman by the Ombudsman Act.
159. In any event section 26(3) is not a statutory provision that governs the exercise of the Ombudsman's powers. It is in fact a power in itself, for the reasons I have set out above.
160. Section 36A(2)(b)(ii) of the ICAC Act has no application to section 26(3) of the Ombudsman Act.
161. Section 26(3) is not confined to publishing the contents of a report publicly.
162. Section 26(3) empowers the Ombudsman (and for the reasons I have mentioned the ICAC) to cause a report on an investigation, or a statement about an investigation, or a decision

not to investigate or discontinue an investigation to be published. Provided that the Ombudsman (or the ICAC if the ICAC is exercising the Ombudsman's powers) is satisfied that it is in the public interest to do so the manner of the exercise of that power is unfettered.

163. Section 42(1a) is not a power. Section 42(1) contains the powers to write a report. As I have said section 42(1a) is merely an instruction as to the manner in which the power in section 42(1)(b) should be exercised.
164. Section 42 does not address statements about an investigation or decisions not to investigate or discontinue an investigation.
165. That would mean that section 42 (1a) of the ICAC Act would need to be read as having a limited effect on section 26 of the Ombudsman Act by only applying to reports or alternatively to treat section 42 as taking away powers from the ICAC i.e. to make a statement or a decision to which section 42 itself does not refer.
166. The critical words in section 42 (1a) are that that subsection applies to preparing a report "under this section". A report made utilising the powers of the Ombudsman is not made under section 42.
167. The report that is referred to in section 42 is a report of a kind that is intended to be presented to Parliament setting out findings and recommendations following completed corruption, misconduct or maladministration investigations which the ICAC considers should be drawn to the attention of the public authority responsible for any public officer to whom the report relates and to the Minister responsible for that public authority and in any case to the Attorney General and the Parliament.
168. As I have already said, section 42(1)(b) is not intended to apply to an individual investigation. It applies to 'investigations' and section 42(1a) is engaged when a report of the kind intended in section 42(1)(b) is intended to be prepared. At that stage no one who is identified in any individual investigation which comprises one of the investigations referred to in the report can be named in the report without his or her consent.
169. An investigation of the kind that is carried out exercising the powers of the Ombudsman under the Ombudsman Act is not an investigation that relates to report "under this section" as mentioned in section 42 of the ICAC Act.
170. If section 42 were to apply to an investigation of this kind it would be almost impossible to ever prepare a report of the kind that would be required to address all aspects of the investigation.
171. In a practical sense it could not be envisaged that a person who might be found to have engaged in misconduct or maladministration would consent to being identified in any report.
172. If section 42 were the only source of power to prepare a report following an investigation exercising the powers of the Ombudsman, absent such consent it would be impossible to prepare any kind of understandable and meaningful report.
173. Mrs Harrison also appeared to advance the submission that the ICAC could only refer a public officer to a public authority under section 36 of the ICAC Act, and could not make findings in respect of potential maladministration. I do not accept that submission because it is inconsistent with section 36 itself. In those circumstances it does not support the argument that section 42 is the only source of power for the ICAC to prepare a report and for its dissemination.

174. It could not have been Parliament's intention to empower the ICAC to investigate serious or systemic misconduct or maladministration in public administration but to effectively deny the ICAC the ability to prepare any understandable and meaningful report on the investigation.
175. Moreover because the ICAC cannot prepare a report without a person's consent, the person whose consent is required could never know what was proposed to be in the report in advance of being asked to consent. Nobody would be likely to consent.
176. The three parties did not address the interaction between s42 and s25 of the ICAC Act. If s42 were read literally as applying to any matter investigated by the ICAC the ICAC's ability to make a public statement would be seriously curtailed.
177. As I have already said a complaint or report alleging misconduct or maladministration must be dealt with in accordance with s24(2) of the ICAC Act.
178. The argument therefore is that the Ombudsman can report publicly on an investigation referred by the ICAC under the ICAC Act but the ICAC who would necessarily be investigating serious or systemic misconduct or maladministration could not do so. That would be a most odd result.
179. There is a further observation that can be made. The Ombudsman Act requires the investigation to be in private: s18(3). If s42(1a) had the effect contended for the ICAC would have to carry out an investigation in private and only be able to prepare a report identifying a person involved in the investigation if the person consents. That would include persons who may not be the subject of the investigation. The ICAC could not justify carrying out any investigation in those circumstances.
180. In my opinion section 42 has no application to an investigation of this kind and as I have said I am of the opinion that I have the power to prepare a report on my investigation and publish that report if I consider it in the public interest to do so.
181. Having concluded that section 42 has no application I shall proceed to prepare my report. I intend to publish the report publicly because I am satisfied that it is in the public interest to do so, unless of course I am restrained by the Supreme Court.



The Hon. Bruce Lander QC
INDEPENDENT COMMISSIONER AGAINST CORRUPTION

2 February 2018

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APPENDIX 2

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**PERSONS WHO RECEIVED 18 DECEMBER 2018 EMAIL PERSONALLY OR
VIA LEGAL REPRESENTATIVE**

- Dr Aaron Groves
- Arthur Moutakis
- Barbara Spriggs
- Dr Brian McKenny
- Chris Sexton
- Daniel Torzyn
- David Swan
- Dr Duncan McKellar
- Dr Elias Rafalowicz
- The Hon. Gail Gago
- Jacheline (Jackie) Hanson
- The Hon. Jack Snelling
- Jenny Richter
- The Hon. John Hill
- Julie Harrison
- Karim Goel
- Kerim Skelton
- Learne Durrington
- The Hon. Leesa Vlahos
- Leonie Nowland
- Dr Margaret Honeyman
- Maria West
- Margot Mains
- Mark Leggett
- Maurice Corcoran
- Marilyn Penery
- Dr Peter Tyllis
- Dr Russell Draper
- Stephen Simon
- Vanessa Owen
- Vickie Kaminski

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APPENDIX 3

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SCHEDULE OF PERSONS WHO PROVIDED DOCUMENTS TO THE COMMISSIONER OTHERWISE THAN IN ANSWER TO A SUMMONS

Name	Manner in which documentation provided
Dr Aaron Groves	Request and voluntary
Alan Scarborough	Voluntary
Alec Mathie	Voluntary
Professor Alexander McFarlane	Voluntary
Alma Krecu	Voluntary
Anne Schneyder	Voluntary
Barbara Spriggs	Voluntary
Carla and Neil Baron	Voluntary
Chris Northcott	Voluntary
Christine Hillingdon	Voluntary
Dianne Mack	Voluntary
Dr Fiona Meredith	Voluntary
Dr Geoffrey Seidel	Voluntary
Graeme Murphy	Voluntary
Jacheline (Jackie) Hanson	Request
Karim Goel	Voluntary
Dr Katherine Sheppard	Voluntary
The Hon. Leesa Vlahos	Examination and voluntary
Mark Leggett	Voluntary
Maurice Corcoran	Voluntary
Dr Michelle Atchinson	Voluntary
Michelle Martin	Voluntary
Patrina Cole	Voluntary
Dr Peter Tyllis	Voluntary
Public Advocate	Voluntary
Dr Rebecca Wheatley	Voluntary
Rosalind Webb	Voluntary
Russell Draper	Examination
SA Coroner	Request
SA Health	Request
SA Police	Request
SA Salaried Medical Officers Association	Voluntary
Dr Sally Rischbieth	Voluntary
Sangeeta Dhanorkar	Voluntary
Sharon Olsson	Voluntary
Steven Marshall MP	Voluntary
Vickie Chapman MP	Voluntary
Winston Spruance	Voluntary

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APPENDIX 4

MINISTERS

During the period commencing on 4 November 2005 the following were the Ministers for the periods mentioned.

Minister for Health:

4 November 2005 to 21 October 2011 - The Hon. John Hill

Minister for Health & Ageing:

21 October 2011 to 21 January 2013 - The Hon. John Hill

21 January 2013 to 26 March 2014 - The Hon. Jack Snelling

Minister for Health:

26 March 2014 to 18 September 2017 - The Hon. Jack Snelling

Minister for Ageing:

26 March 2014 to Present - The Hon. Zoe Bettison

On 21 October 2011 the Ministry for Health was dissolved and on the same day the Ministry for Health & Ageing was established. The Ministry for Health & Ageing was dissolved on 26 March 2014 and the Ministry for Health and the Ministry for Ageing were established on the same day.

Minister for Mental Health and Substance Abuse:

23 March 2006 to 24 July 2008 - The Hon. Gail Gago

24 July 2008 to 25 March 2010 - The Hon. Jane Lomax-Smith

25 March 2010 to 21 January 2013 - The Hon. John Hill

21 January 2013 to 19 January 2016 - The Hon. Jack Snelling

19 January 2016 to 18 September 2017 - The Hon. Leesa Vlahos

CHIEF EXECUTIVES (SA HEALTH)

2006 to November 2010 – Mr Tony Sherbon

December 2010 to 2 September 2016 – Mr David Swan

September 2016 to December 2016 – Ms Vickie Kaminski (Interim)

December 2016 to Present – Ms Vickie Kaminski

CHIEF EXECUTIVE OFFICERS

The following entities had responsibilities for Oakden during the reference period:

- 14 July 2004 to 1 July 2010: Central Northern Adelaide Health Service.
- 1 July 2010 to 1 July 2011: Adelaide Health Service.

- 1 July 2011: Northern Adelaide Local Health Network, albeit management of mental health services fell within the remit of the Adelaide Metropolitan Mental Health Directorate which reported directly into the Department of Health at this time.
- 31 January 2013 to Present: Northern Adelaide Local Health Network.

The relevant CEOs of those entities were as follows:

1 January 2007 - David Panter, CEO of CNAHS
 2 January 2007 to 22 July 2007 - Kaye Challinger, Acting CEO of CNAHS
 23 July 2007 to 6 November 2009 - Karleen Edwards, CEO of CNAHS
 7 November 2009 to 6 December 2009 - Lesley Dwyer, Acting CEO of CNAHS
 7 December 2009 to 30 June 2011 - Martin Turner, CEO of CNAHS and then AHS
 1 July 2011 to 14 August 2011 - Julie-Ann Burgess, Acting CEO of NALHN
 15 August 2011 to 10 October 2014 - Margot Mains, CEO of NALHN
 10 October 2014 to 19 December 2014 - Maree Geraghty, Acting CEO of NALHN
 22 December 2014 to 18 January 2015 - Brett Thompson, Acting CEO of NALHN
 19 January 2015 to February 2018 - Jackie Hanson, CEO of NALHN

CHIEF PSYCHIATRISTS

July 2010 to November 2011 – Dr Margaret Honeyman
 November 2011 to January 2015 – Dr Panayiotis Tyllis
 February 2015 to 17 November 2017 – Dr Aaron Groves
 18 November 2017 to May 2018 – Dr Brian McKenny¹

PRINCIPAL COMMUNITY VISITOR

July 2011 to Present – Maurice Corcoran

¹ Dr Brian McKenny was appointed Interim Chief Psychiatrist on 18 November 2017 following the resignation of Dr Aaron Groves. His initial appointment was until 17 January 2018 but his interim appointment has been extended to May 2018.

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APPENDIX 5

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PERSONS WHO WERE INTERVIEWED

- | | | |
|-----------------------------------|---------------------------------|----------------------------|
| • Dr Aaron Groves ² | • Dr Geoffrey Seidel | • Steven Cleland |
| • Alan Bottrill | • The Hon. Dr Jane Lomax-Smith | • Dr Sujeeve Sanmuganatham |
| • Alan Scarborough | • Jay Christie | • The Hon. Tony Zappia |
| • Alec Mathie | • Julie Dundon | • Trudy Smith-Sparrow |
| • Prof Alexander McFarlane | • Katherine Shephard | |
| • Alma Krecu | • Kurt Towers | |
| • Anne Schneyder | • Lorraine Allen | |
| • Barbara Spriggs ³ | • Lorraine Baff | |
| • Bernadette Mulholland | • Maggie Nagyszollosi | |
| • Carla Baron | • Mark Martin | |
| • Caterina Serpo | • Maurice Corcoran ⁵ | |
| • Catherine Pirie | • Dr Michelle Atchison | |
| • Chris Northcott | • Michelle Martin | |
| • Christine Hillingdon | • Neil Baron | |
| • Craig Foster-Lynham | • Prof Nicholas Procter | |
| • David Stevens | • Dr Patrick Flynn | |
| • David Waterford | • Peter Morris | |
| • Deanna Stojanovic | • Dr Rebecca Wheatley | |
| • Dianne Mack | • Rosalind Webb | |
| • Dr Duncan McKellar ⁴ | • Dr Sally Rischbeith | |
| • Dr Elaine Pretorius | • Sangeeta Dhanorkar | |
| • Ervino Serpo | • Scott McMullen | |
| • Fiona Meredith | • Sharon Olsson | |
| | • Stewart Johnston | |

² Also gave evidence on 28 November 2017 by way of examination.

³ Also gave evidence on 31 October 2017 by way of examination.

⁴ Also gave evidence on 20 November 2017 by way of examination.

⁵ Also gave evidence on 1 November 2017 by way of examination.

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APPENDIX 6

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PERSONS WHO WERE EXAMINED

- Dr Aaron Groves⁶
- Arthur Moutakis
- Barbara Spriggs⁷
- Chris Sexton
- Daniel Torzyn
- David Swan
- Dr Duncan McKellar⁸
- Dr Elias Rafalowicz
- The Hon. Gail Gago⁹
- Jackie Hanson¹⁰
- The Hon. Jack Snelling¹¹
- Jenny Richter
- The Hon. John Hill
- Julie Harrison¹²
- Karim Goel¹³
- Kerim Skelton
- The Hon. Leesa Vlahos¹⁴
- Leonie Nowland
- Maria West¹⁵
- Margot Mains¹⁶
- Mark Leggett
- Maurice Corcoran¹⁷
- Merrilyn Penery
- Dr Peter Tyllis
- Dr Russell Draper
- Stephen Simon
- Vanessa Owen

⁶ Was also interviewed prior to his examination, and provided an affidavit after the examination.

⁷ Was also interviewed prior to her examination.

⁸ Was also interviewed prior to his examination.

⁹ Also provided a witness statement.

¹⁰ Also provided a witness statement and was cross examined by Mr Abbott QC, counsel for Mrs Vlahos.

¹¹ Also provided a witness statement.

¹² Provided an affidavit after the examination.

¹³ By request provided supplementary evidence by affidavit.

¹⁴ Provided an unsigned witness statement that was adopted at the examination.

¹⁵ Also provided a witness statement.

¹⁶ Also provided a witness statement.

¹⁷ Was also interviewed prior to his examination.

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APPENDIX 7

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**OAKDEN MALADMINISTRATION INVESTIGATION
(SUBMISSIONS RECIPIENTS)**

	Recipient
1	Kerim Skelton
2	Julie Harrison
3	Arthur Moutakis
4	Karim Goel
5	Vanessa Owen
6	Daniel Torzyn
7	Margot Mains
8	Maurice Corcoran
9	Jenny Richter
10	Jackie Hanson
11	Maria West
12	Chris Sexton
13	Dr Russell Draper
14	Jack Snelling
15	Dr Eli Rafalowicz
16	Gail Gago
17	Dr Peter Tyllis
18	Leesa Vlahos
19	John Hill
20	Leonie Nowland
21	Merrilyn Penery
22	David Swan
23	Dr Aaron Groves
24	Dr Margaret Honeyman
25	Dr Jane Lomax-Smith
26	SA Health
27	Interim Chief Psychiatrist (Dr Brian McKenny)
28	Learne Durrington
29	NALHN
30	State of SA

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APPENDIX 8

Oakden Maladministration Investigation (Schedule of submissions received from interested persons)

	Interested Person	Procedural submission (18 January 2018)	Substantive submission (25 January 2018)
1	Kerim Skelton	Nil	Nil
2	Julie Harrison	18 January 2018	31 January 2018
3	Arthur Moutakis	Nil	22 January 2018
4	Karim Goel	Nil	25 January 2018
5	Vanessa Owen	15 January 2018	15 January 2018, 25 January 2018
6	Daniel Torzyn	Nil	24 January 2018
7	Margot Mains	Nil	25 January 2018
8	Maurice Corcoran	Nil	2 January 2018, 5 January 2018
9	Jenny Richter	Nil	Nil
10	Jackie Hanson	Nil	Nil
11	Maria West	Nil	Nil
12	Chris Sexton	Nil	24 January 2018
13	Russell Draper	18 January 2018	25 January 2018
14	Jack Snelling	Nil	Nil
15	Eli Rafalowicz	Nil	Nil
16	Gail Gago	Nil	23 January 2018
17	Peter Tyllis	Nil	24 January 2018
18	Leesa Vlahos	18 January 2018 ¹	25 January 2018, 31 January 2018
19	John Hill	Nil	Nil

¹ Mrs Vlahos also made several informal requests and procedural submissions.

	Interested Person	Procedural submission (18 January 2018)	Substantive submission (25 January 2018)
20	Leonie Nowland	Nil	25 January
21	Merrilyn Penery	13 January 2018	25 January 2018
22	David Swan	Nil	23 January 2018 ²
23	Aaron Groves	18 January 2018	25 January 2018
24	Margaret Honeyman	Nil	19 January 2018
25	Jane Lomax-Smith	Nil	5 January 2018
26	SA Health	Nil	Nil
27	Brian McKenney Interim Chief Psychiatrist	Nil	8 February 2018
28	Learne Durrington	Nil	Nil
29	NALHN	Nil	See State of SA Submission
30	State of SA	Nil	25 January 2018

² Mr Swan responded confirming he did not wish to submit anything in response.

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APPENDIX 9

Progress on Oakden Recommendations – Report to the Office for Public Integrity

ANNEXURE A

Introduction

In April 2017, Dr Aaron Groves, former South Australian Chief Psychiatrist, submitted the Oakden Report to the Chief Executive Officer of the Northern Adelaide Local Health Network (NALHN) and to the then Minister for Mental Health and Substance Abuse. The Oakden Report documented the extensive and significant failures of services delivered through the Older Persons' Mental Health Service (OPMHS) at the Oakden Campus, resulting in poor quality care of older people with severe to extreme behavioural and psychological symptoms of dementia (BPSD) and severe and enduring mental illness.

The SA Health Oakden Response Plan Oversight Committee (the Committee) was established in June 2017 to provide oversight and guidance in implementing the six recommendations in the Oakden Report. Six distinct but interrelated expert working groups have been established to implement each of the recommendations.

The membership of the Committee is as follows, noting the Committee's discussions and decisions have been informed by key independent advisors including Dr Tom Stubbs:

Dr Tom Stubbs	Chair
Jackie Hanson	Chief Executive Officer, Northern Adelaide Local Health Network
Dr Brian McKenny	Chief Psychiatrist of South Australia
Dr Duncan McKellar	Head of Unit, Older Persons Mental Health Services, Northern Adelaide Local Health Network
Michele McKinnon	Executive Director, Quality, Information and Performance, Systems Performance and Service Delivery SA Health
Skye Jacobi/ Jeanette Walters	Executive Director, Policy and Governance
Lydia Dennett	Chief Nurse and Midwifery Officer, SA Health
Kurt Towers	Director Aboriginal Health, Northern and Central Adelaide Local Health Network
Dr John Maddison	SA Health Geriatric Medicine Representative
Dr Carole Fraser	Mental Health Representative, Central Adelaide Local Health Network
Dr Michael Page	Head of Unit, Older Persons Mental Health Services, Southern Adelaide Local Health Network
Dr Warwick Black	Head of Unit, Older Persons Mental Health Services, Country Health SA
Kirsty Delguste	Nursing Director, Geriatric Nursing Representative, Northern Adelaide Local Health Network
Joanne Molsher	Nurse Consultant, Older Persons Mental Health, Southern Adelaide Local Health Network
Michael Cousins/ E Kerrins	Chief Executive, Health Consumer Alliance
Carolanne Barkla	Chief Executive, Aged Rights Advocacy Service
Jane Mussared	Chief Executive, COTA
Anne Gale	Public Advocate, Office of the Public Advocate
Maurice Corcoran	Principal Community Visitor, Community Visitor Scheme

Development of a specialised contemporary model of care for people over 65 years of age who live with the most severe forms of disabling mental illness and/or extreme behavioural and psychological manifestations of Dementia.

1. The provision of appropriate infrastructure to implement the model of care.
2. Development of a staffing model that utilises the full range of members of a multidisciplinary service.

Progress on Oakden Recommendations – Report to the Office for Public Integrity

3. Development of a new and appropriate clinical governance system.
 4. Ensuring there are people in senior leadership positions that can create a culture that values dignity, respect, care and kindness for both consumers and staff.
 5. Development of an action plan based on Trauma Informed Principles and the six core strategies developed by the National Centre for Trauma Informed Care.
- 1. *Development of a specialised contemporary model of care for people over 65 years of age who live with the most severe forms of disabling mental illness and/or extreme behavioural and psychological manifestations of Dementia.***

The *Oakden Response Models of Care Project: Volume 1* (the MOC) document presents work undertaken by the State-wide Model of Care Expert Working Group (EWG), comprising members with lived experience, industry and community stakeholders, representatives from industrial bodies and health professionals from a variety of different disciplines from all South Australian local health networks (LHNs) (excluding the Women's and Children's LHN).

The MOC EWG conducted gallery walks with consumers, family members, advocacy groups, SA Health staff and industry partners, collecting valuable feedback and data to inform the MOC, which was then subsequently approved by the Oakden Response Plan Oversight Committee.

Ms Vickie Kaminski, Chief Executive, SA Health, then endorsed the MOC through to the Hon Minister for Health & Mental Health on 6 November 2017. Industry stakeholder ANMF requested via Minister further opportunity for consultation. A meeting with NALHN and ANMF occurred on 13 December 2017. The outcomes of the meeting were tabled and discussed at the meeting of the Committee on 15 December 2017.

The MOC contains a comprehensive model of care for people with very severe and extreme BPSD. Key recommendations are:

- Streamed models of care for people with very severe and extreme BPSD and for people with severe and enduring mental illness.
- Development of a 24-bed single site Neuro-Behavioural Unit (NBU) as a Centre of Excellence for sub-acute care of very severe to extreme BPSD.
- Development of Specialist Residential Units (SRUs) through a partnership model between SA Health, the Australian Commonwealth and approved non-government aged care providers, for non-acute accommodation and care of severe to very severe BPSD. The EWG recommends a stage 1 development of 60 beds across metropolitan Adelaide, led by SA Health, with a further 60 beds in stage 2.
- Development of the Rapid Access Service (RAS) model of specialist and responsive in-reach to mainstream residential aged care facilities from community Older Persons Mental Health Service. This is an important capacity building strategy for both future service needs and with immediate implications in the interim period while NBU and SRU services are under development.

The EWG is continuing its development of the Models of Care for:

- Residential Services for older people with severe and enduring mental illness

Progress on Oakden Recommendations – Report to the Office for Public Integrity

- Services for regional communities.

These models will be delivered in Volume 2 of The Oakden Response Models of Care Project document, which will likely be discussed and endorsed at the 9 February 2018 meeting of the Committee.

2. *The provision of appropriate infrastructure to implement the model of care.*

The MOC recommends a new Facility for people with very severe and extreme behavioral and psychological symptoms of dementia be:

- A single facility.
- Be located at a site that supports recovery, geriatrician partnerships and potential palliative Care and rehabilitation, and is as centrally located as possible.
- A 24 bed facility, configured into four pods of six beds each.
- Design that support the active involvement of consumers carers and family members
- The importance of good internal and outdoor space.

Key facility requirements were developed by the New Facility EWG in line with the model of care, and several site options including Glenside (dismissed as insufficient available area), and TQEH (dismissed as insufficient available area) were considered. Noarlunga, Glenside and Modbury Hospital sites were all considered suitable to house the 24 bed facility, at this stage the Modbury Hospital option is preferred for its:

- accessibility from central Adelaide;
- collocation with medical services;
- collocation with geriatric services;
- access to imaging, pathology, pharmacy services;
- rehabilitation services, including gymnasium and hydrotherapy;
- facilities that support Allied Health led recovery;
- support from community mental health services;
- public transport; and
- ability to deliver the project within the next 1-2 years.

This position was endorsed at the 15 December 2018 Steering Committee meeting, noting the Committee requested further scoping and costing work be undertaken prior to confirming Modbury as the new site.

All efforts are being taken for the proposed building site to accommodate the existing \$14.7 million funding allocated from the previous State Budget. However, given the specialised and technical requirements of the facility, final confirmation of a costing estimate is required and will be considered by the Oversight Committee.

