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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

9.31 AM, WEDNESDAY, 2 MARCH 2016

Continued from 1.3.16

DAY 18

RESUMED **[9.31 am]**

COMMISSIONER WILSON: Good morning, ladies and gentlemen. Yes, Mr
5 Freeburn.

MR FREEBURN: Commissioner, first of all a housekeeping matter.

COMMISSIONER WILSON: Yes.

10

MR FREEBURN: Can I hand up a list of exhibits tendered yesterday with provisional exhibit numbers.

COMMISSIONER WILSON: That's been circulated to the other parties, has it?

15

MR FREEBURN: It has and I think I got most people.

COMMISSIONER WILSON: Very well. I'll adopt what's become the usual course. If nothing has been said about it by lunchtime they will be given the
20 numbers that have been provisionally assigned to them.

MR FREEBURN: Thank you, Commissioner.

COMMISSIONER WILSON: Thanks, Mr Freeburn.

25

MR FREEBURN: Commissioner, we have Professor Patrick McGorry in the witness box.

30 **PATRICK McGORRY, SWORN** **[9.32 am]**

EXAMINATION BY MR FREEBURN

35

MR FREEBURN: Professor McGorry, I just want to ask you a few things. In paragraph 39 of your statement – if we quickly go to that?---Yes.

It's on page 12 of the document. Scroll down a bit further. You talk about – first of
40 all in the first you talk about the prevailing philosophy of community-based rather than institutional treatment. Then you talk about the concept of institutionalisation. Can you explain that concept?---Well, the concept of institutionalisation describes what happens to human beings when they're – when they spend a period of time in a relatively closed institution such as a hospital or a mental hospital, a prison, a
45 convent, a monastery. People – there are certain effects that that has on – on people and they become less able to function independently and a whole lot of other negative effects which led to a major reform starting in the middle of the last century

which saw, I suppose, and particularly in this case the downsizing and – and – and in many cases closing of the old 19th century mental hospitals. And unfortunately as I – I don't know if you want me to go on about this but - - -

5 Yes, please?--- - - - what – what then happened in every developed country was a complete failure to provide the appropriate community services to make those older institutions unnecessary.

Right. You talk then in about the fourth line of the field being beset by either/or
10 thinking. What's the either/or? What's the - - -?---Well, the either/or here is hospital versus community and – and to get that shift to the community, reformers and advocates going back, you know, several decades – and it's still continuing – had to really sort of create a – what is really a false dichotomy that you can – you can do everything in the community and – and – and beds are sort of unnecessary. And that
15 actually also played into the hands of governments because they were able to then provide inadequate numbers of acute beds as well let alone long-term beds. So we've got a very bad situation as a result of this either/or thinking that the community is the total solution and – and on the other hand that – one and the same – same argument that beds are therefore bad but – and – and what has actually
20 happened is the community – the community investment has really been inadequate and is actually shrinking so we've got a disastrous situation actually in mental health now.

So I might paraphrase – if you forgive me for paraphrasing – but a more mature
25 debate involves both concepts - - -?---In balance.

In balance. Of beds and community care?---Yeah. And different types of beds, too, which I think you've probably already been discussing. So you need acute beds. We saw this in the media in the last couple of days in the Northern Territory where they
30 did provide some new beds for young people but they – they still didn't have the full range of beds so a very acute patient had to be put in an adult ward so that caused some controversy. So you need a spectrum of beds from very acute through to recovery-orientated and – and rehabilitation and I think – yeah. So that's – that's the – it's not just one type of bed.

35

And you're aware, aren't you – and I think from your statement you describe this – or sometimes we've called the Barrett cohort – but you've described them as a group of severely damaged emerging adults. You've set out, I think, the types of mental illness that these young people suffer from. For that cohort, what sort of mix do you
40 need?---Well, in an ideal world you'd need everything from primary care right through to, you know, very specialised tertiary facilities with everything in between. I think I've listed some of those – those options. There's probably three different types of beds would be necessary at different points in their – in their illnesses and – and course and – and there's several types of community-based services ranging
45 from primary care and the best example of that is the headspace model that we're – that's been developed in Australia in the last decade. And you know, but some – some people would need at different points in time more intensive case management,

assertive community treatment. Home-based acute care would be another option in an ideal world. But sadly, you know, this spectrum of options is – is rarely – rarely available and – and you're lucky if you've got one or two of those available in the community so that means that, you know, I suppose that there's pressure back onto
5 the acute and – and longer-term sort of end because – because other things haven't been done.

