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TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE MARGARET WILSON QC, Commissioner

MR P. FREEBURN QC, Counsel Assisting

MS C. MUIR, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 4) 2015

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

BRISBANE

9.34 AM, MONDAY, 15 FEBRUARY 2016

Continued from 28.1.16

DAY 6

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RESUMED **[9.34 am]**

COMMISSIONER WILSON: Good morning, ladies and gentlemen. Can I begin by taking the appearances, please.

MR P.A. FREEBURN QC: Commissioner, Freeburn, initials P.A., Queen's Counsel. I appear with MS MUIR as Counsel Assisting.

COMMISSIONER WILSON: Thanks, Mr Freeburn.

MS E.S. WILSON: Good morning, Commissioner. My name is Wilson, initials E., and I'm here with my learned friends MS KEFFORD, initial N. and MS CRAWFORD, initial J. And we represent the State of Queensland, instructed by Crown Law.

COMMISSIONER WILSON: Thank you, Ms Wilson.

MS K.A. McMILLAN QC: Yes. Good morning, Commissioner. My name is McMillan, initials K.A., Queen's Counsel. I appear with MR FITZPATRICK for the West Moreton Health Service and Board.

COMMISSIONER WILSON: Thank you. Now, I understand Mr Allen is not here from Metro North this morning. Is there anyone else here from Metro North? No. Very well. Mr Diehm.

MR G.W. DIEHM QC: Commissioner, my name is Diehm, D-i-e-h-m, initials G.W. of Queen's Counsel. I appear with my learned friend MS CONWAY, initials C.J. We are instructed by Avant Law and appear on behalf of Drs Brennan, O'Connell and Cleary.

COMMISSIONER WILSON: Thank you.

MS K.A. MELLIFONT QC: Good morning, Commissioner. My name is Mellifont, M-e-l-l-i-f-o-n-t, QC, initials K.A. I appear together with my learned friend MS ZERNER, Z-e-r-n-e-r, initials M.E. I'm instructed by Clayton Utz, and I appear for Metro South Hospital and Health Service.

COMMISSIONER WILSON: Thanks, Ms Mellifont.

MR D. O'BRIEN QC: Good morning, Commissioner. My name is O'Brien, initial D. of Queen's Counsel. I appear with my learned junior MS NICHOLAS, initial A. I appear for Mr Ian Maynard, and I'm instructed by Herbert Smith Freehills.

COMMISSIONER WILSON: Thanks, Mr O'Brien.

MR D.V. O'SULLIVAN QC: May it please the Commission, my name is O'Sullivan, initials D.V., Queen's Counsel. I appear with MR O'REGAN, R-e-g-a-n, of counsel instructed by McCullough Robertson for the Honourable Lawrence Springborg.

COMMISSIONER WILSON: Thank you, Mr O'Sullivan.

MR A.W. DUFFY QC: Good morning, Commissioner. My name is Duffy, D-u-f-f-y, initials A.W. of Queen's Counsel. I'm instructed by Ashurst Australia, and I appear for Dr Bill Kingswell.

COMMISSIONER WILSON: Thank you, Mr Duffy.

MR B. WESSLING-SMITH: May it please the Commission, my name is Wessling-Smith, W-e-s-s-l-i-n-g hyphen Smith, initial B. I'm a barrister instructed by Shine Lawyers, and I appear for Ms Pryde, Ms Wilkinson and Ms Olliver.

COMMISSIONER WILSON: Thanks, Mr Wessling-Smith.

MS J. ROSENGREN: Yes. Good morning, Commissioner. My name is Rosengren. For the record, it's R-o-s-e-n-g-r-e-n, initial J. I'm instructed by K&L Gates Lawyers, and I appear on behalf of Dr Trevor Sadler.

COMMISSIONER WILSON: Thank you, Ms Rosengren.

MS ROSENGREN: Thank you, Commissioner.

MS K. PHILIPSON: Commissioner, my name is Philipson, P-h-i-l-i-p-s-o-n, initial K., barrister instructed by Meridian Lawyers, and I appear on behalf of Professor Brett McDermott.

COMMISSIONER WILSON: Thank you, Ms Philipson.

MR B.I. McMILLAN: Commissioner, my name is McMillan, initials B.I., counsel instructed by Gilshenan & Luton Legal Practice. I appear on behalf of Deborah Rankin.

COMMISSIONER WILSON: Thanks, Mr McMillan.

MS S.V. ROBB: Commissioner, my name is Robb, R-o-b-b, initials S.V. I'm instructed by Roberts & Kane Solicitors. I'm appearing for a number of registered nurses, being Registered Nurse Kochardy, Beswick, Richardson, Daniel, Young, Yorke, MacLeod, Sault, Wong, Burke and Bowra.

COMMISSIONER WILSON: Thank you, Ms Robb.

MR D.G. PRATT: May it please the Commission, my name is Pratt, P-r-a-t-t, initials D.G., principal of the firm Franklin Athanasellis Cullen. We're appearing for Dr Groves. Appearing with me is Mr Anthanasellis, also of the same firm.

COMMISSIONER WILSON: Thank you, Mr Pratt.

MR R.W. O'REGAN: May it please the Commission, my name is O'Regan, initials R.W. from Käden Boriss Legal. I appear for Mr Ronald Simpson.

COMMISSIONER WILSON: Thank you, Mr O'Regan. Are there any other appearances this morning? No. Thank you very much. Can I begin with several preliminary matters. These public hearings have been scheduled to take four weeks. A large number of parties have been given leave to appear and to be legally represented. It will not be necessary that they or their lawyers attend the hearings all day, every day. They may do so if they wish, but if they wish, they may restrict their attendance to days on which they or their legal representatives are particularly interested.

As we all know, these proceedings are not adversarial in character. Therefore, I do not propose to require a person who will be giving evidence to remain out of the hearing room until called to enter the witness box. Of course, when hearings are closed, there will be restrictions on who may be in the hearing room. I expect that some witnesses will give all of their evidence in closed hearings. For others, the hearing will be closed for part of their evidence. At this stage, I do not anticipate that there will be any closed sessions this week.

Today, the Commission will sit between approximately 9.30 am and 1 pm and then from 2 pm to about 4 pm. Every sitting day, there must be a mid-morning break and a mid-afternoon break, each of about 15 minutes. Generally, I will leave it to the counsel who is on his or her feet to nominate an appropriate time for a break.

So far as possible, these proceedings are being conducted electronically. If counsel wishes to take a witness to a document, he or she should identify the first page of that document by its Delium reference number and then ask the operator to display any particular page of the document. For example, DPC.001.001.0001 at page 45. Those are the preliminary matters. I will now ask Senior Counsel Assisting to commence the opening statements. Mr Freeburn.

MR FREEBURN: Thank you, Commissioner. This Inquiry into the matters raised by the Terms of Reference commenced on 14 September last year. Since then, approximately 108,000 documents have been produced to the Commission. By now, almost all have been read and analysed. The Commission continues to receive documents. And on Friday, we received a further 288 documents. There are 158 witness statements which have been produced to the Commission. There are a few to come – we think probably less than 10 – possibly five. Those 158 statements have been prepared in some cases by the witnesses themselves, in other cases by the lawyers for the witness and in still other cases by Commission staff.

In a few minutes, I propose to tender all 158 statements. However, before I do so, I should make some matters clear. The first is there will be some material in those 158 witness statements that may be said to be either irrelevant or beyond the Terms of Reference or of little weight or no weight at all or contested. This Commission, if it is to finish within the time allowed, does not have time to entertain objections to the 158 statements, and so it is proposed that each witness statement be received by you, Commissioner, subject to any submissions the parties wish to make on three things: relevance, that is, whether the evidence is within the Terms of Reference; weight; and, thirdly, whether the evidence is contrary to other evidence.

Parties may make those submissions at any time up till the date set aside for submissions, which is 21 March 2016. Obviously, though, the earlier we receive those submissions, the better. A schedule of objections – and I use that term loosely – to parts of the evidence has already commenced – has already been prepared and can be added to as we proceed. Of course, in many cases, an objection to a paragraph may not need to be resolved because, for example, the Commission may not be relying or may not propose to rely on that evidence.

The next point I wish to make is this. It is important for Ms Muir and I to assure the parties that we will not be relying on evidence which falls outside the Terms of Reference. The terms of reference are wide enough as they are.

The next point is that the parties can also be assured that we will not be relying on evidence that is inherently unreliable such as hearsay or speculation. This Commission is not bound by the rules of evidence, but it has the task of finding the facts, and facts are generally not found by reliance on rumour or speculation.

The next point is that as the witness statements work their way through the Commission's confidentiality process, they'll be posted on the Commission's website. Approximately 50 statements that have been through that process will be posted today. Others will follow as they are redacted to remove confidential information in accordance with the Commission's confidentiality process.

The next point is that, importantly, the parties, the public and the press should be perfectly clear that publication of witness statements on the Commission's website and, indeed, acceptance of that evidence as having been tendered does not indicate that the content of any of those witness statements has been accepted as true or even as relevant by the Commission. In fact, significant parts of the evidence are or will be contested. Some parts of the evidence may even be rejected or struck out. In short, nothing in the 158 statements or in the handful of further statements should be taken as proved or accepted by the Commission unless and until that evidence is the subject of findings in the ultimate report of the Commissioner.

Commissioner, at previous hearings you made clear that no finding adverse to an individual or a corporation would be made unless there is an opportunity given to that person to be heard. Ms Muir and I once again make that clear.

Commissioner, at the outset you invited all concerned to provide the Commission with their evidence. I thank those who have provided their evidence. In many cases, there has been a great deal of time and effort devoted to the preparation of the witness statements. However, I once again extend the invitation to any person who has any further evidence relevant to the Terms of Reference to come forward and speak to Commission staff.

The last of these preliminary points is this: as explained at the directions hearing two weeks ago, some of the oral evidence given during this next four weeks will be taken in closed hearings. That is because of the nature of the evidence. Patients and their families are entitled to some confidentiality about their medical treatment, and there are some risks associated with some aspects of the evidence. However, where possible, evidence will be conducted in open hearings.

Now, Commissioner, subject to what I've said about the right of parties to raise matters that are outside the Terms of Reference and matters of weight, I propose to tender the 158 statements. Before I do so, I understand that Ms Wilson has something to say.

COMMISSIONER WILSON: Yes, Ms Wilson.

MS WILSON: Thank you, your Honour. I'm just finding my spot. In terms of – we thank – the State of Queensland thanks Counsel Assisting for the clarification that it has provided in relation to the use that is going to be made of the statements and the opportunity for any of the parties to be able to respond in terms of matters that may be of contention and to the matters that have been outlined. I was going to raise this morning that perhaps the appropriate process would be to tender them – tender all of the statements for identification, but it is my view that the clarification that has been provided by Mr Freeburn gives us some satisfaction about a robust process to be undertaken and a process that the parties can contribute to.

There's only one small point that I wish to raise, and perhaps not – this is not the right place to do it. The Counsel Assisting said that any findings adverse to a party, that it be given an opportunity. I would submit that that should be extended to any recommendation that may affect a party, that a party should be given an opportunity, because that would be the best way to ensure that recommendations are both appropriate and doable.

COMMISSIONER WILSON: Can that be taken on notice and addressed later in the hearing. Can I repeat what I said at the last directions hearing: I am not anticipating further oral hearings for the purposes of giving parties against whom potentially adverse findings might be made the opportunity to be heard. I am anticipating that they will have an opportunity to make submissions in writing.

MS WILSON: Thank you, Commissioner.

COMMISSIONER WILSON: Yes.

MS McMILLAN: Yes, Commissioner. Might I be heard about that issue. Firstly, can I say there were some further statements forwarded to us all Saturday night. We have not yet read all of those, so it would be difficult to understand why all of the statements need to be tendered today. Secondly, we would propose that they also be for identification. With respect, it's one thing for it to be said that parties and the public and the press should understand that there is evidence that will be contested, speculative, hearsay, but that's all right as lawyers to understand. It's a very different thing for the press or, indeed, members of the public to grapple with that. So that one wonders why it needs to be done today. Two, it should only be done after any objections are raised and those matters dealt with. Clearly, as witnesses come forward to give evidence, their statements will be tendered at that time, but there really is no need to do it today and, as I say, it doesn't take account of the fact that, once posted, then effectively they're out in the public arena.

COMMISSIONER WILSON: Can I say a couple of things in response to that, Ms McMillan. No statements will be going onto the web until they have been examined for any possible redactions, and you'll be aware of the redaction process. If statements were received as late as the weekend, I think it is most unlikely they would've been redacted yet, so I don't think you have any concern with respect to those statements.

The next point I would make is this: the Commission is endeavouring to conduct the proceeding as transparently as possible, given that the nature of the subject matter will necessitate some matters being dealt with in closed hearings and some material being redacted from the statements. I hear what you say about merely tendering for identification, but given that this is not an adversarial proceeding and given that the course which Mr Freeburn has proposed is one that has been followed in other Commissions of Inquiry, and given further the confidence that I have in the ability and willingness of members of the media and others to take on board what Mr Freeburn has said about the conditions attaching to the documents being tendered at this stage and placed on the web at this stage, I'm not minded to do what you ask.

MS McMILLAN: As you please, Commissioner.

COMMISSIONER WILSON: Does anyone else wish to say anything? Very well. Mr Freeburn.

MR FREEBURN: Your Honour, so subject to what I've said about the right of parties to raise matters that are outside the terms of reference and matters of weight, I tender the 158 witness statements. Commissioner, to save you reading out the details of the 158 witness statements, I have provisionally assigned exhibit numbers to each of those statements. Can I hand up a statement list, and I think we can probably get it up on the screen.

COMMISSIONER WILSON: Thank you.

MR FREEBURN: And I should explain that this list of statements – witness statements does not include the names of patients or family members to maintain confidentiality. You will see that we've used codes for those confidential witnesses. And I should say that a full list has been supplied confidentially to the parties via their data room.

COMMISSIONER WILSON: I see that the exhibits start at number 14. I assume that takes into account documents that have been tendered previously at directions hearings.

MR FREEBURN: Yes.

COMMISSIONER WILSON: Very well.

MR FREEBURN: So I tender those statements, Commissioner.

COMMISSIONER WILSON: Well, I will receive them on the basis you put forward earlier and they will be marked in accordance with the numbers you have provisionally assigned to them.

MR FREEBURN: Thank you, Commissioner. Commissioner, I now wish to move to a different topic. On Wednesday last week, Ms Muir and I produced a discussion paper. It is called Discussion Paper Number 4. And it identifies the key issues. That was done in accordance with your order, Commissioner. And I've arranged for that document to be placed on the Commission's website.

The discussion paper and its attachments are all drafts. They are designed to provide a preliminary explanation of the issues. Again, some issues may be contested and we welcome some corrections and – welcome submissions, corrections and additions. Can I see if we can get that discussion paper up on the screen just to explain the components of it.

So that's the discussion paper itself. And if we move to discussion paper 4A, we'll see that that's an explanation of the legislation that underpins this inquiry. And discussion paper 4B, this is an explanation of the, as it states, the background of the whole mental health policy background. And the next one is discussion paper 4C. Now, this is an attempt to put into table form the various reasons given for the closure of the BAC, including the reasons for the cancellation of the Redlands project.

Discussion paper 4D, now, the Commission staff have prepared this discussion paper to explain the – what's called the models of care or models of service in the evidence. And it explains the various features of each model of care or model of service. And it does so by reference to a program that the evidence will explain which is called AMHETI, that is, Adolescent Mental Health Extended Treatment Initiative. It's a technical document and I understand that already some

representatives of Children's Health are examining the document in order to fill in some of the gaps and queries raised in the document.

The discussion paper 4E – it needs to be a little expanded so you can see it. But, essentially, this is a table that portrays a snapshot of the services available at the time of closure of the BAC which was January 2014 – sorry, pre-closure which is the blue, post-closure which is the yellow. And the next one along is the end of 2014, that's the green. And the next one is as at last month, that is, at the end of – no, it's current to the end of January.

Now, already some of the parties have told us that they are endeavouring to fill in some of the gaps. Already some of the parties have told us that they will – that they have some issues with parts of these – this discussion paper. Given – sorry, we will be grateful for any assistance like that and, indeed, the purpose of producing these documents was to promote discussion and to get an increased level of accuracy.

Commissioner, it will probably not assist any of the parties for Ms Muir and I to go over what is in the discussion paper. Instead, we thought the best way to introduce the case would be for me to highlight some of the major events that occurred on the way to the decision to close the BAC and for Ms Muir to explain the transition evidence and issues. So I will briefly give something of a snapshot of the major events relevant to the decision parts of the terms of reference.

The BAC commenced in 1983. Dr Breakey was medical director from 1983 until 1989. Dr Sadler was medical director or at least had a similar role under a different title from 1989 until 2013. For this Commission's purposes, the first major event to occur was a cabinet decision made on 25 February 2008. I will see if we can call it up. It's DPC.003.001.0643. Now, it might take a little while to load that document.

So on the front page we can see that cabinet endorses what's called the Queensland Plan for Mental Health 2007 to 2017. Now, just to explain, one of the major architects of this plan was Dr Aaron Groves who will be giving evidence tomorrow. Now, if we go to the second page, under the heading Background at the top of the page, we can see the context which is that:

> *The plan is to provide a framework for the development of a comprehensive cross-sector mental health system over the next 10 years.*

And it's said that the plan dovetails with another plan and the COAG, meaning the Commonwealth body – Commonwealth plan and other plans and government priorities. So then if we go to paragraphs 9, 10 and 11 we can see that there's a commitment of 528.8 million dollars over four years. That's in paragraph 10. And most of it is funded and announced, or has been funded and announced in the previous year's budget. That is, this document is dated February 2008. And some of the – and the initiatives had been previously announced in the government's 2007/2008 budget.

There is some suggestion that parts of the funding were to either be funded – sorry, I'll start again. Most of that $528 million was funded in that prior budget, but there is some suggestion in the document that other parts of the funding were to be funded by Queensland Health or were to be the subject of further budgetary allocations in following years. Page 3 of the document is the policy submission. Again, a figure of $528.8 million is explained.

Paragraph – if we can go to page 5 now. Paragraph 5 on that page – little bit too far – that explains that the previous budget – that is, the 2007/2008 budget – had committed that sum of $528.8 million as detailed in a document called Outline of the 2007/2008 State Budget Outcomes for Mental Health. And we'll come to that document in a moment. Page – sorry, paragraph 7 on page 6. If we can go to the next page. It speaks of 17 capital works. See the third dot point. As we can see later in the document, a replacement of the BAC was one of those 17 capital projects. In fact, as it turned out, it was the only one of the 17 that did not proceed.

Paragraph 29, if we can flick to that paragraph – it's probably not necessary. Paragraph 29 speaks of Queensland Health leading a whole of government plan. That is, this plan went across government. Page 12, if we can go to it, identifies the attachments to the cabinet submission. And we can see that there are four attachments. The first is the Queensland Plan for Mental Health 2007 to 2017. This document was later produced about six months later into a glossy brochure, but the substance of the plan is there. The second attachment is the document I referred to a moment ago called the Outline of the 2007/2008 State Budget Outcomes for Mental Health. Attachment 3 is some key indicators, and attachment 4 is operational funding.