Further to the above, the Infrastructure EWG Chair is tasked with considering a more centrally located Metropolitan Greenfield site.

3. *Development of a staffing model that utilises the full range of members of a multidisciplinary service.*

Several meetings of the Staffing EWG have occurred since the finalisation of the MOC in early November 2017.

Progress on Oakden Recommendations – Report to the Office for Public Integrity

A recommended staffing profile for the state-wide Neuro-behavioral Unit is nearing completion. Following the finalisation of the staffing profile, the Staffing Expert Working Group will recommend in March 2018 a staffing profile for the proposed Specialist Residential Units and community based Rapid Access Service contained within the draft Volume 2 of the Oakden Response Models of Care Project document.

4. *Development of a new and appropriate clinical governance system.*

The Quality and Safety EWG undertook an extensive research exercise, analysing relevant documentation and information from Local Health Networks and the Department for Health and Ageing relating to clinical governance reporting and accountability structures. A comprehensive consultation and engagement process with each Local Health Network's clinical governance leaders, Mental Health Directors and Older Persons' Mental Health Services leads was also undertaken.

Following that work, a draft Clinical Governance was developed in consultation with Consultant Dr David McGrath and provided to the Oakden Response Plan Oversight Committee on 15 December 2017 for consideration and feedback. The draft Clinical Governance Framework will be finalised and presented again to the Committee, following the closing of the consultation period on 9 February 2018.

5. *Ensuring there are people in senior leadership positions that can create a culture that values dignity, respect, care and kindness for both consumers and staff.*

Following a comprehensive literature review of best practice cultural change documentation, the Culture Expert Working Group conducted a series of gallery walks in November 2017 to guide the development of a culture framework that will address and promote respectful behaviours, team building and effective team work, values-based leadership, providing and receiving constructive feedback, effective problem solving and positive communication.

Key themes, ideas and visions were developed and tested at well attended Focus Groups held on 23 January 2018.

A draft Cultural Framework will now be developed in consultation with Mary Freer from Freerthinking Consulting, before being presented to the Culture Expert Working Group in February 2018 and Oakden Response Plan Oversight Committee for consideration and approval in March.

It should be noted that "Oakden Culture" no longer exists. Northgate House is providing respectful person-centered care, the environment promotes and values the reporting of Medication errors, restraint, falls, resident to resident and staff to resident incidences.

6. *Development of an action plan based on Trauma Informed Principles and the six core strategies developed by the National Centre for Trauma Informed Care.*

The Restrictive Practices Expert Working Group, whose members comprise a broad range of specialist clinicians, stakeholders, industry partners and lived experience consumers, has made significant progress against their remit, including:

- The development of the Reducing Restrictive Practices Implementation Plan, which was considered and approved by the Oakden Response Plan Oversight Committee on 17 November 2017. This final plan will be considered by Department of Health & Aging in February 2018.
- The development and distribution to Older Persons' Mental Health staff of two surveys: Workforce Readiness for Change and Knowledge on Restraint and Seclusion.

Progress on Oakden Recommendations – Report to the Office for Public Integrity

- The Western Australia and New South Wales Older Persons' Services have agreed to explore peer benchmarking with South Australia.
- Weekly reports showing past week and trending data being displayed and visible to staff, consumers, carers and visitors to Ward 1H Lyell McEwin Hospital, and Beachside and Woodlands Wards at Northgate House. This enables transparency and engages families and staff in meaningful monitoring of performance, management of challenges, and celebration of successes on a weekly basis.
- Fifty-four Northgate House and 1H staff have completed Managing Aggressive and Potential Aggressive (MAPA) training. This has included nursing, medical and allied health staff. The two Older Persons Mental Health Services (OPMHS) MAPA trainers will develop a training schedule to deliver training to staff who haven't yet received it and provide capacity throughout 2018 for training of new OPMHS staff and refresher training for staff, including Trauma Informed Care and Medication Competencies.

It is anticipated that the Committee will review its work against all recommendations in May 2018 and recommend to the Chief Executive DoHA that it stands down in June 2018 as it has fulfilled its charter and all recommendations are implemented.

APPENDIX 10

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN



Located on SLS (from 2010)



Located on Complaints Register

Date	Complainant	Recipient	Subject	Medium
21 January 2007	Joy Mallett	Hon. John Hill	Accommodation difficulties in aged care where person suffers from dementia.	Letter
9 July 2007	Rosalind Webb	HCSCC	Ineptitude of care, lack of doctors, little evidence of medical examination.	Email
27 August 2007	Joy Mallett	Hon. Gail Gago	Quality of care at Oakden, daughter denied the ability to walk around.	Letter
30 November 2007	Tanya Granger	Kerim Skelton ACCC	Consumer absconded from Oakden, attitude of staff, lack of response to complaints.	Letter
14 December 2007	Sharon Olsson	Julie Harrison	Cultural and nursing practices, lack of leadership, prolonged restraint, seclusion, staff having inadequate knowledge and skills.	Report
December 2007	ACCC	Chris Sexton	Consumer restrained for up to 24 hours per day, lack of recreation for consumers.	Letter
December 2007	ACCC	Jeff Cook Merrilyn Penery	Consumer escaped from the facility.	Face to face
2 January 2008	Josephine Monk	Unrecorded	Consumer given another consumer's medication.	Face to face
3 January 2008	Consumers, Families	Learne Durrington Chris Sexton Rebecca Graham Julie Harrison Sharon Olsson Kerim Skelton Arthur Moutakis Andrew Modra Karen Pocock Carla Baron Neil Baron	Medication issues, environment is restrictive, feeding process issues.	Residents and Families Information Session
9 January 2008	Tanya Granger	Arthur Moutakis	Consumer found in wrong bed, increase in rate of falls by a consumer.	Telephone
11 January 2008	Neil Baron Carla Baron	Julie Harrison	Rostering was overly convoluted.	Report

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

16 January 2008	Janine Buob	Julie Harrison	Facility is malodorous, gloomy, uninviting, impersonal, lack of space, insufficient toilets. Lack of leadership visibility, excessive use of agency staff, lack of medical supervision, medical mismanagement, staff lacked knowledge and education, documentation issues.	Report
21 January 2008	Fiona Meredith	Learne Durrington Sharon Olsson Julie Harrison Chris Sexton	Management not addressing concerns, co-ordinated response to decision making, staff in a state of occupational burnout.	Face to face Report
21 January 2008	Sue Sedivy	Learne Durrington Chris Sexton Julie Harrison Sharon Olsson	Incidents not being reported correctly, lack of commitment from managers to health and safety, lack of effective hazard management, management culture of risk aversion.	Email
22 January 2008	Natasha Searcy	Hon. Gail Gago	Security of tenure of violent consumers and the need for greater service links.	Letter
31 January 2008	Various Families	Chris Sexton Julie Harrison Sharon Olsson Arthur Moutakis Andrew Modra	Concerns as to how Oakden was allowed to "get so bad".	Meeting
31 January 2008	Tanya Granger	Arthur Moutakis	Unexplained weight loss of consumer, scratches and bruises on consumer.	Telephone
January 2008	Fiona Meredith	Sharon Olsson	Lack of psychiatrists and geriatricians.	Undetermined
January 2008	Fiona Meredith	Derek Wright	Lack of resources, staff cultural issues, no improvements, akin to human rights abuse.	Face to face
January 2008	Julie Dundon Anne Schneyder	Julie Harrison	Staff assuming weight loss is inevitable, malnourishment, weigh scales were unreliable, no system for ensuring correct meals, worst facility reviewed in 25-30 years.	Report
January 2008	Julie Dundon Anne Schneyder	Julie Harrison	Nutrition issues at Oakden.	Report
13 February 2008	Maggie Nagyszollosi	Arthur Moutakis	Doctor not willing to listen to concerns regarding medication.	Telephone

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

13 February 2008	Unrecorded	Arthur Moutakis	Bruising on consumer.	Verbal
15 February 2008	Fiona Meredith	Julie Harrison	Enclosed the Recommendations to Management again.	Letter
15 February 2008	Fiona Meredith	Julie Harrison	Limited evidence of consumers being treated with dignity and respect; values inconsistent with best practice; facility is not homelike and is malodorous; institutional prison-like feel; key members of leadership are largely absent; poor morale; little staff training; lack of recreational activities; poor management practices; culture of risk aversion; lack of medical and psychiatric review; no regular assessments or evaluations.	Report
26 February 2008	Tanya Granger Gina Leifhert	Arthur Moutakis	Failure by staff to follow care plan.	Telephone
26 February 2008	Maria Carbone	Arthur Moutakis	Injuries sustained by consumer.	Telephone
29 February 2008	Tina Beaton	Hon. Jay Weatherill Hon. Gail Gago	Serious issues impinging on consumer and staff safety, staffing and training level issues, dated management systems, lack of mental health nurses available.	Letter
February 2008	Simon Stafrace Alan Lilly	CNAHS Dept. of Health	No systematic approach to quality improvement or risk management or clinical governance; confusion around nursing home status; little evidence of multidisciplinary input; lack of leisure and lifestyle activities; high reliance on agency staff.	Report
6 March 2008	Hon. Justine Elliot	Hon. Gail Gago	Safety of consumer at Makk and McLeay, risk of violent behaviours, arrangements for Peter Palmer following death of Graham Rollbusch.	Letter
11 March 2008	Sharon Olsson	Karleen Edwards	Management intervening in decision-making, multiple resignations, lack of transparency and information.	Memo
12 March 2008	Geoff Whatley	Arthur Moutakis	Consumer not given medication.	Verbal
19 March 2008	Mrs Hennessy	Arthur Moutakis	Medication given without knowledge/consent.	Telephone
1 April 2008	Steve Barilla	Arthur Moutakis	Recently deceased consumer shown on television.	Telephone
14 April 2008	Maggie Nagyszollosi	Unrecorded	Increase in lost clothing.	Letter

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

14 April 2008	Barbara Barrington	Unrecorded	Medication issues.	Face to face
15 April 2008	Richard Glendon	Hon. Gail Gago	Worn-out equipment, air-conditioning was ineffective, meals poor quality.	Letter
1 May 2008	Unrecorded	Unrecorded	Allegation of abuse by staff member, consumer inappropriately dressed.	Written
5 May 2008	Unrecorded	Unrecorded	Inappropriate use of PRN medication as restraint for behaviour management, lack of doctors, outdoor areas need fixing, living areas too small, lack of leisure and lifestyle activities, agency staff unfamiliar with needs of the consumer.	Face to face
7 May 2008	Ashley Barrington	Arthur Moutakis	Nursing staff disregarding complaints, lack of respect.	Telephone
15 May 2008	ACCC	Julie Harrison	Bruising and injuries on consumers, issues with staff handovers.	Face to face
29 May 2008	Unrecorded	Unrecorded	Lack of staff skills in relation to dementia, lack of English spoken by some staff.	Verbal
30 May 2008	Unrecorded	Unrecorded	Dentures inserted into incorrect consumer.	Verbal
30 May 2008	Neil Baron	Hon. Gail Gago Hon. Justine Elliot	Families exasperated from dealing with issues, little evidence of constructive change in the facility, inability to provide basic needs to consumers, consumers placed in lockdown, breaches of duty of care owed to consumers.	Letter
1 June 2008	Neil Baron	Greg Adey Hon. Gail Gago Hon. Justine Elliot	Concerns about the situation generally at Oakden.	Letter
4 June 2008	Unrecorded	Unrecorded	Staff told not to communicate with a consumer who struggled to understand, insufficient supply of stoma bags.	Verbal
5 June 2008	Unrecorded	Unrecorded	Consumers do not have access to their rooms during the day.	Verbal
6 June 2008	DOHA	Unrecorded	Use of nutritional supplements without review/assessment, no proper care plan review.	Written
10 June 2008	DOHA	Unrecorded	Service is not homely, poor quality of care, family not consulted on decisions, competence of staff, no access to external services, poor hydration, poor dental care, poor laundry services.	Written

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

12 June 2008	DOHA	Unrecorded	Bruising to consumer, poor signage, poor communication from staff including about medication, high use of agency staff, poor staff attitude, poor internal complaints mechanisms, poor grooming, lack of exercise, lack of dignity and respect, wrong clothing used, increased restraint practices, overmedication, strong urine odour, lack of private area, staff not engaging with consumers, poor continence management, training issues, physical assaults.	Written
16 June 2008	Unrecorded	Unrecorded	Dignity of consumer compromised, lack of respect to consumer.	Written
17 June 2008	Arthur Moutakis	Philip Galley Merrilyn Penery	Lack of clarity in complaints mechanism.	Management meeting
22 June 2008	Glenis Glamock	Mike Mitchell	Alleged sexual interference.	Face to face
30 June 2008	Unrecorded	Unrecorded	Lack of concern shown by doctor, failure to advise family of medical issues.	Written
June 2008	Fiona Meredith Sharon Olsson	HCSCC	General issues at Oakden.	Undetermined
June 2008	Fiona Meredith Sharon Olsson	Health Ombudsman	General issues at Oakden.	Undetermined
4 July 2008	DOHA	Unrecorded	Family members given different information about investigation findings.	Written
5 July 2008	DOHA	Unrecorded	Lack of consultation about PRN medication, lack of staff training.	Written
5 July 2008	Unrecorded	Unrecorded	Representative Meeting Forums are negative and deter people from attending.	Written
9 July 2008	"Humphries"	Julie Harrison	Nurse forcibly pushing resident into chair, consumer not allowed to go to toilet.	Undetermined
10 July 2008	HCSCC	Karleen Edwards	Complaint made in relation to consumer.	Letter
10 July 2008	Unrecorded	Unrecorded	Consumer had faeces on hands.	Verbal
30 July 2008	ACCC	Kerim Skelton	Medication error.	Written
31 July 2008	Unrecorded	Kerim Skelton	Staff member asleep while on duty.	Verbal

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

26 August 2008	ACCC	CNAHS Julie Harrison	Breach of the Charter of Residents' Rights and Responsibilities.	Letter
August 2008	ACCC	CNAHS	Failure to complete restraint assessment and authorisation forms, failure to provide an adequate internal complaints process.	Letter
1 September 2008	DOHA	Unrecorded	Education for staff about medication, nutrition issues.	Written
27 September 2008	Unrecorded	Unrecorded	Bruising on consumer.	Verbal
20 October 2008	Maggie Nagyszolosi	Unrecorded	Injuries caused to consumer.	Face to face
27 October 2008	Maggie Nagyszolosi	HCSCC	Family was declined access to case notes relating to family member consumer.	Telephone
28 October 2008	Josephine Monk	Kerim Skelton	Performance of care worker.	Written
28 October 2008	Unrecorded	Unrecorded	Poor attitude of staff.	Written
29 October 2008	Unrecorded	Unrecorded	Change of medication without consultation and review.	Written
~4 November 2008	Tanya Granger	Arthur Moutakis	Increasing rate of falls of consumer.	Telephone
6 November 2008	Neil Baron	Karlene Edwards	Concerns about a malicious letter sent by Executive Director, Mental Health Services.	Letter
10 November 2008	Unrecorded	Unrecorded	Bruising on consumer.	Written
20 November 2008	Unrecorded	Unrecorded	Attitude of staff, poor communication from medical staff.	Written
28 November 2008	Carmine Ricci	Kerim Skelton	Consumer was put in strangle-hold, restrained from behind, verbal altercations with staff.	Complaints Form
4 December 2008	Maggie Nagyszolosi	Arthur Moutakis	Consumer on the floor, consumer injury.	Telephone
6 December 2008	DOHA	Unrecorded	Complaint resolution processes at Oakden.	Written
19 December 2008	Maggie Nagyszolosi	Unrecorded	Inadequate staff supervision.	Face to face
2 January 2009	DOHA	Unrecorded	Advocate denied access to Oakden.	Written

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

9 January 2009	Unrecorded	Unrecorded	Staff behaviour.	Verbal
2 February 2009	ACCC	CNAHS	Issues with consultation, medication management, detention orders, pain assessments, behaviour management, access to information, safety and supervision of consumers.	Letter
4 February 2009	Neil Baron	Annie Hosking Charmaine Ostermann Mary Nagy	Perceived retribution for raising complaints, staff ignoring requests.	Email
16 February 2009	Maggie Nagyszollosi	Derek Wright	Inappropriate prescription to consumer, refusal to provide information.	Letter
17 February 2009	Maggie Nagyszollosi	ACQAA	Unsafe furniture, broken toilet, use of medication, issues with particular agency worker, supervision after hours, restraint authorisation forms, access to care plans.	Face to face
27 February 2009	Natasa Mladenovic	Eli Rafalowicz	Culture at Makk and McLeay prohibited good care as vital records were perverted, staff conspired to cover up facts, and relatives are bullied/insulted.	Letter
6 March 2009	Natasa Mladenovic	Hon. Jane Lomax-Smith Hon. John Hill	Culture at Makk and McLeay prohibited good care as vital records were perverted, staff conspired to cover up facts, and relatives are bullied/insulted.	Letter
11 March 2009	Natasa Mladenovic	Chris Sexton	Staff member misrepresented information in case notes, bullying/harassment.	Letter
16 March 2009	Don Freeman	OPA	Verbal abuse from consumers.	Verbal
23 March 2009	ACCC	CNAHS	Failure to maintain, review and update policies and procedures for managing complaints. Failing to respond appropriately to complaints and address issues without causing complainants to feel intimidated and bullied.	Letter
24 March 2009	Susan Smith	Kerim Skelton	Consumer entered out-of-bounds area and could have escaped.	Email
1 July 2009	ANMF	Kerim Skelton	Staffing levels at Oakden.	Letter
15 July 2009	Dept. of Health	Unrecorded	Consumer not receiving physiotherapy, no activities offered by staff.	Complaints register

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

20 July 2009	Sally Smith	Arthur Moutakis	Lack of response to needs of consumer.	Undetermined
27 July 2009	Annette Dakin	Julie Harrison	Staff swearing at consumer, assault on consumer.	Letter
30 July 2009	Chris Northcott	Robin Mutton Lane Fletcher Sally Rischbeith Kerim Skelton Julie Harrison	Behaviour management strategies including denial of access to food, assaults by consumers, disrespectful responses from staff.	Email
10 August 2009	Unrecorded	Unrecorded	Broken equipment.	Written
18 September 2009	Josephine Monk	Unrecorded	Damage to property as a form of perceived retribution, lack of consultation.	Written
18 September 2009	Josephine Monk	Unrecorded	Poor hygiene, staff turnover leading to lack of familiarity with needs of consumers.	Written
23 October 2009	Clem Demetrious	Unrecorded	Vaccination given without consent.	Verbal
26 October 2009	Maria Portolesi	Hon. John Hill Chris Sexton	Inadequate staffing levels, lack of a dedicated manager.	Email
2 November 2009	Clem Demetrious	Unrecorded	Medication stopped without consultation.	Letter
10 December 2009	Lee Miller	Julie Harrison	Potential elder abuse, poor behaviour and attitude of staff.	Undetermined
16 December 2009	Unrecorded	Unrecorded	Quality of food.	Verbal
17 December 2009	Unrecorded	Unrecorded	Issues with princess chairs (restraint), consumer eye infection.	Verbal
25 December 2009	Cheryl King	Unrecorded	Lack of communication with families.	Written
5 January 2010	David Samson	Sandra Bayley	Assault by staff member on a consumer, inadequate staffing levels.	Telephone
8 January 2010	Giles Family	Arthur Moutakis Merrilyn Penery	Consumer assault.	Face to face

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

8 January 2010	Julie Harrison	Kerim Skelton Chris Sexton Alan Scarborough	Incidents of aggression.	Email
10 January 2010	Unrecorded	Unrecorded	Consumer gained access to kitchen and was stabbing things with fork, poor process adopted for medication crushing for consumers.	Written
22 January 2010	Patricia Frizzari	HCSCC	Failure to consult on costs.	Telephone
17 February 2010	Clem Demetrious	Unrecorded	Noise pollution and fumes.	Written
26 March 2010	Joy Mallett	Julie Harrison	Unable to enter the building as locked, lack of English spoken by workers.	Letter
28 April 2010	Dora Mushangera	Merrilyn Penery	Issue involving restraint of a consumer.	Face to face
19 May 2010	Julie Harrison	Alan Scarborough Chris Sexton	Lack of on-site clinical leadership.	Memo
9 June 2010	Lesley Dwyer	Hon. John Hill	Elder abuse, restraint.	Letter
19 June 2010	Christine Blakeley Beryl Blakeley	HCSCC	Level of sedation, lack of hygiene, lack of concern from staff, unexplained bruises, lack of communication.	Letter
5 July 2010	Grace Carbone	Unrecorded	Safety of consumers.	Written
3 August 2010	Unrecorded	Unrecorded	Issues with care and treatment, and need for improvement to alarm systems.	Email
6 August 2010	Unrecorded	Unrecorded	Issues with care and treatment.	Email
18 August 2010	Clem Demetrious	Unrecorded	No staff available in the office.	Written
23 August 2010	Joy Mallett	Julie Harrison	Staff disrespectful.	Letter
27 August 2010	Patricia Marotta	OPA	Care given to a consumer.	Face to face
30 August 2010	HCSCC	Martin Turner	Treatment of a consumer.	Letter

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

3 September 2010	Joy Mallett	Unrecorded	Disrespectful behaviour of staff.	Letter
11 September 2010	Clem Demetrious	Unrecorded	Assault by consumer.	Written
15 September 2010	Will Robertson	Unrecorded	Staff sitting around in foyer with their eyes closed.	Verbal
16 September 2010	Unrecorded	Unrecorded	Lack of information provided to family.	Unrecorded
27 September 2010	Clem Demetrious	Unrecorded	Facility is too noisy.	Written
2 October 2010	Theresa Paech	Unrecorded	Assault by consumer.	Written
~4 October 2010	Theresa Paech	Unrecorded	Assault by consumer.	Complaints register
6 October 2010	Will Robertson	Unrecorded	Assault by consumer.	Complaints register
15 October 2010	Matthew Tyler	Arthur Moutakis	Excessive force, restraint, rough handling, staff rushing to finish duties.	Email
1 November 2010	Unrecorded	"CNC at Clements"	Consumer locked in bedroom and left for a long time, failure to provide meals.	Letter
10 November 2010	Unrecorded	Unrecorded	Service issues and care plan with consumer.	Letter
25 November 2010	Joy Mallett	Chris Sexton	Concerns that responses given were untrue, failure to provide lunch to a consumer, agency staff ignoring doorbell and not opening the doors to families.	Letter
1 December 2010	Unrecorded	Unrecorded	Communication with staff.	Letter
23 December 2010	Joy Mallett	Arthur Moutakis Emilio Mancuso	Communication issues with staff, lack of leisure/lifestyle activities.	Verbal
24 December 2010	Betty Denton	Unrecorded	Issues with treatment and care.	Telephone
30 December 2010	Betty Denton	Arthur Moutakis	Lack of medical support, issues with standard of care, safety concerns.	Telephone
17 January 2011	Lorraine Allen	HCSCC	Concerns about whether risk of assaults in future.	Telephone

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

18 January 2011	Betty Denton	Hon. John Hill	Aggressive consumers mixed with non-aggressive consumers, lack of space at facility, consumers assaulting each other, lack of reporting to families.	Letter
3 February 2011	HCSCC	AHS	Assault on consumer, delay in calling an ambulance.	Letter
14 February 2011	Lesley Dwyer Paula Hakesley	Hon. John Hill	Safety concerns regarding aggressive consumers being mixed with non-aggressive consumers. Relates to complaint by Betty Denton.	Letter
19 February 2011	Steve Cornish	Merrilyn Penery	Bruising on father who was a consumer, medication not regularly being provided.	Complaint Form
21 February 2011	Unrecorded	Unrecorded	Unreasonable delay in access to medical practitioner.	Feedback form
21 February 2011	Unrecorded	Unrecorded	Issues with clinical care.	Feedback form
23 February 2011	HCSCC	Unrecorded	Issues in relation to the death of Graham Rollbusch.	Letter
8 March 2011	Unrecorded	Unrecorded	Allegation of elder abuse, care issues.	Feedback form
8 April 2011	Clem Demetrios	Unrecorded	Concerns about the care and treatment provided to a consumer.	Feedback form
10 May 2011	Unrecorded	Unrecorded	Safety issues with bed rail.	Feedback form
3 June 2011	Pina Gerardis	Arthur Moutakis	Staff member was rude and disrespectful.	Telephone
23 June 2011	Denzel Washington	Hon. John Hill	Aggressive consumers being mixed with non-aggressive consumers.	Email
1 August 2011	Claire Andrews	Kerim Skelton	Assault of a consumer by staff member.	Verbal
25 August 2011	Unrecorded	Unrecorded	Health issues experienced by consumers, no staff available to attend as on break.	Face to face
15 November 2011	Unrecorded	Unrecorded	Lack of timely response to request by consumer.	Feedback form
5 December 2011	Unrecorded	Unrecorded	Lack of available wheelchairs.	Feedback form
13 January 2012	SASMOA	Paula Hakesley	Workload for medical officers was unreasonable.	Email
27 January 2012	Unrecorded	Unrecorded	Unprofessional language used by staff member.	Feedback form