And then you say:

10 *My view is that longer inpatient admission is always likely to be necessary.*

What you're saying is likely to be necessary for this – the Barrett Adolescent cohort?---Well, I think – I think for some of them you could – you probably always are going to need that option. The actual number can be shrunk quite considerably if
15 all of the other elements are in place.

Right. Can I deal with another topic. We talk about evidence-base – I gather from what you've said that evidence base is a difficulty in this area?---Yeah. Well, of course, evidence base is – is becoming a rapidly devalued term, isn't it, because
20 everyone uses it for everything that they're trying to justify but I'm – my definition of it is as a medical researcher – and I've spent most of my career trying to develop the best possible scientific evidence for what we actually do in – in psychiatric care – and you know, there's a hierarchy of evidence so – so you know, the level 1 Cochrane evidence from the Cochrane Collaboration would be – if you had more
25 than one randomised control trial so that you could actually do a sort of a synthesis of a range of clinical trials to support what – what you were advocating or proposing. That's a challenge anyway and there are lots of areas of – sorry, I thought I'd turned it off – they'd – that's a challenge even – even – a lot of the things that we – we do haven't got that level of evidence and therefore you have to drop down and – and
30 there are other types of trials and studies that can be done that give you an indication of what is probably the best available treatment or best available approach. And when you get to health services, you know, research – when you get to trying to work out what's the right model of care for people, that's the most difficult thing to get high level evidence for because you have to be able to manipulate pieces of
35 infrastructure and – and systems of care which governments, you know, don't necessarily cooperate that well with medical researchers to do that so – so you can't actually get the highest level of evidence for health services. And then you just have to rely on – on I suppose, more descriptive studies and – and expert consensus – that sort of lower level of – of evidence according to Cochrane.
40
So is the problem – is one of the problems with the higher level of study the difficulty with having a comparator?---Yeah. Yeah, that's right because – and especially when you – when you're dealing with, you know, a small – you know, the tip of the iceberg but the sort of population we're talking about here. They're not
45 that numerous in a – in a sense and – and it's not – they're – they're a group that have got a whole range of problems too so they don't fit into neat diagnostic categories that you can just compare one group with the other. So it's extremely

challenging to get really high level evidence for this group of patients. You can extrapolate evidence from other, you know, overlapping groups and try to apply them to the treatment of these patients but that's probably the best you can actually do. And you can also look at models in other parts of the world which may have
5 been evaluated and compare. And, yet, you know, for this particular group of patients there isn't a great deal of really good international research. I was just discussing that with a colleague from the UK yesterday.

The – can I deal with another topic. You deal with what we call the alignment issue.
10 And perhaps I can short circuit that. Is – how do you deal with the alignment issue? How – is it a way – is one method to effectively overlap your services so essentially you have a service for 18 to – for 13 to 20 year olds, rather than 13 to 18? Is that the way to do it?---Well, this whole issue is in a state of flux and reform. There's – it's starting to be an international field that's developing, youth mental health. And it's
15 transcending the old divisions between child and adolescent mental health and adult mental health. And Australia has played a very prominent role in that with the sort of prototype program being headspace. It's done that from the primary care end. So we have programs that cover the 12 to 25 age group. It's a lot easier to do that in primary care because you don't have these silos of care that you have in more
20 specialised, you know, State funded care which use the benchmark of 18, you know, for legal and educational reasons rather than for health or developmental reasons. So they've got nothing to do with the needs of the patient, you see. It's got to do with, you know, the age of being able to vote or, you know - - -

25 So is there a solution for trying to deal with that problem in – and setting aside headspace and dealing with a more – the Barrett cohort type, is there a way to deal with that?---Yeah. Yes. Yeah. I think there definitely is. And, I mean, just to just – before – if I just return to the previous point, the reason this is necessary is because young people do not become adults at age 18 in terms of their capacity to be mature,
30 independent adults. That's been a change from several decades ago. That was much more the case in the past. It's definitely not the case these days, mainly for social and economic reasons. And particularly for these kids that have got mental health problems, because they've been developmentally delayed by virtue of having depression or psychosis or whatever that combination of problems they have. So
35 they are definitely not ready to be treated as independent adults. So you cannot have a system of care in mental health that just regards the 19 year old as the same as the 35 or 40 year old patient. And that's what patients face with this current system. They get – they face the prospect of being cast into a system of care which is quite – it's struggling in itself and it's orientated around the needs of middle aged people.
40 And so it absolutely doesn't work for them. So you have to create a system that's capable of looking after young people from the point of – from the time they go through puberty and start to become adults until they finish that process, usually these days in the mid-20s or late 20s even. And we have developed systems of care at Orygen in Melbourne for this more specialised cohort. We have been doing that
45 for 15 or 20 years and we realised we needed a primary care version of this, which became headspace. But we still haven't been able to building most State jurisdictions, a backup specialist system for this wider cohort of patients. But that is

our goal and that is what is going to happen. That's what we're working on with our colleagues in other countries as well. So that's what I mean by saying it's a changing landscape of care.