Now, if we go to page 35 of the 57 page document, we can hone in on what was to happen with these capital works. Now, one can see in the middle of the page there:

> *Mental health services to people in acute/extended treatment facilities and community mental health would be improved by providing –*

and then the first item is:

> *$121.55 million to expand the range of acute and extended treatment beds by providing more than 140 new beds and to upgrade existing services to meet contemporary standards.*

Now, that $121.55 million was to be – sorry, what that $121 million was to be spent on is not explained in the 10 year plan. It's explained in the other document, the outline of the 2007/2008 budget outcomes document, which starts at page 49 of this document. I'm sorry for the delay, Commissioner. So that's the second document, the outlines document. Now, on the next – very next page, page 50, we should see the total figure of $528.8 million, and then the subsequent pages provide the detail of where that money was to be spent.

Now, if we go to page 52 – I'll just read out what I've got noted while that's coming up. If we go to page 52, we will see in the first column – and there it is – scroll down a little, please. In the first column at the bottom, towards the bottom of the page, we can see:

> *Mental health services to people to acute in extended treatment facilities –*

now, that includes the BAC –

> *will be improved by providing $121.55 million for 276 new, upgraded or redeveloped acute and extended treatment beds that meet contemporary standards.*

Then in the second column, the sixth dot item down – so if you scroll up a little bit, we should see it. The sixth item down is:

> *Develop a new 15 bed adolescent extended care unit following the closure of the Barrett Adolescent Centre at the Park Centre for Mental Health.*

So the $121 million was allocated to a number of projects, including a replacement of the BAC, and the replacement was to be – hadn't yet been determined where that was to be, but there was a provision for it.

Now, in October 2008 there was a site evaluation subgroup report, and that report essentially discussed the options for the redevelopment of the BAC. You can call that up. It's document MSS.001.002.2229. So that report was an appraisal of the options for redevelopment of the BAC. The report was – the report considered five options and concluded that Redlands was the preferred options. I should say for those who are interested, koalas were identified as an environmental consideration from the outset in that report.

In late October and early November 2008, that recommendation was accepted by Dr Groves, who is the senior director of the mental health branch. It was also accepted by representatives of Metro South – that was the area into which the new centre would be going – and by West Moreton Health and Hospital Service, which was the centre that then contained the BAC. So from this point on, the new site for the BAC replacement was Redlands. A site was acquired adjacent to the Redlands Hospital at Cleveland.

Professor Crompton, who I think is giving evidence tomorrow, established a committee called the facility project team meeting to establish the new unit on the Redlands site. That committee first met on 20 August 2009. There were then a series of meetings between August 2009 and February 2012 which dealt with a number of issues, including models of service, koalas and drainage on the site.

Commissioner, as at the first meeting of that committee, the budget for the project was not certain. It was noted at the first meeting that the indicated budget was $10.2

million but could reach up to $15 million. By June in that year – sorry – June 2010, the budget was a little bit more specific. If I can take you to one of the many documents identifying the capital works program of the budget. It's document WMS.6006.0002.54354. And you can see there most of the way down if we scroll down a little there's a budget allocation at the second-last of the items. Budget allocation of $10.2 million for the Barrett Adolescent Extended Treatment Unit plus a further budget allocation of $5.8 million, an anticipated shortfall of $2.7 million at that point. And an anticipated cost of $18.8 million. Of course, those figures changed over time as the project developed.

In July 2011, Dr Groves prepared the Queensland Plan for Mental Health 2007 to 2017 First Evaluation Report. Now, this was an update on where the Queensland Plan for Mental Health had got to in its first three to four years. The document that attaches it is a Cabinet document. I probably can skip through that.

The next major event is – can be explained by reference to a briefing note that's dated 16 May – or at least it's signed on 16 May 2012 by Dr Tony O'Connell. It's – the document is DBK.001.001.0067. Now, if we first go to the very end of this document – if we can scroll down. It's only four pages, so hopefully we won't have too much of a delay. We can see that it's signed as approved by Dr O'Connell on 16 May 2012. And a tick is adjacent to the words:

> *To Minister's office for approval.*

If I can go back to the front of the document, we can see it follows a pattern that the first item is that the Director-General approved the cessation of the Redlands Adolescent Extended Treatment Unit capital program. And it's also proposed that the Director-General provide this brief to the Minister for noting. Under a heading Urgency, one can see the word "critical". And if we go – we can see the headlining issues. There is, under the first dot point:

> *The capital program has encountered multiple delays to date and has an estimated budget overrun of $1.4 million. Additionally, recent sector advice proposes a re-scoping of the clinical service model and government structure for the unit.*

And then the second dot point explains where the funding is to go. There's a shortfall, according to this document, of $3.1 million for regional mental health HHF projects. Now, HHF projects are Commonwealth-funded projects, and those projects – the shortfall apparently relates to information communications technology, escalation and land acquisition. So it was proposed to fund that shortfall through the cost savings achieved by ceasing the Redlands project.

Now, it's early days in the evidence of this Commission, but that briefing note appears not to have gone to the then Minister, Minister Springborg. But a subsequent August 2012 briefing note seems to have been signed by both Dr O'Connell and Mr Springborg. If I can go to that, it says – this – that first briefing

note is May 2012. And if we go to the one from August 2012, we can see that the object was to fund – the object of this briefing note was to fund – approve the plan strategy for the targeted rectification of the [indistinct] infrastructure issues and subsequent planning for 12 rural hospitals. Now, the funding for those 12 rural hospitals projects looks to come from a number of sources, but the second of those is, again, the cessation of the Redlands project.

So that's the objective. If we can look at page 2 of that document, we can see a similar brief to the Director-General. And if we scroll down, we can see – on page 4, we will see some consultation and recommendations. See on page 4:

> *Some consultation has occurred with the relevant hospital and health services to identify current critical infrastructure issues.*

And then there's mention Dr Kingswell recommended the cessation of the replacement adolescent extended treatment unit at Redlands. Then if we scroll down to the next page, we can see that Mr – that Dr O'Connell has noted – circled as noted the document on 17 August - - -

COMMISSIONER WILSON: Excuse me, Mr Freeburn. I don't think that's Dr O'Connell's signature if you look at it.

MR FREEBURN: No, it isn't.

COMMISSIONER WILSON: He struck through it.

MR FREEBURN: Struck through, that's right. It looks like it may be Jeanette Young's. That's correct. So by August 2012 a decision had been made by certainly the Minister and possibly the Director-General's office that the Redlands project was to be discontinued. The decision doesn't – this decision doesn't seem to have been made public at the time. And, of course, if I can step back a bit for a moment, by this point, though, under the legislation framework, West Moreton Hospital and Health Service had become a separate legal entity and had its own responsibilities under its service agreement. You will recall that the discussion paper deals with that framework.

What then seems to have happened is later that year, in October 2012, Dr Cleary, who seems to have been the deputy director-general at that point, asked health – the – asked the Queensland Health Infrastructure Branch to look at the prospect of refurbishing the BAC, and later that month there was a meeting involved, and Dr Geppert, Dr Kingswell, Dr Gilhotra – they were all effectively from Queensland Health – and Ms Kelly, representing West Moreton Hospital and Health Service, and a day later Ms Kelly sent an email to the others who were at the meeting, and it's instructive to have a look at that email. It's DVK.001.001.0075.

Commissioner, I'm going to keep reading these document IDs out, because even though the document comes up on the screen, just for the matters of record, so that it's clear on the transcript which document I'm taking the – taking you to.

COMMISSIONER WILSON: Can I ask you a question before you move on to this email. I noted when you had that briefing note of 17August 2012 on the screen, there was a box relating to the Minister which had a cross in it. Does that mean it went to the Minister? It was near the signature of the acting deputy – of the acting director-general.

MR FREEBURN: I'm not sure. I'll check that.

COMMISSIONER WILSON: Thank you.

MR FREEBURN: Certainly the 2012 one looks to have been signed by Mr Springborg, but we'll check that. Now, this email – if we scroll down a little, we'll see at the bottom of the first page – if I can recap, there are some matters that are – we keep going down to the second page. The third dot point on that page:

> *It's confirmed that the Barrett Adolescent Centre is a somewhat sensitive issue.*

Ms Kelly's saying that she understands that a brief has gone to the Minister, and she talks about:

> *As such, the option is to close BAC as early as December 2012, given that all or most of the consumers all go home for the Christmas break.*

So she then talks about what's to happen following that meeting. Now, what happened shortly after this email is that on 8 November Dr McDermott gave evidence at the Queensland Child Protection Commission of Inquiry, and he publicly disclosed that the BAC was to close by Christmas that year, or that he'd been informed of that. To abbreviate a little, that led to some protests from various clinicians and members of the community. It also led to West Moreton Hospital and Health Service sending letters in a particular form – particular standard form – to various stakeholders who voiced concerns.

Can I just pull up one of those letters. It's LNS.0012.0001.10181. As it happens, this is a letter to Dr James Scott, who will also be a witness. And Mr Scott had written a letter of concern, and the response – can I draw your attention to the fourth paragraph. Dr Corbett, the author of this letter from the West Moreton Hospital and Health Board, tells Mr Scott:

> *I would like to advise you that, as yet, no final decision about Barrett Adolescent Centre has been made. However, I am able to advise you that West Moreton Hospital and Health Service is collaborating with an expert clinical reference group, who will develop a model of care that will be contemporary*

and evidence-based. This model of care will be developed to meet the needs of adolescents in Queensland requiring longer term mental health treatment.

So that's roughly a standard form. Similar letters were sent to a number of other interested people.

Can I deal with the expert clinical reference group, which is referred to in that letter and was – and commenced in about December – commenced or met from December 2012 and eventually prepared a report on 8 May 2013. Now, the ECRG, to abbreviate it, comprised a number of clinicians, allied health professionals and community representatives. As it happens, it included Dr Scott, Dr Fryer, who's made a submission in these proceedings, Dr Hazell, who will also be giving evidence, and Dr Hartner. Now, the four of those clinicians are all specialist child and adolescent psychiatrists.

Now, copies of the ECRG report are littered throughout the material. For present purposes, I'll bring up one of the copies. It's WMS.0012.0001.08528. So this is the report produced in May 2013, and this report, before I go to its terms, went to a planning group. The planning group seemed to comprise at least these people: Dr Stathis, Dr Sadler, Dr Kingswell and Ms Michelle Bond from the RBH school.

Now, if I can just quickly go to a couple of the parts of the ECRG report. We scroll down that first page a little. You'll see at the bottom of the page the ECRG there are the words:

The ECRG met regularly to define the target group, their needs, conduct a service gap analysis, consider community and sector feedback and review a range of contemporary evidence based knowledge of care and service type.

And if we scroll down a bit further:

The ECRG have considered evidence and data from the field, national and international benchmarks, clinical expertise and experience and consumer and carer feedback to develop a service model elements document for adolescent extended treatment and rehabilitation services in Queensland.

They then say:

This elements document is not a model of service. It is a conceptual document that delineates the key components of a service continuum type for the identified target group.

Now, there's reference in this document to a number of tiers. I'll leave you to read that but tier 3 – this tier system is not in common use but the ECRG seem to have adopted it. But the table that is part of the discussion paper identifies what these tier levels mean in terms of the components of it and also in terms of other measures used commonly. Now, the next paragraph is important:

The final service model elements document produced was cognisant of constraints associated with funding and other resources. For example, there is no capital funding available to build BAC on another site.

They then say that the ECRG was also mindful of the current policy context which indicates that:

Non-acute bed based services should be community based where possible.

They say:

A key principle for the Child and Youth Mental Health Services which is supported by all members of the ECRG is that young people are treated in the least restrictive environment possible and one which recognises the need for safety and cultural sensitivity with the minimum possible disruption to family, educational, social and community networks.

Now, if we can just scroll down. There's, again, some explanation of who comprised the ECRG, particularly, the consumer and carer representatives. Then most of the way down that paragraph:

However, it is the view –

if I could say – so I'll start about line 7:

While there was also validation of other CYMHS services –

that's Child and Youth Mental Health Service –

types including community mental health clinics, day programs and acute inpatient units, it was strongly articulated that these other service types are not as effective in providing safe medium term extended care and rehabilitation to the target group focused on here. It is understood that BAC cannot continue in its current form.

And that's – the abbreviation is The Park Centre for Mental Health:

However, it is the view of the ECRG that like the community care units within the Adult Mental Health Service stream, a design specific and clinically staffed bed based service is essential for adolescents who require medium term extended care and rehabilitation. This type of care and rehabilitation program is considered life saving for young people and is available currently in both Queensland and New South Wales.

And they give the example of the Walker Unit. So if I could just quickly go to the recommendations so that you can see the form of them. There are seven key messages. The second is important:

According to the ECRG, a tier 3 type facility was an essential service component.

And if we scroll down to number 3:

The ECRG specifically considered the prospect that if the BAC closes and another replacement facility is not available –

and their conclusion was that was associated with risk. There will be some debate before you, Commissioner, about the length of stay and what long stay means. Can I just – if we scroll down one – a little more to – you will see that the recommendations up to 12 months was the ECRG's view for the duration of treatment.

The ECRG also in later recommendations considers the education component. Now, we'll go to the next step in the process. This ECRG report went to a planning group – the planning group. The planning group mostly accepted the ECRG recommendations but added some qualifications. Then both reports went to a meeting of the West Moreton Health and Hospital Services Board on 24 May 2013. And that document is WMS.600. – I'm not sure I've got that right in my notes. No. That's the – can you scroll to the next document, please. Excuse me a moment. And go to WMB.1000.0001.00012. It should be West Moreton Meeting Minutes. It should be WMB.1000.0001.00012. That's it.

Now, this is a meeting of the West Moreton Board when Dr Mary Corbett is the chair. Mr Timothy Eltham is the deputy chair. Both will be giving evidence. And if we scroll through to page 5, please. And scroll down a little, please. Now, at the bottom you will see an item 5.1, Barrett Adolescent Centre. And Commissioner, it appears that whilst these minutes do not record an express resolution by the board, they have decided to close the BAC. That seems to be implicit in this part of the minutes.

Now, if we scroll down a little bit we will see – so Ms Kelly and Ms Dwyer do a presentation to the board. And they talk about – at the top of that page they talk about the need to move as rapidly as possible to an alternative model based on the recommendations of the planning board. The action noted is that:

The Minister is to be updated regarding proposed closure, a plan for development of alternatives and community engagement strategy.

Then the Minister's approval is sought not to accept any further patients into the BAC. And then the last – the decision is that:

The board approved the development of a communication and implementation plan inclusive of finance strategy to support the proposed closure of BAC.

Now, if I can take you back – and if we scroll back up again to the first part of 5.1 we can see that Ms Kelly joins the meeting:

> *The board discussed the recommendation from the planning group that proposes the closure of the Barrett Adolescent Centre and the issues that this presents. The board recognised that the facility is no longer suitable but is concerned that there is currently no alternative for consumers.*

That, of course, was also the concern of the ECRG. That is, whether there were alternatives for the patients. The ECRG took a slightly different attitude because the ECRG expressly noted that the closure of the BAC without alternatives was associated with risk. And in the ECRG's view, there should be a tier 3 or a BAC replacement. Now, that will be an issue for this inquiry to consider and, importantly, what, if anything, was done about that concern. That is, the concern that there was, as at May 2013, then no alternatives for consumers – for those consumers.

Continuing with the chronology, on 15 July there was a meeting involving the Minister, Ms Dwyer, Ms Kelly and Dr Corbett. Mr Springborg's evidence is that he recalls that at this meeting or at some other meeting he said his concern was that if the BAC was to be closed, there should be adequate replacement services. That's at paragraphs 56 and 57 of his statement. The next day, Ms Dwyer noted that the Minister had given his support to proceed following communication with the Director General, the Department of Education and the Queensland Mental Health Commissioner.

Now, on 6 August the Minister announced the decision on ABC Radio. There is an audio of that radio interview available and an updated transcript of that radio interview is also available. The audio – I'll just go to the transcript for the moment. It's document number COI.008.0001.0002. If we scroll down a little. There's a part in this transcript I'll just – it's probably easier if I read it. This is Minister Springborg:

> *An expert clinician panel will be made up of clinicians from within Queensland and also outside of the State, plus a resident and a resident's parent or former resident's parent will be providing advice to us. We expect to have options available to people in early 2014 and the transition process will start sometime in the early part of 2014 as we build up services in other areas around the State.*

And just to stop him there, what the Minister has in mind is a slightly longer term program than eventually occurred. In answer to a question, the Minister says:

> *Absolutely. And where the options are, an additional $2 million has been put into it over and above the money which is currently allocated. So we believe that that will be able to not only properly have facilities and support for these young people with complex needs but to accommodate additional young people as well who have these care needs. We will have a much clearer picture by the*

latter stages of this year and the final details around it will be the early part of next year.

Now, again, that timing does not reflect what, in fact, happened. From this point on, the closure seemed to be set for January 2014. There is some evidence in the documents that that closure date was a flexible closure date but no evidence that the flexibility was actually considered. In fact, whilst there was a committee formed – I think it had the abbreviation SWAETRI, and it subsequently became AMHETI – there is no evidence that anybody actually undertook a process of review. That is, despite the concerns which have been expressed by the board and the Minister, nobody from the Minister's office or from the board or from the West Moreton Executive or from Queensland Health actually seems to have reviewed the alternatives in place for the BAC cohort to make sure that these young people were properly catered for by alternative services.

Now, Ms Muir will speak about the dilemma that faced Dr Brennan when she arrived in September on the ground there was, firstly, something of a battle to find proper places for the BAC patients. And, secondly, no knowledge of any flexibility to the closure date, let alone what the Minister described as a process of transition which was to start, not finish, in January 2014.

There are a couple of pieces of evidence that some in Queensland Health realised that proposed alternative facilities were not going to be available in time. And so there was a discussion of patients being accommodated in, effectively, interim arrangements whilst new services came online. Commissioner, can I take you to one last briefing note. It's DMZ.001.001.1442. It looks like I can't take you to that one last briefing note.

Can I sort of take a back step and helicopter view. It's necessary, in my submission, to warn the parties and those interested in this Inquiry against viewing the issues that we're considering and the evidence of the witnesses through a pro-Barrett or anti-Barrett prism. On the one hand, you will hear evidence that the BAC has its passionate supporters. Some parents described the Barrett – the BAC as their last resort. On the other hand, there are some reports that are critical of the care at the BAC. And some will say that the BAC was isolated both geographically and in a clinical sense.

No doubt both sides of those arguments can mount powerful submissions to you, Commissioner. However, in a sense, that's a stale debate. The situation was that the BAC was to be replaced, and it was to be replaced with, it seems, a new building adjacent to the Redlands Hospital with a new upgraded model of care. Interestingly, I should say, that that model of care or at least the versions of it that we've seen has a six-month recommended time period for patients to be at that Centre.