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

31 January 2012	Unrecorded	Unrecorded	Bruising on consumer.	Feedback form
10 February 2012	Unrecorded	Unrecorded	Signage at the facility was not clear.	Feedback form
10 February 2012	Unrecorded	Unrecorded	Poor grooming of consumer.	Feedback form
7 March 2012	SASMOA	Paula Hakesley	Workload issues due to failure to backfill junior medical positon.	Letter
9 March 2012	Unrecorded	Unrecorded	Staff member was condescending when communicating death of consumer.	Face to face
10 April 2012	Amanda Sims	HCSCC	Lack of medical reviews.	Telephone
24 April 2012	John Brayley	Maurice Corcoran	Conditions were poor, environment was stark, ward was cold, staff arguing.	Email
30 April 2012	Unrecorded	Unrecorded	Failure to rectify equipment compromised the health of a consumer.	Email
20 May 2012	Unrecorded	Unrecorded	Failure to properly address consumer wound, poor attitude of staff	Telephone
~20 May 2012	Unrecorded	Unrecorded	Consumer left on toilet for unnecessarily long period of time.	Face to face
21 May 2012	Amanda Sims	Arthur Moutakis	Odour at the facility, staff member was dismissive and inattentive.	Telephone
30 May 2012	Unrecorded	Unrecorded	Inappropriate tools used to brush hair of consumer.	Telephone
8 August 2012	Unrecorded	Unrecorded	Staff unavailable to take consumer to toilet, lack of staff visibility.	Letter
3 September 2012	Unrecorded	Unrecorded	Lack of English spoken amongst staff.	Feedback form
3 September 2012	Unrecorded	Unrecorded	Consumers becoming agitated by alarm testing.	Feedback form
20 September 2012	Unrecorded	Unrecorded	Unexplained injury to consumer.	Telephone
17 October 2012	Unrecorded	Unrecorded	Staff delay in responding to bell.	Face to face
10 January 2013	Unrecorded	Unrecorded	Agency staff not given induction when starting at Oakden.	Letter
10 January 2013	Unrecorded	Unrecorded	Staff were disrespectful, staff not given induction.	Letter

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

12 January 2013	Unrecorded	Unrecorded	Delay in providing medication to consumer.	Telephone
5 March 2013	SASMOA	Leonie Nowland	Need for additional medical staff at Oakden.	Email
5 March 2013	Unrecorded	Unrecorded	Overmedication incident.	Face to face
12 March 2013	Unrecorded	Unrecorded	Failure to provide medication to consumer.	Face to face
16 March 2013	Unrecorded	Unrecorded	Failure to advise family of consumer incident.	Feedback form
22 April 2013	Unrecorded	Unrecorded	Family member verbally abused consumer for wearing clothing of another consumer.	Face to face
2 May 2013	Unrecorded	Unrecorded	Medication changes without consultation with family.	Email
8 May 2013	ARAS	Unrecorded	Issues with the treatment and care of a consumer.	Email
11 May 2013	Unrecorded	Unrecorded	Family member verbally abused by another consumer.	Face to face
13 May 2013	Chris Olsen	Kerim Skelton	Inappropriate interaction between consumers.	Letter
15 May 2013	Kerim Skelton	Leonie Nowland Vanessa Owen Julie Harrison Jenny Simcock	Staff member removed drugs from safe.	Email
16 May 2013	Santo Ricci	HCSCC	Movement of consumer.	Telephone
22 May 2013	Olsen Family	Arthur Moutakis	Issues with nursing care, supervision issues, consumer found naked, belt around neck of a consumer as a restraint.	Letter
31 May 2013	Maurice Corcoran	Leonie Nowland John Mannion Karla Bergquist	Concerns that staff are taking too long to respond to concerns and adopting a formal/bureaucratic approach rather than addressing the matters with CVS.	Email
12 June 2013	Unrecorded	Unrecorded	Issues with nursing supervision and care.	Letter
19 June 2016	Unrecorded	Unrecorded	Lack of knowledge by staff.	Unrecorded

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

20 June 2013	Unrecorded	Unrecorded	Staff providing mixed information to family members.	Face to face
12 July 2013	Unrecorded	Unrecorded	Conduct of staff member.	Telephone
12 August 2013	Unrecorded	Unrecorded	Issues with treatment and care received.	Face to face
7 September 2013	Unrecorded	Unrecorded	Lack of staff supervision.	Face to face
13 September 2013	RANZCP	Hon. Jack Snelling	Transfer of bed licenses.	Face to face
24 September 2013	Unrecorded	Unrecorded	Assault by a consumer.	Telephone
1 October 2013	Unrecorded	Unrecorded	Family member verbally abused by a consumer.	Telephone
1 October 2013	Kenneth Claughton	HCSCC	Assault by a staff member.	Complaint form
2 October 2013	HCSCC	Margot Mains	Staff member acted unreasonably towards a consumer.	Letter
9 October 2013	John Brayley Anonymous	HCSCC	Abuse of consumers, staff leaving site to go shopping, cultural problems.	Letter
10 October 2013	HCSCC	Unrecorded	Staff member acting unreasonably.	Email
15 October 2013	Troy Shepherd Kym Shepherd	Arthur Moutakis	Disrespectful behaviour directed at consumer, bruising on consumer.	Face to face
21 October 2013	Anne Franklin	Unrecorded	Consumer being held against will, victim of violence.	Letter
22 October 2013	Marissa Highfold	Arthur Moutakis	Racial vilification.	Telephone
28 October 2013	Unrecorded	Unrecorded	Consumer gained access to cleaning fluid and drank it.	Face to face
29 October 2013	Unrecorded	Unrecorded	Staff acting disrespectfully.	Face to face
30 October 2013	CVS	Unrecorded	Care and treatment of a consumer.	Email

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

8 November 2013	Sally Rischbeith Duncan McKellar Pat Flynn	Leonie Nowland	Business plan for FTE increase, need for increased staffing.	Business plan
11 December 2013	Maurice Corcoran	Bryce Beinke Julie Harrison Leonie Nowland Rebekah Mansfield	Consumers lying on the ground and sleeping on the floor.	Email
16 December 2013	Serpo Family	Arthur Moutakis Julie Harrison	Disrespectful agency worker, assault by agency worker.	Face to face
13 January 2014	Anne Franklin	Daniel Torzyn	Concerns regarding safety.	Face to face
17 January 2014	Daniel Torzyn Anne Franklin	Hon. Jay Weatherill	Consumer incarcerated without freedom, lack of activities.	Facsimile
29 January 2014	Unrecorded	Unrecorded	Assault by staff, inadequate treatment and care.	Face to face
7 February 2014	Maurice Corcoran	Leonie Nowland Daniel Torzyn	Particular consumer ought not to have been at Clements.	Email
13 February 2014	Ken Claughton	Arthur Moutakis	Lack of disclosure, concerns about particular staff member.	Face to face
20 February 2014	Unrecorded	Unrecorded	Issues with treatment and care.	Face to face
17 March 2014	Unrecorded	Unrecorded	Weight loss experienced by consumer, issues with level of care.	Face to face
28 March 2014	Hon. Steven Griffiths	Hon. Jack Snelling	Concerns with potential outsourcing of services.	Letter
10 April 2014	Unrecorded	Unrecorded	Management of the funds of a consumer.	Face to face
10 April 2014	Carol Ort	OPA	The state of the facility, care provided to a consumer.	Verbal
16 April 2014	Ana Orellana	Unrecorded	Workplace bullying.	Verbal
12 May 2014	SASMOA	Leonie Nowland	Additional funding for OPMHS given closure of Glenside wards.	Email

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

26 May 2014	Unrecorded	Unrecorded	Issues with level of care, insufficient staff to care for consumers.	Feedback form
30 May 2014	Maria Carbone	ACCC	Staffing ratio, aggressive consumers, lack of handovers between staff.	Letter
3 June 2014	Unrecorded	Unrecorded	Bruising of consumer, lack of information from staff.	Email
11 June 2014	Serpo Family	Arthur Moutakis	Consumer locked outside without shoes.	Telephone
16 June 2014	Maria Carbone	Karim Goel	Lack of staff, bruising on consumer, lack of staff handovers.	Face to face, letter
30 June 2014	Sally Rischbeith	Julie Harrison	Staffing levels.	Email
1 July 2014	SASMOA	Leonie Nowland Margot Mains	Workload impact for medical officers, potential for critical adverse consumer event.	Email
2 July 2014	Katherine Shephard Duncan McKellar	Hon. Jack Snelling Hon. Leesa Vlahos	Staffing levels and general concerns about Oakden.	Face to face
~7 July 2014	Sally Rischbeith	Margot Mains	Medical staffing numbers.	Memorandum
8 July 2014	Daniel Torzyn	Julie Harrison Kerim Skelton	Serious concerns about the conduct of a particular nurse.	Email
8 July 2014	SASMOA	Leonie Nowland	Medical staffing.	Face to face
11 July 2014	SASMOA	Leonie Nowland Julie Harrison Margot Mains	Medical staffing.	Email
11 July 2014	Bharti Sharma	Daniel Torzyn	Rough handling of consumers, very little effort by staff to feed consumers.	Face to face
14 July 2014	Bharti Sharma Peter Day	Kerim Skelton	Behaviour and attitude of staff, issues involving feeding.	Face to face
17 July 2014	Sally Rischbeith	Stephen Simon	Medical staffing numbers.	Risk register
21 July 2014	Unrecorded	Unrecorded	Delay in taking consumer to toilet.	Face to face

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

July 2014	Daniel Torzyn	Julie Harrison	Lack of allied health structure, restraint practices.	Project Plan
15 August 2014	Unrecorded	Unrecorded	Lack of staff visibility.	Telephone
~ 4 December 2014	Lorraine Baff	Snelling office*	Low staff to consumer ratio, poor condition of equipment, staff overworked.	Letter
11 December 2014	John Benn	OPA	Assault against a consumer by staff.	Verbal
16 December 2014	Hon. Tony Zappia	Hon. Jack Snelling	Low staff to consumer ratio, inappropriate mix of dementia and violent behaviours, high risk of severe injury or death.	Letter
5 January 2015	Unrecorded	Unrecorded	Staff failed to clean up faeces and urine from consumer.	Face to face
10 February 2015	Unrecorded	Unrecorded	"practice SLS not to act upon"	Report
~11 February 2015	Gail Stubberfield Maurice Corcoran	Karim Goel	Little recreational activity, staff defensive to questions from CVS, placement of particular individual was inappropriate, and CVS visitors are chaperoned on visits.	Email Phone
5 March 2015	Aaron Groves	Jackie Hanson	Increase in restraint reporting.	Letter
23 March 2015	Unrecorded	Unrecorded	Medication management by an agency staff member.	Face to face
30 March 2015	Sally Rischbeith	Russell Draper Eli Rafalowicz	Concern there may be a sentinel event.	Email
28 April 2015	SASMOA	Jackie Hanson	Resourcing for OPMHS.	Letter
24 June 2015	Jarrid Brunton	Leonie Nowland Kathy Stanojevic	Equipment for measuring vital signs not calibrated for 2 years.	Email
15 July 2015	Unrecorded	Unrecorded	Inadequate communication, treatment and care.	Email
18 July 2015	Unrecorded	Unrecorded	Delay in communication about incident.	Telephone
15 August 2015	Unrecorded	Unrecorded	Lack of staff visibility and presence.	Face to face
18 September 2015	ANMF	Kerim Skelton	Tidiness and cleanliness, hip protectors missing.	Letter
22 September 2015	Maurice Corcoran	Leonie Nowland	Need for social worker position at Oakden.	Email

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

22 September 2015	Karim Goel	Prem Manuel Patrick Flynn Russell Draper Rebecca Wheatley Kerim Skelton Daniel Torzyn Merrilyn Penery Robert Caley James Chaousis Maurice Corcoran	Removal of social worker role would undermine the productivity of the service.	Email
22 September 2015	Daniel Torzyn	Wendy Sheehy Robert Caley Russell Draper Patrick Flynn Karim Goel Doreen Heslop David Jolly Prem Manuel Balram Naipal Merrilyn Penery Paula Rae Raluca Tudor Rebecca Wheatley Glenn Zerjal Joann Molsher	Concerns about how Clements could operate as a transitional unit without a social worker or an occupational therapist.	Email
10 October 2015	Unrecorded	Unrecorded	Restraint applied, use of PRN medication, staff more focussing on smoking in the courtyard and talking than assisting the consumers.	Unrecorded
October 2015	Kathryn McEwen	Jackie Hanson	Low morale, staff feeling undervalued and anxious.	Report
October 2015	Liam Hernen	Kerim Skelton	Staff conflict.	Face to face
5 November 2015	Unrecorded	Unrecorded	Unexplained injuries, concerns that staff deliberately keeping it quiet.	Telephone
2 December 2015	ANMF	Kerim Skelton	Alleged bullying, rostering issues.	Email

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

3 December 2015	Lorraine Baff	Snelling Office*	Assault on consumer.	Telephone
11 December 2015	Alwyn Madyiwa	ANMF	Racism and disrespectful behaviour.	Letter
13 December 2015	Sangeeta Dhanorkar	Karim Goel	Staff conflict, medication issues.	Email
16 December 2015	ANMF	Leonie Nowland	Need for mental health qualifications in OPMHS.	Letter
28 December 2015	Alwyn Madyiwa	Daniel Torzyn	Poor emergency and serious breach processes.	Letter
17 January 2016	Unrecorded	Unrecorded	Air-conditioner not working.	Face to face
3 February 2016	Roger Panlilio	Kerim Skelton	Discrimination.	Letter
13 March 2016	Sangeeta Dhanorkar	Karim Goel	Staff issue.	Email
14 March 2016	Unrecorded	Unrecorded	Staff lacked compassion with consumer and family.	Telephone
16 March 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict.	Email
17 March 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, medication issues.	Email
18 March 2016	Undetermined	Kurt Towers	Consumers locked in corridor.	Undetermined
22 March 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict.	Email
31 March 2016	Unrecorded	Unrecorded	Poor attitude among staff.	Telephone
6 April 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, confidential papers being placed in rubbish bin.	Email
11 April 2016	Jackie Hanson	Hon. Leesa Vlahos	Cultural and operational issues.	Face to face
14 April 2016	Sangeeta Dhanorkar	Karim Goel	Staff issue.	Email
28 April 2016	CVS	Unrecorded	Need to improve signage.	Suggestion box
9 May 2016	Rebecca Wheatley	Susan Hazon	Assault at Clements House.	Undetermined
15 May 2016	"Michelle"	OPA	Issues with Oakden management, care about consumer.	Verbal

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

17 May 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, medication issues.	Email
1 June 2016	Barbara Spriggs	Maurice Corcoran	Death of Bob Spriggs, issues with treatment and care.	Face to face
3 June 2016	Aaron Groves	Jackie Hanson	Rate of restraint too high, no improvements seen in NALHN.	Email
7 June 2016	Maurice Corcoran	Daniel Torzyn	Death of Bob Spriggs, issues with treatment and care	Email
9 June 2016	Maurice Corcoran	Aaron Groves Ben Sunstrom	Overmedication, bruising suffered by consumer.	Email
9 June 2016	Rebecca Wheatley	Daniel Torzyn	Excessive force by nurse.	Email
9 June 2016	Sangeeta Dhanorkar	Karim Goel	Staff issue, handover issues.	Email
9 June 2016	Sangeeta Dhanorkar	Karim Goel	Staff issue, handover issues.	Handwritten note
10 June 2016	CVS	Unrecorded	Disrespectful behaviour of staff, issues with care and treatment.	Face to face
17 June 2016	Rebecca Wheatley	Daniel Torzyn	Agency nurse delaying in taking consumer to toilet and speaking aggressively.	Email
20 June 2016	Anish Kurisummoottil	Daniel Torzyn	Harassment, bullying, discrimination.	Letter
20 June 2016	ANMF	Kurt Towers	Bullying, harassment.	Email
22 June 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict.	Handwritten note
5 July 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, medication issues.	Email
7 July 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, medication issues.	Email
8 July 2016	Maurice Corcoran	Aaron Groves	Concern about consumer dying following choking on food.	Email
13 July 2016	Aaron Groves	Jackie Hanson	Overmedication, increase in seclusion and restraints.	Email
13 July 2016	Kate Gillam	Rebecca Wheatley	Treatment and care of a consumer, intimidation.	Telephone

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

17 July 2016	Anonymous	OPA	Particular staff member should not be working with vulnerable consumers.	Email
25 July 2016	Maurice Corcoran	Aaron Groves	Bruising found on consumer, three staff members suspended.	Email
27 July 2016	Connie Migliore	Maria West	Care provided to Bob Spriggs.	Email
8 August 2016	Lorraine Gum	Arthur Moutakis	Lack of stimulation and activities, limited staffing, bugs in the facilities, missing clothing.	Face to face
8 August 2016	Unrecorded	Unrecorded	Lack of stimulation just a television, restraints being used inappropriately.	Face to face
15 August 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict.	Email
30 August 2016	Maurice Corcoran	Aaron Groves	Bruising to three consumers, consumers found on the floor.	Email
2 September 2016	Maria West	Grace Bakos	Funding required for social worker for Clements.	Email
2 September 2016	Stephen Simon	Maria West	Assault on a consumer.	Undetermined
2 September 2016	Maurice Corcoran	Maria West Aaron Groves	Delay in investigating the complaint relating to Mr Spriggs.	Email
5 September 2016	Rebecca Wheatley	Russell Draper	Need for allied health staff.	Email
7 September 2016	Dianne Mack	Maurice Corcoran	Assault on consumer, lack of communication and support.	Verbal
7 September 2016	Maurice Corcoran	Aaron Groves	Delay in investigating the complaint relating to Mr Spriggs.	Email
8 September 2016	Dianne Mack	Daniel Torzyn	Assault of a consumer, consumer placed in same area as the consumer who allegedly assaulted the consumer, concern that an SLS report should be made.	Face to face or telephone
10 September 2016	Sangeeta Dhanorkar	Daniel Torzyn Karim Goel	Staff conflict.	Email
10 September 2016	Elfeda Cid	Daniel Torzyn Karim Goel	Staff conflict.	Email
11 September 2016	Alwyn Madyiwa	Karim Goel	Staff conflict.	Email

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

12 September 2016	Navdeep Noorpuri	Karim Goel	Staff conflict.	Email
13 September 2016	Vicky Nagy	Karim Goel Daniel Torzyn	Staff conflict.	Face to face
26 September 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict.	Email
29 September 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, handover issues.	Email
29 September 2016	Navdeep Noorpuri	Karim Goel	Staff conflict, handover issues.	Email
September 2016	Karim Goel	ACCC	Consumer pinned to the bed by the hands, excessive force.	Undetermined
4 October 2016	Karim Goel	Vanessa Owen Maria West	Staff conflict, poor documentation.	Email
6 October 2016	Sangeeta Dhanorkar	Karim Goel Charlotte Watson	Staff conflict, misuse of union representative powers.	Email
6 October 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, restraints not reported, progress notes not being completed.	Emails
6 October 2016	Karim Goel	Daniel Torzyn Vanessa Owen Maria West Vicki Nagy Trudy Smith-Sparrow	Issues involving staff, staff culture and attitude, consumer care affected by staff.	Email
7 October 2016	Maurice Corcoran	Steve Tully Aaron Groves	Delays experienced in getting response to concerns, consumer assault.	Email
7 October 2016	Lorraine Bristow	Arthur Moutakis	Health of a consumer.	Telephone
8 October 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict, staff member failing to record use of restraint.	Email
9 October 2016	Unrecorded	Unrecorded	Unexplained wound on consumer.	Face to face
10 October 2016	HCSCC	Unrecorded	Services provided to a consumer.	Email

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

13 October 2016	Jim Leppa	Karim Goel	Consumer injury.	Undetermined
14 October 2016	Maurice Corcoran	Hon. Leesa Vlahos Aaron Groves	Death of Bob Spriggs, staffing ratio issues, delay in response from NALHN.	Letter
17 October 2016	Unrecorded	Unrecorded	Assault on a consumer.	Telephone
19 October 2016	Sangeeta Dhanorkar	Karim Goel	Staff conflict.	Email
31 October 2016	Unrecorded	Unrecorded	Inadequate treatment and care	Telephone
31 October 2016	Unrecorded	Unrecorded	Need for improvements to staff education.	Letter
17 November 2016	RANZCP Duncan McKellar	Hon. Leesa Vlahos Aaron Groves	Facility not fit for purpose, illegal restraint and seclusion.	Face to face
21 November 2016	Connie Migliore	Maria West	Lack of activities for consumers, consumers falling, food quality.	Email
22 November 2016	ANMF	Maria West	Cultural and morale issues.	Email
24 November 2016	Anonymous	Snelling Office*	Consumer locked in a separate room, lack of paperwork, consumer choked on food, bullying of staff, and medication issues.	Letter
25 November 2016	Jay Christie	Vanessa Owen Trudy Smith-Sparrow	Concerns raised by students in relation to mistreatment of consumers.	Face to face
30 November 2016	HCSCC and CVS	Unrecorded	Delayed response to complaint.	Email
30 November 2016	Unrecorded	Unrecorded	Inadequate care and treatment.	Letter
2 December 2016	HCSCC	Unrecorded	Care and treatment of a consumer.	Letter
6 December 2016	Maurice Corcoran	Hon. Leesa Vlahos	Delay in response to complaint regarding Mr Spriggs.	Email
15 December 2016	Spriggs Family Maurice Corcoran	Jackie Hanson Maria West	Death of Mr Spriggs.	Face to face

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

20 December 2016	Ms McCallum	Unrecorded	Bruising and injuries to consumer, odour, broken chairs.	Unrecorded
28 December 2016	Unrecorded	Unrecorded	Delay in responding to complaints.	Letter
28 December 2016	Anonymous	Unrecorded	Issues with treatment and care of two consumers.	Letter
28 December 2016	Unrecorded	Unrecorded	Dietary needs of consumers not met.	Face to face
16 January 2017	Connie Migliore	Maria West	Lack of staff, atmosphere.	Email
26 January 2017	"Bernadette"	Unrecorded	Drug administration error.	Telephone
12 February 2017	Unrecorded	Unrecorded	No staff visible in facility, delay in communication about incident.	Telephone
14 February 2017	Deanna Stojnovic	Unrecorded	Use of catheter without consent.	Feedback Forum
15 February 2017	Aaron Groves	Jackie Hanson	Theft, lack of bathing, furniture issues, laundry issues.	Email
~17 February 2017	Unrecorded	Unrecorded	Medication administered for longer than the prescribed period.	Unrecorded
19 February 2017	SASMOA	Jackie Hanson Scott McMullen Sujeeve Sanmuganatham Maria West Aaron Groves	Displeasure that NALHN management was suggesting that it had no knowledge of issues at Oakden yet SASMOA had been raising concerns frequently.	Email
21 February 2017	Unrecorded	Unrecorded	Consumers not being attended to.	Telephone
27 February 2017	Deanne Stojnovic	Kirsty Delguste	Inappropriate use of catheter on a consumer.	Telephone
2 March 2017	Unrecorded	Unrecorded	Repeated assaults.	Telephone
6 March 2017	Unrecorded Staff	Maria West	No standard process for washing and bathing consumers.	Face to face