5 Alright. You talk about a full range of community supports further down that paragraph. What does that mean? Can you explain that? So at the bottom of paragraph 39, on the screen you should be able to see it?---I see. Yeah. So I think the number of people needing the type of unit that the Barrett was – and I've obviously said elsewhere in the statement that it was not in an ideal setting by any
10 means. It was in a very stigmatised old-fashioned sort of setting. So – but let's say it was a purpose built unit in a good setting, in an appropriate setting. The number of people using – needing to use such a facility would be less if there were the full range of services available in the community and other forms of care. And, also, the length of stay would be able to be a lot less. I think the long lengths of stay were just
15 a kind of a testament to the fact there was nothing else for these kids or very little else for them.

Is what you're saying that there's a big – there was then a big jump from – for a patient who was staying at Barrett to what other service they might go to?---Yeah,
20 yeah. And they were an especially marginalised and disconnected group from what I read of the types of individual cases that were described in the material I was provided with.

Right?---And people may have been critical for the length – about the lengths of stay
25 but you just look at what else would've been possible for them and, very little.

Right. Can I just deal with one more topic. You're aware that the Barrett Adolescent Centre was closed. And you've commented on that towards the end of your statement. What kind of planning ought to go into, I think as you describe it,
30 deinstitutionalisation? That is, effectively, emptying out the institution?---Yeah. Well, I lived through that in Victoria in the 1990s when all the major mental hospitals were closed within about a two or three year period. It was a massive transitional process. And that meant people that had been in hospital for not just two years, but maybe 20 years, had to be moved into community settings. And so these
35 community settings were established. In some cases – or in many cases, new facilities were built and new teams, new community based teams were funded and set up. There was tremendous planning involved. And even to the individual patient level. It was an incredibly professional process. And, you know, I think even though since we've seen erosion of those services, it hasn't kept up with population demand
40 so it's not as good as it was initially, the actual transitional process was handled better than anywhere else I've ever seen.

So what are the features of the sort of planning that would be desirable in this situation?---Well, this is – this should've been very simple. There was a very small
45 number of patients. You'd only have to build one new facility if that's what was going to be required. And some of the patients quite possibly could've been placed

in community settings but that could've been done with great care. I don't actually know the details of what happened with the planning. But - - -

Alright?---But I would've thought, when you compare it to the sale of what
5 happened in Victoria, it was able to be done fairly safely and professionally and with the lowest possible risk. This is not a very big job.

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

10 COMMISSIONER WILSON: Cross-examination, Ms Wilson?

EXAMINATION BY MS WILSON **[9.50 am]**

15

MS WILSON: Yes. Thank you, Commissioner.

If I can just take you to paragraph 5 of your statement. And you can just scroll back up?---Yes.

20

You referred to, in your evidence, about the material that you were provided with. Can I just confirm what you actually were provided with when you gave your statement and what you actually have been provided, may have been provided, since giving your statement and giving evidence here today? We see those four things that
25 are - - -?---Yes. I was provided with those documents.

Yes?---And I haven't been provided with anything since.

Okay. In terms of the services that are presently available or being planned for
30 Queensland, do you have any idea of the detail of those services?---Well, just from those documents that are mentioned there, they were fairly sketchy, actually, so I'm not – what's the word – familiar in detail with what currently is on the books.

Okay. We talked about – you've given evidence, and it's evident in your statement
35 about the continuum of care. You talk about the continuum of care?---Yes.

At one end you've got services that are offered in the community of CYMHS, and then you've got acute beds, and then there is the continuum of care in between that - - -?---Yes.

40

- - - that needs to be filled out by the services. Are you aware of the AMYOS service, which is the Assertive Mobile Youth Outreach Services? Now, I ask these questions, I appreciate, in the context that you said you have very little knowledge, but I'm just wondering if - - -?---Sure.

45

- - - any of these may trigger some - - -?---Yeah, I am aware that that has been considered. I'm not sure – I wasn't – I'm not aware of to what extent that already is

in place. But that is based on something that we saw established probably over the last decade in Victoria, the IMYOS model, which I actually worked on myself, clinically.

5 And also when you talk about resis or residential services, you're not sure about the detail of the residential services that are provided in Queensland?---I don't know the extent of that, yes.