Commissioner, on our initial view of the evidence, there are two real issues. The first is a fundamental issue. Was there and is there a need for a facility like the BAC or its proposed replacement at Redlands. Let me deal with that fundamental issue for

a moment. One view that will be put to you is that the BAC cohort were readily able to be absorbed into the existing health services and absorbed at the time, that is, January 2014. Another view is that new services such as AMYOS, which you will hear something of, make the present situation a different situation to January 2014 in the sense that these young people can now be accommodated. But some, including in some cases the BAC's harshest critics, see a need for something in the place of the Barrett Adolescent Centre, that is, what the ECRG called a tier 3 facility or what was proposed for Redlands. So at the core of this Inquiry, at least as we see it at present, is this question: by what sort of services should we look after these vulnerable young people?

The second question arises in this way – and it's a decision-making process question. If there is a need for a facility – a Barrett-like facility or a Redlands-like facility or a tier 3 facility, this decision-making issue arises: how did we get to the point where there is presently no similar extended treatment facility available to young people who up to January 2014 would have been treated in the Barrett Centre or, as proposed, might have been treated at the Redlands. In other words, what are the reasons we got to this point, and can we do this type of decision-making better.

On that process issue, you may have noticed as we went through the briefing notes and the Board decision – let's call them the decision documents. They often contain headings like Headline Issues, Key Issues and Communication Plans. Those documents do not appear to include a heading or a reference to detailed analysis. And one might think that in a situation like this where the services are being discontinued that there was some need for analysis. Part of the focus on key issues and headline issues is that the decisions in this case, at least on a preliminary view, seem to be based on short-hand expressions. And I'll give you an example, Commissioner: contemporary models of care. Now, Commissioner, is that an appropriate time to have a break before Ms Muir starts on the question of transition?

COMMISSIONER WILSON: Yes, it is, Mr Freeburn. It's just after 11 o'clock. We'll come back at 20 past 11.

ADJOURNED **[11.02 am]**

RESUMED **[11.21 am]**

COMMISSIONER WILSON: When you're ready, Ms Muir.

MS MUIR: Thank you, Commissioner. Under the Terms of Reference 3(d), you are also tasked with making a full and careful inquiry in an open and independent manner into what I will describe generally for present purposes as the adequacy of the transition arrangements for the transition clients. This begs an obvious question: who are the transition clients?

The Commission's Terms of Reference 3(d) introduce the concept of transition clients with the preamble that it is those:

> *BAC patients transitioned to alternative care arrangements in association with the closure or anticipated closure, whether before or after the closure announcement.*

Plainly, then, the language used requires there to be some association between the particular patients' transition from the Barrett Centre to alternative care arrangements and the closure or anticipated closure. That association, Commissioner, in our respectful submission, does not require that the transition be solely or only related to the closure. There may be an association because, for example, the likely closure was one of a number of factors which influenced the clinical staff to recommend transition to another facility.

Commissioner, as you have just heard from Senior Counsel Assisting, the evidence is that whilst the formal announcement of the decision to close the Barrett Centre was made on 6 August 2013, the likelihood of the Centre closing was foreshadowed to medical staff, to the public, including staff, Barrett Centre patients and their families from early November 2012. Therefore, at least on one view, there was an anticipated closure of the Barrett Centre from early November 2012. The question then becomes how, if at all, this anticipated closure affected any decisions by families, patients, staff and decision-makers associated with the Barrett Centre as to the ongoing treatment of the young people accessing the Centre at the time.

With this issue in mind, from the outset of the Inquiry, Counsel Assisting took the view that the evidence may reveal that some Barrett Centre patients commenced transitioning to alternative care arrangements from early November 2012. With the very much appreciated early assistance from both the West Moreton Hospital and Health Service and the Department of Health, the Commission was provided with a list of 42 young people. This list contained the names of young people who between 31 October 2012 and January 2014 had been admitted as inpatients, outpatients and day patients at the Barrett Centre, those who had successfully been placed on a waiting list and those who were still waiting to be placed on such a waiting list.

Commission staff have subsequently commenced a review of 41 files and what are known as consumer integrated mental health application records or CIMHA records. These records are confidential and are being treated as such in accordance with the Commission's confidentiality order and protocol. The records of the 41 young people are in many cases voluminous. The review is ongoing but very instructive. Commissioner, to allay any confusion, I said that there had been a review of 41 young people despite having just told you that there were 42 names on the list. This is because there is an unusual lack of information about one of the names. This is not a criticism of anyone. Documents are currently being obtained so that an assessment can be made as to whether this young person should be on the list.

At this point in time, Commissioner, I can tell you that it seems that not all of the young people whose information has been reviewed were transitioned in association with the closure or anticipated closure. Some left for other reasons, and some

transitioned out in the usual sense of transitioning that occurred at the Barrett Centre. I will return to this concept of transition shortly, Commissioner, but, before I do, I would like to tell you something about the young people and their families who accessed or who were trying to access the Barrett Centre in the 14 or so months before it closed.

This overview is based on the records and statements reviewed to date. Of the 41 young people, there were 14 males and 27 females ranging from 15 years to 19 years old at the time of their discharge. Of those 41 young people, 26 were admitted to the Barrett Centre, meaning 15 were never admitted. Of the 15 that were not admitted, eight were on the waitlist for admission but never admitted, seven were referred but were never assessed for admission, two were referred but refused treatment.

Of the review of diagnostic profiles, schizophrenia, anorexia nervosa, oppositional defiant disorder and autistic spectrum disorder were much less prevalent at the Barrett Centre than complex post-traumatic stress disorder, social anxiety disorder and depression. All of the patients with complex post-traumatic stress disorder and borderline personality were female. This condition was eight times more prevalent than schizophrenia. The range of duration of stay at the Barrett Centre of the 41 cases reviewed – remembering, Commissioner, that 15 were never admitted – was one to 34 months, with an average length of stay of 13 months.

Insofar as their acuity is concerned, patients with complex post-traumatic stress disorder presented with suicidal behaviour and self-harm. Patients with anxiety disorder and autistic spectrum disorder presented with school refusal. And patients with depression presented with social withdrawal and suicidal behaviour. Schizophrenic patients had treatment-resistant psychotic symptoms, and anorexia patients had food and fluid restrictions with weight loss.

Of the 42 young people that were initially identified, the Commission has been in contact with 34 families whose children were admitted or on the waitlist for admission. Of these families, the Commission took statements from 17 family members and five patients. Six of these witnesses initiated first contact with the Commission, and the remainder of these witnesses provided statements after being contacted by Commission staff. Commission staff also contacted a further four families who declined to give statements and attempted to contact a further three families to no avail. The Commission has also received a further five statements from family members through their legal representatives.

Commissioner, as you would imagine, the conditions of these young people place enormous stress on their families and, of course, the young people themselves. Counsel Assisting and, indeed, all Commission staff feel very privileged to have spoken to the families and young people we did speak to and are particularly understanding of why, for some, such contact would cause unnecessary anxiety, stress and, possibly in some cases, harm. Generally, the Commission will receive the evidence of these patients and family members only through these statements and, if necessary, further supplementary statements. However, the Commission will be hearing directly from at least five family members, and other parties have applied to ask questions of these family members during the closed hearings from 7 to 9 March.

Commissioner, what does emerge from the evidence of patients and family members at this stage is that the patients come from a variety of family backgrounds with a mix of traditional and non-traditional family structures and different socio-economic circumstances. However, each family, no matter how hard they tried, struggled to care for and obtain appropriate treatment for their adolescent with complex and severe mental health concerns prior to the admission to the Barrett Centre. Most but certainly not all of the patients and family members have positive things to say about the Centre. Although, the evidence of patients and family members is that the Centre was not perfect. A number have told us that they tried everything else and it was their last hope.

While some of the patients and family members were aware that the Centre might be closing from November 2012, families were not informed that this decision had been made until just prior to the public announcement of this decision on 6 August 2013. Early communications to the families, patients and staff were confusing. And some families say they did not receive these communications. A number of patients and families were distressed by the standing down of the clinical director, Dr Sadler, in September 2013. Many patients and families speak of not hearing anything further from West Moreton Hospital and Health Service after they were discharged.

At least five of the former patients whose families we spoke to are in recovery. However, others are not doing so well. The evidence to date suggests that the Barrett Centre closed on 31 January 2014 prior to the new range of contemporary service options envisaged as part of the expert clinical reference group or the ECRG that Mr Freeburn QC spoke to you about earlier being place.

Of the 27 young people who were admitted to the Barrett Centre at some stage during the November 2012 to January 2014 period, it appears that at least five have been discharged to the community in line with their recovery journey. At least five young people were discharged to Adult Mental Health Services. At least six had readmissions to acute adolescent inpatient units after their discharge. Less than five were discharged to some form of supported accommodation. And up to 10 young people were referred back to Child and Young Mental Health Services or CYMHS, as it is known, or to a private psychiatrist, psychologist or a non-government service provider or a combination of these. We also know, Commissioner, that a number of young people have had some contact with the new Assertive Mobile Youth Outreach Service, AMYOS, since their discharge from the Centre.

I'll now return to the issue of what is meant by transition. This Term of Reference and, indeed, the evidence refers to the expression transition, transitioned and transitioning. The most widely-cited definition of transition in the literature is that it is the purposeful, planned movement of adolescents and young adults with chronic physical and medical conditions from child-centred to adult-oriented health care systems. Whilst the timeframes in which it took to transition young people are certainly controversial, the transition of Barrett Centre patients at least at some stage, whether back to their families or otherwise into the community or to another

adolescent mental health service or, in some cases, to an adult mental health service, was an integral aspect of their care and management at the Barrett Centre.

Transition in this sense appears to mean moving patients from one service to another for clinical reasons based on individual assessments. Both the evidence and the literature that the Commission has reviewed suggests that this period of transition is a known risk factor for mental health patients and can bring about periods of vulnerability. However, Commissioner, the consideration of the transition of Barrett Centre patients as required under Terms of Reference 3(d) is arguably a more complex one. That's because in some cases it may be considered to be an administrative process and not a medical one on the basis that it occurred because the Centre was to close, not for clinical reasons. On one view, then, what occurred was not a transition as that expression is usually understood but, in fact, a de-institutionalisation or the emptying out of an entire extended treatment adolescent unit. There appears to have been no relevant literature or guidelines available at the time. Transition in this context was unprecedented.

Commissioner, Counsel Assisting are interested in understanding a number of issues about transition through this hearing process. First, what were the established guidelines/practices for transitioning planning, transition management and transition implementation at the Barrett Centre? This is both in the broader historical sense, and then with particular focus on the 2012/2013 period.

Second, there is this question as to whether transitioning in the context of the closing of the Barrett Centre was a different concept and process from the usual. For example, before any transition could commence, was extra planning required? Should formal guidelines have been developed? Was a detailed evaluation and assessment of available replacement services needed?

Thirdly on this issue, Counsel Assisting are interested in what, if any, resource materials were available to staff engaged in transition planning, management and implementation, both at the time and now? For example, there is evidence of a guideline for the transition of care for young people receiving mental health services being produced by the Department of Health in September 2015. This followed the delivery of a report entitled Transitional Care for Adolescent Patients at the Barrett Adolescent Centre, authored by Professor Beth Kotzé and Ms Tania Skippen, which was delivered to Queensland Health on 30 October 2014. Both Ms Kotzé and Ms Skippen will give evidence in the oral hearings.

This guideline speaks of things such as early preparation, including, where possible, six months prior to the actual transition and that the young person is to be involved in all decision-making process regarding transition. It also speaks of the timing of the transition, where possible, needing to avoid any crisis that the young person might be experiencing. And, finally, it speaks of, not unusually, good communication being important.

I now turn to deal with the expression "transition arrangements", as it is referred to in the Terms of Reference. By Terms of Reference 3(d) roman (i) and roman (ii), you are required, Commissioner, to ascertain the facts associated with how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure – that is, the transition arrangements – and the adequacy of the transition arrangements. Further, the Terms of Reference 3(h) require you, Commissioner, without limitation, to ascertain the facts associated with the information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements.

Commissioner, I would like to give you a brief summary of the overarching narrative, insofar as the transitioning arrangements are concerned, as has emerged from the evidence received to date. It is hoped that a number of gaps in the evidence and questions that arise from the review to date will be addressed during the course of these oral hearings. It seems that the responsibility for implementing the transitioning arrangements rested with West Moreton Hospital and Health Service, with oversight from its board. The development of the new range of contemporary service options was and is being led by Children's Health Queensland hospital and health service. The performance of these two responsibilities seems, at least on one view, to have occurred in isolation, even though the various groups involved in the development of new services were expressly charged with developing services to ensure continuity of services for the Barrett Centre cohort.

As a result, what has emerged from the review of the evidence to date, and which, as I have said, it is hoped will be clarified during the hearing process, is that the transition process involved the transition of patients to whatever services were available at the time rather than to the range of health service model elements recommended by the ECRG in the event that the Barrett Centre closed. There is some evidence of a plan by the West Moreton Hospital and Health Service Board in about 24 May 2013 to bring in a senior clinician to support the transition and closure. Presently, it's unclear from the evidence what happened to that plan. Certainly, a senior clinician, Dr Brennan, was temporarily appointed to act as clinical director of the Barrett Centre from 10 September 2013 after Dr Sadler, a senior psychiatrist and the then clinical director of the Barrett Centre for a total of 25 years, was stood down whilst complaints about clinical governance associated with the Barrett Centre were investigated.

Whilst a handover between Dr Brennan and Dr Sadler was promised, it appears that no handover was allowed, and a handover does not seem to have been, at least on the evidence to date, facilitated. It appears that Dr Brennan was not told that, on accepting the role as acting clinical director, she would be required to both devise and implement transition plans. She assumed from a number of conversations, including with those appointing her, that the transition process was already in place and her role would be to look after the young people until they had moved to new services. It's not entirely clear why, but there is a dearth of evidence, at least in any formal sense, of any process in place for the transitioning of Barrett Centre patients until Dr Brennan took over from Dr Sadler.

In late September 2013 a panel called the Barrett Centre Clinical Care Transition Panel, chaired by Dr Brennan, with nominated Barrett Centre staff and West Moreton Hospital and Health Services staff as members, was tasked with developing the individual transition plans. When Dr Brennan took charge, it appears she was forced to go back to basics, including flicking through the phone book in order to locate existing services that may have been suitable to the young people she was required to transition. As soon as she could, Dr Brennan informed the Barrett Centre Clinical Care Transition Panel and a number of other working groups, and, with assistance from a number of dedicated, tireless and, in many cases, concerned staff, immediately went about developing and implementing transition plans.

There appears to be some conjecture about timing, but the evidence suggests that the Barrett Centre was to close by the end of January 2014, with some unidentified flexibility. Commissioner, the evidence reveals that Dr Brennan and a number of the staff worked around the clock at times in order to meet the imposed time frame. On any view, the orchestration and implementation of the transition arrangements in the circumstances was a mammoth, unprecedented and, some might say, impossible task. The overwhelming evidence is that Dr Brennan and staff tried their very best in extraordinary and emotional circumstances.

As I've said earlier, the Barrett Centre closed its doors on 31 January 2014. The evidence suggests that at this time, any responsibility for the care, support, service quality and safety risks of the young people who had been accessing the Barrett Centre and who had been transitioned, ceased. It appears that the view was as the Barrett Centre no longer existed, there was no need for any follow up. The evidence does show, however, that there were many involved in the transitioning, including Dr Brennan, a number of nurses, allied health staff and teachers, who felt personal obligations to contact receiving services and, indeed, took steps of their own imitative to do so. In many cases, they were told by receiving service staff not to interfere with the patients, as responsibility for ongoing care lay with the receiving service.

Commissioner, as I have said earlier, you are tasked with inquiring into the adequacy of the transition arrangements. In other words, with reference to the Oxford dictionary definition, this means you are to assess whether the arrangements were sufficient or satisfactory. This assessment can only be made after a full and careful analysis of how care, support, service quality and safety risks were identified, assessed, planned or managed and implemented. This task cannot be done in isolation.

It must also be considered in the context that the transition arrangements relate to one of the most vulnerable groups in society, that is, adolescents with severe and complex mental health conditions. A full and careful analysis of the transition arrangements for each and every young person who is potentially a transition client within the Terms of Reference is underway and ongoing. If particular inadequacies or concerns with respect to individual transition clients are identified during this process, these issues will need to be raised in closed hearings and through a process

affording all those involved opportunity to respond. In the meantime, Commissioner, a number of themes have emerged from the Commission's review of the evidence to date which are relevant to the factual inquiry into the adequacy of the transition arrangements.

The overriding theme is that the transition arrangements were carried out amidst a backdrop of extraordinary and heightened emotions which reached a crescendo at the time of the announcement of the closure. There is ample and at times conflicting evidence from Barrett Centre staff – this is allied health staff, clinical staff and education staff – and from the families of former Barrett Centre patients and from the patients themselves that reveals confusion, uncertainty and anxiety surrounding the circumstances and conditions upon which the Barrett Centre would be closed. Some of the evidence from allied staff at the Barrett Centre in early March 2013 speaks of confusion and chaos and having absolutely no clarity at all about the future of the Barrett Centre.

The early communications from West Moreton Hospital and Health Service to the families, patients and staff in November 2012 were that no final decision had been made and that adolescents requiring longer term mental health care will continue to receive the care that was most appropriate to them. In May 2013, these same people were told that no decision would be made about the Barrett Centre until after all the recommendations of the ECRG had been carefully considered. In August 2013, the announcement was made in terms that the patients would be supported to other contemporary service options that best met their individual needs.

The uncertain future of the Barrett Centre over the proceeding years from about the time of the decision to cease the Redlands project in approximately May 2012 seems to have resulted in a change in the staff structure of the Centre. Particularly in terms of the clinical staff, the evidence is that there were inexperienced staff who were less known to the patients and who, in some cases, had no previous experience with adolescent patients.

This loss of experienced clinical staff can be attributed in some cases and, of course, not surprisingly, to uncertainty of tenure. Families, staff and patients of the Barrett Centre provide a variety of accounts as to what they were told about Dr Sadler's sudden departure and why he was absent at such a crucial time. The evidence is that Dr Sadler's removal in the circumstances only added to the pot of abandonment, mistrust and uncertainty that existed amongst many of the Barrett Centre staff, patients and their families at the time.

Around this time, for reasons that will hopefully become clearer during the course of the hearings, there also seems to have been a breakdown of the previous conciliatory and collaborative relationship between the education staff, allied health and clinical staff at the Barrett Centre.

Commissioner, the evidence speaks of the range of therapies of treatment available to the young people accessing the Barrett Centre. This involved close and consistent

dealings between allied health staff, clinical staff, education staff and nursing staff. The minutes of the ECRG of 7 December 2012 are most instructive as to the importance of this combined professional interaction. They identify that the ECRG committee itself consisted of a multidisciplinary group who are experts in the field of adolescent mental health, having expertise in psychiatry, nursing, allied health and education.

The Commission has received a substantial volume of evidence through witness statements from individuals who fall within each of these categories, many of whom were involved in some way with the transitioning of the young people in light of the impending closure. Commissioner, you will hear from a number of allied health workers such as occupational therapists, social workers, speech pathologists and psychologists, all of whom have given up their valuable time to provide assistance and to answer numerous questions already provided to them by Commission staff.