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

8 March 2017	RANZCP	Hon. Leesa Vlahos	Confirming previous complaints made including lack of medical and allied health staffing, use of illegal seclusion and restraint, vulnerable nature of consumers at Oakden, neglect with respect to resourcing, absence of sustainable model of care and work environment.	Letter
14 March 2017	Unrecorded	Unrecorded	Staff being rough with a consumer.	Telephone
14 March 2017	Murray Bristow	Unrecorded	Staff pushed consumer's head into paper towel dispenser.	Face to face
23 March 2017	Mark Harris	Hon. Jack Snelling	Unexplained bruising on a consumer.	Email
30 March 2017	Lisa-Marie Jones	Vanessa Owen	Infection control issues.	Email
4 April 2017	Unrecorded	Unrecorded	Lack of activities for consumers.	Telephone
13 April 2017	Connie Migliore	Maria West	Lack of allied health staff, senior staff unexpectedly on leave and away from facility.	Email
13 April 2017	Unrecorded	Unrecorded	Demand to speak with CEO following death of a consumer.	Face to face
23 April 2017	Stewart Johnston	Hon. Jay Weatherill	Issues with executive and management team, concerns around notice given for visits to allow staff to prepare for the visit (should be unannounced visits so not time to prepare).	Online feedback
24 April 2017	Ming Wei	Hon. Leesa Vlahos	Questionable conduct and decision-making by senior management.	Email
24 April 2017	Daniel Torzyn	Maria West	Assault between consumers.	Email
27 April 2017	Unrecorded	Unrecorded	Number of falls by a consumer.	Email
1 May 2017	Lorraine Baff	Hon. Jay Weatherill	Failure by Ministers to respond, assault on husband.	Letter
1 May 2017	Christine Edwards-Brown	Hon. Jay Weatherill	Gross mismanagement at Oakden.	Online feedback
3 May 2017	Maria Costa	Hon. Jay Weatherill	Dissatisfaction with level of care, over-sedation, insufficient staff, abuse, Princess chairs.	Letter

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

3 May 2017	Families of consumers	Hon. Jay Weatherill	Issues at Oakden generally.	Face to face
3 May 2017	Paul Brown	Hon. Jay Weatherill Jackie Hanson Daniel Torzyn Karen Stockdale Robyn Coultard	Treatment and care.	Email/letter
3 May 2017	Unrecorded	Unrecorded	Overmedication	Face to face
4 May 2017	Rosie Ratcliff	Jackie Hanson	Staffing mix at Oakden.	Email
5 May 2017	SASMOA	Jackie Hanson	Lack of transparency regarding misconduct investigations.	Email
8 May 2017	Alexandra Douvlas	Jane O'Sullivan	Issues with staff communication, diabetes management.	Verbal
9 May 2017	ANMF	Vicki Kaminski	Restraint, bullying issues, lack of incident review meetings, operational issues.	Email
12 May 2017	Marissa Highfold	OPA	Lack of communication and support, Oakden was a "hell hole".	Face to face
12 May 2017	Unrecorded	Unrecorded	Ward being treated like a zoo.	Face to face
12 May 2017	Unrecorded	Unrecorded	Lack of communication with families.	Face to face
18 May 2017	Leah Swann	Hon. Leesa Vlahos	Bruising on consumer, physical abuse, lack of bathing/showering.	Email
21 May 2017	Unrecorded	Unrecorded	Inadequate staffing resulted in incidents that should not have occurred, inadequate ongoing education for staff, inadequate restraint practices, broken and dirty equipment, poor hygiene maintained, lack of access to medical staff at the facility.	Face to face
24 May 2017	Nick Ryan	Vickie Kaminski	Safety and quality of care	Letter
24 May 2017	Unrecorded	Unrecorded	Use of restraint, lack of carer to assist consumer with walking.	Face to face

SCHEDULE OF COMPLAINTS RELATING TO OAKDEN

25 May 2007	Unrecorded	Unrecorded	Smell of urine, blood stain on wall, use of restraint, unexplained bruising on consumer.	Telephone
26 May 2017	Serpo Family Michelle McKinnon	HCSCC	Staff member was rough with a consumer, trust issues with employees at Oakden, little regard given to families, feeling of powerlessness by families.	Face to face
29 May 2017	OPA	Maria West	Safety of consumers.	Email
31 May 2017	Unrecorded	Unrecorded	Issues with fees.	Telephone

APPENDIX 11

Older Persons Mental Health Service Profit and Loss Statements 2009-10 to 2016-17

Source: SHARP reporting tool SA Health

Note: 2015-16 FY reported is an extrapolation of May 2016 figures. A financial accounting adjustment in June 2016 resulted in an error in reporting for June16, deeming June16 report unreliable

Refer to worksheet labelled "Assumptions and Exclusions" for more detailed notes on data provided.

Sum of Actual YTD Row Labels	Column Labels							
	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
OPERATING EXPENDITURE	12,584,444	11,915,186	12,179,141	12,242,766	12,022,722	11,383,213	11,400,448	12,622,761
Employee Benefits	8,790,062	8,419,520	9,167,910	9,239,905	9,103,842	8,233,789	8,393,093	10,296,067
AL, LSL and Revals for Leave and Oncosts	987,431	829,890	1,285,505	1,157,808	1,311,971	1,012,550	1,022,594	1,128,289
Other Employee Related Expenses	1,030,956	822,790	910,785	1,028,895	854,708	729,929	696,767	971,894
Salaries and Wages - Medical Officers	1,108,457	666,320	497,724	500,150	476,357	367,947	395,864	767,308
Salaries and Wages - Nursing	3,679,098	4,085,352	4,575,106	4,656,749	4,498,411	4,157,193	4,361,961	5,369,654
Salaries and Wages - Salaried Employees	647,021	649,797	595,577	547,743	484,904	542,979	472,194	506,908
Salaries and Wages - Weekly Paid	1,337,098	1,365,371	1,303,212	1,348,559	1,477,491	1,423,192	1,443,713	1,552,014
Other Expenses	-5,040	1,547	0			0	0	
Other Expenses	-5,040	1,547	0			0	0	
Supplies & Services Expenses	3,799,423	3,494,119	3,011,231	3,002,861	2,918,880	3,149,423	3,007,355	2,326,694
Agency Staffing	1,412,066	1,038,107	862,963	598,415	859,605	1,132,728	1,163,084	463,985
Diagnostic Testing Charges	11,282	8,483	6,508	6,172	10,645	9,016	12,563	13,185
Drug supplies	65,172	30,770	31,728	28,746	33,093	33,388	27,144	23,907
Electricity_ Gas_ Fuel	143,154	135,482	191,388	217,378	215,551	221,943	179,385	165,500
Fee For Service	0	0				27,676	23,002	27,353
Food Supplies	554,069	482,527	413,624	466,514	466,964	488,098	481,507	424,425
Housekeeping	183,199	179,408	175,612	163,176	125,532	128,400	48,871	238,987
Linen Services	240,276	250,030	238,995	212,538	215,944	247,513	264,122	29,901
Medical_ Para Med & Laboratory Supplies	60,061	67,096	81,376	122,781	120,629	71,848	95,184	112,349
Minor Equipment	70,765	30,535	18,225	12,703	34,287	48,412	35,824	36,258
Other Supplies & Services	601,269	650,566	448,809	499,801	324,988	345,593	376,459	277,735
Patient/Client Transport Assistance	29,835	67,500	45,721	89,741	108,614	73,359	99,787	18,801
Repairs & Maintenance	428,274	553,616	496,282	584,624	403,029	286,052	199,491	456,385
S & W Purchased Staff from Other SA Health Regions				271	0	35,396	934	37,924
OPERATING REVENUE	-2,699,117	-2,992,953	-2,755,340	-2,887,336	-2,729,496	-2,987,574	-2,507,979	-2,108,553
Grants and Subsidies Revenue	-1,804,989	-2,111,856	-1,982,359	-1,849,479	-1,875,304	-2,033,313	-1,596,445	-1,333,923
Commonwealth Grants	-1,804,989	-2,111,856	-1,982,359	-1,849,479	-1,875,304	-2,033,313	-1,596,445	-1,333,923
Other Revenue	-565	-309	-664	-48,932	-5,359	-168	0	-390
Investment Income & Other Revenue	-565	-309	-664	-48,932	-5,359	-168	0	-390
Sale of Goods and Services	-893,563	-880,789	-772,317	-988,897	-843,793	-954,093	-911,534	-774,241
Goods and Services Recharge / Recoveries				-128,900	0	-1,750	-9,110	0
Patient/Client Fees							0	
Recharges - Employee Related Cost	-18,592	-15,706	0					-29,615
Residential Charges	-874,971	-865,083	-772,317	-859,997	-843,793	-952,343	-902,424	-744,626
User Fees and Charges Revenue				-29	-5,040	0		
User Fees and Charges Revenue				-29	-5,040	0		
Grand Total	9,885,327	8,922,233	9,423,801	9,355,430	9,293,225	8,395,639	8,892,469	10,514,207
Total Commonwealth Revenue	1,804,989	2,111,856	1,982,359	1,849,479	1,875,304	2,033,313	1,596,445	1,333,923
Total Patient Fees	874,971	865,083	772,317	859,997	843,793	952,343	902,424	744,626
State Funding	7,205,368	5,945,294	6,669,124	6,645,955	6,574,128	5,409,983	6,393,600	8,435,659
Grand Total Funding/Expenditure	9,885,327	8,922,233	9,423,801	9,355,430	9,293,225	8,395,639	8,892,469	10,514,207
% State Funding	73%	67%	71%	71%	71%	64%	72%	80%
% Commonwealth Funded	18%	24%	21%	20%	20%	24%	18%	13%
% Patient Funded	9%	10%	8%	9%	9%	11%	10%	7%

Older Persons Mental Health Service Profit and Loss Statements 2009-10 to 2016-17

Clements Makk and McLeay Sub Total Analysis

Source: SHARP reporting tool SA Health

Note: 2015-16 FY reported is an extrapolation of May 2016 figures. A financial accounting adjustment in June 2016 resulted in an error in reporting for June16, deeming June16 report unreliable

Refer to worksheet labelled "**Makk McLeay Clements breakdown**" for detail and workings to support data below.

CLEMENTS

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
OPERATING EXPENDITURE	2,636,709	2,373,730	3,031,354	2,776,319	2,712,910	2,608,880	2,906,522	2,928,732
Employee Benefits	1,837,983	1,803,704	2,540,005	2,341,393	2,183,219	2,072,295	2,332,220	2,591,832
AL, LSL and Revals for Leave and Oncosts	217,859	170,024	386,270	325,639	252,272	251,901	268,630	292,733
Other Employee Related Expenses	230,365	171,098	245,343	235,372	234,241	198,724	201,182	257,118
Salaries and Wages - Medical Officers	0	0	0	0	0	0	4,449	59,227
Salaries and Wages - Nursing	1,356,841	1,437,484	1,889,731	1,760,937	1,676,394	1,577,620	1,827,943	1,957,443
Salaries and Wages - Salaried Employees	32,853	25,098	18,661	19,446	20,312	44,050	30,016	19,719
Salaries and Wages - Weekly Paid	65	0	0	0	0	0	0	5,592
Other Expenses	0	0	0	0	0	0	0	0
Other Expenses	0	0	0	0	0	0	0	0
Supplies & Services Expenses	798,726	570,026	491,349	434,926	529,691	536,585	574,302	336,900
Agency Staffing	515,079	328,455	221,878	154,498	307,600	305,690	354,202	137,393
Diagnostic Testing Charges	3,992	2,643	2,108	2,478	4,053	4,736	5,283	5,078
Drug supplies	19,875	10,152	10,014	8,423	9,235	7,597	5,769	5,447
Electricity_ Gas_ Fuel	36,862	30,561	54,749	54,507	64,671	66,670	54,153	50,124
Fee For Service	0	0	0	0	0	7,142	7,138	4,855
Food Supplies	1,496	1,895	955	959	438	2,160	2,617	3,884
Housekeeping	31,103	25,860	28,556	22,935	8,519	8,106	5,291	65,988
Linen Services	77,537	79,640	77,365	68,675	64,021	85,571	85,882	13,493
Medical_ Para Med & Laboratory Supplies	16,876	17,684	20,092	26,353	19,845	14,260	19,916	26,887
Minor Equipment	29,527	4,767	2,885	1,380	3,105	3,436	11,115	6,361
Other Supplies & Services	17,423	18,035	26,148	19,282	15,085	23,956	17,598	14,254
Patient/Client Transport Assistance	10,369	4,287	5,701	6,059	7,007	5,888	4,745	1,619
Repairs & Maintenance	38,589	46,048	40,897	69,378	26,113	1,374	593	611
S & W Purchased Staff from Other SA Health Regions	0	0	0	0	0	0	0	907
OPERATING REVENUE	-381,571	-361,157	-459,396	-402,813	-281,465	-295,298	-308,345	-491,908
Grants and Subsidies Revenue	0	0	0	0	0	0	0	0
Commonwealth Grants	0	0	0	0	0	0	0	0
Other Revenue	0	0	-664	0	0	0	0	0
Investment Income & Other Revenue	0	0	-664	0	0	0	0	0
Sale of Goods and Services	-381,571	-361,157	-458,733	-402,813	-281,465	-295,298	-308,345	-491,908
Goods and Services Recharge / Recoveries	0	0	0	0	0	0	0	0
Patient/Client Fees	0	0	0	0	0	0	0	0
Recharges - Employee Related Cost	0	0	0	0	0	0	0	0
Residential Charges	-381,571	-361,157	-458,733	-402,813	-281,465	-295,298	-308,345	-491,908
User Fees and Charges Revenue	0	0	0	0	0	0	0	0
User Fees and Charges Revenue	0	0	0	0	0	0	0	0
Sub Total Clements	2,255,138	2,012,573	2,571,958	2,373,506	2,431,444	2,313,582	2,598,177	2,436,824
Allocation of Support Costs held centrally	1,853,003	1,792,712	1,669,845	1,503,823	1,642,044	1,480,394	1,455,759	1,971,051
Grand Total Clements & Allocated costs	4,108,141	3,805,285	4,241,802	3,877,330	4,073,488	3,793,975	4,053,936	4,407,875

CLEMENTS SUMMARY	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Total Commonwealth Revenue	0	0	0	0	0	0	0	0
Total Patient Fees	381,571	361,157	458,733	402,813	281,465	295,298	308,345	491,908
State Funding	3,726,570	3,444,129	3,783,069	3,474,517	3,792,022	3,498,678	3,745,592	3,915,968
Grand Total Funding/Expenditure	4,108,141	3,805,285	4,241,802	3,877,330	4,073,488	3,793,975	4,053,936	4,407,875
% State Funding	91%	91%	89%	90%	93%	92%	92%	89%
% Commonwealth Funded	0%	0%	0%	0%	0%	0%	0%	0%
% Patient Funded	9%	9%	11%	10%	7%	8%	8%	11%

MAKK & MCLEAY

	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
OPERATING EXPENDITURE	4,812,776	4,704,049	4,537,427	4,895,294	4,641,209	4,484,632	4,658,946	4,504,046
Employee Benefits	3,142,617	3,261,887	3,279,719	3,646,817	3,490,523	3,190,847	3,355,490	3,840,022
AL, LSL and Revals for Leave and Oncosts	411,115	311,514	440,965	590,525	482,195	430,608	439,396	458,512
Other Employee Related Expenses	313,052	291,465	316,926	328,120	289,445	261,663	280,002	311,409
Salaries and Wages - Medical Officers	0	0	0	0	0	0	0	0
Salaries and Wages - Nursing	2,036,601	2,254,441	2,219,376	2,474,541	2,382,132	2,118,475	2,225,884	2,714,760
Salaries and Wages - Salaried Employees	58,362	32,035	18,661	19,446	20,312	63,268	73,087	19,719
Salaries and Wages - Weekly Paid	323,487	372,432	283,791	234,185	316,439	316,833	337,121	335,621
Other Expenses	0	0	0	0	0	0	0	0
Other Expenses	0	0	0	0	0	0	0	0
Supplies & Services Expenses	1,670,159	1,442,161	1,257,707	1,248,477	1,150,685	1,293,785	1,303,456	664,025
Agency Staffing	833,081	664,008	535,425	426,475	535,131	714,365	785,252	245,451
Diagnostic Testing Charges	7,087	5,285	4,400	3,695	6,591	4,280	7,280	8,106
Drug supplies	44,943	20,512	21,709	20,197	23,629	25,059	20,487	16,599
Electricity_ Gas_ Fuel	73,723	61,122	105,890	109,013	129,341	133,340	108,302	100,248
Fee For Service	0	0	0	0	0	20,534	13,378	8,483
Food Supplies	1,621	215	295	3,033	1,739	948	6,766	7,957
Housekeeping	63,686	56,118	57,668	49,473	26,420	14,044	16,236	131,363
Linen Services	153,942	160,745	153,805	137,201	128,043	161,863	171,765	10,740
Medical_ Para Med & Laboratory Supplies	40,829	43,010	57,670	93,792	84,751	41,298	45,723	33,409
Minor Equipment	26,005	16,112	6,596	4,408	22,412	33,143	19,228	11,341
Other Supplies & Services	350,570	276,531	171,267	197,505	126,410	94,952	77,374	71,637
Patient/Client Transport Assistance	13,850	57,432	35,684	78,200	25,651	14,147	31,317	15,411
Repairs & Maintenance	60,822	81,071	107,299	125,487	40,567	2,653	348	1,385
S & W Purchased Staff from Other SA Health Regions	0	0	0	0	0	33,158	0	1,896
OPERATING REVENUE	-2,279,485	-2,606,506	-2,338,923	-2,307,092	-2,437,632	-2,690,358	-2,190,524	-1,586,641
Grants and Subsidies Revenue	-1,804,989	-2,111,856	-1,982,359	-1,849,479	-1,875,304	-2,033,313	-1,596,445	-1,333,923
Commonwealth Grants	-1,804,989	-2,111,856	-1,982,359	-1,849,479	-1,875,304	-2,033,313	-1,596,445	-1,333,923
Other Revenue	0	0	0	-430	0	0	0	0
Investment Income & Other Revenue	0	0	0	-430	0	0	0	0
Sale of Goods and Services	-474,497	-494,650	-356,564	-457,184	-562,328	-657,045	-594,079	-252,718
Goods and Services Recharge / Recoveries	0	0	0	0	0	0	0	0
Patient/Client Fees	0	0	0	0	0	0	0	0
Recharges - Employee Related Cost	-3,402	0	0	0	0	0	0	0
Residential Charges	-471,095	-494,650	-356,564	-457,184	-562,328	-657,045	-594,079	-252,718
User Fees and Charges Revenue	0	0	0	0	0	0	0	0
User Fees and Charges Revenue	0	0	0	0	0	0	0	0
Sub Total Makk & McLeay	2,533,290	2,097,543	2,198,504	2,588,202	2,203,577	1,794,274	2,468,422	2,917,406
Allocation of Support Costs held centrally	3,243,897	3,019,404	2,983,495	2,889,898	3,016,161	2,807,389	2,370,111	3,188,926
Grand Total Makk & McLeay & Allocated costs	5,777,187	5,116,947	5,181,999	5,478,100	5,219,738	4,601,663	4,838,533	6,106,332

MAKK & MCLEAY SUMMARY	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Total Commonwealth Revenue	1,804,989	2,111,856	1,982,359	1,849,479	1,875,304	2,033,313	1,596,445	1,333,923
Total Patient Fees	471,095	494,650	356,564	457,184	562,328	657,045	594,079	252,718
State Funding	3,501,103	2,510,441	2,843,076	3,171,438	2,782,106	1,911,305	2,648,009	4,519,691
Grand Total Funding/Expenditure	5,777,187	5,116,947	5,181,999	5,478,100	5,219,738	4,601,663	4,838,533	6,106,332
% State Funding	61%	49%	55%	58%	53%	42%	55%	74%
% Commonwealth Funded	31%	41%	38%	34%	36%	44%	33%	22%
% Patient Funded	8%	10%	7%	8%	11%	14%	12%	4%

CHECK GRAND TOTAL	9,885,327	8,922,233	9,423,801	9,355,430	9,293,225	8,395,639	8,892,469	10,514,207
RECONCILIATION TOTAL FROM SOURCE DATA	9,885,327	8,922,233	9,423,801	9,355,430	9,293,225	8,395,639	8,892,469	10,514,207
	0	0	0	0	0	0	0	0