Day programs I think is a term that is used across borders?---Yes.

10

But, again, going through the detail, you're not aware of the services that are provided?---Not the extent of it, no.

And then there is a proposed service of Step Up Step Down units, which provides a 15 step up service option to prevent inpatient admission through intense, short-term treatment, and a step down option to assist early in seamless transition?---Yes.

Are you aware of that concept?---Yes. Yeah, we have those in Victoria.

20 But, again, you're not across the detail of what is proposed in Queensland?---No.

Okay. And then before you get to acute beds, obviously there's subacute beds?---Yes.

25 And that's a part of the continuum?---Well, I think subacute beds and Step Up Step Down are more or less the same thing.

Okay. And it's an understanding of how all of these services work that is essential, isn't it, in planning?---Absolutely, yes, yes.

30

Now, just if you can assist me, Professor, you talk in your statement about an emerging adult population aged 12 through 25. You'd be familiar with the National Mental Health Service Planning Framework?---Yes.

35 Can you assist me: is the age range of 12 to 25, is that recognised within the National Mental Health Service Planning Framework?---It's not recognised yet, but that's – that's what I meant by – this is a work in progress. Obviously, some reforms in Australia within the national mental health context have moved beyond the barrier at 18, and some haven't.

40

You were asked questions about the alignment issue, and the questions from Counsel Assisting were on the basis of, look, how do you deal with that. Can I suggest that what would be – would – before determining what services may be required to address this youth patient group in Queensland, a service mapping exercise should be 45 undertaken?---That'd be a good first step.

Which would identify the similarities and differences between current services, the ones that are available in the child and youth mental health services, and the ones that are involved in – available in adult services?---Yes. I assume that that information is already available, though, to the government.

5

And but looking also for the – identifying the service needs for specific age groups?---Well, yes, that would be good, a needs analysis, yes.

And identifying any potential gaps in the service delivery?---Yeah, and I think I
10 provided a UK-based study which would provide a methodology for how to do that, at least insofar as transitions from CYMHS to adult would be – how well that's working. That's a very limited perspective, but it would show the extent to which problems exist around that transition point.

15 Okay. And what – would it also be worthwhile to do a similar mapping exercise to identify services available and any potential gaps with respect to young people who experience mental illness with a co-existing disability?---Yes.

Thank you, Commissioner. They are all the questions I have.

20

COMMISSIONER WILSON: Ms McMillan.

MS McMILLAN: Yes, just a few questions, thank you.

25

EXAMINATION BY MS McMILLAN [9.56 am]

MS McMILLAN: Professor, can I just clarify in relation – you were asked about
30 paragraph 5. Which statement of Dr Sadler were you provided with? Do you know the date?---Not off the top of my head.

Right. Okay?---I don't have it with me, I'm sorry.

35 And the draft model of service for – and I'll just call it Redlands in a nutshell?---Yeah.

As I understand the thrust of your statement, you say it was somewhat difficult to really assess it, because you were seeing it in isolation?---Yeah.

40

So it would've been helpful for you to see, I imagine, minutes of the group working up to that model, other contextual documents, wouldn't it?---It was hard to get a clear picture, and I understand it didn't happen.

45 Right. And when you – although you say you were asked to review the following, including Dr Brennan and Professor Crompton, I see only that it seems you analysed

Dr Sadler's and the draft model for Redlands, correct? In the body of your statement?---I think those are the only references I've made to these documents, yes.

Yes, thank you. Paragraph 46, please. It's 0015. Paragraph – subparagraph (b).
5 Did you sight a model of service for Barrett?---I'm not sure if I saw a diagram, but I read descriptions of it mainly in Dr Sadler's statement.

I see. So it wasn't a particular document that you saw that was the model of service for - - -?---Not that I can recall, no.

10

- - - Barrett. Right. Thank you. Can I just go back. In terms of the issues earlier in your statement, paragraph 7, please, on 0008. Sorry - - -?---Yep.

- - - 003. Sorry, it's – it's obscured at the top. We'll just scroll down, please, 7.
15 Based on your view to say something about the cohort – now, I want you to go over the page, please, and scroll down, please, to (f) and (g). Thank you. Right. Just if we pause there. Professor, can I just ask – as I understand, a very significant area of your interest is in the early diagnosis and treatment of psychoses in adolescents. Is that correct?---Yes, yep.

20

And you know of Professor Hazell, I imagine, in New South Wales?---Yes, I do.

And you know that the Walker Unit treats adolescents with severe psychosis?---Yes, I do.