The Commission has received 14 witness statements in relation to nursing staff at the Barrett Centre. During the transition period, the nursing staff were managed by a nursing director while strategic oversight was provided by the Director of Nursing West Moreton Mental Health and Specialised Service. The Commission will hear from both these nurses. On the floor, the nursing staff were lead by clinical nurses, referred to as CNs, who were overseen by a nurse unit manager who were known as NUMs. A nurse also held the position of community liaison with responsibility for admissions.

The Commission will hear from two acting clinical nurses and two clinical liaison nurses. The statements of the nursing staff reveal a hardworking, dedicated cohort who have taken the time to provide detailed statements to the Commission. Some of the nurses have provided supplementary statements in response to further questions from the Commission. The statements received reflect a cross section of the nursing staff working at the Barrett during the transition period including contract and permanent employees, nurses with varying levels of experience in mental health and nurses who had been employed at the Barrett Centre for a few months to a few years.

Some themes emerge from their collective evidence. Many mention the decline in experienced and permanent staff from 2012 and leading into the transition period. They describe the increase in patient acuity following the announcement of the closure decision and the concerns amongst staff for the patients' future welfare. Many were care coordinators for the patients and were involved in implementing their transition arrangements. Most of the permanent nurses expressed that they were stressed about their future job security.

Commissioner, Counsel Assisting will be calling a number of teachers and teachers-aides to give evidence during the course of these hearings. I would like to pause for a moment and say something to you about the evidence of the onsite integrated education program at the Barrett Centre and its important role alongside the clinical care and treatment of Barrett Centre patients.

The Barrett Adolescent Centre Special School is an Education Queensland Special School which, since the inception of the Barrett Centre, had operated from buildings owned by Queensland Health at The Park Centre for Mental Health. Following the announcement of the decision to close the Barrett Centre in August 2013, the Education Department was advised that Queensland Health required the buildings occupied by the school to be vacated by 31 December 2013.

At the time of the closure announcement there were 24 students in attendance at the Barrett Centre School. The adolescent ward at the Barrett Centre had 15 inpatient beds and, health permitting, all inpatients attended the school which was adjacent to the sleeping quarters from 9.30 am to 3 pm weekdays. The Barrett School also provided educational programs for young people with outpatient status or day patients, as they are known.

The Barrett Centre School was a band 7 special school and offered classes for Barrett Centre inpatients and day patients aged from 12 to 18. Those older than 18 were permitted to attend the school if they had not completed 24 semesters of education. The evidence is, Commissioner, that the school provided comprehensive educational support for the young people at the Barrett Centre.

All too frequently, these young people had disengaged from their mainstream schools, some of which appear to have lacked the resources to support young people with severe mental health illness. There is some evidence that the specialised educational support that the young people of the Barrett Centre received from the adjacent school underpinned improvements in their psychosocial functioning. In addition, there was special emphasis on vocational education which past pupils have reported as being invaluable to their future lives and long term recovery.

At least until their closure announcement of 6 August 2013, the evidence describes a sense of community and a cohesive and cooperative working environment in which the educations staff worked closely with the medical, nursing and allied health staff to provide the young people with an extensive education program which not only included classes in core subjects such as reading, writing, numeracy, science and information technology but also art therapy, drama, music, wood work, home economics and gardening.

The education, clinical, allied health staff and nurses also worked together to provide the young people with a range of activities that would assist them in gaining exposure to the outside world and to assist in increasing their social interaction with life skills in general. The evidence gives examples such as outings to the movies, gyms, restaurants, the beach, camps, art galleries and participation in work experience programs.

The Barrett Centre School had three classrooms and each class had at least one teacher and one teacher-aide. The young people who attended the school were provided with an education program known as Personal Education Plan, or PEP, which was tailored to meet their individual needs. This plan was developed in

consultation with the teaching and support staff and the families or carers of the young people. The school catered for students who, due to their illness, had not been engaged in a school for years and lacked foundation knowledge to those who were completing their QCS, which is the Queensland Core Skills, and applying for university positions.

Each morning, the education and clinical staff attended a meeting during which the clinical staff would inform the education staff of any incidents that had occurred on the ward overnight and that might impact on a young person's ability to attend school at a particular day. Conversely, at the end of the school day, education staff would inform the clinical staff of any issues that had arisen during the day.

With the impending closure of the Barrett Centre, the evidence is, Commissioner, that understandably, many of the clinical staff left as they took up offers of employment that offered job security long-term. Casual staff were employed to fill the gaps but through no fault of their own, they largely lacked experience in dealing with this cohort of young people and unfortunately, of course, they were just not familiar with them.

The evidence reveals that there was no reduction in the education staff who had reached a consensus that they would stay until the last day to support the young people at the Barrett Centre. Most of the education staff had worked at the Centre almost from its inception in the 80s. The school principal, for example, who will give evidence, commenced at the school in 1987 and was there until ill health forced him to take leave in September 2013.

Not surprisingly, too, Commissioner, there was disruption to the education program in 2013. Prior to the closure announcement, the nursing staff would take the young people – would escort the young people personally to ensure their attendance at school. But as the permanent staff left and were replaced by casual staff, the assistance could no longer be relied upon. And the evidence is attendance at the school decreased. The evidence from the education staff is also that as allied health services were withdrawn, students suffered a decline in their health, as evidenced by the rapid decline in attendance.

From late 2012, there were fewer outings due to the lack of nursing and allied health staff who in the past would have been available to accompany the students and who knew the students well. When the school program for the September 2013 school holidays was cancelled, the teachers from the school gave up their own time and personally provided a holiday program for the remaining inpatients of the Centre. Commissioner, the evidence from the education staff is that they were satisfied with the level of support they received from the Education Department but that following the closure announcement they felt marginalised during the transition period. The staff – the evidence is that the young people increasingly relied on the school staff for emotional support and that teachers struggled to separate their educational programming issues with their general concern for the young peoples' health.

Whilst the Barrett Centre school ceased operation from the location at The Park in December 2013, the Barrett Adolescent Special School was not closed. It was relocated from Wacol to a site at Yeronga and then again one year later to a site at Tennyson. When the school relocated to Yeronga for the 2014 school year, the staff attempted to maintain the existing school program. However, many of the young people who had been inpatients at the Barrett Centre were unable to attend the school because of the severity of their mental illness or because it was not possible to make transport arrangements for them. Some of these young people accessed and received outreach services.

Commissioner, it appears that the model of the Barrett Adolescent Special School is continually changing in line with developments being made within the Department of Education insofar as education for young people with severe and complex mental health issues is concerned. Counsel Assisting are grateful to the legal representatives from the Department of Education for identifying a number of relevant education people who they consider the Commission should speak to about these developments. Statements from such witnesses are currently being reviewed, and one is yet to be requested so therefore yet to be obtained. That will happen hopefully today, Commissioner.

Before concluding, I want to address briefly two other Terms of Reference that relate to the support to transition clients and their families and the support to Barrett Centre staff. By Terms of Reference 3(e) and 3(h), you are required, Commissioner, to ascertain the facts associated with the care and the support and the services that were provided to the transition clients and the care and the support and the services that were provided to the families of the transition clients.

In our view, Commissioner, this means a factual inquiry must be made as to what, if any, care, what, if any, support and what, if any, services were provided to the transition clients and their families and the impact and consequence of any such care, the impact and consequence of the support that was given and the impact and consequence of any services upon the transition clients – impact and consequences upon any such services upon the transition clients and their families.

The concepts of care, support and services are not defined in the Terms of Reference. Nor do the Terms of Reference identify who may have been obliged to provide the care and support and services to the transition clients and their families. Counsel Assisting consider that the reference to care, support and services covers matters that affect the health, safety and welfare of the patients and their families. The likelihood is that the responsibility for providing care, support and services lay with those charged with both the oversight and implementation of the transition arrangements.

Given that a consideration of the adequacy of the transition arrangements for the transition clients under Terms of Reference 3, subparagraph (d), subparagraph (ii) of the Terms of Reference requires a consideration of the care, support and the services given to the transition clients, Counsel Assisting also consider that the focus of

Terms of Reference 3, subparagraph (e) of the Terms of Reference is really on the families of the transition clients.

The evidence from former Barrett Centre patients and their families is of mixed messages being given about the future of the Barrett Centre from in or about early November 2012. In some instances, it was the young person who was telling their parent about the proposed closure. Whilst there is certainly evidence that Barrett Centre staff did make contact with families and West Moreton Hospital and Health Service issued a series of bulletins called Fast Facts, there appears to have been a great deal of uncertainty about the date and the conditions or circumstances upon which the Barrett Centre would close. The evidence is that the consultation with the families about the transition plans varied. Membership of parents on the transition panel was on a case-by-case basis. Some received family visits and telephone calls from Dr Brennan and case coordinators. Further, the information provided to parents about the transition plans, again, varied. There is evidence of arrangements being made for some families to have access to counselling to assist with any concerns about the Barrett Centre closure through, for example, the Consumer Advocate at The Park.

Once the Barrett Centre closed, there is very little evidence of any formal processes of follow up of both the transition clients and the families. Once the Barrett Centre closed, the care, support and access to services seems to have become the responsibility of the individual families or the receiving services.

Finally, Commissioner, Terms of Reference 3, subparagraph (f) require you to ascertain the facts associated with the adequacy of support to BAC staff in relation to the closure and transitioning arrangements for transitioning clients. This Inquiry requires an investigation into whether support was given to staff and, if so, what support was given and the impact and consequences of the support that was given. The investigation of these issues, in our respectful submission, cannot be done in a vacuum. In other words, Commissioner, you cannot properly examine and assess the adequacy of the support given to staff without looking at the impacts and consequences of a particular type of support or an alleged lack of support. The support issues cannot be sensibly divorced from the consequences of support or lack of support. As I have said, the concept of support is not defined in the Terms of Reference. Nor, again, do the Terms of Reference identify who might have been obliged to give support to the staff of the Barrett Centre.

Counsel Assisting view is that the categories of support are not closed and not necessarily confined to the formal legal workplace obligations owed by an employer to an employee. This Term of Reference appears to cover matters that affect, for example, the health, safety or welfare of the staff. For example, the staff may not have been supported if they were not adequately trained or not adequately supervised or if their work burden was too onerous or if they were subjected to unreasonable pressure or stress in otherwise what was a very difficult job.

In summary, Commissioner, the Commission's investigation of the adequacy of support for staff requires you to not only consider the fact of support or not, but also to consider the impacts or consequences of the support or lack of support. Some staff may have received no support, but that may have had no impact on their service delivery or on their own health. Others may be in the opposite situation. Both are within the scope of the Commission's factual investigations, in our respectful submission.

There is ample evidence from the allied health staff, education staff, medical staff and nurses who were employed at the Barrett Centre from 2009 until its closure. As I have said, this evidence reveals an environment of confusion, anxiety and concern leading up tot he closure of the Barrett Centre. But what I must say, Commissioner, is that what the evidence does reveal – that the overriding concern was not for their own future, but a concern for the wellbeing of the young people for whom they cared.

Commissioner, I will be calling the first two witnesses to give oral evidence at the hearings. These witnesses are Dr Cary Breakey and Dr David Ward. Counsel Assisting considered that it would be useful to call these two witnesses at the outset to give some background and context to the Barrett Centre.

The first witness, Dr Cary Breakey, has practiced as a child and adolescent and family psychiatrist since 1980, both as a government employee and a private consultant. Dr Breakey was the founding medical director of the Barrett Adolescent Centre, which, as Mr Freeburn QC has told you, Commissioner, opened as a day patient service in 1982 and then as an inpatient service in 1983. Dr Breakey resigned as the medical director in 1989, but is unable to – sorry, but is able to provide some perspective to the centre over the ensuing years, as he stood in as a locum for Dr Sadler up to mid-2013.

The second witness I will call today is Dr David Ward. Dr Ward is a social worker who was employed at the Barrett Centre for eight years, up until early 2013, and has provided evidence to the Commission in a statement declared on 4 February 2016. Dr Ward's PhD thesis was submitted in November 2014, and the degree was conferred in May 2015. This thesis, entitled The Long Sleepover: The Lived Experience of Teenagers, Parents and Staff in an Adolescent Psychiatry Unit, is an exploration of the subjective experiences of inpatient life from the perspective of the adolescents, parents and staff at the Barrett Centre. The data collection for this thesis was carried out while Dr Ward was an employee of the Barrett Centre, with the data analysis written up after he left. The thesis has been described, both in the draft Children's Health Queensland discussion paper on state-wide sub-acute beds produced to the Commission in November 2015, and the final version, produced by Children's Health Queensland on Friday, as being a valuable addition to the literature, as it appears to be the first qualitative examination of an adolescent inpatient unit in Australia.

Commissioner, I call Dr Cary Breakey.

COMMISSIONER WILSON: Thank you.

CARY BREAKEY, SWORN **[12.09 pm]**

EXAMINATION BY MS MUIR

MS MUIR: Commissioner, Dr Breakey has provided two statements to the Commission. The first statement was executed on 29 September 2015 and is exhibit 27. It is located in Delium at WIT.900.002.0001. The second statement was executed on 9 February 2016 and is located in Delium at WIT.900.0021.0001. Commissioner, the second statement was not on the list that was tendered to you earlier by Mr Freeburn. Before I take – before I ask for the statement to appear on the screen, could I take you to paragraph 32 of Dr Breakey's statement.

COMMISSIONER WILSON: This is the first statement or the second?

MS MUIR: Sorry, this is the second statement. This is the second statement that's currently not an exhibit.

COMMISSIONER WILSON: Thank you.

MS MUIR: Commissioner, do you have that paragraph?

COMMISSIONER WILSON: Yes, I do.

MS MUIR: Commissioner, I do not propose to rely on this paragraph. In my submission, it doesn't provide any assistance to the Commission in reporting upon the Terms of Reference.

COMMISSIONER WILSON: Does any other counsel wish to make any submission with respect to that paragraph?

MS MUIR: So that's paragraph 32 of the second statement.

MR DIEHM: Commissioner, I would ask that the paragraph be struck out.

COMMISSIONER WILSON: Thanks, Mr Diehm. Anyone else?

MS MUIR: I'm content for that course, Commissioner.

COMMISSIONER WILSON: Very well. I'll strike out paragraph 32 of Dr Breakey's second statement.

MS MUIR: Thank you, and, Commissioner, a revised version of this statement will then be made available over the next day. And could I ask that the statement – I think the next number on the numbering is 172.

COMMISSIONER WILSON: I'll just check that. Yes, it will be 172.

EXHIBIT #172 ADMITTED AND MARKED

MS MUIR: Could I ask – Dr Breakey, before I ask you some questions about your statements, I understand that you would like to correct an error in paragraph 4 of your statement, which is WIT.900.002.001, at page 2. Page 2?---It's the wrong statement.

That's – I think that's the – if I could have the first statement. I don't think that's Dr Breakey's statement.

COMMISSIONER WILSON: It's 900.002.0001, is it not, that you want?

MS MUIR: It's WIT.900.002.0001.

Dr Breakey, we'll show you paragraph 4 of your first statement. Can you tell the Commissioner what the error is?---Yes. Commissioner, I think that the – actually, they've been corrected in that document. That actually is now correct. It may be that the draft that I was looking at had been corrected, so actually we don't – we don't need to alter that. Apologies.

There's a sentence that says:

> *I am a fellow of the Royal Australian and New Zealand College of General Practitioners.*

?---That's correct.

And you are?---Yes.

And my psychiatry qualification is the Diploma of Psychological Medicine.

So there's no change you wish to make to that - - -?---There's no change necessary.

- - - paragraph. Thank you. Dr Breakey, your evidence is that you were the founding medical director of the Barrett Adolescent Centre when it was first established as a day patient service in 1982 and then as a 15 bed inpatient facility 12 months later, in 1983. Can you please explain your motivation in opening the centre all those years ago?---Yes. At the time, there were no designated adolescent inpatient beds in Queensland. One of my roles was director of an adolescent

outpatient service in Spring Hill. And it was – we had kids that did need admission for both their treatment of their mental illness and also for safety. The paediatric services offered beds up to over 14 or 15 depending on which service. That was the Mater or Royal Children's. But for the older kids, it was very difficult to get any safe hospital admission for them. We could get 17 year olds into adult services. Occasionally, a – I managed to admit a sort of fairly mature 16 year old. But that was very – a very precarious situation, so there really was no service for kids with severe mental illness as inpatients at that time.

You also – I was interested – you said in your statement that when you were looking at location, you evaluated locations at Prince Charles at Chermside, Wynnum Hospital at Redlands and the Barrett Centre at The Park. Can you explain why in the end you chose The Park as the location?---In many ways, it was an ideal location. The Wynnum possibility was at the time when Wynnum Hospital was shutting and this would be a replacement use of the facility. Dr Shearer, who was the senior medical director of the Division of Youth Welfare and Guidance at the time, which is now called the CYMHS service – and I looked at the – the difficulties of establishing a unit there. There was certainly a lot of community concern about the loss of the hospital. Mental health inpatient services generally aren't seen as supported by local communities as are not adolescent services. So - - -

Can I just stop you there and ask why – what your understanding of the reason behind that lack of support is?---Generally it's to do – and particularly we're talking about the 70s and 80s here – we're talking about the stigma associated with mental health patients – the anxiety of communities about aggression and abnormal behaviours. So – and also Wynnum was quite isolated from the resources that – and travel for patients. Chermside – my major concern about Chermside, I have to admit, was the fact that it had quite busy traffic on several sides. I had actually worked at Chermside, and the risk of suicidal behaviour from the kids, I perceived as quite a – quite a major risk. The Wolston Park I had also worked in previously, and the – one of the appeals for that was the ancillary – the other facilities that were there at the time. It had an oval – cricket oval right outside our unit. It had a lot of space around it with golf course complete with kangaroos and the kids could have a bit of space, which wasn't available at either of the other services. The ancillary things that Wolston Park service had with workshops – it actually had at that time an auditorium where the kids could put on performances. We had access to the Basil Stafford Swimming Pool. There were all of these other activities that we could use that were normalising for the adolescents – for the inpatients.

So you talk about in your evidence when you established the Centre that a 15-bed inpatient service was ideal. What's the magic in the number 15?---The concept, really, is that if you have a small – too small a number for a group, you don't get the advantage of group cohesion and relationships within the kids – kids that they can identify, learn from – hopefully positively; sometimes negatively. And if you have – I thought that more than 15 would be very difficult to manage, even with the population in the 80s which was far less severe than our subsequent populations.

You've just mentioned – you talked about the positive and negative aspects of young people being in an inpatient facility. Can you just explain a little bit more about what you mean about those positive and negative aspects?---Yeah. The positive ones first – many of the kids that we admitted to Barrett over many years were – had been extremely isolated in their home – living at home, some not coming out of their room for days at a time except for toileting and maybe eating during the nights. So the opportunity for these kids to actually – well, I guess, have to relate but to be able to sort of manage that relating in a structured, supportive environment was very powerful. And the use of the milieu so that the kids could actually see other kids learning, coping, coping with things either greater or less than they'd had to cope with in their lives. So that they lost that sense of being abnormal – of being isolated and could get back into doing many of the things that ordinary adolescents do with that group. The negatives – as I'm sure everyone is aware, the self-harm is something that Barrett patients regularly had to handle and deal with. And sometimes we had some contagion of that at particularly stressful times. But that was also able to be used therapeutically for the kids to learn from us and from the staff and from each other how – what worked for them that they didn't need to cut. And so it was still usable in a therapeutic way.