APPENDIX 12

Review of Community Visitor Scheme Reports

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
29 July 2011	Maurice Corcoran Joan Cunningham	<ul style="list-style-type: none"> None. 	<ul style="list-style-type: none"> Surroundings are fresh, clean and bright. We are sure staff are kept very busy maintaining this standard.
1 August 2011	Maurice Corcoran Joan Cunningham	<ul style="list-style-type: none"> None. 	<ul style="list-style-type: none"> Home was welcoming, clean, airy and bright. Extremely extensive range of activities for clients. Information packs are extremely informative. All interactions were kind, gentle and considerate.
7 September 2011	Maurice Corcoran Joan Cunningham	<ul style="list-style-type: none"> None. 	<ul style="list-style-type: none"> Facility was welcoming, clean, airy and bright. Pleasant fresh air feel throughout the home. All interactions were kind, encouraging and considerate. Staff were open and willing to answer all questions.
13 April 2012	Joan Cunningham Yvette Gray	<ul style="list-style-type: none"> Only two clerical support staff. Need for additional clerical staff for data entry. 	<ul style="list-style-type: none"> Warm, respectful, laughing, welcoming.
11 May 2012	Maurice Corcoran Joan Cunningham Yvette Gray	<ul style="list-style-type: none"> Consumer felt she had been at Oakden too long. Two consumers had poor dental health. Staff raised need for social worker. 	<ul style="list-style-type: none"> Facility was warm and inviting, good outdoor areas. Bright and airy, welcoming and stimulating. Sensory garden was a scenic retreat for consumers. Staff were friendly and attentive to consumer needs.
21 June 2012	Maurice Corcoran Tricia Snell	<ul style="list-style-type: none"> None. 	<ul style="list-style-type: none"> Reception area was warm and cosy with gas fire burning. New wardrobes were modern. Consumers eating cake and playing with dogs. Mood was happy, consumer laughed with the dogs.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
11 July 2012	Yvette Gray Gail Stubberfield	<ul style="list-style-type: none"> Two consumers said they had not been doing much. Current alarm systems are ageing. No issues to be referred to PCV. 	
17 August 2012	Yvette Gray	<ul style="list-style-type: none"> None – no issues to be referred to PCV. 	<ul style="list-style-type: none"> Consumers being taken to Royal Adelaide Show which is a large investment and reflects positively on the hospital's commitment to resident welfare.
28 September 2012	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> Concerned about dehydration, access to drinks. Nurse raised concerns about use of agency staff. No issues to be referred to PCV. 	<ul style="list-style-type: none"> Outside area was well appointed and would allow for open air enjoyment in the finer weather. Staff greeted consumers, giving them hugs.
19 November 2012	Maurice Corcoran Joan Cunningham	<ul style="list-style-type: none"> Consumer escaped into carpark. Some consumers were unresponsive to the world. Staff said that some consumers were required to be restrained for safety reasons. 	<ul style="list-style-type: none"> Home was welcoming, clean, airy and bright. Pleasant fresh air feel throughout the home. Clients were engaged in activities.
15 January 2013	Maurice Corcoran Gail Stubberfield	<ul style="list-style-type: none"> Makk and McLeay had outdated tired layout. Staff arranging a hearing aid for a consumer for some 14 months which affected quality of life. Several consumers seemed "dead to the world". Patient restrained in a mobile chair, has a weak leg. Special purpose room unsafe for seclusion. Potential overmedication. 	<ul style="list-style-type: none"> Bright airy atmosphere. Staff are responsive to consumers. Nurses relate kindly to consumers.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
25 February 2013	Tricia Snell Gail Stubberfield	<ul style="list-style-type: none"> • Wards are a little bland. • Fewer staff, didn't seem to engage with consumers. • Shortage of mental health nurses. • Many consumers appeared comatose. • Nurses are less skilled. • Issues with staffing levels. 	<ul style="list-style-type: none"> • As usual facility smells clean and inviting. • Cleaners are to be applauded for hygiene. • Pleasant lounge areas. • Walls have soothing prints.
25 March 2013	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> • Four consumers passed away since last visit. • Staff said if a consumer became difficult the consumer would be held down and medicated. • No issues to be referred to PCV. 	<ul style="list-style-type: none"> • Facility was clean and tidy. • Facility was being strategically painted. • Facility is looking fresh and vibrant.
29 April 2013	Tricia Snell Gail Stubberfield	<ul style="list-style-type: none"> • Staff numbers at reduced level. • Some consumers seem to be dozing on each visit. • No issues to be referred to PCV. 	<ul style="list-style-type: none"> • As always clean and tidy with pleasant smell. • Cleaners should be applauded for the great job. • Nurses interacted with consumers in interested manner. • Staff said rarely using mechanical restraint (last resort), monitored every 15 minutes, authority forms signed. • Reference to "the man who lies on the floor".
24 May 2013 (date may be wrong)	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> • Glass door needs repair. • Car park has potholes. • Skirting board coming away from a wall. • Potential overmedication. 	<ul style="list-style-type: none"> • Facility is warm, inviting, fresh, clean, tidy. • Always a pleasant smell. • Cleaning staff take exceptional care of the facility. • Contractors not wearing high-visibility vests. • Staff said that the facility doctor reviews medication charts weekly and if needed daily. • Staff said medication errors were rare. • Staff said aggressive consumers were always dealt with using de-escalation rather than medication.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
27 May 2013	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> Glass door needs repair. No issues to be referred to PCV. 	<ul style="list-style-type: none"> Facility was exceptionally clean and tidy. It had a fresh smell. Looked very smart in its painted warm yellow colour (presumably the same colour as at time of Oakden Report). Very welcoming atmosphere and warmth. Grounds were well looked after. New coffee machine, selling for \$2 per cup.
24 June 2013	Gail Stubberfield Tricia Snell	Identical to the 24 May 2013 CVS report – may be duplicate.	
22 July 2013	Tricia Snell Gail Stubberfield	<ul style="list-style-type: none"> Glass door has crack. Heavy rain has led to a drip in the corridor. Doctor stressed the need for geriatrician. 	<ul style="list-style-type: none"> Pleasant aroma wafting through facility. We enjoyed a cuppa on the comfortable lounge. Aesthetically pleasing. Soccer oval, staff take consumers to kick the ball. Staff handle the residents with sensitivity and compassion, always using appropriate holds. Staff should be congratulated for their professionalism, alertness and support for each other. Staff have the option of segregating consumers. Staff member said “this is the best place I’ve worked in – staff get looked after very well here”.
26 August 2013	Tricia Snell Gail stubberfield	<ul style="list-style-type: none"> Karim mentioned possums were getting in the roof. Staff reduced from 6 to 5. No issues to be referred to PCV. 	<ul style="list-style-type: none"> Obvious odour from a dead possum rather than the usual pleasant smell that greets the Community Visitors. Staff member said Oakden was a good place to work as staff always help and work as a team.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
23 September 2013	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> • Consumer complained she has no treatment. • Consumer noted some injuries on a consumer. • No issues to be referred to PCV. 	<ul style="list-style-type: none"> • Facility in good repair, looked fresh. • Extremely clean and tidy. • Staff were hugged and greeted with smiles. • Internet café was being discussed for the facility.
21 October 2013	Tricia Snell Gail Stubberfield	<ul style="list-style-type: none"> • Injuries on a consumer from being lifted. • A consumer needs to be fed. • Consumer felt left out, unmotivated, lack of activities. 	<ul style="list-style-type: none"> • Spacious, bright, homely, pleasant. • Facility is clean and sweet smelling. • Smell from the dead possum has virtually disappeared. • Nurses are calm and gentle, patient and kind. • Visitors told consumers “often like to do nothing at all”.
21 November 2013	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> • Consumer said she was locked in her room. • Consumer said she felt groggy all day. • Consumer laying on the floor (but staff explained he likes this and is able to get himself up off the floor). • No issues to be referred to PCV. 	
11 December 2013	Tricia Snell Gail Stubberfield	<ul style="list-style-type: none"> • Doctor was abrupt and defensive with consumer. • Consumer was “dead to the world” in princess chair. • Consumer seemed quite sedated. • Consumer had loss of enthusiasm. 	<ul style="list-style-type: none"> • Beautifully decorated. • Cleaning staff should be congratulated, sterling effort. • Nurses are calm and gentle. • Nurses give hugs to consumers and show friendship, compassion and genuine interest in their wellbeing. • Staff said “they are very good to us here”.
14 January 2014	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> • Concerns at the facility there is no psychologist. • Possible overmedication. 	<ul style="list-style-type: none"> • Warm and welcoming. • Cleaning staff do an impeccable job.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
18 February 2014	Tricia Snell Gail Stubberfield	<ul style="list-style-type: none"> • A number of leaks requiring maintenance. • A consumer's behaviour was too complex for staff. • Consumer is always lying on floor. • At times only one staff is available. • Limit psychologist and OT access. • No issues of sub-optimal care referred to PCV. 	<ul style="list-style-type: none"> • Welcoming ambience. • Photographs of consumers patting Delta Dogs. • Pleasant aroma. • Staff give hugs and show friendship.
19 March 2014	Gail Stubberfield Tricia Snell	<ul style="list-style-type: none"> • Little information written in care plans. • Most care plans were out-dated. • No issues of sub-optimal care referred to PCV. 	<ul style="list-style-type: none"> • Facility was clean and well-presented, as always. • Cleaning staff are fabulous. • Staff are constantly communicating with consumers. • Strategically placed Air Wick air fresheners. • Some arguments over who uses the TV remote.
18 April 2014	Gail Stubberfield	<ul style="list-style-type: none"> • No allied health services (raised by clients/staff). • Consumer is restrained in his seat to prevent falls. He is released each hour for 6 minutes. • No issues referred to PCV. 	<ul style="list-style-type: none"> • Welcoming spotless appearance. • Pleasant aroma wafts.
12 May 2014	Tricia Snell Colleen Gavan Gail Stubberfield	<ul style="list-style-type: none"> • Staff are unnerved by impending privatisation. • No issues of sub-optimal care referred to PCV. 	<ul style="list-style-type: none"> • Pleasant environment, spotlessly cleaned. • Sweet smelling. • Consumer arranged driving lessons. • Staff are always helpful and friendly.
2 July 2014	Tricia Snell Gail Stubberfield Greg Wilton	<ul style="list-style-type: none"> • Consumer had broken her foot. • Concern over medication follow-ups. • Staff feel reporting requirements and processes detract from the quality of care as always filling out paperwork. • No designated psychologist. <p>No issues of sub-optimal care referred to PCV</p>	<ul style="list-style-type: none"> • Facility is clean, tidy, welcoming. • Grounds are well-maintained.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
4 August 2014	Tricia Snell	<ul style="list-style-type: none"> • Consumer often lays on the floor. • Care could be improved with OT and psychologist. • Social worker needed more days per week. • No issues of sub-optimal care referred to PCV. 	<ul style="list-style-type: none"> • Facility was clean, warm and inviting. • Staff are always friendly and quick to say hello. • Staff are constantly with clients and assisting them. • Client was put in an area to read and relax (i.e secluded). • Magazines are damaged and passed their shelf life.
23 September 2014 (Oakden staff confused about day of visit)	Joan Cunningham Gail Stubberfield	<ul style="list-style-type: none"> • Concern by staff about lack of allied health services. • Social worker is required more often per week. • Insufficient staff to engage with consumers. 	<ul style="list-style-type: none"> • As always a delight to visit the facility. • Fresh and spotless appearance. • Coffee machine has been well received.
20 October 2014	Baile Bonokwane Gail Stubberfield	<ul style="list-style-type: none"> • Lack of allied health professional support. • No issues of sub-optimal care referred to PCV. 	<ul style="list-style-type: none"> • Facility is fastidiously clean, pleasingly decorated. • Gardens are well maintained.
18 November 2014	Gail Stubberfield	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Delight to visit as always. • Spotlessly clean and inviting. • Staff are quick to have chats. • Coffee machine for visitors is a welcome addition. • Cheerfulness and professionalism.
22 December 2014	Lindy Thai Maurice Corcoran	<ul style="list-style-type: none"> • None 	NB: change in format to CVS reports. <ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
21 January 2015	Gail Stubberfield Ingrid Davies	<ul style="list-style-type: none"> • Consumer said staff member said "You'll be here until you die". 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
11 February 2015	Gail Stubberfield Stephanie Keightley	<ul style="list-style-type: none"> • Outside area needs better shade. • High risk of falls so consumers restrained. 	<ul style="list-style-type: none"> • Activities program is exceptional. • Atmosphere was conducive to quality care: agree.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
18 March 2015	Gail Stubberfield Stephanie Keightley	<ul style="list-style-type: none"> • Consumer had a black eye, cause unknown. • No psychologist but interviews soon. • Need for new dining room furniture. 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
13 April 2015	Ingrid Davies Gail Stubberfield	<ul style="list-style-type: none"> • Consumer has swollen hand/arm. 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
6 May 2015	Gail Stubberfield Ingrid Davies	<ul style="list-style-type: none"> • Equipment to measure vital signs not calibrated since 2013, readings are far from accurate. • Consumer escaped from facility. • Lack of office space. 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: strongly agree.
29 June 2015 (Staff thought visit was to occur different day)	Gail Stubberfield Elle Churches	<ul style="list-style-type: none"> • Staff said they are short-staffed. 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
15 July 2015	Tony Rankine	<ul style="list-style-type: none"> • Staff said staff:patient ratio was below appropriate/legal requirements. CVS said in report: "I question whether that is the case". 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
25 August 2015 (senior staff not at Oakden as at training)	Tony Rankine Ingrid Davies Cecil Camilleri	<ul style="list-style-type: none"> • Little to no interaction observed. • Social worker contract not renewed. • Consumers were encouraged to write letters to friends and loved ones, but staff would not send them (destroyed or stockpiled). 	<ul style="list-style-type: none"> • Atmosphere was conducive to quality care: agree.
22 September 2015	Jim Evans Maurice Corcoran	<ul style="list-style-type: none"> • Staff expressing dismay at lack of social worker. 	<ul style="list-style-type: none"> • Consumer had a faulty DVD player. • Atmosphere was conducive to quality care: agree.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
7 October 2015	Jim Evans Michele Slatter	<ul style="list-style-type: none"> Building is old and outdated 	<ul style="list-style-type: none"> Brochures and flyers are old, need replacement. Environment was welcoming. Atmosphere was conducive to quality care: strongly agree.
23 November 2015	Tracy Haskins Jim Evans	<ul style="list-style-type: none"> Consumer observed in restraint. Queried with staff who said there was an order for the restraint. No occupational therapist, lack of social worker. 	<ul style="list-style-type: none"> Facility is extremely well organised. Atmosphere was conducive to quality care: strongly agree.
21 December 2015	Jim Evans Tracy Haskins	<ul style="list-style-type: none"> Observed 5 restraints on consumers (all restraints were minimal and designed to stop falls, CVs were satisfied after discussions with staff and accepted their assurances that restraint orders are in place). Higher percentage of agency staff. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: strongly agree.
18 January 2016	Tracy Haskins Jim Evans	<ul style="list-style-type: none"> No psychologist or occupational therapist. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree. Always something planned to celebrate. You can see staff put their hearts into supporting.
15 February 2016	Jim Evans Tracy Haskins	<ul style="list-style-type: none"> Internal discussion around restraints, Oakden has a very high level of incident reports. It is argued this is because of the consumer-base and reporting regimes are strictly observed at Oakden. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.
21 March 2016	Jim Evans Maurice Corcoran	<ul style="list-style-type: none"> Still no OT or psychologist. Most consumers were unresponsive. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.
28 April 2016	Jim Evans Julie Margaret	<ul style="list-style-type: none"> Allied health positions are unfilled. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
23 May 2016	Fiona Pullen Jim Evans	<ul style="list-style-type: none"> No progress on allied health positions. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.
22 June 2016	Jim Evans Fiona Pullen	<ul style="list-style-type: none"> Staff commented that communal areas were large, noisy, not conducive to quality care. Consumer had bruise on arm, cause unknown but consumer said it was caused by staff or the doctor. Consumer reported being locked in a room. Long breaks between toileting. Allied health positions remain vacant. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.
25 July 2016	Fiona Pullen Greg Wilton	<ul style="list-style-type: none"> No OT or social worker. Dr Groves visited as concerned about restraints. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.
26 August 2016	Jim Evans Fiona Pullen	<ul style="list-style-type: none"> 3 consumers had bruises on their heads. Lack of allied health staff. 	<ul style="list-style-type: none"> Atmosphere was conducive to quality care: agree.
19 September 2016	Helen Winefield Fiona Pullen	<ul style="list-style-type: none"> Staff said Oakden is a "Ward" not a "home" Rooms and corridors bare, doors kept locked. Staff said Oakden was not dementia friendly. Lack of stimulation and diversional therapy. Lack of allied health staff. Staff shortages lead to falls not being observed. 	<ul style="list-style-type: none"> Disagreed that atmosphere conducive to quality care.

Date	Visitors	Issues of sub-optimal care identified	Comments suggesting issues not identified
27 October 2016	Marianne Dahl Jim Evans	<ul style="list-style-type: none"> • Little meaningful interaction by staff. • Consumers left alone in their rooms. • Consumers restrained for their safety, distressed. • Environment is sparse, tired, dismal, uninspiring. • Leisure program offered little respite. • Staffing shortages. • Staff said no resources for improvements. • Consumers in unhappy and desperate state. • Many consumers have bruises. • Urgent review required on so many levels. 	<ul style="list-style-type: none"> • Strongly disagreed atmosphere conducive to quality care.
17 November 2016	Fiona Pullen Marianne Dahl	<ul style="list-style-type: none"> • Limited allied health staff 	<ul style="list-style-type: none"> • Disagreed atmosphere was conducive to quality care.
14 December 2016	Marianne Dahl Fiona Pullen	<ul style="list-style-type: none"> • No new issues of concern. 	<ul style="list-style-type: none"> • Neutral on if atmosphere conducive to quality care.

APPENDIX 13

Consumer Liaison Officer – Consumer Feedback Northern Mental Health Service

Data report for May 2013

NALHN SLS KPI Complaints May 2013

Location	May-13		
	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	49	100%	100%

Apr-13		
Total Complaints	Acknowledged <48 Hours	Closed <35 Days
28	86%	92%

NALHN	May 2013 Acknowledged <48 Hours (KPI target 80%)	May 2013 Closed < 35 Days (KPI target 80%)
	100%	100%
NALHN	April 2012 Acknowledged <48 Hours (KPI target 80%)	April 2012 Closed < 35 Days (KPI target 80%)
	86%	92%

NORTHERN ADELAIDE LOCAL HEALTH NETWORK MENTAL HEALTH SERVICES May 2013 report

Total of 30 Consumer Feedback contacts.

- 20 Complaints
- 5 Compliments
- 5 Advice/Information/Suggestion

Advice –

- Assistance with information to Minister's Office, HCSCC, MHU, LMH General
- Assistance with information to a consumer

Primary Categories of Complaint:

- Consent – 1
- Corporate Services – 2
- Communication – 1
- Access - 1
- Treatment – 6

Themes

- Increased number of complaints related to lost valuable property noted from acute unit. Investigation underway into this matter.
- Treatment complaints relate to care and treatment provided as an inpatient and / or medication management.
- Inappropriate discharge from Community Mental Health Services.
- Increased number of requests for advice from HCSCC
- More complaints been received by OCP and forwarded to CLOs for ongoing management.
- Staff disrespectful behaviour towards consumers and families.
- Inadequate communication with carers/family around treatment and care provided to consumer.
- Compliments are being received predominantly in OPMHS service areas with one from Modbury MH ED.

Other

- Inconsistent categorisation of feedback on SLS
- Local feedback continues not captured. Need for senior staff to upskilled in use of SLS Consumer Feedback module.
- Staff SLS Consumer Feedback training and education session conducted on 28 May 2013 with 'The Gully' staff. Feedback from staff positive.
- Consumer education regarding consumer feedback remains ongoing. Last session given on 1 May 2013 at 'The Gully'.

**NORTHERN ADELAIDE LOCAL HEALTH NETWORK
MENTAL HEALTH SERVICES May 2013 report**



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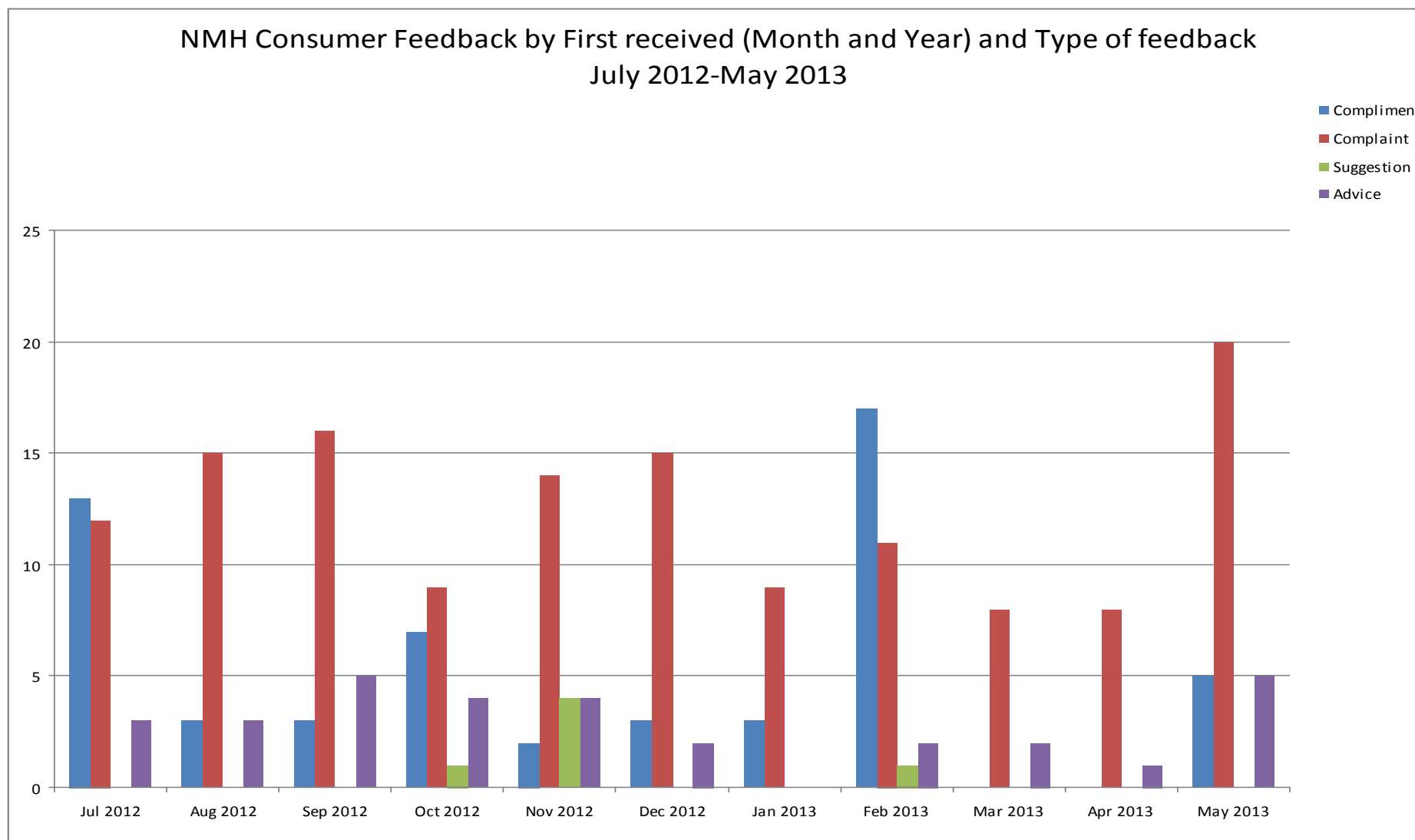
Arthur Moutakis

Consumer Liaison Officer

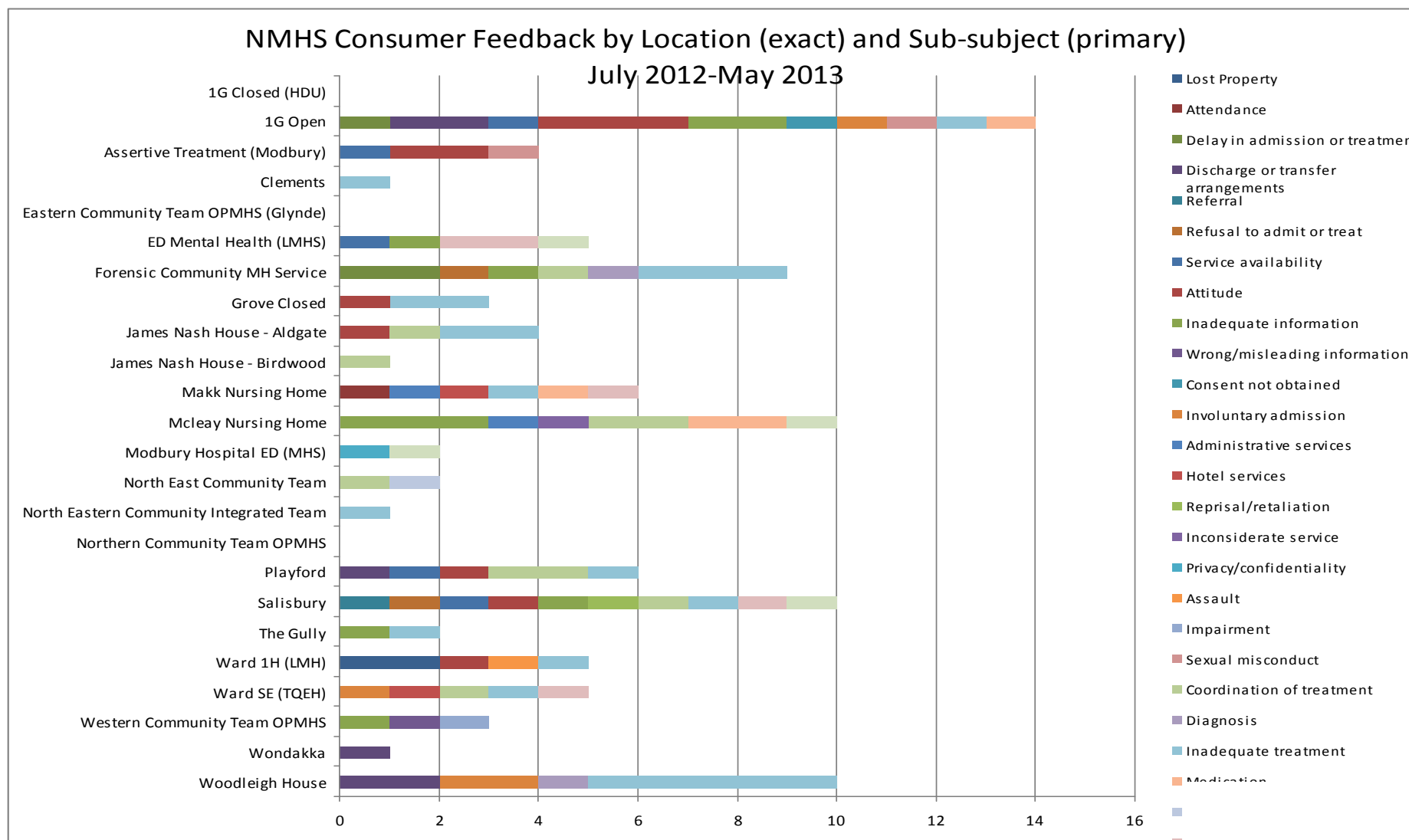
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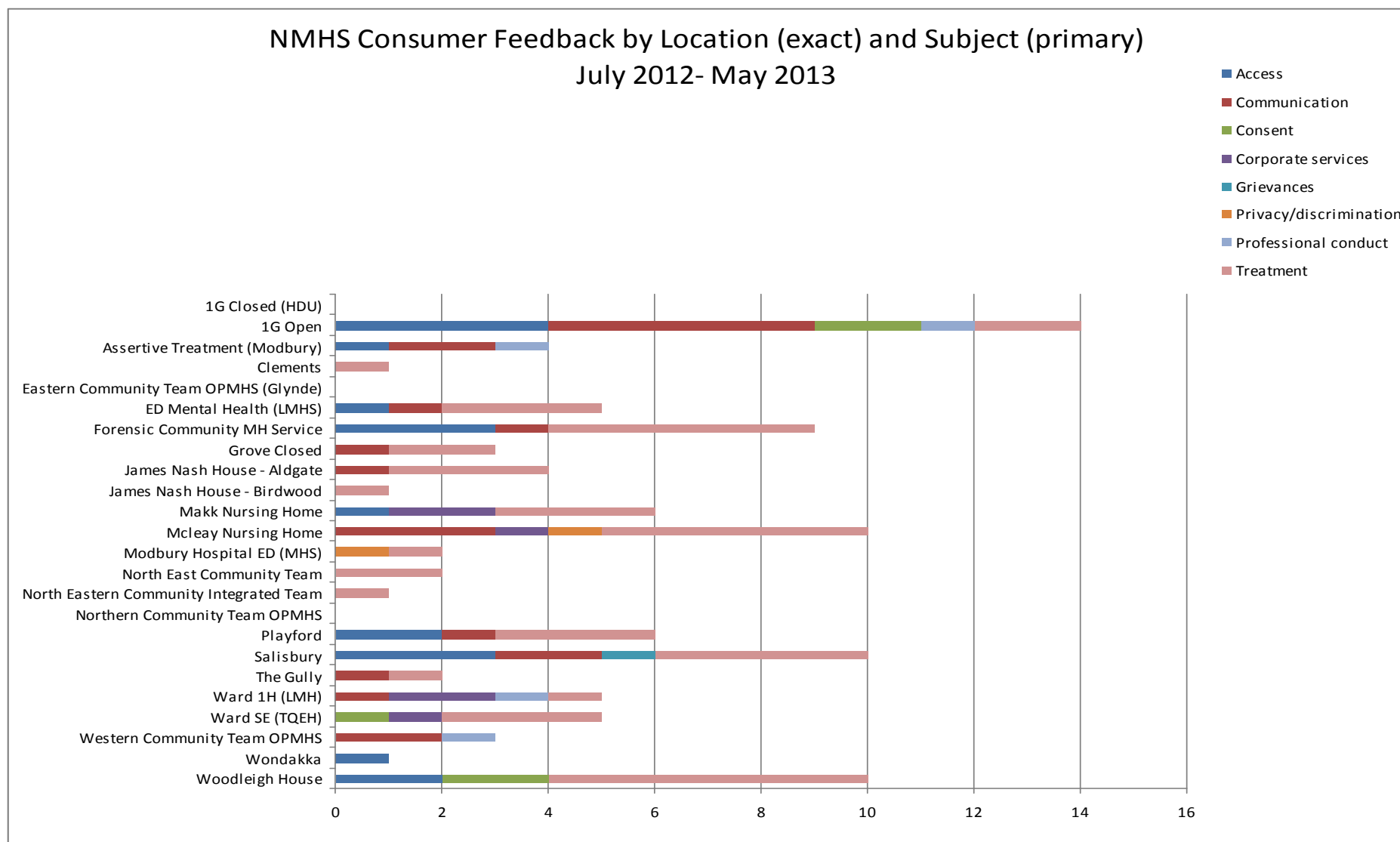
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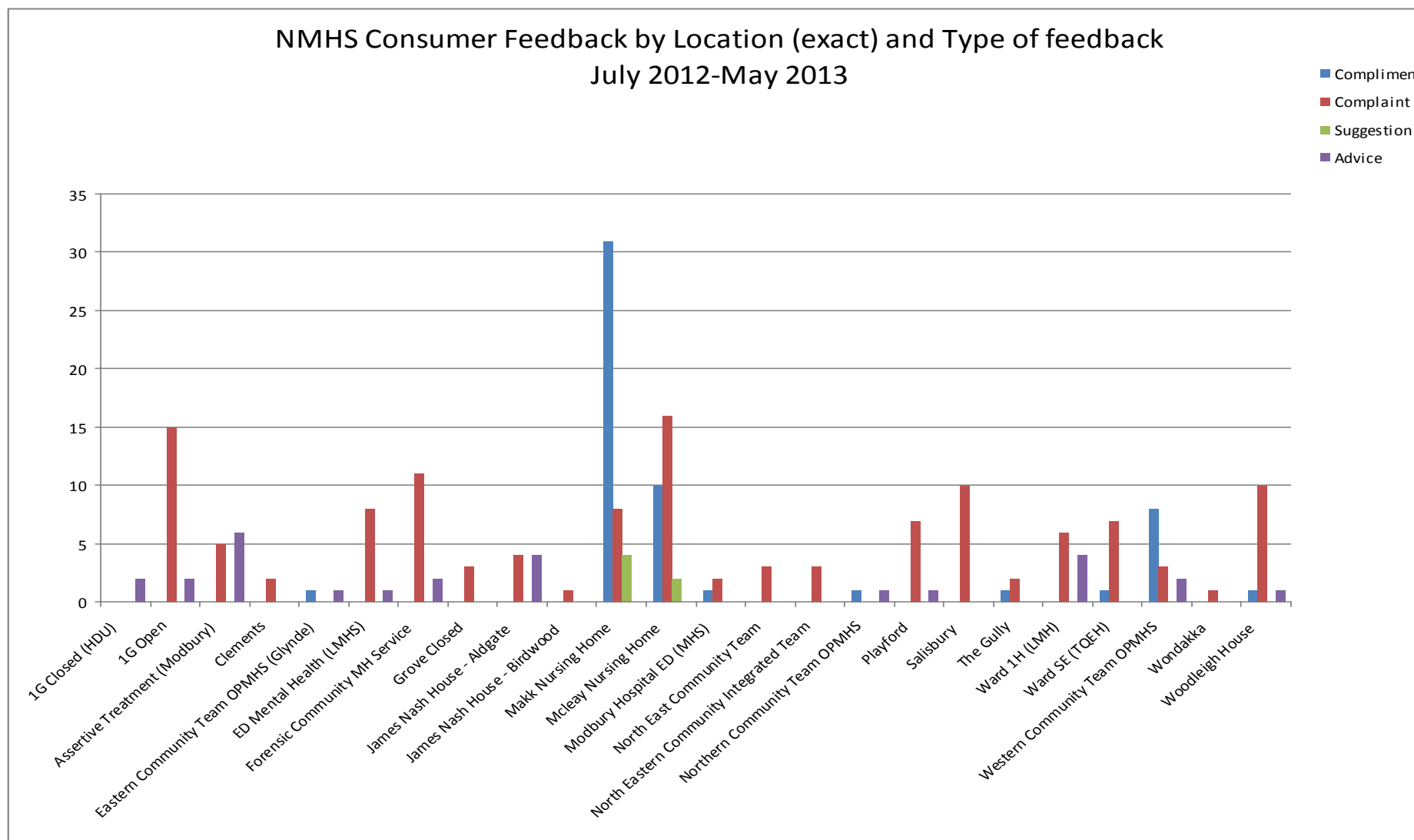
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Consumer Liaison Officer – Consumer Feedback Northern Mental Health Service