25

Right. And his evidence was that they are the most severe type of adolescents presenting. Would you agree with that in general terms?---In general terms I think it's probably the most – but I think – I'd just like to say that what you normally see is, you know, what we call comorbidities, so that patients have, you know, a whole
30 range of problems, and they don't fit so neatly into these categories. So severity comes from an accumulation of multiple problems, not just from a specific diagnosis.

Well, if we put it this way: the most – one of the most, if not the most significant presentation would be psychosis, wouldn't it?---Absolutely, yes.

35

Yes. So you're saying there's often a range of co-morbidities but if we're looking at presentation, psychosis is down there at the most severe end?---Yeah. I agree. I only made that comment because I think other patients can be equally severe with other diagnoses - - -

40

Yes, but - - -?--- - - - that's all.

But in terms of severity, in terms of presentation, psychosis is at that end?---It's very severe, yes.

45

Yes. And so is that what you then raise in paragraph 9 when you talk about the most severely damaged group? You're talking about, wouldn't you, in terms of an array of symptoms particularly including severe psychotic disorders?---Paragraph 9.

5 If we scroll down to paragraph 9 – the fourth last line?---The most severely damaged group - - -

Yeah?--- - - - is that what you mean?

10 Yes?---No. I – I was talking more generally.

Right?---I think – I think they were all – all those patients – and the other reason is say that is because it's not just the individual sort of medical diagnosis. It's the social damage that these patients have actually suffered, too, that puts them in that
15 category.

Alright. And if we just scroll up then, I take it then did you particularly have in mind where you way they may have been abandoned, removed or otherwise be experiencing?---Yes. Yeah, that's – that's another dimension to it.
20

Right. So when you say removed, I take it you mean by the child protection - - -?---Yes.

- - - authorities. Alright. And abandoned – that is abandoned by the family of origin
25 or carers?---Yes.

Alright. And obviously I take it that your opinion expressed in paragraph 9 obviously bear those things in mind. You've assumed those to be correct?---Yes.

30 Right. Thank you. Paragraph 31, please, on 0009. When you talk of the impact of mental disorders on older – adults is very different:

Risk of suicide, self-harm and aggression tends to subside –

35 I take it that in the general population is also the case because adolescents in and of themselves tend to be more risky in terms of their behaviour generally?---Yeah, I think – I think it's a generalisation but – but that is true in the general sense that this age group has got high levels of – of risk of both aggression and – and suicide and – and also the other risks of homelessness and victimisation in other ways, as well.
40 And just as evidence of that, if I could just elaborate slightly on that, there are studies carried out by Monash University in Victoria who have followed up kids like these who had in statutory care and looked at the outcomes between 18 and 25 which is part of the basis for what I was saying earlier. And those kids had very, very high levels of premature death, imprisonment and mental illness and – and suicide
45 attempts – a whole range of things. So – so I think they – those – those behaviours and those outcomes are not – not as florid in – in middle-aged adults.

Yes. So as I understand it, you're staying if they were in statutory care they're at more risk of those issues - - -?---Well, those were the ones that have been studied but - - -

5 Yes?--- - - - there's probably a wider group that would probably have the same type of outcomes that haven't necessarily been in statutory care.

Alright. Thank you.

10 COMMISSIONER WILSON: Could you explain what you mean by statutory care?---Sorry, child protection.

Thank you.

15 MS McMILLAN: And is this correct, that with child protection you've got either them being – they might be at home. They might be in foster care. Or they may be – do you have residentials or resis in Victoria for - - -?---Yes.

- - - adolescents who are under the care of - - -?---Yes.

20

- - - the relevant child protection authorities?---Yes, yeah.

And I take it within that there are all types of experiences that they would endure including dislocation, that is, changing care, the quality of care that they might in fact
25 receive. Correct?---Yes.

Also, whether they're at risk themselves of being abused within any of those types of placements. Correct?---Yes.

30 And that would build for them, wouldn't it, that usually the fact they're removed is because they're at risk of abuse?---Yeah, that's - - -

Or have been abused?---That's right. And – and this group is growing.

35 Right?---These children in out-of-home care – it's growing and it overlaps a lot with the – with the sort of patients we're talking about here. So – so only some of those patients in Queensland would have been in the Barrett unit but – but you assume they would have been at the – from the more severe end of the pool.

40 So you're assuming that some of the child protection cohort, if I can put it that way, would have been in Barrett?---Yes. I - - -

Right?---I'm assuming that.

45 Do you know of a service called Evolve in Queensland? No. Alright. Thank you. And I take it when you're looking at – you talked about young people turning 18 and whether it's appropriate, as I understand, to put them – if I can put it this way – or

move them into the adult system and I take it that there wouldn't be one size fits all, would there, so that some 18 year olds are going to be more mature than 18 year olds. Correct?---That's true.