I asked you a question a moment ago about the 15 bed number. On the subject of beds, Dr Breakey, at the end of your first statement, you say that:

Bed occupancy is an inappropriate measure of the utility of the Barrett Centre.

Can you explain how bed occupancy worked at the Barrett Centre?---The – the way it was counted was the occupied bed that – a particular night. And so that's a measure of the number of kids literally sleeping in Barrett. That's actually not a measure of what we were hoping to do, because the aim of Barrett was to get the kids back into normal life as much as possible. So as soon as the kids were ready – and sometimes, unfortunately, sooner – they'd have to come back – we would organise them to be regularly on leave with families. So – and that was very often at weekends when there's more family available, of course, but also during the week if it could be managed or particularly if there were special things that we could arrange for the kid and family to do or special things that the family could arrange – particularly birthdays of other siblings, etcetera. So whilst – and the other important aspect is that while the kids were on leave, be that overnight or weekends even, the Barrett staff were still very actively involved. We would regularly get phone calls from a kid. The staff would regularly get phone calls from the kids or from the family if there was some sort of crisis or question or some development. And the staff would cope with giving them the appropriate advice or occasionally going out and collecting the kid from wherever if things had got out of hand.

So is what you're saying, then, if a young person went home on leave, you just didn't give your bed to someone else?---It was just not – well, we never knew when the kid was actually going to be coming back, for starters.

COMMISSIONER WILSON: Ms Muir, keep an eye on the time. You've got about four minutes of your 20 minutes left.

MS MUIR: Thank you, your Honour. Thank you, Commissioner. Ms Wilson said I could have some of her time.

WITNESS: I'll try to be briefer.

MS MUIR: In paragraph 22 of your second statement, you refer to a common criticism of the Barrett Centre being that adolescents were staying too long. When did you first become aware of this criticism?---I think it has been a criticism over quite a few years, and I couldn't locate it to any particular year. I was aware that we were having progressively more complex and more difficult kids in the unit and that their stays were longer. Some of – I guess each individual kid stay related to where that kid was at, and they were moved on as soon as they were ready. Sometimes we'd test it out too soon. Sometimes we were fairly anxious about the outcomes, and that delayed the kid being discharged. And it was facilities that were – I mean, finding facilities in the community and having the other services ready was very important for each of the kids that we discharged over the years.

So is it your evidence, then, that the availability of services or certain services could've reduced lengths of stay?---Well, yes. I mean, over the years we'd tried to get support for Step Up Step Down programs and safer community placements for kids, as well as CYMH services that looked after families. At one stage we actually had a group home in Ipswich that took a couple of our girls over a period.

Just finally, Dr Breakey, in your statement – your second statement – you refer to the Assertive Mobile Youth Outreach Service, which is known as AMYOS, as not being a useful stopgap for the Barrett Centre. Can you now just tell the Commissioner what you actually know about this service?---Yes. I think I was working in either Logan or Toowoomba at the time when those positions became available, and I guess I was very conscious that it was a Monday to Friday operational service. I had concerns at the time with that iteration of the AMYOS positions. There was the plan that they would work until 8 o'clock in the evening, which, again, is not necessarily the particular time when these kids need the support. Middle of night is the most risk times for many of these kids.

COMMISSIONER WILSON: So when was this that you had experience with AMYOS?---I'm sorry, I can't date it. It would be in the times when AMYOS appointments were approved to be filled. So that would, I guess, have been sometime – sometime 2013.

MS MUIR: I did say one – there is - - -

COMMISSIONER WILSON: Ask the question, Ms Muir.

MS MUIR: I might have one more minute, Commissioner.

In – Dr Breakey, in your statement you talk about the non-government organisations, and you say that there's been a progressive tendency for government departments to contract care responsibilities to NGOs and that many do not fulfil their commitments, and you had some concerns about the management of a Barrett Centre-type model being managed by an NGO. Could you elaborate on what your concerns are?---Yes. They arise because I've worked in several Evolve services – Evolve Therapeutic Services – as their consultant psychiatrist, and one of the ongoing problems that they and I identified was the experience and expertise and confidence of many of the staff who were appointed in NGOs doing residential work for the Evolve patients who, in many ways, have a lot of similarities to our Barrett patients with histories of trauma, histories of self-harm and suicidality and substance use. And the – one of my big concerns was the lack of constancy of staff in these residences from almost week to week, so that the attachment issues that are really important and trust issues that are really important for these group of kids just were not being dealt with, and the opportunity for the kids to learn and to feel safer just couldn't happen in those situations.

Thank you, Dr Breakey. Thank you. I have no further questions.

COMMISSIONER WILSON: Thank you. Yes, Ms Wilson.

EXAMINATION BY MS WILSON **[12.31 pm]**

MS WILSON: Dr Breakey, as you may appreciate, I've got to be quick, so what I'm really focusing on and where I want to just ask some questions on is your knowledge of the present continuum of care available and any future model. And I see in your statement that you're semi-retired, but still keeping your hand in and doing a bit of locum work?---Yes.

So can you – do you – are you fully aware of the current continuum of care for adolescent mental health services in Queensland presently being provided?---Up to about six or eight months ago, but subsequent to that, no.

Okay. So just to break it down, at one end of the spectrum we've got – at one end of the spectrum of continuum of care we've got community-based services, that is, the Kings clinics, and at the other end we've got the acute beds. Now, it's the bit in between that I'm interested in, in terms of your knowledge about what is being available presently in Queensland about those services?---I understand that some sub-acute beds were being set up, but I'm not sure about the admission criteria and the process for those. And my concern is that they're attached to basically acute services. I'm aware there were some resis planned. Again, I don't – I'm not sure what is operating now. I did have concerns about the – their capacity to handle patients of the severity of the Barrett cohort.

Okay. Stop there, but to be fair, your knowledge and experience in dealing with resis is limited?---I wouldn't – current is - - -

Yes, yes, yes?---The current available resis.

What's available now - - -?---Not resis in the past.

What's available now, in terms of – I'm not directing my questions to the past. I'm directing my questions to what is available now?---Yes.

And in terms of your knowledge about the services that are available through the resis, which would be the residential rehabilitative services, your experience and knowledge of those is very limited?---Is limited.

And, in fact, any at all?---I think I did see a document with the admission criteria, and I had concerns that, again, they would not match the Barrett - - -

Okay?--- - - - patients.

That's it, in terms of - - -?---Yes.

- - - your – okay. Now, in terms of young people with long-term severe and complex mental health needs, the prime – one of the primary aims of the extended treatment and rehabilitation model of care is to provide an integrated continuum of care outside of an inpatient setting and as close to their home as possible. Are you aware of that?---Mmm.

And that the current child and youth suite of mental health services available builds on and complements existing child and youth mental health services, including mental health and acute services with links with primary care and non-government and youth services. Are you aware of that? Now, you gave some evidence from questions to Counsel Assisting and talked about your experience with AMYOS?---Mmm.

Now, are you aware that AMYOS is just one part of the suite that is available?---Yes.

Okay. So it's not just that's where you focus on; it's just one part?---Mmm.

And where – that – and are you aware that AMYOS provides mobile assertive engagement and prevention-focused interventions in a community or residential setting?---Yes.

Now, in terms of your work – your experience in dealing with AMYOS, you talked about some experience in Logan and Toowoomba but you – that was very early on, was it?---Yes.

And you – and was it – was it extensive experience or was it just a - - -?---No. It was at the time when the positions were becoming available and appointments were being looked at.

Okay. And did you do much work with these AMYOS services and see how they operate?---No.

We talked about the resis, the residential rehabilitation services and your evidence is there that you have very limited experience?---Mmm.

Now, what about the day programs that are being offered to reduce the severity of mental health symptoms and promote effective participation areas such schooling, social functioning, symptom management and other life skills. Any experience in that?---Yes, I helped develop the Toowoomba adolescent unit Yannanda - - -

Yes?--- - - - and develop its day program.

And when was that, Doctor?---Twelve – probably during 11/12 and then last year I was the acting director at Toowoomba whilst the director was on maternity leave.

Have you got any knowledge of the proposed Step Up and Step Down units which is a new service type for young people in Queensland coming on in sometime about 2017/18?---I read some of the early documentation for it.

Okay. So are you - - -?---But I'm not aware of where it's at at this stage.

But that service would provide a Step Up service option to prevent inpatient admission through intense short term treatment and a Step Down option to assist early and seamless transition for young people when re-entering the community following inpatient admission?---And they will be very valuable services that Dr Sadler and I have asked for for many years.

And they all work together in providing a total suite in dealing with adolescent mental health with the subacute beds. Now, you have made some mention of your – about subacute beds in your statement and in your evidence with Counsel Assisting. Now, have you been out to the Lady Cilento Hospital – the subacute unit out there?---No.

So you have got no experience of the services that are being offered out there at the Lady Cilento?---No.

Okay?---Not on the ground.

Now, one of the issues that you raise is the alignment issues. And that is in paragraphs 37 and 40 of your supplementary statement which is WIT.900.021.0001 and is at paragraphs 37 and 40. And that should come up on your screen. And if we can go to page 8 of that, please.

Okay. And for – if we can just scroll down, as I said, to 34 – 37. In fact, can we just stay there while we've got it. We talk here about the Evolve model. And you gave some evidence about the Evolve model. Are you aware that the Evolve model is limited to child protection order patients?---Yes.

Yes. And AMYOS has a broader reach?---Yes.

It's just not limited to child protection order - - -?---Yes.

Okay?---No. I was paralleling it from the Health Department point of view.

Okay. And if we can just go down we can actually see it at the bottom. We have got a heading called Alignment. And that is that you say that there was a gap in the alignment of adolescent and mental health services that are presently available. Would you accept that before determining what services may be required to address any gap in the alignment of adolescent and adult mental health services, a service mapping exercise really should be undertaken?---Yes.

Okay. And that should – looking at the differences between current services available and CYMHS and the adult mental health services?---Yes.

And identifying service needs for specific age groups, looking at the specific age groups?---Yes. I guess age and maturity.

Yes?---Yes.

And identifying any potential gaps in service delivery for these age groups?---Of course.

And forming an options paper for discussion between a number of the stakeholders, including Mental Health Alcohol and Other Drugs Branch, Office of the Chief Psychiatrist, Mental Health Commissioner, Child and Youth Mental Health Services and Adult Mental Health Services and any other interested stakeholders?---Yes.

Thank you, Doctor. They are my only questions. Thank you.

COMMISSIONER WILSON: Yes, Ms McMillan.

EXAMINATION BY MS McMILLAN **[12.40 pm]**

MS McMILLAN: Thank you.

Dr Breakey, can I just ask you, you've locumed for Dr Sadler, you say, on a number of occasions. Correct?---Yes.

And he arranged that with you directly. Is that right?---Yes.

And just so we have some idea in, say, the last four to five years of you locuming there, would you agree that in 2008 you locumed for two days?---If that's possible. But I – if that's what you have on record, I wouldn't contradict.

2009, one day?---Possibly. No. Well, that's – one day is unlikely. I think that I may have gone in one day but covered for a week period perhaps.

Okay. Thank you. 2010, none?---And that would be, generally, my way of working, that I would cover for case conference and emergencies.

So just so I understand, that means you may not have actually stepped foot on the premises?---I would've – I would've set foot on for whatever days that you've counted because they're the ones that would be billed to the Department.

I see?---But – to West Moreton.

But you say you offered cover for - - -?---But – yes.

- - - a period longer but you may not have actually been involved clinically doing any work?---No.

Right?---I would've just been on phone or – I would've come in if necessary.

So 2010, none?---I think I was travelling a lot in 2010.

2011, one week and three days?---That's – that would be several. Two weeks or three, yes.

2012, 17 days?---That probably breaks down into five or seven weeks, I would imagine.

2013, four days?---Again, that would be two or three weeks.

Right. But you say those would be the days you'd actually go into the unit?---Into the service. Yes.

Right. Thank you. Now, if I can take you to the document 900.002.020, please. This is a letter by you, Dr Breakey, to Mr Springborg on 9 November 2012.

MR FREEBURN: I think the number needs to be repeated.

MS McMILLAN: 900.002.0020. It's an annexure to his first statement – WIT, W-I-T, sorry. Perhaps while that's just being done I might take – Dr Breakey, in that letter, it's to Mr Springborg, you wrote:

BAC works vigorously with the patient's family, extended families and all community ties to reintegrate the adolescents back to normal life.

Do you remember writing that?---Yes.

Okay. Thanks. And, further, at the same document – and it will be page 5 of that document, please – paragraph 25, Doctor. You'll see there, second line down:

The philosophy of the BAC was that a patient was being transitioned out from the day they arrived as appropriate to their needs and with cognisance of waiting list pressure.

Correct?---Yes.

And that was so in your time when you were director until 1989?---Uh-huh.

And you understood that to be a recurring philosophy?---And it – yes. Yep.

Right. So even from day 1, or even perhaps previously, you'd expect to see something in the notes, for instance, for that patient about a transition plan out of some form?---I'm not sure that we would have noted a transition plan out, as such.

Well, whether it's – sorry, a formal plan or not, you would expect to see something, one would think, even pre-admission - - -?---Well - - -

- - - about how they may be transitioned out?---And pre-admission discussions would have been conducted with, say, the CYMHS referral agency as to what was going to happen with the kid was discharged. Yes.

Right. So that would be, really, from day 1?---Yeah.

Right. So someone like Dr Brennan coming in would've expected to see something already, at least in an early form, about how to transition out each of the patients; correct?---Whether it was recorded, I guess. It certainly would be discussed in case conference and would be somewhere in case conference notes, I would imagine.

Well, one would expect if it was discussed it would probably be noted, wouldn't it?---In case conference notes.

Yes?---Yeah.

Well, whatever form, you'd expect to see some notes of it; correct?---Well, that's – the case conference notes would be where - - -

You'd find it?--- - - - that was – would be found.

Alright. Thank you. Can I take you then to the document WIT.900.021.0003. This is your second statement, paragraph 14, please. You'll see – if you just read that paragraph to yourself, Mr Breakey?---It's the "One of the difficulties - - -"

Yes?--- - - - "was the BAC population was very diverse."

Was very diverse. So you say it makes it difficult to research the population as a group. And I take it from that also probably the relatively small number of the cohort as well?---Yes.

And diversity not only of condition but also of gender, for instance. That would be important. And I take it, too, whether they were pursuant to something like an involuntary treatment order?---Yeah, that would be included. Family history, educational experience; all of those things.

Alright. And them being pursuant to an involuntary treatment order, I suggest to you, is also important because the particular mandates that stand around that, aren't there?---Yes.

In terms of governance, how often they need to be reviewed, the fact that they're obviously by nature an involuntary admission?---Yes.

Right, whereas many of the Barrett patients were voluntary admissions?---Were voluntary.

Right. Thank you. Now, in terms – can I just take you to a couple of things. Family therapy, which is on page 5 of that document, 005. Yes, thanks. Thank you. That's it. So family therapy. At your time at the Barrett Centre, both as the director and following, how often did family therapy occur, as a general rule?---I couldn't' give you a figure on that. Whenever – I mean, all of the families who were local, in terms of southeast Queensland area, if they could make themselves available or if we could visit, would be seen. So I'd like to make the distinction between what's called formal family therapy and work with the families, because a lot of informal work was done with parents when they were picking up kids from the unit, when they were delivering them back there. You know, the nursing staff particularly were very valuable in supporting parents, in hearing what was happening. Formal family therapy work, ie., sitting in a room somewhere with the family, would often happen on those changeover, end of leave or start of leave times. I would not have any record of the, you know, statistics of the numbers of families that were seen.

On a formal basis?---On a formal basis.

Alright. Thank you. Now, you made some mention in your statements about casual staff or staffing issues?---Mmm.

It's correct, is it not, that your understanding is nurses who were termed casual came from a pool of nurses that only worked at the Park?---I don't know where some of

them came from, to be honest. I was just conscious that – in fact, one of the issues of opening Barrett was that I actually got a change so that we could actually have our permanent designated staff so that there was constancy for the kids.

So this was while you were director?---And that was one of the requirements that we had before we even opened the service. And that was maintained for many years. When the confusion about whether Barrett was going to move or was going to be closed arose, then there were many more staff either on very brief contracts or who didn't even know next month whether they were continuing, and there were other staff that I would arrive and they were just there for those days.

So just so I understand, when you say about the uncertainty, is this 2012?---2012/13, yes.

Right. Thanks. So for instance, were you aware that all of the nursing staff – even casuals, as you might term it – were – obviously, clearly had mental health skills?---Yes, but not necessarily experience with adolescents - - -

But you say - - -?--- - - - and not necessarily experienced with the degree of disturbed adolescents at ours.

But nonetheless you're not sure where the pool, if you like, was drawn from?---No, I'm not.

No. Right. Thank you?---I didn't have a role in selecting nursing staff at that point.

No. Thank you, Doctor. In relation to the length of stay, you've also mentioned the length of stay, as I understand your oral evidence, was – you commented on that because of the issues of finding services in the communities for treatment. That, plus staffing, appeared to be the twin issues that you say militated a longer stay?---Yes.

Correct?---Yes.

But, of course, it's the case, isn't it, that over – certainly since your days in 1983, there have been more and more services available, both inpatient and outpatient, for young people?---Yes.

Yes?---Yes.

Right. Thank you?---Yes.

The bed occupancy – you say that it's perhaps – you say it's incorrectly skewed. Is that what you mean? Because it takes up where there may have gone on – consumers, if we can put it that way, go on weekend leave or week leave, for instance. And I suppose it would take up, too, lengthy periods when they go home for holidays?---Yes. Yes.

So it was common, wasn't it, that most, if not all, the patients would often go home, for instance, over the Christmas school holidays?---We would try desperately to get the kids home, yes.

And over other - - -?---And – yes.

- - - gazetted school holidays?---Yes.

Right. Thank you?---Although the Christmas holidays particularly. The in-between term ones, we tended to have a program that the kids would come in for a couple of days off.

You mean a couple of days off from being at home with their families, usually?---Yes, and it would give us the chance to see how things were going at home without the full sort of stress of 10 days or two weeks at home.

Alright. Now, just so I understand, you have annexed an email from – to Ms Kelly and her response to you about locuming for Dr Sadler in 2013; correct?---Yes.

Are you critical of Ms Kelly for not taking up your offer?---No, no. As I understand it, Dr Brennan had already been organised into that position.

And could the witness see WIT.900.021.0030. It's annexure F to his second statement. Just while that's being located, did you understand that Dr Sadler, in addition to his duties at the Barrett Centre, also had duties at the Mater Hospital?---Yes, yes.

Right?---We've chronically been short of child and adolescent psychiatrists, and all of us – well, not all, but most of us have multiple roles.

So this is page 0030. I'll read this to you, Doctor. See if this rings a bell. You emailed Ms Kelly, and you said that – commented upon:

> *I know – having known Dr Brennan well even from her training days, I have implicit faith in her experience and expertise. I'm sure she will care for BAC and patients well.*

Do you remember writing that?---I'll accept I did. Yeah.