Data report for May 2014

NALHN MH SLS KPI Complaints May
 2014

May-2014			
Location	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	23	100%	71%

April-2013			
	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	21	100%	67%

*Please Note: Rate of complaints closed is commensurate with complexity of responses among other factors.

Total of 29 Consumer Feedback contacts.

- 23 Complaints
- 4 Compliments
- 2 Advice/Information/Suggestion

Advice –

- Assistance with information to Minister's Office, HCSCC, CVS, and CALHN.
- Assistance with information to staff.

Primary Categories of Complaint:

- Consent – 1
- Corporate Services – 0
- Communication – 9
- Access - 5
- Treatment – 7
- Privacy/Discrimination – 0
- Professional conduct - 1

Themes

- Slight increase in consumer feedback being managed this month.
- Increased number of complaints related to community mental health treatment and care being provided or not provided and access to the same.
- Further requests for information from local MP about a community mental health consumer's care being provided in a driveway.
- Staff disrespectful behaviour towards consumers and families.
- Inadequate communication with carers/family around treatment and care provided to consumer. Staff not communicating adequately with them regarding their care.
- Complaint received from Disability SA about their consumer who presented on three occasions to LMH MH ED in an 8 hour period and was discharged home. Consumer was receiving ongoing community support from Disability SA.
- Complaints received via HCSCC from a discharged NECMHS consumer who believes she was wrongfully detained at home, transported to hospital and provided medication without her consent and or consultation. Complaint from a current NECMHS consumer requesting that she have another Consultant Psychiatrist due to his disrespectful behaviour
- Ministerial complaint – 2: which pertains to ward 1H, LMH, regarding allegations of staff behaving disrespectfully towards her. Another ministerial was in relation to inadequate communication about changes to a former Northern Mental Health Service CAC.
- Multiple complaints being received from one NECMHS consumer (3-4 emails/daily and forwarded ministerial correspondence) due to recent to mental health plan changes. The sheer volume has not been all entered on SLS.
- There were three consumers who made more than one complaint for the month of May 2014.

- Four compliments received one from mother of consumer about her son's care in Ashton House and another from Ashton House consumer. Compliments received from ward SE consumer / family and NCMHS service.

Service Improvement recommendations

- Consideration to be given to a review and development of action plan to address communication issues with consumers, and or their families.
- Need for communication strategy to be developed when Consumer Advisory Groups are suspended that members of that group are kept abreast of any planned changes.
- Consideration to be given to improving communication with Disability SA and their consumers. ie. Addressing service interface issues.

Other

- Most local feedback continues not to be captured. Need for senior staff to upskilled in use of SLS Consumer Feedback module.
- SLS Consumer Feedback module education training completed for FMHS and OPMHS staff.
- Consumer Feedback education and training provided to The Gully staff and consumers. Feedback positive.
- Significant work continues with assisting the organisation towards meeting Standard 2 including development of action plan.
- Participation on NMH Incident Review Panel continues monthly.

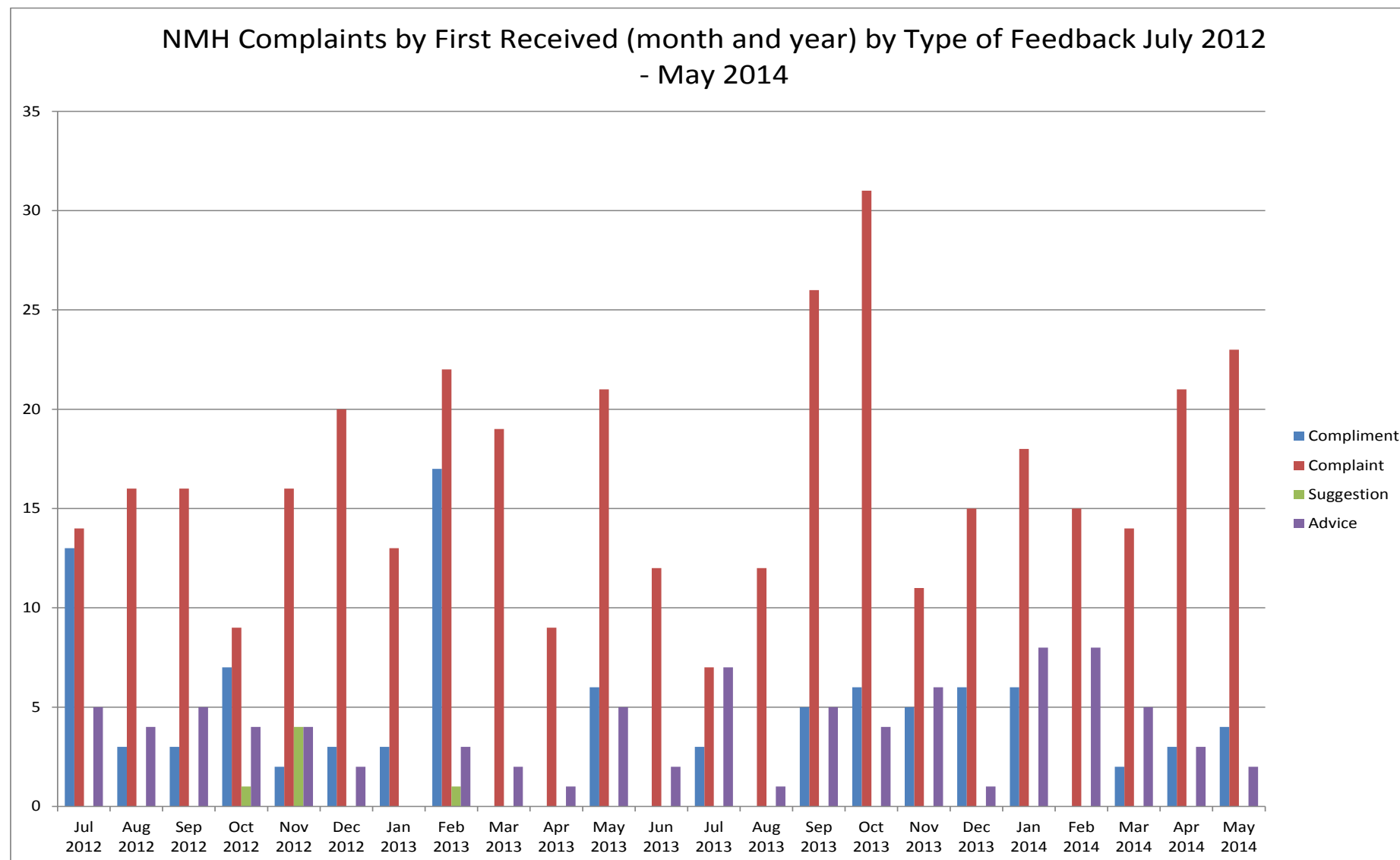
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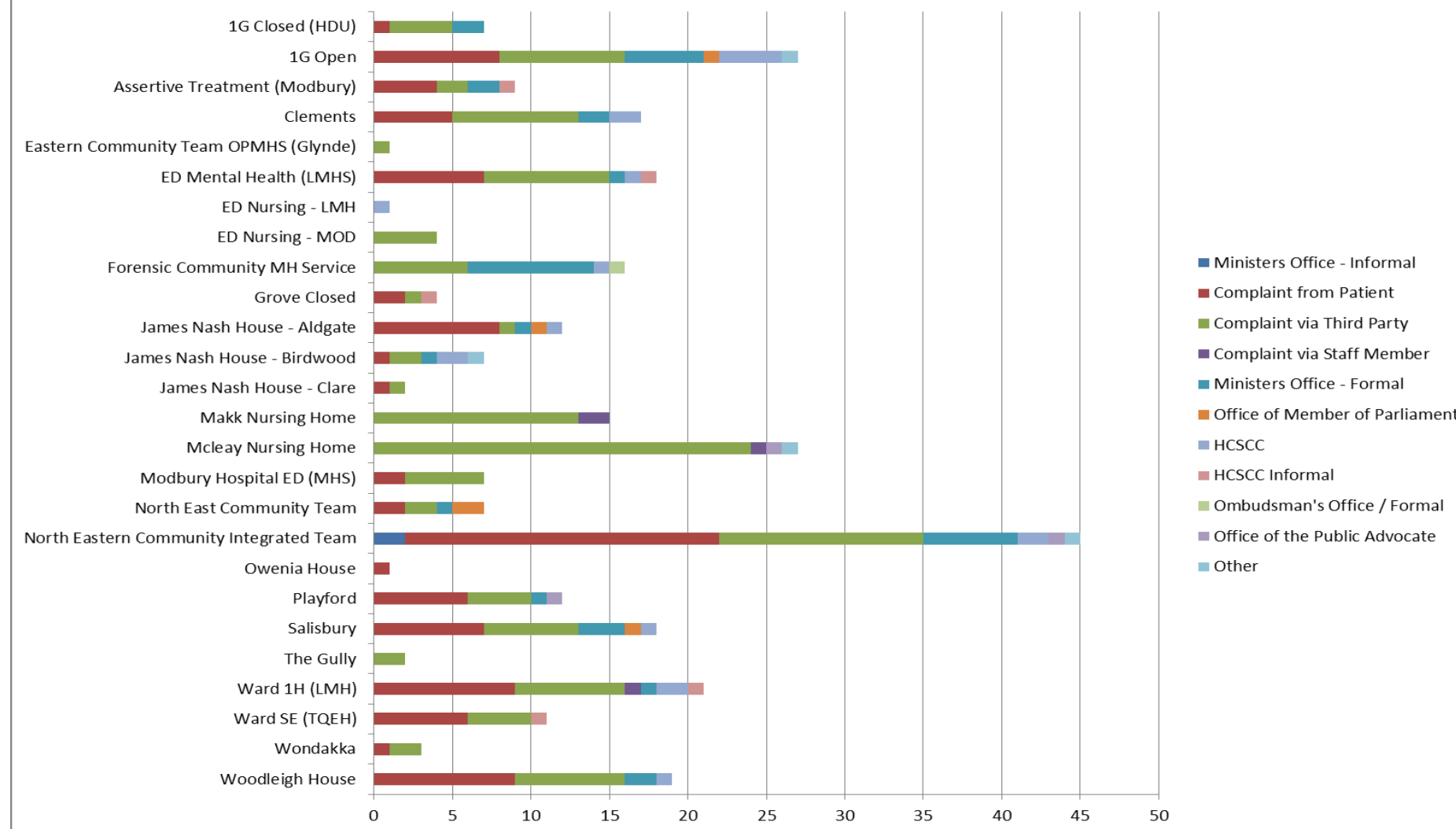
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MENTAL HEALTH DIVISION May 2014 report**

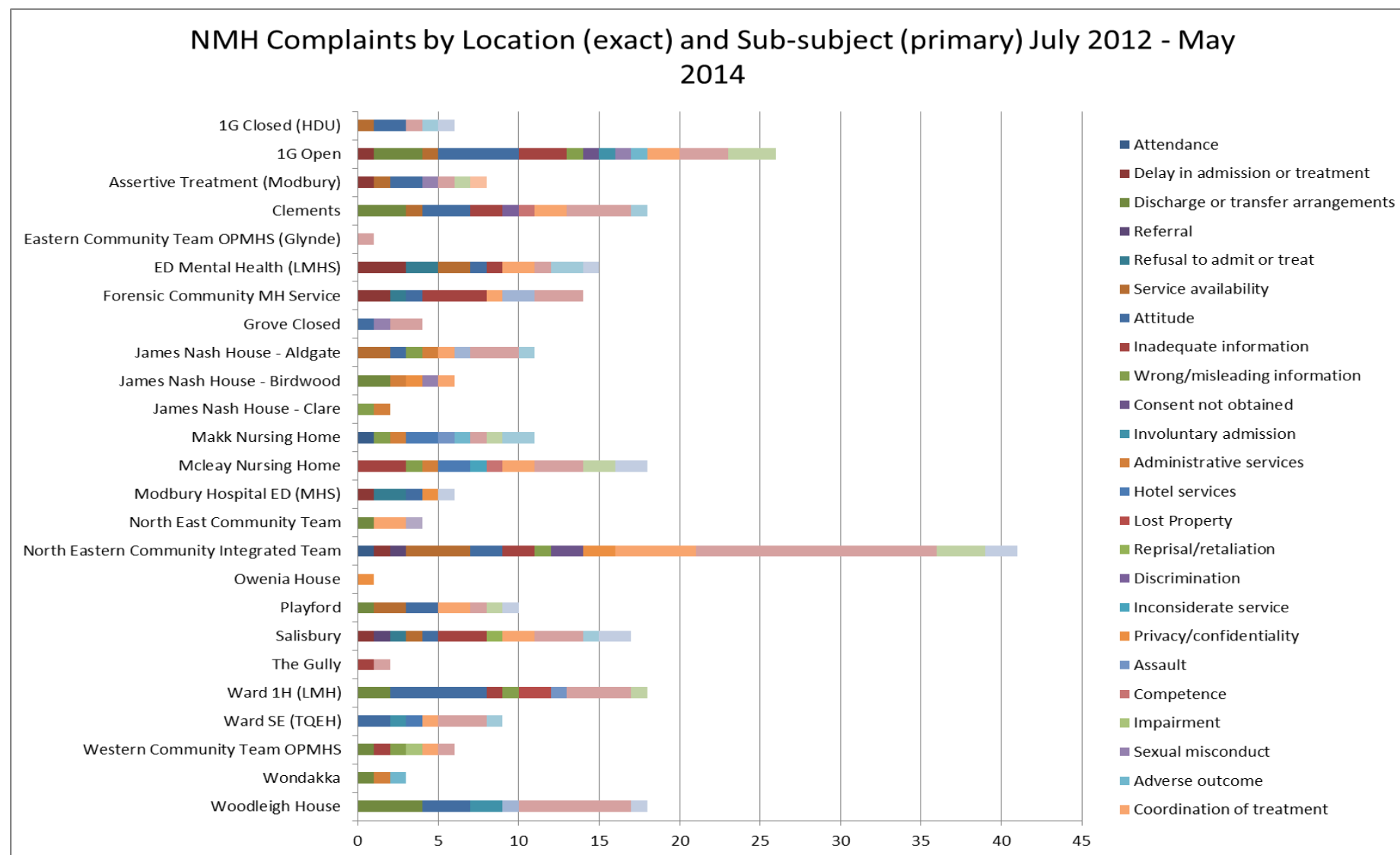


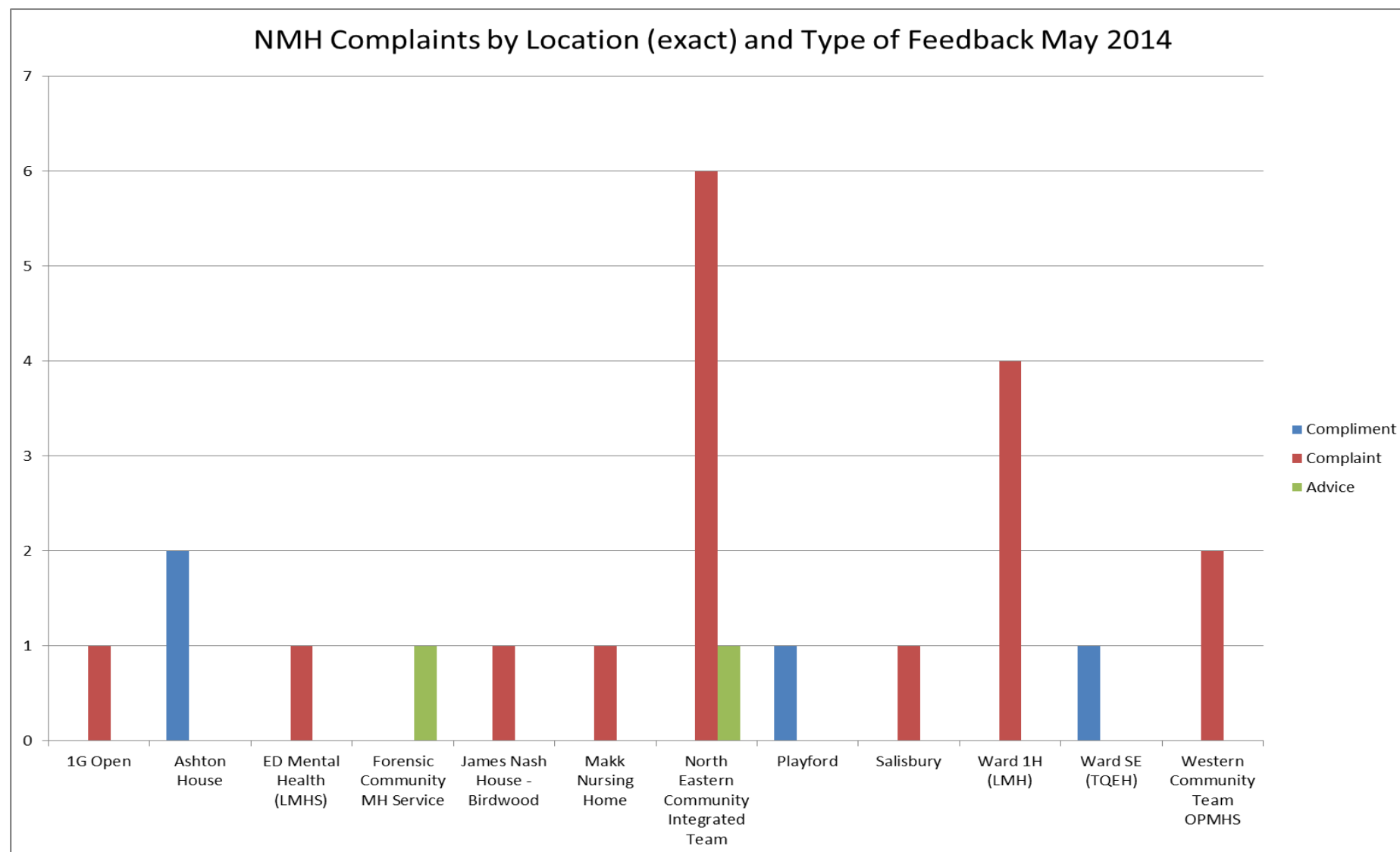
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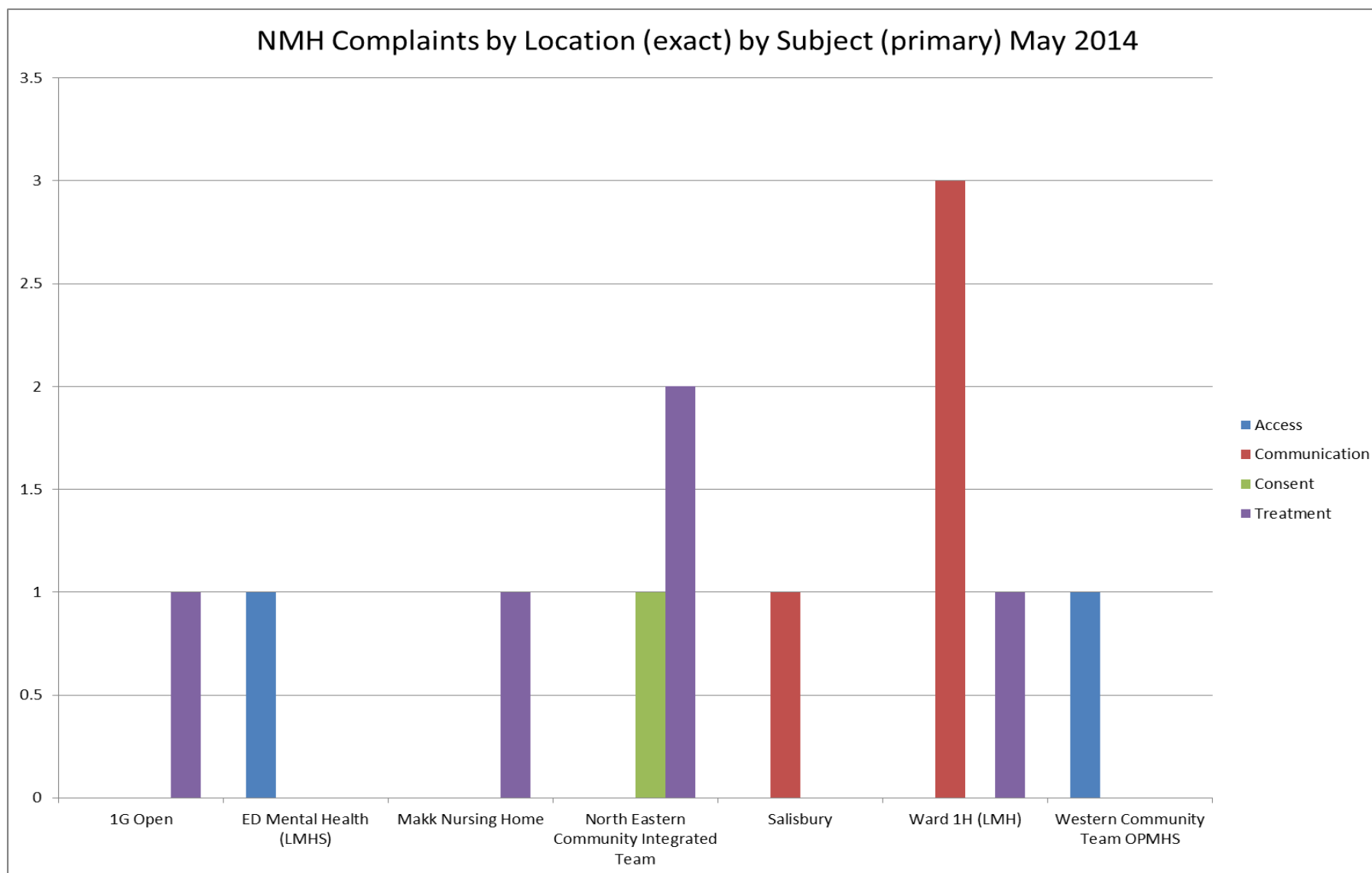


NMH Complaints by Location exact and Type of Complaint July 2012 - May 2014









Consumer Liaison Officer – Consumer Feedback Northern Mental Health Service

Data report for May 2015

NALHN MH SLS KPI Complaints April
2015

May 2015			
Location	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	20	100%	94%

April 2015			
	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	10	100%	97%

*Please Note: Rate of complaints closed is commensurate with complexity of responses among other factors.