5 And I take it that one of the things you would need to look at if there is institutionalisation present with an 18 year old there might be real issues about maturation and acquiring appropriate life skills?---Absolutely. And – and in the face of – of mental illness even – yeah, I would even say more mild – mild forms of mental illness – that – even with that you see developmental delay on – in relation to
10 the – the young person. So they might be, you know, chronologically 18 but they're more like 15 because they've been experiencing mental ill health. And it doesn't have to be that severe to have that effect.

Right. So again, you could have both the issue – because you wouldn't be admitted
15 somewhere like Barrett without some mental health or significant mental health component and if you add that to perhaps institutionalisation you've got some real issues, I would suggest, about maturity?---Yeah. Maturity and also capacity to function independently like – like, say, a healthy 18 year old who – even – even a health 18 year old these days, as I say, is not ready for prime time in terms of adult
20 life and – and – and when you add these extra lead in the saddle bags that these kids have got they're nowhere near it.

Which would require then, if they're being discharged, obviously, if you like, perhaps a range of services to be provided for them?---Yeah. Absolutely.

25

Yes. Thank you, Commissioner.

COMMISSIONER WILSON: Does anyone else wish to cross-examine? Mr O'Sullivan.

30

EXAMINATION BY MR O'SULLIVAN [10.07 am]

35 MR O'SULLIVAN: Professor, could you have a look at paragraph 55 of your statement at page 15 – 16 of Delium?---Yes.

This is a statement that you provided to Counsel Assisting the Commission. Yes?---Yes.

40

And paragraph 55 is the question that you were asked to answer, was it not?---Yes.

Now, you explain in 56 that if that's the question you were asked you would have described it as irresponsible de-institutionalisation of the kind that has happened in
45 the past?---Yes.

And you've given some oral evidence about the trend throughout the Western world in the last 30 years about trends towards de-institutionalisation and the risks. You recall giving that evidence, Professor?---Yes.

5 Yes. Now, when you were asked the question at paragraph 55, were you provided with an explanation for why the Centre was in fact closed in early 2014?---Yes. Well, I was – I was given a – a picture of – of what – what had actually happened - - -

10 Yes?--- - - - and obviously, you know, it's not the decision to close it that – that was – seemed to be the problem from what I was told. It was – it was – it was the decision to close it without a range of services being built – a replacement service or more modern services to replace it.

15 And that's what you were told?---Yes.

It's not something – you weren't in Queensland at the time - - -?---No, no.

You weren't advising either the government or the mental health branch?---No.

20

No. You weren't here providing firsthand – I withdraw that. Now, was any explanation provided to you about changes in The Park which you visited, Professor, changes in The Park that were happening in 2013?---I'm just trying to recall – I probably was given an explanation of what was happening but I can't recall the
25 details that well. It sounded like – my memory is something like this, this was one of the – one of the few remaining physical facilities but perhaps there were forensic facilities there or being built - - -

Yes?--- - - - and that's why it obviously wasn't a suitable – if that's the case, that's it
30 was why it was obviously not a suitable or an ideal location for such a unit.

Yes. And I think you were aware for some time that had been the case. It had been - - -?---Yeah. People had been trying to close it for years, I was told.

35 Yeah?---And – and they'd also been trying to – to construct a replacement but that – that – that – that attempt to construct some sort of replacement had – had seemed to have not – not – not been followed through.

I understand. Now, were you told or are you aware of the specific modifications that
40 were going on at The Park in relation to the care and rehabilitation of forensic patients during 2013?---I might have been and – and that's my memory that there were some new developments in the forensic space there.

Yes. To your recollection were you provided with an explanation of whether there
45 was an assessment of the risk to the young adolescents by reason of the changes that were going on at The Park at the time?---I don't think I was provided with detail about an objective assessment of risk to the – to the patients.

I understand. I take it from that evidence that sitting here now you don't think that you had visibility over the details of what was going on at The Park in 2013 in terms of potential risk to the young people?---Not – not in – not in sufficient detail.

5 No?---But – but I – but I suppose the impression I got from the discussions was that it was an appropriate thing to – to close – to try to close the unit for – perhaps for those – those sorts of reasons.

I understand. When you provide your opinion to the learned Commissioner about it
10 being irresponsible de-institutionalisation that's on the basis of your understanding of what was happening at the time as explained to you by Counsel Assisting?---Yeah, yeah. If – if that proposition, as in the question, that the thing was closed before a replacement model of care had been finalised and implemented – if that – if that was the reality and, as you say, I've got no knowledge as to – to actually – whether it was
15 the reality or not and I mean, that's probably – those are facts which are probably - - -

Outside your knowledge?--- - - - fairly clear.