Continuing:

> *However, I assume the BAC commitment is in addition to her usual positions.*

Now, just pausing there, do you remember writing that?---That's – that's sounding more familiar, yes. Yeah.

Continuing:

And may be particularly onerous for her at this particularly stressful time for the unit.

Do you remember writing that?---Mmm.

Now, can I ask you – you don't know whether it was in addition to her other responsibilities, did you?---No.

No?---No.

So you were speculating about that?---Yeah. I was offering because I've regularly been in the position because we are so short of experienced staff that people sort of take on - - -

I don't need that up now. Thank you?--- - - - positions under pressure that if there's another option they would be quite happy to hand over to.

Now, you also depose as to risks of harm from forensic patients. And you say that that's not a valid concern, correct?---Yes.

Is a risk – or have you ever considered whether a risk might be that a Barrett adolescent may, in fact, form inappropriate attachment to any of the forensic patients?---That was never - - -

And I don't mean in any other way other than forming, say, a friendship or anything of that nature?---Yeah. There's never been contact between the forensic patients when we opened Barrett.

When you opened. Yes?---When we opened or at any time.

MS MUIR: Commissioner – sorry. I hate to interrupt, but I'm concerned that this evidence should be in closed court.

MS McMILLAN: Well, I'm not descending to any detail.

MS MUIR: Perhaps I can just have a - - -

MS McMILLAN: I've got no fixed view about it.

MS MUIR: I do have a concern. I realise to express that concern, I can't – adequately, I can't do in open court. I'm happy to raise my concern directly with Ms McMillan.

COMMISSIONER WILSON: Ms McMillan, can you move on to another point and we'll come back to this one.

MS McMILLAN: Sure. All right. Thank you.

Dr Breakey, I would take it that, consistent with the tenor of your evidence, any public announcement, for instance, about the closure – the potential closure of the Barrett Centre would need to be done sensitively, wouldn't it?---Yes.

And would need to take into account that it's likely to cause significant anxiety for both patients and their families?---Definitely.

All right. And because, for instance, it's far different from closing something like an orthopaedic ward or something of that nature that you would need to be particularly sensitive to those sorts of issues?---Yes.

Commissioner, that's all I had apart from that issue. Is that a convenient time?

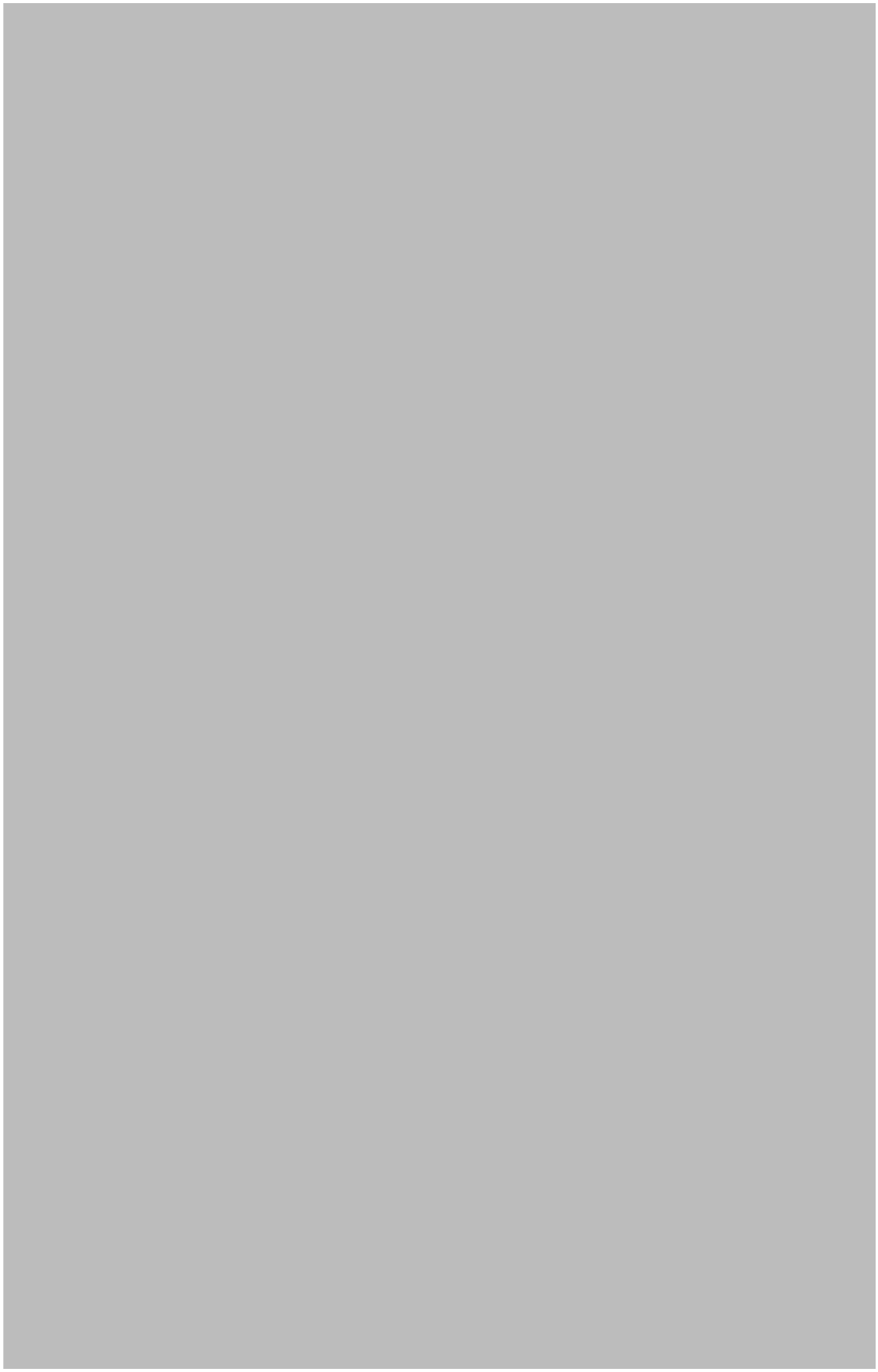
COMMISSIONER WILSON: Well, I think we have time before lunch to deal with that issue, so I will ask that the hearing room be closed now and I can hear the argument from Ms Muir. And it will be necessary for the live streaming to be turned off. And it will be necessary for those in the courtroom who are not legal representatives or members of the Commission staff to leave the courtroom.

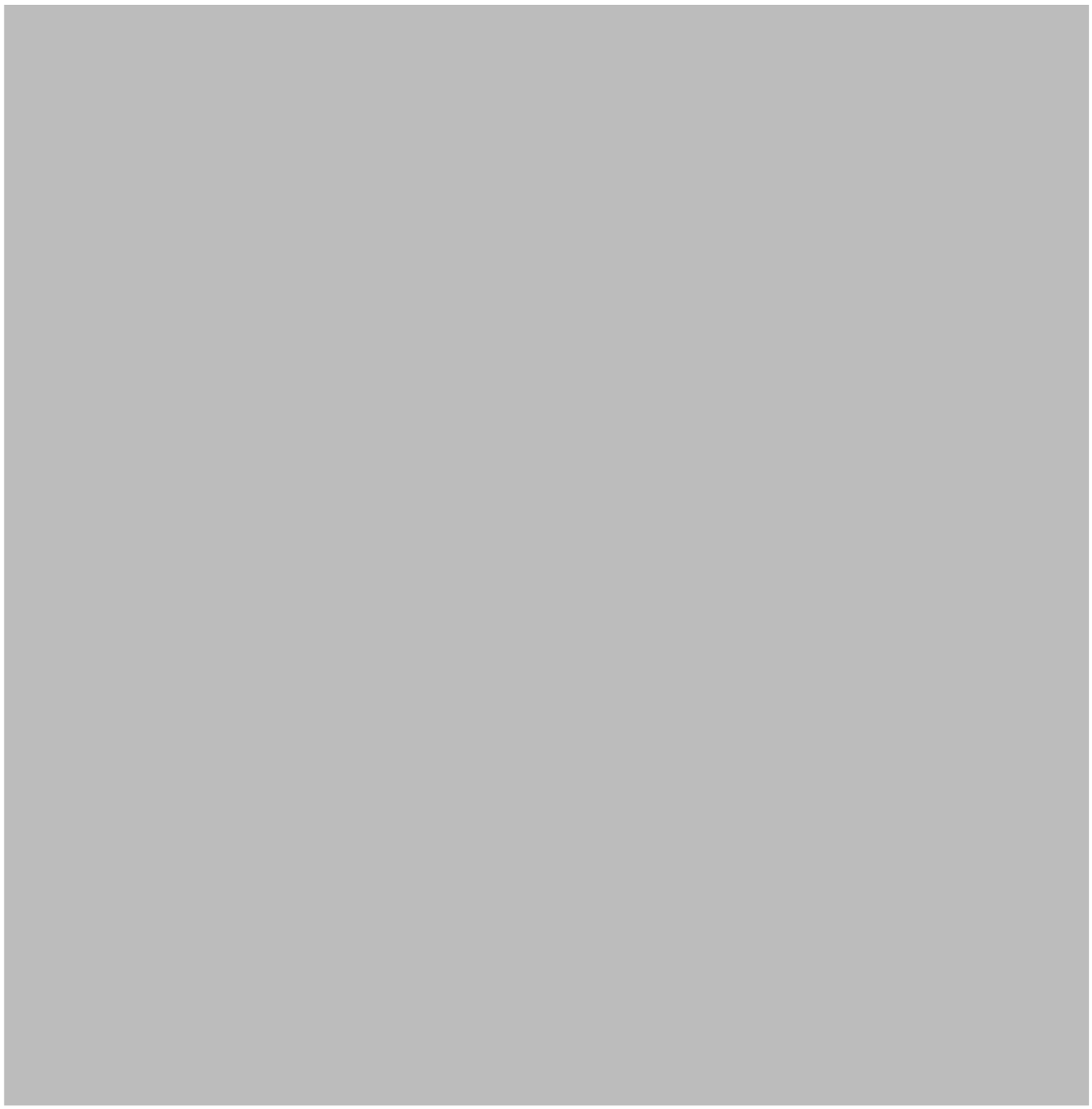
MR DIEHM: Or those parties with leave to appear and be represented before the Commission, as I understood the draft document that was circulated over the weekend, Commissioner.

COMMISSIONER WILSON: Well, Mr Diehm, the draft hasn't been finalised yet. For the purpose of this particular argument, I'm going to ask that all but legal representatives leave the courtroom.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER WILSON: So if there are any members of the media here, they should leave the courtroom. Can I be assured that the live streaming has been turned off? Is there someone here to give me that assurance?





MS McMILLAN: Yes. Thank you, Commissioner.

Mr – Dr Breakey – I'm sorry. Perhaps if I just also approach it this way. You're aware that, of course, The Park in terms of the adult facility moved to what's known as EFTRU, correct?---Sorry – the term?

EFTRU – the extended forensic treatment unit?---Yeah.

And did you understand that part of that vision, if I can put it that way, was for the patients in that facility to have fairly unfettered use of the grounds at The Park?---Yes, but that would not be new, because even when I opened Barrett we considered the situation that Pearce and Osler House were actually across the oval and patients moved in and out of Pearce from the rest of the hospital.

All right. And, of course, going to EFTRU, they were forensic patients, correct?---As were the Osler and Barrett and many patients in the open wards of Wolston Park in the 80s were what were called section 50, which were forensic patients.

Right. So it was a mix in your day of patients?---Mmm.

Right. My question to you, really, is there's obviously the potentiality of some physical risk to the adolescents on a co-located site, correct?---Well, we hadn't had any issues in 30 years. I – as part of opening Barrett, I actually had security screens put on the windows, but that was all.

And the other aspect is, as I was asking you before, the potentiality of a Barrett adolescent forming some attachment or friendship with a forensic patient. Would you accept that?---No.

No. All right. Just excuse me. Thank you, Commissioner.

COMMISSIONER WILSON: Before you sit down, Ms McMillan, I'd like to clarify one thing with you in case your questioning was based on a wrong assumption.

MS McMILLAN: Yes.

COMMISSIONER WILSON: You talked about The Park moving towards the EFTRU model.

MS McMILLAN: Yes.

COMMISSIONER WILSON: My understanding is that The Park is a secure facility, that is, it has non-forensic patients – adult patients who need secure containment, it has forensic patients who need secure containment, and that EFTRU is a new – a new unit within that complex which is a less secure unit than some of the others.

MS McMILLAN: It's a step down.

COMMISSIONER WILSON: It's a step down.

MS McMILLAN: Yes. Perhaps I didn't - - -

COMMISSIONER WILSON: So it's not that the whole of The Park has been taken over by an EFTRU model.

MS McMILLAN: No, no.

COMMISSIONER WILSON: Which I thought was the substance of your question.

MS McMILLAN: If that was the way it was portrayed, then I was in error. Yes. That's my understanding.

COMMISSIONER WILSON: All right.

MS McMILLAN: Thank you.

COMMISSIONER WILSON: Thanks. Now, was there someone else who wanted to question Dr Breakey? It was Mr Wessling-Smith.

MR WESSLING-SMITH: Yes. I no longer have any questions.

COMMISSIONER WILSON: You don't have any questions. I'm conscious of the time. Ms Muir, do you have any questions that you wish to ask?

EXAMINATION BY MS MUIR **[1.10 pm]**

MS MUIR: I just had one question, Commissioner.

You've mentioned, Dr Breakey, your concern about the location of sub-acute beds in an acute ward at the Lady Cilento Hospital. Can you just tell the Commissioner what your concerns are?---Yes. The particular cohort of kids that we consistently had at Barrett are ones who are generally seen as not coping well with the acute units because of the – the regular changeover of kids and the – these – many of the Barrett cohort have attachment issues and anxieties and learning – coping with new kids at every step is a big problem for them, as is coping with changes in staff. So acute units generally see the Barrett cohort of patients as not – not settling in well or even being disruptive in the acute services.

Thank you, Dr Breaker. I have no further questions, Commissioner.

COMMISSIONER WILSON: Thank you, Dr Breakey. I won't formally excuse you. You will be stood down. But if you are further required, the Commission will be in touch with you to notify you. You're welcome to stay for the rest of the proceedings if you want to, but essentially be on call?---Thank you, Commissioner.

COMMISSIONER WILSON: All right. Thank you.

WITNESS EXCUSED **[1.11 pm]**

MS MUIR: Is that a convenient time, Commissioner?

COMMISSIONER WILSON: Yes. If you'd adjourn, please, until 2.15.

ADJOURNED **[1.11 pm]**

RESUMED **[2.14 pm]**

MS MUIR: Thank you, Commissioner. I call Dr David Ward.

DAVID JOHN WARD, SWORN **[2.14 pm]**

EXAMINATION BY MS MUIR

MS MUIR: Commissioner, Dr Ward has provided one statement to the Commission. It is declared on 4 February 2016 and has Delium reference number WIT.900.020.0001. I don't have the exhibit number, Commissioner.

COMMISSIONER WILSON: It doesn't matter. Don't worry.

MS MUIR: Dr Ward, you were a social worker at the Barrett Centre for eight years up until early 2014; is that correct?---That's correct.

Can you tell the Commissioner what your qualifications are?---A Bachelor of Social Work, Bachelor of Arts, a graduate diploma, coursework Masters in Counselling, a research Masters of Philosophy and a Doctorate of Philosophy.

In relation to your Doctorate of Philosophy, you say in your statement that you submitted your thesis in November 2014 and your degree was conferred in May 2015 and that your thesis is an examination of the experiences of young people in a long-stay unit and also includes the perspective of parents and staff. As you understand it, Dr Ward, do you agree that your research is the only known Australian study of its kind?---As far as I know, yes.

Now, your thesis is called The Long Sleepover: the Lived Experience of Teenagers, Parents and Staff in an Adolescent Psychiatric Unit. Can you explain to the Commission why you gave your thesis this name?---As I was collecting data from the participants, one of the adolescents used the term in describing some of the benefits of inpatient care – it's like a mass sleepover. And that term always stuck with me.

Why did you choose this topic to write your thesis about?---As I reviewed the – the literature, it seemed to me the adolescent voices were somewhat drowned out amongst all the research. And my initial thoughts were to do a thesis looking at the adolescent experiences. As time went on, though, I saw the value of including staff and parent perspectives. And the three complement each other very nicely.

Can you explain briefly how you went about collecting data for your thesis?---There was a number of ways. With the adolescents, there were face-to-face interviews of which part of that involved the adolescents taking some photos of the unit. A lot of the adolescents struggled with emotions and expressing their emotions – articulating their – their internal lives. And so a common tool in research is using photography to help them express themselves. There was also individual interviews with the staff, with the parents as well as a focus group with the staff.

Dr Ward, in your statement, you say that you're currently employed as a senior social worker at the Child and Youth Acute Unit at the Robina Hospital on the Gold Coast. And you also say that the key purpose of short-term crisis admission is to stabilise the child or adolescent. Can you explain what you mean by the word stabilise with respect to short-term crisis admissions to adolescent inpatient units?---As the term suggests, it's a – to return the adolescent to a reasonable state of emotional and psychological equilibrium so they can then go back into the community to their families where the risk of harm has been minimised to such an extent, obviously, they can be discharged from hospital.

Now, you also say in your statement that you have observed first-hand during your 15 months' employment at the Robina Acute Unit. You say that you've observed multiple admissions with the same young person. Can you tell the Commissioner what your observations are of the effects of these multiple admissions to the brief stay adolescent inpatient unit that you work at?---Multiple – multiple admissions usually revolve around those conditions that are very entrenched and, as the literature would bear out, very difficult to budge such as eating disorders, chronic anxiety, sometimes chronic self-harm. The effect on the adolescents and also the families – it's a number of areas. One, there's an increased stigma – in and out of hospital. With every admission, the sense of despair and despondency grows about their recovery process. There's an impact on the families. They're in the family system; they're outside the family system. And this in and out process has the effect of destabilising the family – relationships in the family.

Doctor, what – I just want to ask you some questions about your employment at the Barrett Centre and your role as a social worker for the eight years that you were there. You say in your statement that the Barrett Centre was never a one-size-fits-all type of service and it tailored each adolescent's treatment individually. Can you tell the Commissioner how the Barrett Centre, from your experience, went about ensuring that treatment was individualised for each of the young people?---The Barrett treatment team saw the adolescents as individuals with their own unique history, own unique personality, own unique difficulties despite some parallels that obviously we would see. And so each adolescent received an individual treatment goal. That was discussed in a weekly case conference. It was discussed also in a six-weekly intensive case review. The model that Barrett used had a very strong developmental framework put out by Dr Sadler where one of the key facets of it was to return them to – return them as best we could to a reasonable developmental trajectory. That demands that the treatment would be individualised with each adolescent. And so there would be no two treatment options identical for each

adolescent. We respected their – their roles as individual emerging adults – individual emerging adults. We didn't treat them like children. We were aware that they weren't going to be there forever. We had to get them back on that developmental track, and that required seeing adolescents as individuals as opposed to a group with the same issues.