NORTHERN ADELAIDE LOCAL HEALTH NETWORK MENTAL HEALTH DIVISION May 2015 report

Total of Consumer Feedback contacts: 36

- 20 Complaints plus numerous contacts from two NE consumers (not all recorded on SLS)
- 4 Advice/Information
- 12 Compliments

Advice – Information and education provided to staff regarding the management or de-escalation of a potential or actual complaint. Advice provided to Office of the Chief Psychiatrist regarding matters they were dealing with that related to Northern Mental Health consumers.

Primary Categories of Complaint:

- | | |
|---------------------|----|
| • Access | 3 |
| • Communication | 10 |
| • Corporate Service | 2 |
| • Treatment | 3 |

Themes

- Inadequate communication with carers/family around treatment and care provided to consumer particularly in relation to discharge planning from hospital.
- Insufficient communication with carers/family around treatment and care provided to consumer. Staffing knowledge around current legislation in relation to the disclosing of information to family members has been identified as a gap.
- Numerous complaints received from families who have been denied visiting access to their family member who is inpatient.
- Disrespectful behaviour of acute inpatient clinical staff towards consumer families/carers.
- Not included in the above stats about are contacts via emails and phone calls plus emails to minister's office for well-known NECMHS consumer (3-4 emails/daily and forwarded ministerial correspondence) the volume has not been entered on SLS.
- Four HCSCC complaints received for the month of May 2015 two from third parties about our service not providing adequate treatment and care to a consumer. Two were from FMHS consumer about being disrespectfully treated by nursing staff which also involved a complaint resolution meeting between HCSCC representatives, Senior Mental Health Staff and consumer.
- Twelve compliments received this month with many having been entered by senior clinical staff at the local unit/ward level. 7 OPMHS compliments regarding excellent care that their family members received from the service. One from NCMHS where a brother of a consumer has written a letter stating that he is happy with the service that her sister is receiving from the Northern Community Mental Health Centre which is enabling her to live independently in the community. Another NCMHS complement received regarding their family members Care Coordinator. One compliment received from parents of Woodleigh House consumer about the care and concern provided to their son.

- **Service Improvement recommendations**

- Consumers need to ensure that they have a copy of their rights and responsibilities. Support should be offered by clinical staff (where appropriate).
- Service to consider respectful behaviour training for all staff particularly acute areas.
- Service to provide updated education and training regarding information sharing and associated legislation in particular the *Carers Recognition Act 2005*.
- Clinicians to include (where appropriate) family and or significant others when assessing, implementing and reviewing consumer care.
- Staff to be reminded about the need to consult with consumers, and their family and or support person (s) to develop a discharge/ transfer plan. Copy of transfer plan to be provided to consumer and family etc.
- Consideration to be given to a review and development of action plan to address communication issues with consumers, and or their families.

Other

- Most local feedback continues not to be captured. Need for senior staff to upskilled in use of SLS Consumer Feedback module. Education and training of staff remains ongoing.
- OPMHS staff training has been evaluated as uptake by senior staff has been slow. Strategies to address are being considered by CLO and Senior OPMHS management.
- Significant work continues with assisting the organisation towards meeting Standard 2 including development of action plan.
- Participation on NMH Incident Review Panel continues monthly.
- Participation in the NALHN Advance Care Directives Champions Group.

**NORTHERN ADELAIDE LOCAL HEALTH NETWORK
MENTAL HEALTH DIVISION May 2015 report**



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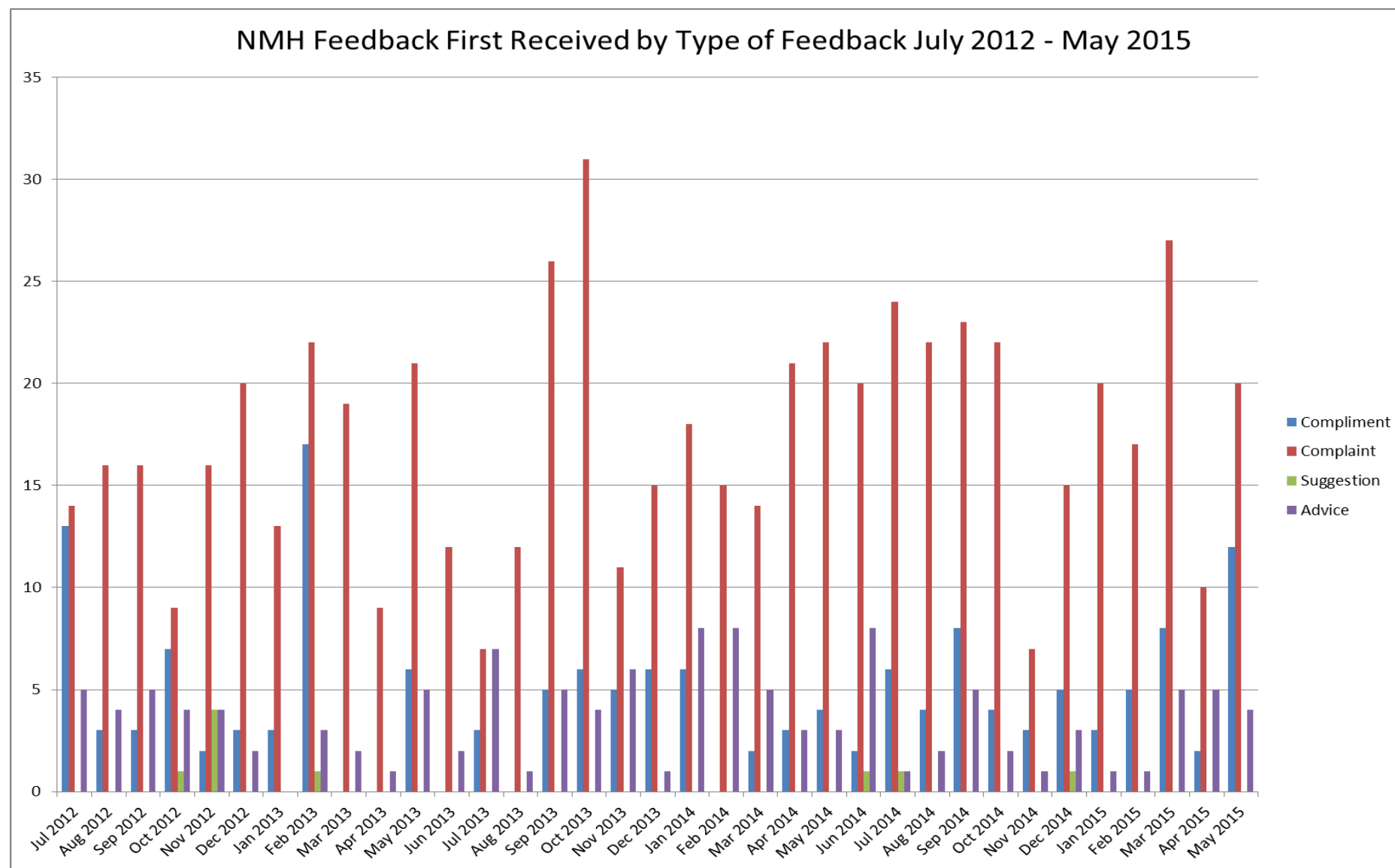
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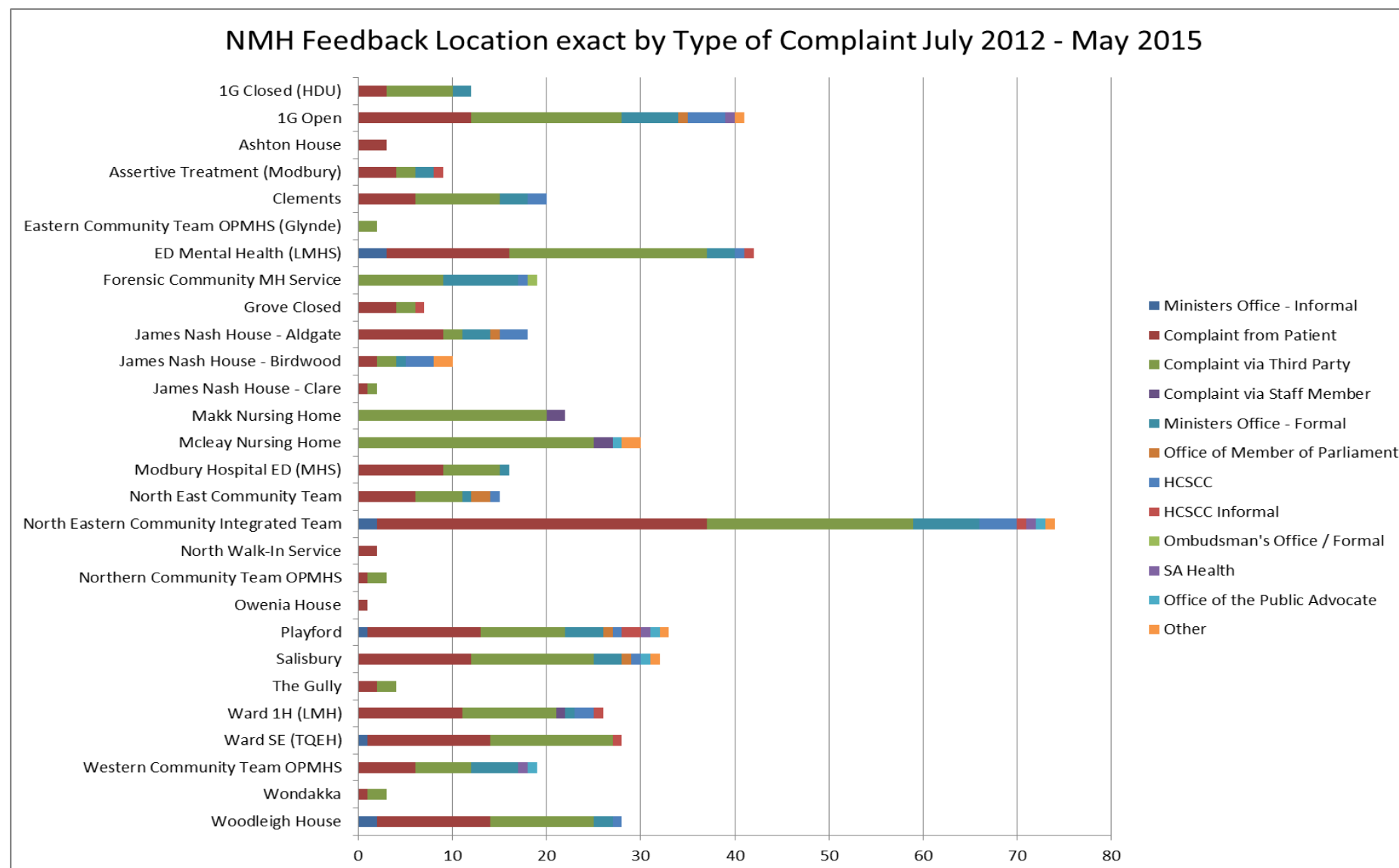
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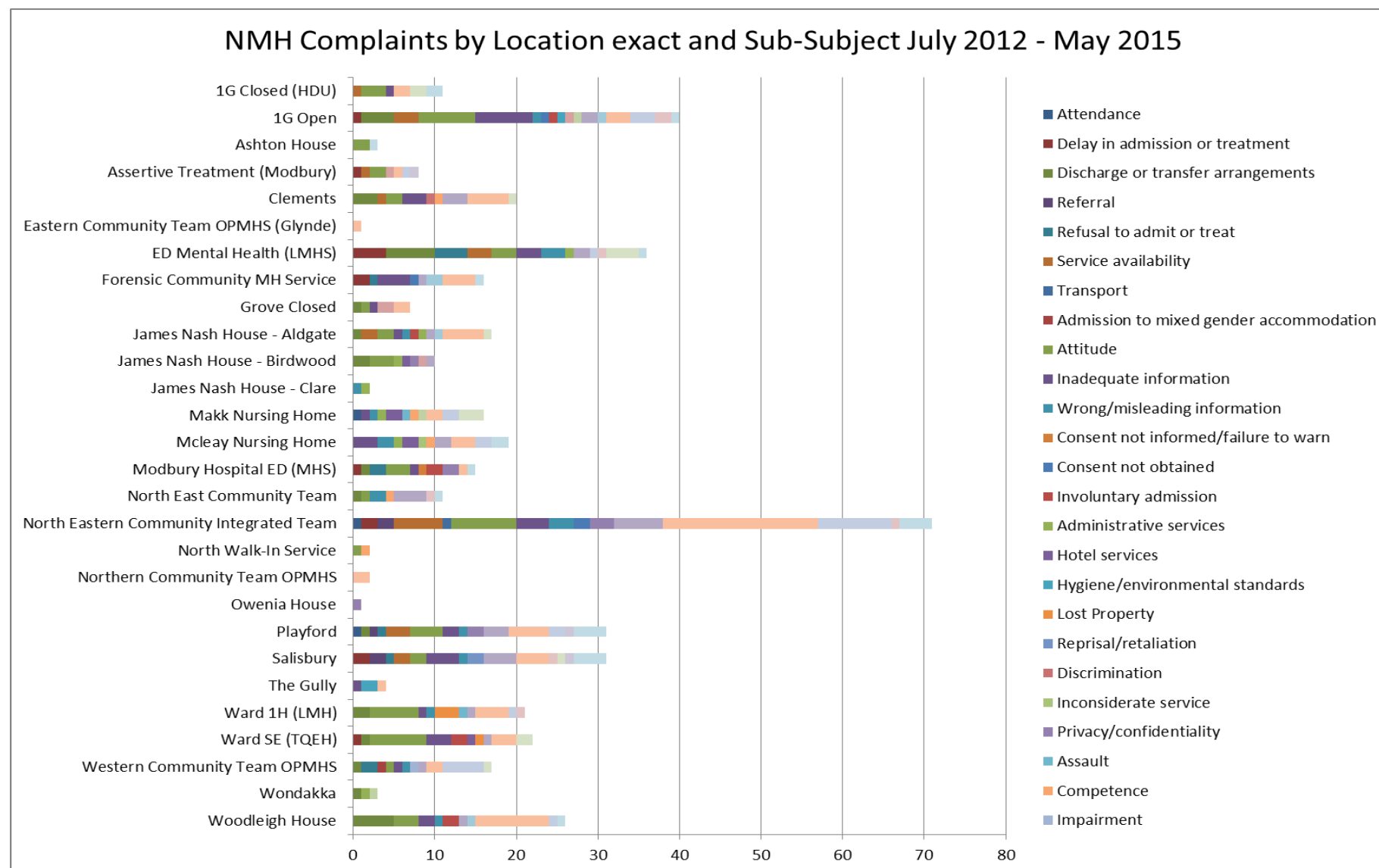
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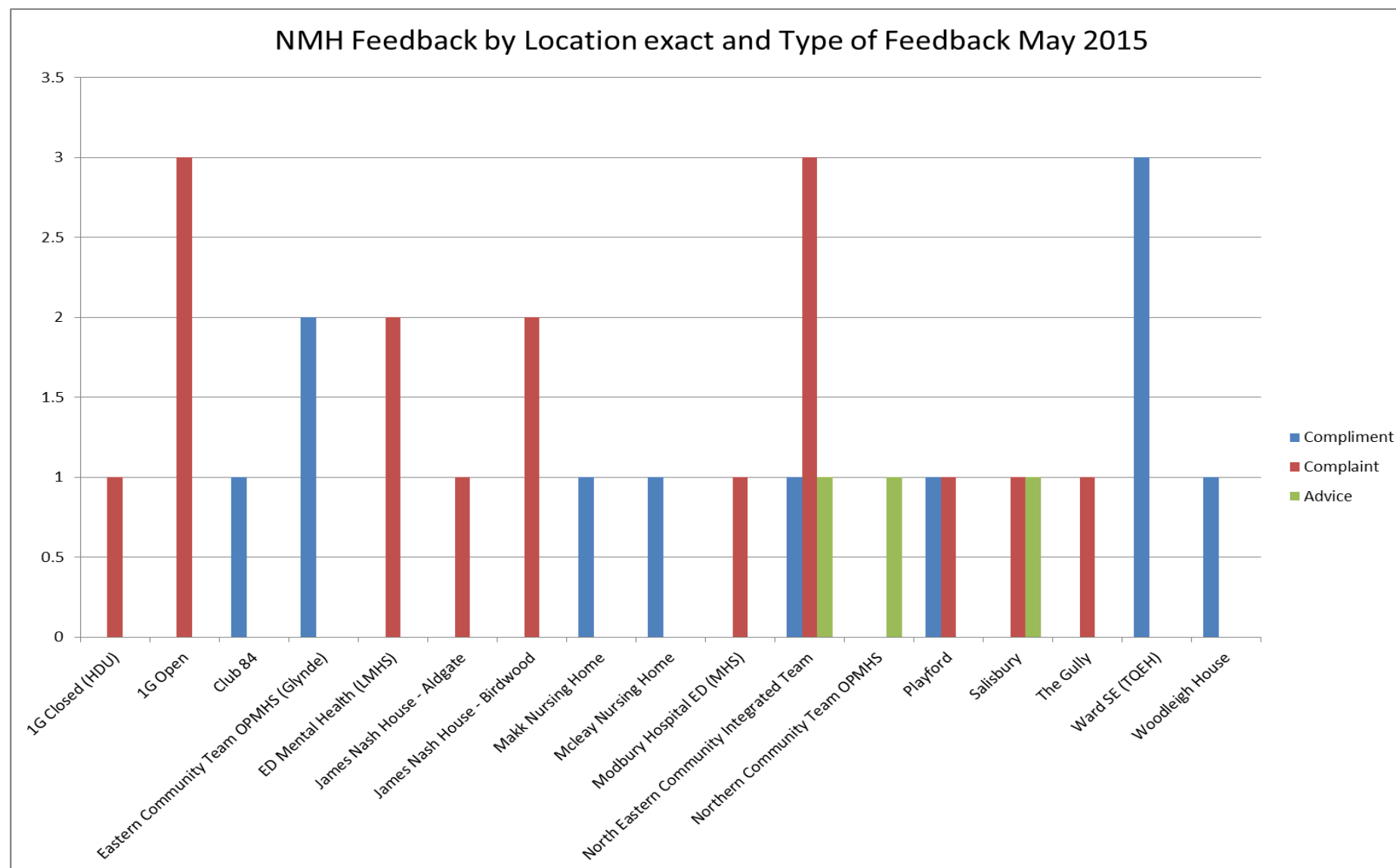
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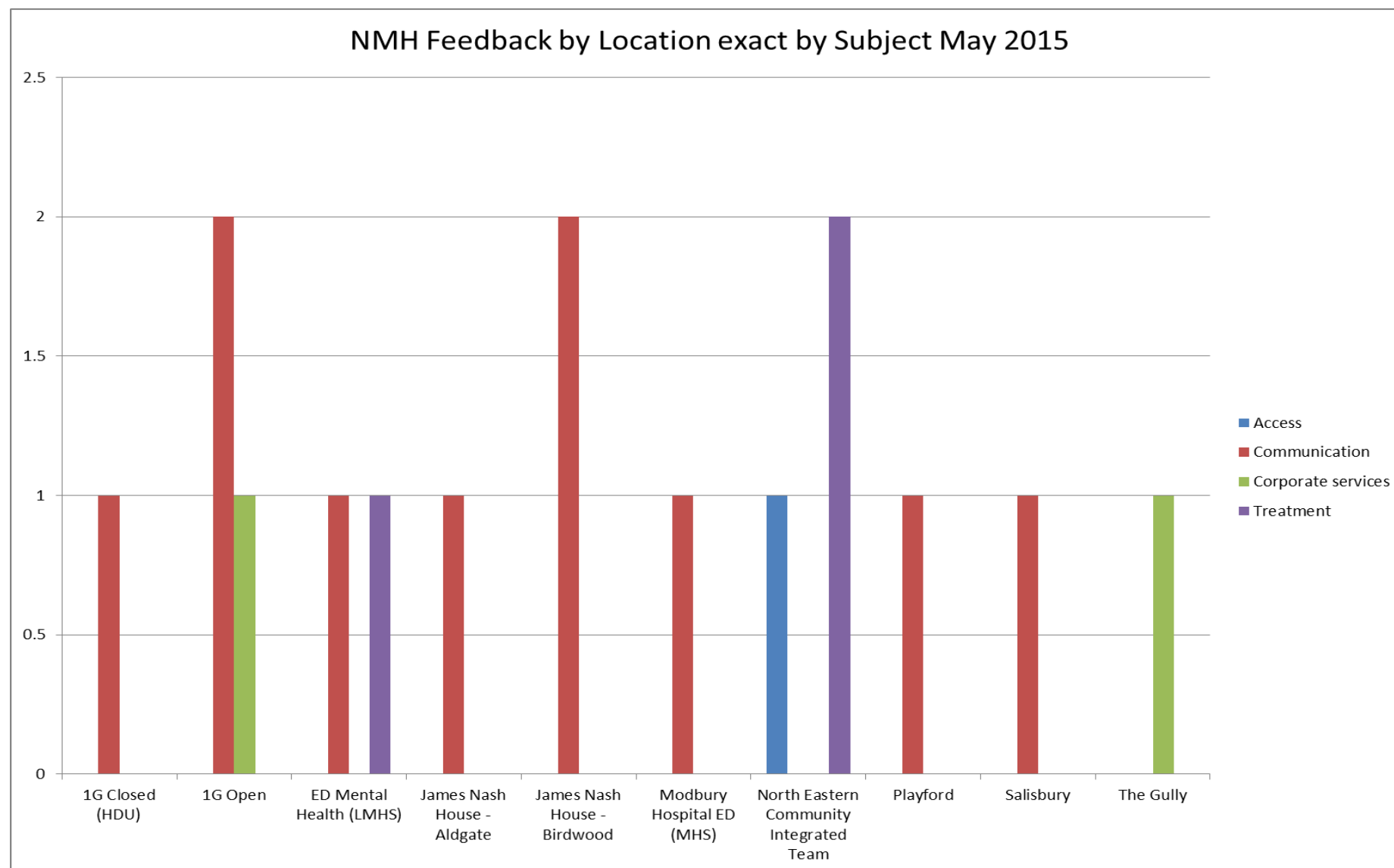
NORTHERN ADELAIDE LOCAL HEALTH NETWORK MENTAL HEALTH DIVISION May 2015 report



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Consumer Liaison Officer – Consumer Feedback Northern Mental Health Service

Data report for May 2016

NALHN MH SLS KPI Complaints May
2016

May 2016			
Location	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	22	100%	90.32%

April 2016			
	Total Complaints	Acknowledged <48 Hours	Closed <35 Days
Mental Health	26	100%	91.43%

*Please Note: Rate of complaints closed is commensurate with complexity of responses among other factors. In addition, the SLS data entry may have been effected due to a reliever covering the CLO for two weeks in the month of May.