20 Absolutely?---But if that proposition is put, that – that would be responsible – irresponsible.

Yes. If those were the only relevant factors, that would be your opinion?---Yes.

25 Yes. I understand that. And if you were provided with new or different information about the risks that may have been present by reason of the redevelopments I imagine you might change your opinion?---I don't think so because it's still the case that you've got to provide something that – that reduces risk before you remove something that's obviously - - -
30
Absolutely. One is dealing **- - -?---** - - - putting a roof over people's heads.

- - - isn't one, Professor, with risks and balancing risks in an appropriate and responsible way?---Yes.
35
Yes?---Yes. That's – that's – I agree with that.

Yes. Now, you were – you gave some evidence that the length of stay in the Barrett was, I think you said, a testament to there being nothing else for those young people.
40 Do you recall giving that evidence?---Yes.

Now, is that an assumption you make or is that based upon the material that you read for the purpose of preparing your statement?---That – that is based on – I suppose I do have knowledge of – of what's available in Australia in mental health and in – in
45 Queensland. I – I have got a general picture of what the – the level of investment and quality of mental health care is and clearly none of those – none of these – none

of the services that I expect to see in a – in an appropriate way are – well, very few of them are – are in place. I know that.

I understand that. That's the position as at 2012/13 when the Centre was undergoing its closure. I think your evidence to my learned friend, Ms Wilson, is that you have not been briefed upon the new statewide model of care that's been developed by Children's Health Queensland and the Mental Health Branch during 2013 and 2014?---Not by the government, no.

No. Have you spoken to Dr Stephen Stathis about what his concept is and what he's done?---No.

Have you spoken to Dr Peter Steer about what his concept is and what he's done?---No.

Have you been provided with any briefing by Counsel Assisting which enables you to form a view today about what it is that Queensland has by way of a statewide model of care for adolescents?---I've – I've got a general picture and my understanding is that – that not a lot has changed yet but there are plans.

I understand. And what's the source of your general picture, Professor?---Sorry?

What is the source of the general picture?---Well, I've – I've spent – I've made several visits to Queensland and I've talked to people on the ground in headspace services and state public mental health services. I was on the Gold Coast a couple of weeks ago.

Yes?---So I – I think I have got a reasonable picture of – of the level of transformation or lack thereof and there may well be plans but I'm not familiar with them.

I understand. But at the moment you haven't been provided, for example, with the briefing notes that were provided to the current Minister for Health setting out what the suite of services is that's either in flight or, in fact, on the ground?---No, no. But I did have an – an – I had a meeting of several hours with the Queensland Minister for Health late last year and we had a, you know, very productive discussions about what might be needed in youth mental health and he seemed very receptive to – to future developments in this space so I'm – if there are more concrete plans now that's very heartening to hear.

Yes. I understand. You said in paragraph 52, Professor, at page 16 of Delium in the first sentence – the second sentence, sorry, I withdraw that. You expressed the view that there's a need for a secure inpatient extended care as a last resort option for young emerging adults who are so damaged, disabled, developmentally-regressed and disconnected that other treatment options would fail – that that's your professional opinion?---That's my professional opinion at the moment. I suppose I've got a slightly open mind about it in the sense that I've never seen a – a

jurisdiction where all of the other elements have been provided so you can't be totally sure that if all those elements like excellent primary care and assertive outreach home-based treatment, Step Up Step Down and – and – and the therapeutic acute unit. If all of those things were there it is possible that you might not have to have this type of unit - - -

Quite?--- - - - but I have never seen it.

I understand. And that's why you say – your premise is all the other options have failed and one has a resort, as it was?---Yeah. Well, that's right. And – and because some of these young people are extraordinarily challenging.

I understand that. And I understand from what you said in giving evidence in answer to questions of my learned friend, Ms Wilson, that in terms of the detail of what Queensland is doing now you have got some idea but not – you haven't been provided with any full briefing about it?---No. I haven't been briefed about the details of – of what's – might – might be planned or – but it would cost a lot of money to put this on – on deck so I - - -

Yes?--- - - - I'm very doubtful, I've got to say, that this is going to be invested in and I think I would have heard about it - - -

Well - - -?--- - - - by now.

- - - would you be surprised if the evidence that the Commission was provided in a briefing note indicated that the recurrent cost of the proposed model as at late last years was $22 million a year?---Of the proposed model for the whole state?

Yes?---That's not very much.