When you talk about these – the treatment of each adolescent individually, were there any written plans for this individual treatment?---Yes. Typically for any mental health unit, there was a weekly case review where the adolescent was reviewed by the multi-disciplinary team. All treatments were documented in the charts. Any concerns or gains made were also noted. But also every six weeks, there's also the intensive case workup – otherwise known as the ICW where a couple of adolescents were discussed in much more detail where the previous six weeks were looked at in more finer detail. The team would come together, discuss treatment options, gains made, potential difficulties. And each of those cases was documented accordingly.

So who were the members – which staff members were members of these teams?---Sorry. Can you repeat the question?

Which staff – without mentioning names, what professions were involved in the teams that came together to meet?---All the professions that were involved – nursing, allied health, occupational therapy [indistinct] psychology. All the individuals in the team had input with the adolescents' treatment.

So, Dr Ward, you've worked obviously at the Barrett Centre, which was a long-term or an extended stay unit. And you're currently working at a acute unit. Are you able to say how the therapeutic methods differ between the extended stay unit and the short-term stay acute unit?---In an acute unit, you're very much restricted by – by time and by resources. In the unit where I'm staying at the moment, you – there's some capacity to take them outside the ward for a walk, for example, the occasional drive in a vehicle to get them off-site the ward. But it's very limited. Ninety-five per cent of all interventions have to occur on the ward. Where I work, there's a small outside area with a basketball hoop, but apart from that there's very little activities we can offer the residents. With Barrett, because it was a long-stay unit and the facilities were different, we had access to far more resources than acute unit. We had the ability to offer more extended life skill groups, trips away during the day and overnight. We had the resources to offer them far more developmentally appropriate interventions than acute unit can do.

When you talk about the multidisciplinary team at the Barrett Centre in your statement that ensured the coordination of treatment, is that the team you just gave evidence about that met to discuss the individual adolescents' treatment? Is that the – is that what you mean by multidisciplinary team?---Yes, sorry. Yes. When I referred to the multidisciplinary team, it refers to the gamut of staff working at the unit. So medical, nursing, allied health, and educational staff as well.

And, in fact, you give evidence in your statement about the Barrett school that was located at the Park. Are you able to tell the Commissioner in what way was the Barrett school integral to the treatment of the young people accessing the Barrett Centre?---I found the school was absolutely crucial in the recovery journey for the adolescents.

COMMISSIONER WILSON: I'm sorry, was crucial in what?---In the recovery process for the adolescents.

The recovery process. Thanks?---In fact, I can't imagine any mental health unit that has adolescents for more than a few days that doesn't have some kind of educational input. The school at the Barrett had a modified program. It had teachers who were, in my view, very compassionate, very knowledgeable in mental health issues and had the capacity to give the adolescents really a corrective emotional experience when they came to the school. Most of the adolescents – a high proportion had experienced bullying, school refusal and academic difficulties. Time and time again, over many years, I saw that those negative experiences start to be diluted with that day-to-day high teacher-student ratio diluting those past experiences and recreating, and very positive in the adolescents' lives, and I believe that flowed over very strongly into their recovery process.

In your statement you give evidence that you had concerns while you were at the Barrett Centre in relation to the length of stay, in particular, admissions beyond two years. Indeed, you say that you voiced these concerns to Dr Sadler. From your observations and experience at the time, what did you understand to be the reasons why the lengths of stay on occasions were extending beyond two years?---There were a number of very complex reasons. Sometimes they were related to the entrenched pathology the adolescents were experience. Some of the conditions were chronic and simply were very hard to budge, despite the best efforts of staff and the treatment we provided. Sometimes - - -

Can I just stop you there?---Yes.

You just used an expression: entrenched - - -?---Entrenched pathology.

- - - pathology?---There were times when a family background – family dynamics – would also make it very difficult, and there were other times where – more systemic organisational issues, such as the lack of step-down program between Barrett and the adult system, or a combination of all the above.

Can you tell me what "entrenched pathology" means?---Mental health difficulties that really are treatment-resistant, chronic in nature, and take a long time to see glimpses of recovery. Eating disorders are a case in point. We see that at the acute unit where I work at the moment, as a good example of where the adolescents will have multiple admissions. They are fed, there is weight restoration, they need to be discharged, and then three or four months later on we find them again.

COMMISSIONER WILSON: Keep an eye on the time. Five minutes.

MS MUIR: Dr Ward, in the last paragraph of your statement and the last sentence, you say that in your experience the number of adolescents requiring such an extended admission is increasing. On what basis do you make this statement?---I make that statement on many years working in child and adolescent work. That includes acute units, Barrett, Headspace and also private practice. I've seen the gamut of child and youth services, and it seems to me there is a trend where the mental health issues are occurring at an earlier and earlier age and becoming more entrenched at an earlier age, thereby making it more difficult to treat. My experience at the acute unit where I'm working at the moment really reinforces to me the beneficial nature – if I could jump the gun here – of an extended treatment program like Barrett, because of the reviling door that I'm seeing. Recently, in the last three or four months, we've had [redacted] there with significant issues. It seems to me that the age is becoming younger and younger, and therefore the need for a range of options to address those is becoming more pronounced, in my opinion.

Finally, Dr Ward, you talk about in your statement hopes of moving forward and about some things that you think are imperative if a new extended state-wide sub-acute unit is to be established in Queensland. Amongst the things you say that are important is there must be an onsite school facility, and you talk about not having an overly medicalised environment. What do you mean by an overly medicalised environment?---One of the things that came out in my research is that particularly for extended stays, the adolescents see that facility as essentially a home away from home. If we are to get the adolescents back on track developmentally, then the physical surrounds – the physical environment has to take that into consideration. For example, activities that are developmentally appropriate; own bedrooms; private space; all the typical and normative aspects of an adolescent's life should be, as much as possible, reflected in that hospital environment.

Thank you, Dr Ward. Commissioner, before I – before Ms Wilson asks some questions, can I just raise an issue that it may be necessary for the transcript to not – to be redacted, insofar as Dr Ward's evidence referred to [redacted]

COMMISSIONER WILSON: Does anyone else want to say anything about that?

MS WILSON: Yes, we agree.

COMMISSIONER WILSON: Alright. I'll have appropriate redactions made to the transcript [redacted]

MS MUIR: Thank you, Commissioner. Commissioner, I overlooked at the beginning of – when I referred you to Dr Ward's statement. Can I say that – could I take you to paragraphs 31 and 32.

COMMISSIONER WILSON: Yes. I have those.

MS MUIR: Can I tell you, Commissioner, I do not wish to rely upon these paragraphs and I request that they be struck out.

COMMISSIONER WILSON: Does anyone want to say anything to the contrary? Very well. Paragraphs 31 and 32 of Dr Ward's statement will be struck out.

MS MUIR: And I can tell you, Commissioner, that David – Dr Ward's statement is exhibit 135.

COMMISSIONER WILSON: Good. Thank you. Yes.

MS WILSON: Thank you, Commissioner.

COMMISSIONER WILSON: Yes, Ms Wilson, when you're ready.

EXAMINATION BY MS WILSON [2.35 pm]

MS WILSON: Dr Ward, can I just ask you just some questions so that I can better understand your thesis which was The Long Sleepover: The Lived Experiences of Teenagers, Parents, Staff and Adolescents at a Psychiatric Unit. As Counsel Assisting said, this was one of the first qualitative studies done of such a facility, an inpatient facility, isn't it?---As far as I know. Yes.

And has there been any other further studies, do you – are you aware?---In Australia?

Yes?---I don't know. Not that I've looked.

Okay, okay. So as far as you're concerned it's the first and the only study that has been done of a qualitative nature?---Thus – thus far.

Okay. Now, the thesis research question was limited to an inpatient setting, wasn't it? You have to actually to – you have to – you have to speak audibly so it's caught?---Sorry.

And then it's recorded on a transcript?---Sorry. Yes. That's correct.

Okay. And no other models of care were considered?---No.

Okay. And I noted when looking through your thesis that you yourself acknowledge certain restrictions and limitations that occurred by the very nature of your study?---Yes.

Okay. And the young people that you sampled were part of the Barrett cohort?---That's right.

Now – and you actually did this thesis when you were a social worker working at Barrett. That's where the – that's where it started, the seed started, and then it – the journey finished, I think, mid last year?---That's right.

Okay. And you have worked in adolescent mental health for the past 12 years primarily in an inpatient setting? Is that the case?---For eight of those years it was at Barrett.

Yes?---Prior to that, there was a short stint at Community Child and Youth Mental Health.

Okay?---Before that there was approximately four and a half years at Lifeline as a child and family counsellor. Before that it was another short stint at another child and youth mental health service.

Okay. So if we're just looking at the recent – your recent work, it has been in an inpatient setting at Robina, which is an acute unit, and at Barrett?---That's right.

Okay. Now, in terms of the sampling that was done of the patients at Barrett, that group was defined by the patients who were there. That's the case, isn't it?---Yes.

And, for example, it wasn't a random or statistically generalised cohort?---No.

And to be fair, because your thesis recognises this, it was not fully representative of the Barrett cohort as many of the Barrett patients didn't fully participate?---Yes. There was a number of – that refused and their wishes were respected.

And then, by looking at your thesis, and then it – through the process, some didn't continue with their participation?---That's right.

Okay. So the questioning of the participants was limited to their personal experience at the Barrett?---The participation – I tried to obviously extract as much data as possible. And all adolescents at that time were invited to participate. Collecting data was slower than what I initially expected and so all were approached. However, if they refused then their wishes were respected.

I think the purpose of my question is that the scope of the study didn't inquire into any other treatment settings. It was just what was occurring at Barrett?---Yes. That's right.

Okay. And you would agree that your findings are not necessarily dependent on the model of care. For example:

> *Themes of relationship building, recovery and resilience are present in all models of care for child and adolescent mental health and in all treatment settings.*

?---That's true.

And when – with questions – following questions from Counsel Assisting, you talked about individual treatment and care, and that also is something that is present in all models of care for child and adolescent mental health?---That's right.

And in all treatment settings. Okay. And so you would agree that your findings do not indicate that the Barrett model is the only way to promote recovery?---No, not at all.

Okay. And you're not an expert in strategic planning and mental health service delivery?---Not at all.

Okay. Now, in terms of – I just want to – this next series of questions focuses on the present continuing practice in mental health in Queensland at the moment. So can you look at it through that lens?---Yes.

Okay. Now, are you aware – now, you're working in an acute inpatient service?---That's right.

And that's at one end of the spectrum, isn't it?---Yes.

Okay. And that's at the – and at the other end of the spectrum is community based services, that is the CYMHS clinics. That's at the other end of – from the acute beds?---Yes. That's right.

Okay. Now, what is your experience of the other services that are provided in Queensland except for, obviously, your experiences in the acute inpatient settings?---Well, I can mention headspace, for example.

Yes?---Headspace – I had some private practice with headspace myself last year as a private practitioner. Not that I'm an authority on headspace by any means. I think headspace is fulfilling a niche there that – to reach those adolescents that don't need the focused care of sort of an inpatient unit or the community clinics.

With respect to young people with long term, severe and complex mental health needs, is it the case that the primary aim of the extended treatment and rehabilitation model of care is to provide an integrated continuum of care outside of an inpatient setting and as close to their home as possible? Are you – do you have any knowledge or expertise in relation to that proposition?---Sorry, could I ask you to be a bit more specific in terms of what you're asking?

Well, the – with respect to young people with long term, severe and complex mental health needs, is it the case that the primary aim of the extended treatment and rehabilitation model of care is to provide an integrated continuum of care outside of an inpatient setting and as close to their home as possible?---Yes. I'd have to say yes.

Okay. Now, in terms of the services that are presently available, can I just ask you whether you have any experience in dealing with these services: that is AMYOS which is the mobile outreach services which provides mobile assertive engagement and prevention focused interventions in a community or residential setting. Have you had any experience with those?---No.

What about the residential rehabilitation services which provides long term accommodation up to a year and recovery orientated treatment for 16 to 21 year olds who have moved out of the acute phase of the mental health illness but lack the skills or expertise for independent living?---No.

Day programs?---The closest thing to day programs were the number of day patients at the adolescent unit but, no.

Okay. And certainly not in more recent times?---No.

Okay. Now, are you aware of the proposed Step Up Step Down units which is a new service type for young people in Queensland which provides a Step Up service option to prevent inpatient admission for intense short term treatment and a Step Down option to assist early and seamless transition for the young people when re-entering the community following an inpatient admission?---I had a vague knowledge of that actually. I haven't looked at that in any depth.

Okay. And the subacute – your experience with subacute would be at Barrett. Is that the case?---Yes.

Okay. Have you had any – have you done any professional work at Lady Cilento's subacute facility?---No, I haven't.

Have you visited that facility at all?---No.

So you're not aware of the services that they provide?---No, I'm not.

The setting that its provided in?---No.

Okay. Just excuse me one moment, Commissioner. Thank you, Commissioner.

COMMISSIONER WILSON: Thank you. Ms McMillan.

EXAMINATION BY MS McMILLAN **[2.44 pm]**

MS McMILLAN: Yes. Thank you.

Dr Ward, you were the only social worker, you say, employed at the Barrett Centre in those eight years. Correct?---That's correct.

And one of your roles, if I could put it – perhaps the major role you performed was family therapy. Is that right?---Primarily, yes.

And you say in your thesis that you – can I just – sorry. I withdraw that. Over what period did you collect data for your thesis?---I can't remember the exact dates. I'm sorry. Look, it was over a period of approximately 16 months.

Right. And you say in your thesis that whilst collecting data you didn't yourself conduct therapy, did you?---That's right.

Right. So in that 16 months, there wasn't another social worker conducting that therapeutic role?---That's right.

Right. Thank you. Now, just in terms of the representation in your thesis, in terms of – this is – in the thesis – it's WIT.900.020.0235. It's page 207 itself of the thesis. Thank you. Just about – if you could go down a little further, please.

You see the paragraph that begins:

> *While the adolescents in this sample were representative of the BAC clinical population –*

you then point out alternative cultures were not available. So you say that the sample you received data – collected data on and conducted interviews were representative of the BAC cohort?---I believe they were, yes.

Right. So just so I can understand this, there were 13 adolescents that you interviewed for your thesis?---Yes.

And is it correct that those who you were of the view were not emotionally stable enough or not cognitively able did not participate, correct?---That's right.

And that's at page 0099, Commissioner, for your reference.

So immediately, that obviously lessens a certain amount of that population at BAC, doesn't it?---It does, yes.

And furthermore, out of the six males that you interviewed, three of them were on involuntary treatment orders, you record. Correct?---That's right.

And four out of the seven females were also on involuntary treatment orders?---Yes.

And you say yourself, don't you, that that wasn't a particular – these are my words – that – page 208. So if we go to the next one down, it's 236 around – down the bottom. Yes. So, secondly, three of the six males. This was not mentioned in a single narrative from any participant. It was not the focus, but I'd say – I understand

that clearly it's relevant if these young people are on involuntary treatment orders, isn't it?---Yes.

Because there are particularly – as you understand, statutorily mandated issues that apply?---That's right.

They're also, by its nature, involuntary patients?---That's right.

So you'd need to take that into account, one would think, in reflecting your data, wouldn't you?---As I've said, this interesting – in hindsight, I think I should have been more purposeful in openly bringing that issue into the – my questionnaire schedule. Nonetheless, it's interesting that none of them mentioned it.

Well, the fact that they might not have mentioned, that would, no doubt, you'd accept, be relevant in terms of you making sense of the data you collected, wouldn't it?---The exploration of what I wanted to find with – in my research, really, was left open as much as possible to the adolescent participants. And so if they chose not to mention a particular facet of inpatient life, then I accepted that.

But, for instance, it would tell you something about the acuity of their condition, wouldn't it, if they're under an involuntary treatment order?---Yes. Again, I wanted to let them verbalise what was the most important to them.

And, of course, there's regular statutory reviews, we know, of these patients, isn't there? There has to be?---Sorry?

Under the Mental Health Act, there needs to be constant reviews of their condition?---Yes.

All right. So that plays a part in terms, again, of their treatment, correct?---Yes.

All right. Now, in terms of the issues – as I understand it, the interviews generally were often under 20 minutes but certainly never any more than 30 minutes?---That's right.

And only, I think, two of the patients you went through to a third interview, correct?---Yes. That's right.

And can I take you, please, particularly to – you record in your thesis – and I might put it this way – at page 0045 – the importance of peer relationship, don't you, to adolescents?---Yes.

And clearly the development of relationships with peers is, I'd suggest, critically important for adolescents?---True.

But also on that page in your thesis, you talk about the importance of the attachments with family, correct?---Yes.

And is it also correct – just pausing there – that at page 0065, which is page 37 of the thesis, second paragraph – the main paragraph on that page:

> *No study could be located that explored adolescents' experiences of inpatient life over an extended timeframe of more than three or four months.*

So that was you discovered no study which went over three or four months?---That's correct.

Now, one of the themes that you develop – or you term it as a sub-theme was – and this is at 0158 – sub-theme 4: Barrett as a second parent. Now, just the title of that sub-theme – I take it that would sound a notion of a caution, wouldn't it, if Barrett is being viewed as a second parent, would it not?---In some – in some ways.

Well, some of the comments indicated, for instance, the next page – [redacted] who was a parent, wasn't she – I'm sorry. I didn't realise that had been redacted. I thought that was – could that be redacted? I'm sorry, Commissioner.

COMMISSIONER WILSON: Yes.

MS McMILLAN: Felt the parenting role was taken away at admission, which made communication crucial. When it didn't occur, it was a frustrating experience. So, for instance, that's an instance where certainly for a parent that was seen as a frustrating experience, correct?---Yes, yes.

But also you go on in the further pages to talk about how, in effect, that the parenting role was subsumed by the staff at the centre, correct?---More or less, yes. It was – it was quite a mixture of experiences for the parents.

And, in fact, you talk about them having to take up what might be seen as ordinary parental roles such as homework, those sorts of – and other discipline measures so that that, I take it, would be one of the downsides, if I could put it, about an extended stay, wouldn't it, for adolescent?---I wouldn't say it's a downside, no, because I don't think we should interpret the theme Barrett as a second parent overly negatively. The staff at the Barrett unit had the opportunity – as I've explained previously, the Barrett school had a chance to give a corrective emotional experience at an educational level. So too did the staff have an opportunity to give a corrective emotional experience at a parental level, as well. Some of these - - -

COMMISSIONER WILSON: Are you saying a corrective emotional experience?---Yes, Commissioner. Yes.

Thank you?---So my point is that the – some of these parenting tasks the staff undertook were often very therapeutic for these adolescents.

MS McMILLAN: Do you think that there was at times a conflation of the roles, that is, a role as a staff member as opposed to a role of a parent?---Sometimes there's a very fine line. Yes.

And I take it that the longer the stay, the more entrenched that might become?---That will differ from staff member to staff member, adolescent to adolescent. Not necessarily.

But in terms of issues in relation to – you talk about the reflectivity of staff members – the issue is that that is – as you say, if they are seen as a second parent, inevitably that attachment must be disrupted, mustn't it?---Yes.