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Total of Consumer Feedback contacts: 28

- 22 Complaints plus numerous contacts from two NE consumers (not all recorded on SLS)
- 0 Advice/Information
- 6 Compliments

Primary Categories of Complaint:

- Access - 3
- Communication – 6
- Privacy / Discrimination – 2
- Treatment – 7
- Consent – 1
- Grievances - 1
- Corporate services – 0
- Professional conduct - 2

Themes

- Slight drop in numbers of consumer feedback managed in May 2016 compared to April 2016.
- Advice provided to staff and directly to consumers and or carers regarding FOI issues and carer's need to communicate with their loved ones Care Coordinator. Advice also provided about complaints management.
- Inadequate disrespectful / communication with consumers, carers/family around treatment and care provided particularly in relation to current treatment and discharge planning from hospital.
- Two ministerials received (Two were informal). One ministerial was received for noting from anonymous person about cameras in JNH. No response was required. Informal ministerial complaint received from discharged OPMHS – NCT about multiple complaints in regards to his treatment and care.
- One NALHN wide HCSCC complaint received due to statewide complaints raised by people who use wheelchairs. Another HCSCC request for copies of consumer's casenotes to follow up on a previous complaint.
- One complaint received via OCP from NECMHS consumer mother about inadequate care and treatment provide to her son. Another received from consumer who believed that she was wrongfully detained in hospital and was being provided wrong/ inappropriate care.
- Not included in the above stats about are multiple contacts via emails and phone calls plus emails to minister's office for well-known NECMHS consumer and carer (up to 30 emails/daily / phone calls and forwarded ministerial correspondence) the volume has not been entered on SLS however correspondence has been stored on Q drive.
- Six compliments received this month. One compliment received from OPMHS - WCT consumer about the treatment and care received. One compliment from wife of deceased Clements House consumer about care received. Another compliment received from NECMHS consumer x2 about the excellent DBT support and program received. One

compliment received from discharged FCMHS consumer about the excellent group work at Owenia House. Another compliment received from NCMHS consumer about their care coordinator's excellent treatment and care.

- Face to face complaint received from member of public about alleged staff professional mis-conduct.

Service Improvement recommendations

- Public information on the range of mental health services available should be readily available via various media.
- Service to consider respectful behaviour training for all staff particularly acute areas.
- Clinicians to include (where appropriate) family and or significant others when assessing, implementing and reviewing consumer care.
- Consumer care plans (where appropriate) to have crisis management plan developed and accessible to all mental health staff via CBIS.
- Staff to receive consumer feedback education and training. Need to identify strategies to address staff communication with families.
- Staff to be reminded about the need to consult with consumers, and their family and or support person (s) to develop a discharge/ transfer plan. Copy of transfer plan to be provided to consumer and family etc.
- Consideration to be given to a review and development of action plan to address communication issues with consumers, and or their families. Staff to be reminded about the new SA Directive on Partnering with carers.
- Consideration to be given to improving the provision of FOI information to consumers and the general community.
- All staff need to be reminded that all MP Office requests for information needed to be directed via Minister Vlahos's Office.
- Consideration to be given to a review of signage on Oakden Campus.

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- Staff to be reminded about the need to ensure that when consumers are admitted that any pets they have at home are cared for. This needs to be clearly documented.

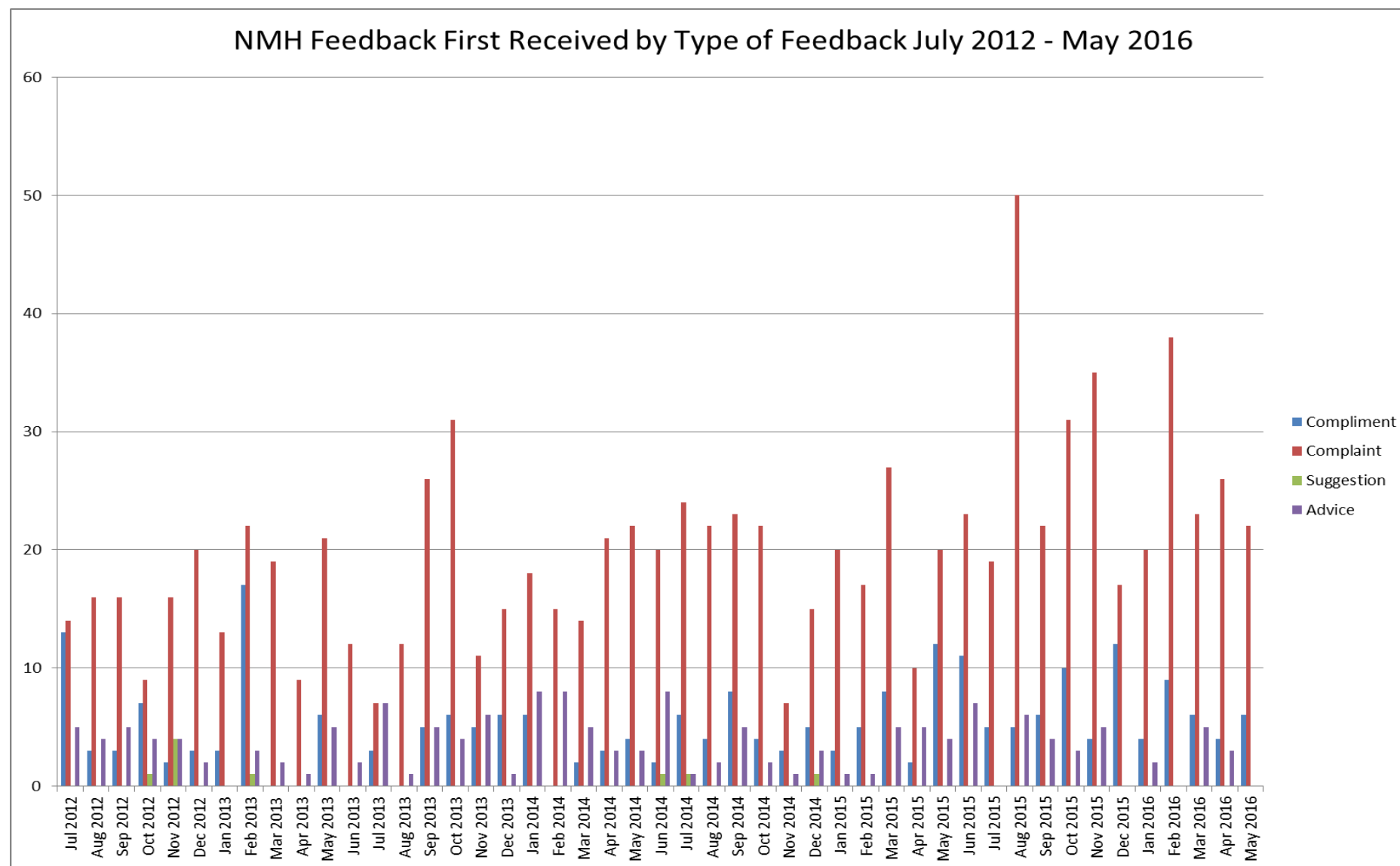
Other

- Most local feedback continues not to be captured. Need for senior staff to be upskilled in use of SLS Consumer Feedback module. Education and training of staff remains ongoing.
- OPMHS staff training has been evaluated as uptake by senior staff has been slow. Strategies to address are being considered by CLO and Senior OPMHS management.
- Significant work continues with assisting the organisation towards meeting Standard 2 including development of action plan.
- Participation on NMH Incident Review Panel and Recommendations Advisory Group continues monthly.
- Participation on NMH Safety and Quality Committee continues fortnightly.
- Participation in the NALHN Advance Care Directives Champions Group.
- Participation in the NALHN CALD working party.
- Active participation in the development and roll out of 'Trauma Informed Care' staff education.

For any additional information please contact:

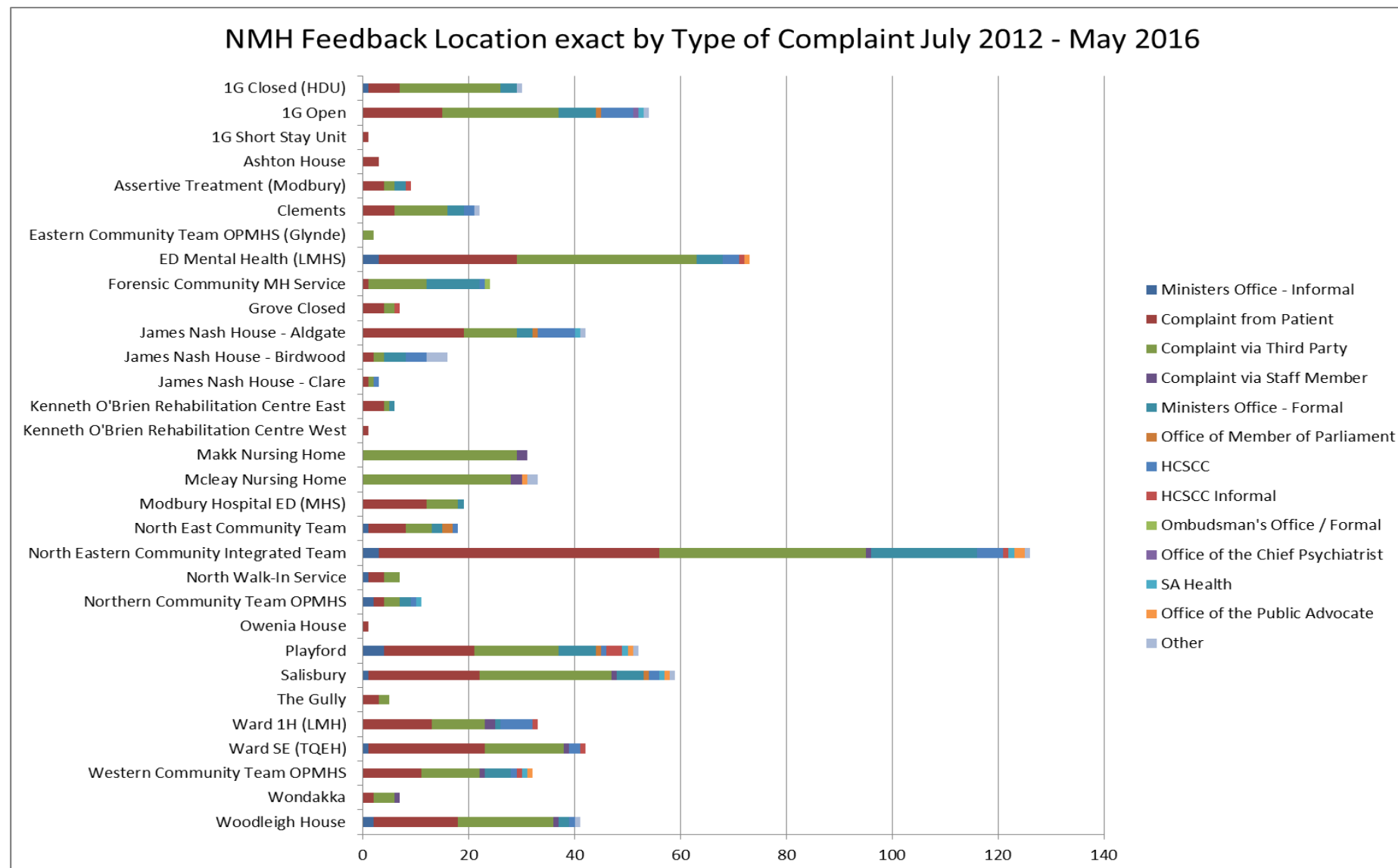
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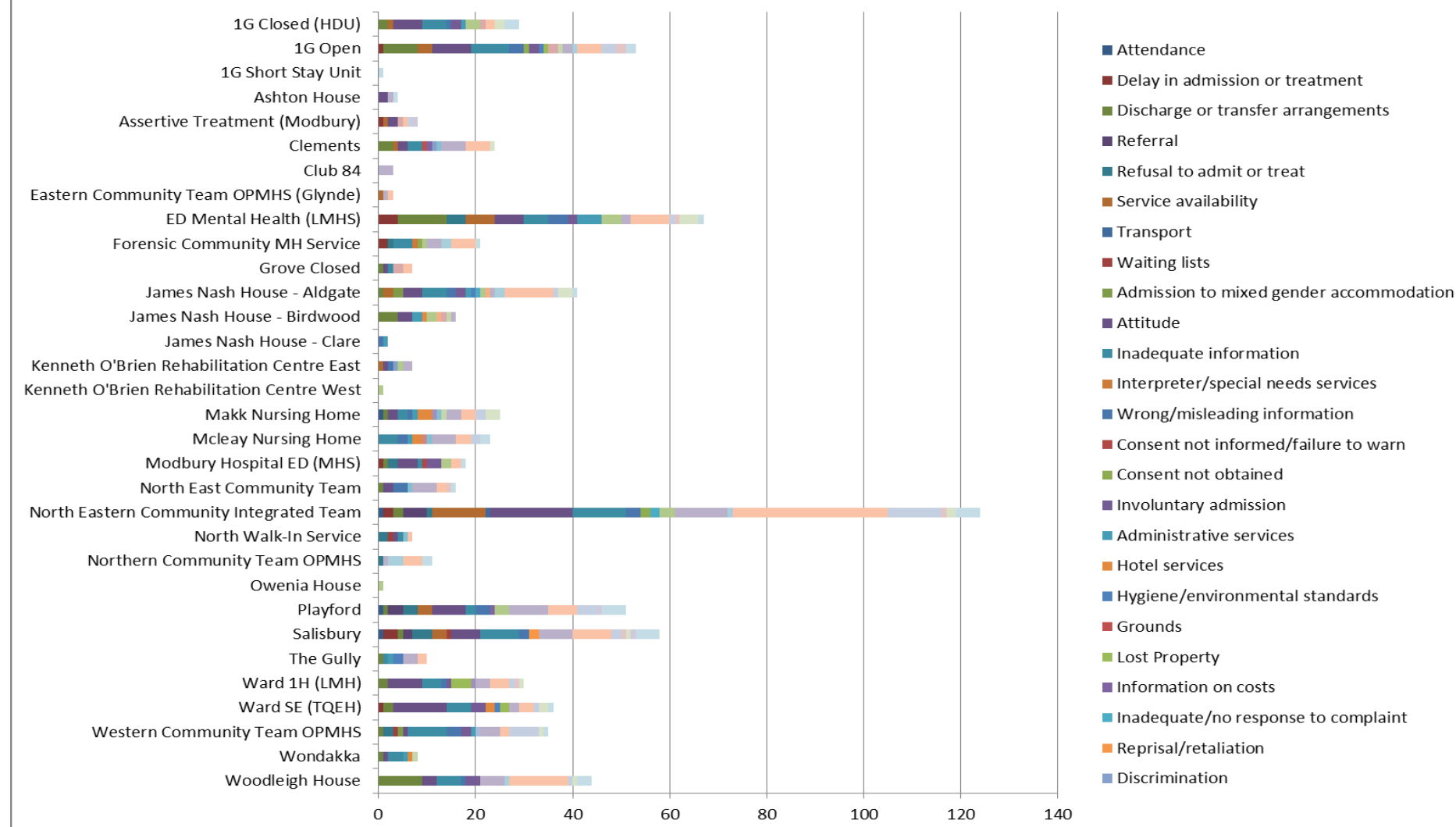
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NMH Feedback Location exact by Type of Complaint July 2012 - May 2016

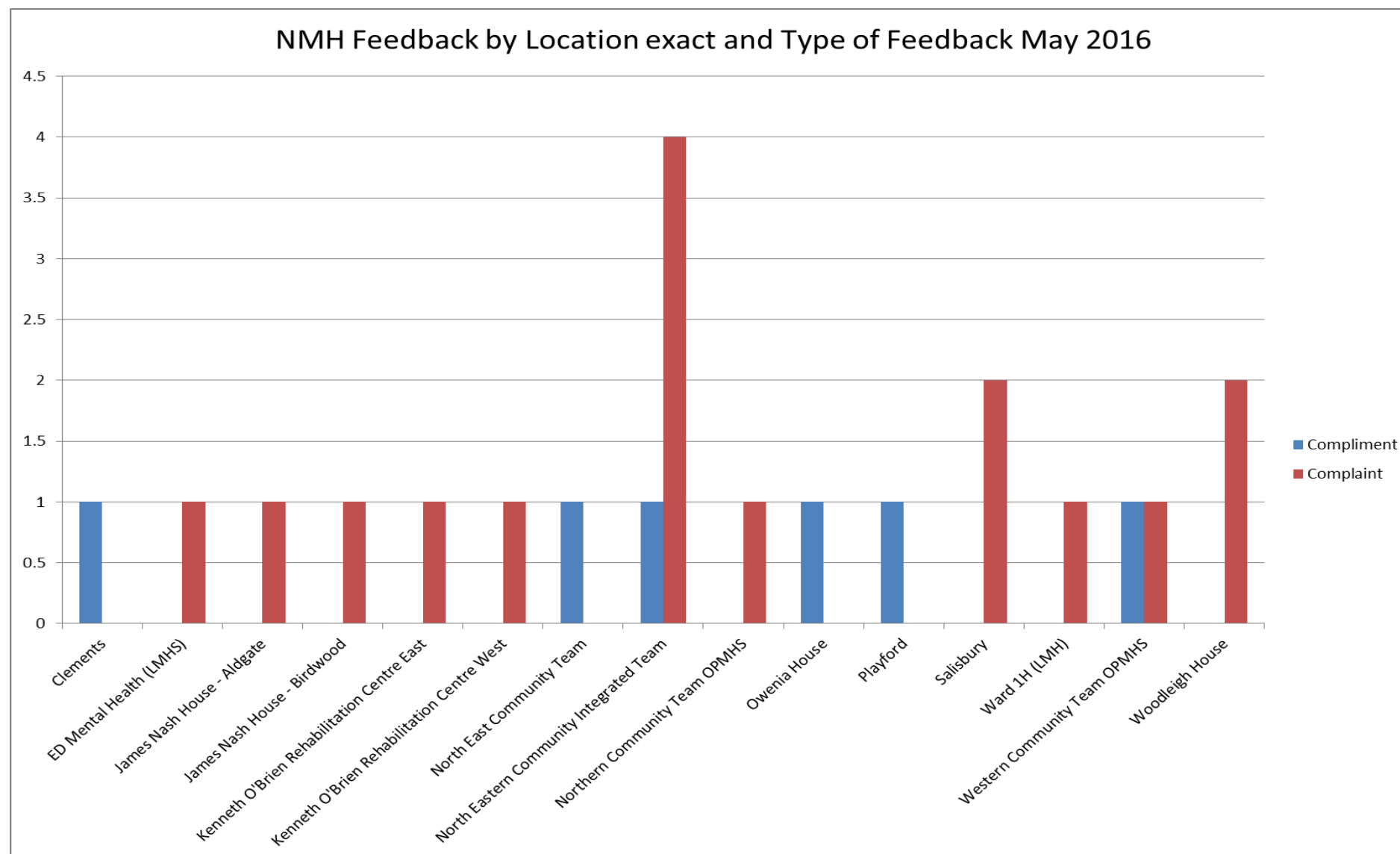


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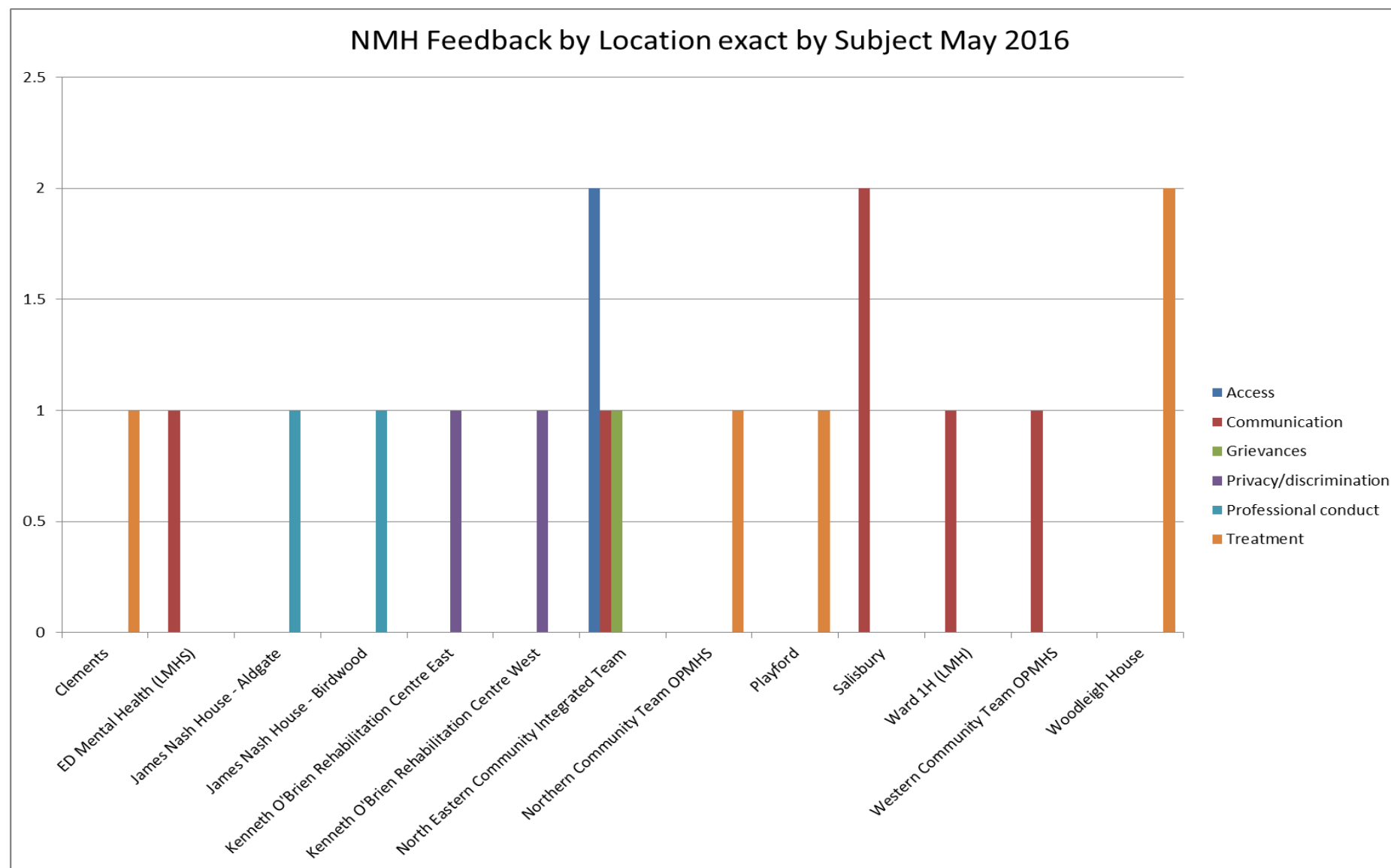
NMH Complaints by Location exact and Sub-Subject July 2012 - May 2016



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