Which, particularly if an adolescent has had a disrupted early life, particularly disrupted attachments with family, then that's a further loss to them, isn't it?---It can be, yes.

And one of the other aspects is page 162 of this witness document. You identify – and it's a direct quote:

> *I think those stay here too long get worse. And, like, a particular patient – she had an eating disorder, but when she left was worse. I think she overstayed her accommodation.*

There are a number of comments such as that, aren't there?---Yes, there is, yes.

And further:

> *Yes, I think maybe they become attached to us.*

Just below that. So that that, I take it, played a part in your view of interpreting the data, the fact that they stayed too long from a number of comments of staff?---On some occasions, yes.

And then further, at 211 of that document you identify again in another quote that – perhaps axiomatically, that it would be:

> *I think this becomes a safe place for kids, okay. If it's safe, they don't want to leave, and then they often sabotage their treatment.*

So I take it that must have been a real factor for you to consider as well?---Yes.

And you refer a number of times to – if I can put it this way – this is the term you use, "contagions of harm", too, don't you?---Yes.

Alright. So I take it, bearing all of those things in mind, you nonetheless advocate – and you use this word at page 230 of your thesis – for a longer term residential facility?---Yes, I do.

And you say that you adequately took into account all of those factors I've identified with you in my questions to you; correct?---Yes.

Thank you.

COMMISSIONER WILSON: Anyone else wishing to ask questions? Ms Muir?

MS MUIR: No re-examination, thank you, commissioner.

COMMISSIONER WILSON: Alright. Thank you, Dr Ward. I'll formally stand you down. I don't expect you will be recalled, but there is always the possibility?---Thank you.

WITNESS EXCUSED **[2.58 pm]**

MR FREEBURN: I call Dr Lesley van Schoubroeck.

COMMISSIONER WILSON: Thank you.

LESLEY VAN SCHOUBROECK, AFFIRMED **[2.59 pm]**

EXAMINATION BY MR FREEBURN

COMMISSIONER WILSON: Thank you.

MR FREEBURN: Dr van Schoubroeck, you've signed two statements in the – for the Commission; correct?---Yep.

Can I take you first of all to the Act. You'll be familiar with your act, which is the Queensland Mental Health Commission Act of 2013. It's document number COI.015.0001.0001. Thank you. And if we could just scroll through to section 11. Now, I should be fairly short with this, Doctor, but section 11 sets out your functions as the Queensland Mental Health Commissioner?---Yes.

And there's a strategic element to that?---Yes.

And there's also a – if we look at (1)(h), for example, a supporter in promoting the general health and wellbeing of people with mental illness?---Yes.

And if we look at (k), to take other action that your Commission considers appropriate to address the needs of relevant persons?---Yes.

And that's mentally ill. The mentally ill?---Yes. Amongst others, yes.

Now, and if we look at (2), in exercising your functions – (2)(d) particularly – you are to engage and consult with people with mental health or substance misuse issue and their families, carers and support persons; correct?---Yes.

And to take into account in (e) the particular views, needs and vulnerabilities of different sections of the Queensland community?---Yep.

I take it it is within your power and your capacity to make recommendations to government or Queensland Health?---Yes, within the objects of the Act, yes, and the functions.

And to make suggestions as to how things can be done better?---Yes.

To give advice to the government?---Yes.

And that is assisted by your power to consult?---All our advice would be based on some form of consultation, yes.

Yes. Okay. Now, I want to now take you to paragraphs 10 and 11 of your affidavit – sorry, your witness statement. Sorry, it is an affidavit. Yes, it's your first witness statement, so hopefully it'll come up on the screen shortly. So if we can scroll through to pages 3 and 4. So just to refresh your memory, Dr van Schoubroeck, you'll see there that this is where you – first of all, in paragraph 10 you talk about receiving a confidential briefing?---Yes.

And this is actually in the month before you started the position?---That's right.

And it's clear from this that the decision to close the Barrett Centre had already been made and you were being advised of that?---Yes.

But there was no date set for that closure?---No.

Now, if we look at paragraph 11, we see that you got a brief – another brief from the department enabling you to answer potential questions?---That's right.

Okay. So – and you – you exhibit it, but you got a written brief as well, a briefing note to you. I think it's exhibit F?---The briefing note. Yes, that came through about then, yes, two weeks after I had arrived.

Yes, you're quite right. 18 July. Now, did you receive information from Dr Leanne Geppert to enable you to respond to some of that information – to some of the queries? Did you get briefings from her – from Dr Geppert?---I don't – not quite sure. I don't think it was from Dr Geppert. I – most of it was written. It was a busy time. We were getting ready for estimates. We'd been there for two weeks and I

was concerned about those things which were within my ambit in terms of strategic planning across government and to those things which were already operational.

Alright?---I do recall the written paper. I'm not sure that I had a verbal briefing from anyone in those first couple of weeks.

And so that would include – that is, you don't recall conversations with Dr Geppert or Ms Kelly or Ms Dwyer?---I did have conversations with them but I'm not quite sure that it would've been in July. I doubt very much it would've been in July.

Alright. And what about later on in September once the initial flurry – because you went on leave in August. Is that right?---Just – right. In August I had pre-planned leave which I took and I know many letters came from families during that period and they were responded to, giving them some understanding of the scope of the role of the Commission.

Alright. And was – what I'm putting to you is one of the reasons why those three people or others were briefing you was to enable you to properly answer the questions and concerns and letters that you were getting about the Barrett Adolescent Centre?---My meeting with Lesley Dwyer, which probably would've been in September/October, was a – one of meetings I had with most of the – all the ..... that I could catch up with in that time. I was systematically meeting all of them and introducing myself to them not specifically around the Barrett, although I suspect it would've been on that – I'm sure it would've been because it was in the press and there was an expectation in the press that I would – I had the power to overturn a decision that had been made.

Alright. Okay. We'll come to that. Can I just take you to the document DDK.001.002.0037. So if we scroll down it's one of those – Dr van Schoubroeck, it's one of those email chains. So you have to start at the bottom. So just stopping there. Scroll back up. So this email chain starts with an email from you to Dr Cleary and Ms Kelly?---Yes.

And this is 30 July 2013?---That's right. That's the day before I went on leave. Yes.

Sorry?---The day before I left the country. Yes.

Right?---Hence the urgency.

Well, you say there that you're inundated with emails re the Barrett Centre and you're under pressure from the media. And you say you're crafting a response with Queensland Health media people. And then you describe some of the features of it. And then you say:

Are there any particular messages you want reinforced or stayed clear of?

?---Yes. I can explain the context for that. I had no media staff appointed at the time. My overriding concern was clearly there were families who thought I could override a decision which they disagreed with. My view on that decision wasn't relevant. They thought I could override that. My concern was not to give them – to not give them an impression that I could change something when a decision has been made. The overriding concern being there are families who are very unhappy. You need to give them hope that this solution is the best solution. There are probably also families who are actually very silent in this process who would like to see the matter progress. So I was making sure that any messages were consistent with what had already been decided and did not give people an undue expectation to mislead them. I would rather them feel badly of them than I misled them when they were so concerned about their children and the decision and its implementation.

Alright. But none of what you've just said appears in that email, does it?---No. Emails tend to be this is where I'm at. No, it doesn't. But that was clearly, through all my actions, my overriding concern.

I see. I want to take you now to paragraph 35 of your witness statement, your first witness statement. So if we can scroll to the – to page 9 which should be .0009. Can you see paragraph 35:

> *When any concerns were raised with me or my office I advised senior Queensland Health officers.*

Now, that would've been normally Dr Cleary or- - -?---That would be Dr Cleary or Dr Kingswell.

Continuing:

> *I was verbally assured by Queensland Health that there was a well resourced plan for each young person.*

?---Yes.

Did you see any plan or was it just an assurance that you took from them?---It was simply an assurance. It would be inappropriate for someone outside the clinical system, I think, to see the detailed plans of anyone who was being treated in the system.

Well, we're not necessarily talking about individual treatment. We're talking about- - -?---But, no, I didn't.

Alright. Alright. So – and I take it from that paragraph that those verbal assurances given by Queensland Health were accepted by you?---Yes.

Now, if we go back a little in your affidavit, you'll recall in your affidavit you talk about a meeting. Now, I don't want to identify – let's see if we can do this without

closing the hearing. So I don't want to identify any of those people. But I gather you had a meeting with three people on 11 September 2013?---Yes.

And there were, I gather, two people – two teachers aides – who were proposed to come to that meeting but didn't. Correct?---I understand they were teachers aides. Yes.

And I gather that you said before they arrived to whoever was arranging the meeting that their presence at a meeting with you would become a matter of public record?---What I would've said to them – because as a principle in public administration, if you work for an agency you don't during your work time speak out against the policies of that agency. What I would've said is, yes, possible that what you say may become a matter of public record. It will be subject to RTI. So given that they were teachers aides and I was – assuming I was a much more experienced public servant, I thought that I should just let them know that this may be the case. They would, therefore – one would expect they would, therefore, either decide not to come or check with their employer. Or perhaps they were coming in their private time. I didn't know. I didn't tell them not to come, I just gave that message that they might want to be aware of that.

See, I gather that your – you commenced that recollection by saying "I would have". Does that suggest that you don't actually have a recollection of the conversation and that you're assuming this is what you would have said? Or do you have an actual recollection?---I don't have a specific recollection. I think that I asked – I asked the person arranging the meeting to pass that message on. I don't believe I spoke to them directly myself.

Alright?---In fact, I'm sure I didn't speak to the teachers aides directly myself.

Yes. So is your concern that they may have been in breach of their contract or in breach of their employment terms by speaking to you?---My concern was as a public servant that these people were employed by the public sector and as teachers aides might not be as aware as I am that there are some matters in terms of code of conduct and ethics in terms of when you agree or when you speak out against public policy. And one doesn't do that during the day in which you're being paid to work for the government. That's just a matter of good practice in the public sector. Had they – had the employee been – had they been doing it in their spare time, that was a call for them, but I would advise any enterprising person in any public – any organisation, be it public or private, that you don't speak against the policy of the agency while they're paying you to do your job.

You see, it would rather limit your role as the Queensland Mental Health Commissioner if you weren't able to do a consultation with public servants in the normal course?---There's a difference, I think, between consultation, getting people's views more broadly, and certainly if you're consulting with staff during work time, then their employer has said you may use this work times. Otherwise, they do it through professional groups in other ways. But certainly if you're paid to do a job,

that's the job that you do. But I have had numbers of consultations with staff, and, generally speaking, they speak their minds, but they do that in the context of ethical practice, where their employer said feel free to take part in this consultation.

I'm just trying to distinguish between, say, the situation where you speak to Dr Kingswell and you speak – if Dr Kingswell is upset about a particular government policy and he comes to you to talk to you about his annoyance at that policy, what's the difference between that situation and talking to a teacher's aide who might be concerned about a particular government policy?---I think you'll find the role description for Dr Kingswell is quite different from the role description of teacher's aide.

But you don't check any of that, do you?---No, I don't, but I was a teacher once and I'm fairly aware of the roles of teachers and other people in service delivery roles across the public sector, as opposed to people in management and policy positions, where part of their role is to get a better understanding of policy and how it's implemented.

Alright. So you were concerned that these teachers aides – teacher aides may well be in breach of their contract of employment?---I – I thought that they might want to think about it, yes. I don't know what their contract was, but I think one has a responsibility to alert people in service delivery positions who don't spend a lot of time reading public administration legislation and policy.

Can I take you to exhibit I in your affidavit. It's – for the operator, it's at page 0072. Now, let's put this in context. Ms van Schoubroeck, I'll come back to that document for a moment – come back to that document in a minute. When we – when you talked about being inundated by calls and letters and things, is it right to say that that inundation involved at least two categories of things: firstly, people who are complaining about the decision to close the Barrett Adolescent Centre; and, secondly, people who were complaining about the speed at which it was being done or the lack of transition?---Yes, I think there were two issues. One was the decision and one was the implementation of the decision.

Alright. And that – you describe it in the email as an inundation. You received a lot of correspondence about that; correct?---Yes, but not – yes, inundation in context of the size of the office and what we – where we were set up to do.

And to do – to deal with that correspondence, it's accepted practice and it's normal public service practice to have effectively a standard response that you adapt for each person?---Yes.

And this exhibit is one of those sort of standard responses; correct?---Given it's the 21st of August, I probably didn't sign that, did I?

No. It's just – it's signed by Dr Hughes?---Yes.

But I just wanted to take your attention to a fourth – to draw your attention to a fourth paragraph in that letter?---The one about "I am aware that there has been ongoing debate"?

Yes?---That one? Yep.

Now, that paragraph or something similar appears in a standard document – I can take you to it, but a standard document that was prepared and discussed by you, I think before you went on holidays. Do you recall?---The words look similar to what I'd say, yes.

Alright. So I just want to ask you about this sentence in the third line – second line:

> *The Commission –*

that's your commission –

> *does not have the mandate or authority to make decisions regarding individual services.*

Now, what were you – you certainly didn't have a decision-making power; correct?---That's right.

But what were you referring to by talking about individual services?---The adolescent Barrett service is a specific service designed to achieve an outcome which is better health and wellbeing for young people, as close as home to is safe – as is safe.

Well, then in the next sentence you say:

> *Our role is to provide strategic advice to government regarding the types of services required in Queensland, and, in doing so, to balance community expectations, personal experience and professional expertise with contemporary evidence to shape and guide reform.*

Is it being unfair to describe that as effectively saying to the interested stakeholder, "Look, I'm more concerned with strategic level issues, and I can't do anything about individual services"?---I think I need to reflect the purpose for which the Commission – it's the honest thing to do. That's what we were established to do. We were not established to – resourced, established or expected to have the oversight and design of specific clinical services. That's the role of the Queensland Health, which is the system manager.

Alright. So your consultation with the community that's talked about in the Act - - -?---Yes.

- - - is limited to strategic things, is it?---It's limited to those things from go to whoa, from birth to death, and from where people are, be they in schools, be they in prison, be they in the workplace. So it's mental health and wellbeing across the spectrum, which is a very high expectation, so you have to sample quite strategically, if I can use that word again.

But correct me if I'm wrong, but this paragraph is really saying to the person, "I'm sorry, we are not – we don't have a decision-making power and we don't have any way of helping you"?---My overriding concern there was to make parents who clearly thought when the Commission was established it would be able to change a decision which was imminent – that wouldn't have been in their interests or in my interests, so as I said before, I was quite concerned to make sure that they understood that I was not in a position to override that decision, and I was not overseeing its implementation. Whether they thought I was powerless or thought badly of me was beside the point. The point was to show people where they could go; make sure that they focused their energies if they thought they could do that in the right direction. I did not want to mislead anybody.

Dr van Schoubroeck, you certainly had no decision-making power about this service?---That's right.

But you had the capacity to give advice, make a recommendation, say to the government, for example, "Let's pause and have a look at this issue"; correct?---Yes, I had that power.

COMMISSIONER WILSON: Keep an eye on the time, Mr Freeburn. Five minutes.

MR FREEBURN: Yes, thank you.

I'll just move on. Now, if we go to paragraph 23 of your first witness statement. There, you say you have monthly meetings with – from February 2014 onwards, you had monthly meetings with Dr Cleary and Dr Kingswell?---Approximately every month. Sometimes individually and sometimes separately because we were all busy.

Okay. Now, I just want to get your commentary on this. On the one hand, you have monthly meetings with senior people from Queensland Health?---Yes.

When the press were involved and there was questions of messages, you were asking Queensland Health whether there were any messages they want reinforced?---In the first month, absolutely. Not wanting to mislead people.

And you accept the verbal assurances of Queensland Health. We've covered that?---I had no reason not to.

All right. But on the other hand, when the stakeholders meet with you, you're effectively saying you've got a strategic role and you can't overturn the decision?---I

think my role is to actually – if I hear things from the community which I think the public system is not hearing, is to reflect that and quite clearly because it was in the media they were hearing the same things. I – I guess in asking for that reassurance was just to be clear in my mind that – so if it was raised with me again [indistinct] I could look them in the eye and say, no, I have checked. I am assured that funding is available.

Dr van Schoubroeck, you understand the point I'm making. The point I'm making is ordinary members of the community looking at this situation might be concerned that your consultation with Queensland Health is close and trusting, if I can abbreviate it like that. Correct?---You can say that.

And your relationship and consultation with the community is less close and less trusting?---I trusted the community. I knew what they were saying, and I said that [indistinct] but they absolutely believe they have not been sufficiently consulted. What I didn't want to do was to have them think that I was in a position to overturn the decision that had been made.

I see. So – all right. Can I take you to another document. Now, I haven't given – Commissioner, I haven't given the parties notice of this. It has only recently come to our attention. But I don't think it will be controversial. The document is QHD.008.004.5176. Now, we need to go to page 5180. I think we've gone a bit too far. If we go back one – two pages. There should be [indistinct] there it is.

So it's a letter from you to Dr Cleary on 14 April last year. And you attach a government – a document prepared by your office called Government Policy Commitments – Opportunities to Improve Mental Health and Wellbeing Issues Paper?---Yeah.

Do you remember that?---Yes.

And if we just go quickly to the issues paper. I want to quickly go to the second page of that issues paper, which should be two pages on. If we scroll down a bit. See on the right-hand side there's a heading Rebuilding Intensive Mental Health Care for Young People?---Yes.

And it talks about the establishment of a tier 3 facility with an integrated school in South-East Queensland. Is that something your office looked at?---That's the government's pre-election commitment. And that's a clinical service. That's very much in the clinical services plan, which is the responsibility of Health.

Okay. So the bold first paragraph is the government commitment?---It's the government's pre-election commitment. Yes.

And then there's commission comment, which is your office's comment?---That's right.

Okay. And we can read that, but you're effectively saying that if you do this process, then it should be community-based and close to the - - -?---With beds where necessary but as close to home as is safe.

All right. All right. Thank you. That's all I have, Commissioner.

COMMISSIONER WILSON: Thank you. Does anyone else wish to ask Dr van Schoubroeck any questions? Ms Wilson?

MS WILSON: Dr van Schoubroeck is represented by Crown Law, so I think I should go last.

COMMISSIONER WILSON: Very well. What about you, Ms McMillan?

MS McMILLAN: No. I don't have anything. Thank you.

COMMISSIONER WILSON: Is there anyone else who wishes to ask her questions? Ms Wilson.

MS WILSON: I've got no questions, Commissioner.

COMMISSIONER WILSON: I take it there's no re-examination, then.

MR FREEBURN: No.

COMMISSIONER WILSON: Thank you, Dr van Schoubroeck. You can stand down.

WITNESS EXCUSED **[3.31 pm]**

MR FREEBURN: I think we've run out of witnesses.

COMMISSIONER WILSON: I think you have run out of witnesses. Is there anything else you want to cover this afternoon?

MR FREEBURN: Not from me.

MS WILSON: Not from me, Commissioner.

COMMISSIONER WILSON: Very well. Will you be in a position to proceed at 9.30 in the morning?

MR FREEBURN: Yes.

COMMISSIONER WILSON: Would you adjourn, please, till 9.30 in the morning.

MATTER ADJOURNED at 3.31 pm UNTIL TUESDAY, 16 FEBRUARY 2016