Not very much?---No. To do this properly - - -

What sort of figures would you regard as being - - -?--- - - - to do this properly would cost a lot more than that.

I see?---Now, just to qualify that, this is hard to do in short timeframe.

Of course?---It's an incremental process and we're starting off from a very low base in mental health generally and particularly in this youth mental health area. And it's a very hard business to get the investment. State governments are obviously financially challenged in the – in the current environment.

Would it sound about right to you that Queensland spends about $1.3 billion a year on mental health in Queensland?---Yes.

Does that sound about right?---Yeah. Do you know what percentage it is of the health – state health budget?

It's about – the budget itself for all of health is about 13 billion for health – 1.3 of that as at about 2014 was mental health?---Right.

What proportion of that – I don't now recall what proportion – I think health was 30 per cent of the whole of the state budget?---Yes. So it's about 10 per cent of the health budget then, it sounds like from what you're saying.

Yes?---And – and mental health is – is at least 13 per cent of the health burden so it's – it's getting better.

Yes?---That's – that's - - -

The evidence also is that in terms of adolescent mental health Queensland is second on a per capita basis in Australia but it's not as high up for adult mental heath. In any event, you're - - -?---Right.

COMMISSIONER WILSON: Mr O'Sullivan, you're putting this information to Professor McGorry and asking him to assume it's correct.

MR O'SULLIVAN: No.

COMMISSIONER WILSON: You're not giving evidence of it, are you?

MR O'SULLIVAN: Absolutely not. There is evidence of it that we can tie together but at the moment there's probably nothing more I need to ask him, Commissioner.

COMMISSIONER WILSON: Thank you. Is there any other cross-examination? Mr Diehm, do you have any questions?

MR DIEHM: No, Commissioner. Thank you.

COMMISSIONER WILSON: Does anyone else? Do you have in questions in reply, Mr Freeburn?

MR FREEBURN: No, Commissioner. May Professor McGorry be able to stand down.

COMMISSIONER WILSON: Yes. Thank you very much, Professor?---Thank you.

You can stand down.

WITNESS STOOD DOWN **[10.19 am]**

COMMISSIONER WILSON: Yes, Mr Freeburn.

MR FREEBURN: Commissioner, I think the next witness is due at 11 so my suggestion would be that we take an early and slightly extended morning tea.

MS McMILLAN: We've made arrangements to have her here at 11 instead of the 12.30 she was scheduled for.

COMMISSIONER WILSON: Thanks, Ms McMillan. Well, it sounds like potentially an easier day than yesterday. I don't want to speak too soon.

MS McMILLAN: Yes. Well, you can thank my instructing solicitor. It's her efforts, not mine.

COMMISSIONER WILSON: Alright. Well, 11 o'clock.

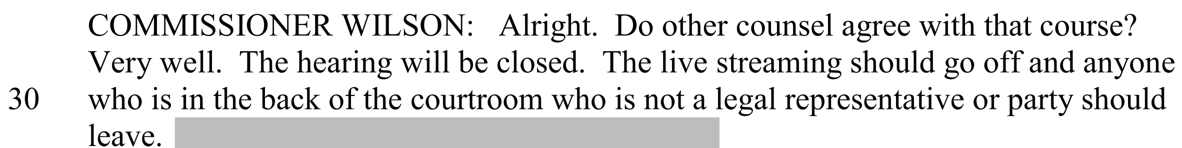
ADJOURNED **[10.20 am]**

RESUMED **[11.01 am]**

COMMISSIONER WILSON: Yes, Ms Muir.

MS MUIR: Commissioner, before I call the next witness, an issue has arisen and I would ask that the issue be dealt with in closed court. It has to do with this witness's ability to give evidence today before you.

COMMISSIONER WILSON: Alright. Do other counsel agree with that course? Very well. The hearing will be closed. The live streaming should go off and anyone who is in the back of the courtroom who is not a legal representative or party should leave.



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RESUMED **[2.01 pm]**

COMMISSIONER WILSON: Yes, Ms Muir.

MS MUIR: Commissioner, I call Ms Ashleigh Trinder.

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ASHLEIGH TRINDER, SWORN [2.01 pm]

EXAMINATION BY MS MUIR

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MS MUIR: Commissioner, Ms Trinder has provided one statement which is at WMS.9000.0011.0001.

15 COMMISSIONER WILSON: Thank you.

MS MUIR: Ms Trinder, you have a Doctorate of Clinical Psychology, and if I understand your statement and your CV correctly, you worked as a locum clinical psychologist at the Barrett Centre on successive 12 month contracts between 2009
20 and the beginning of 2013, and thereafter on three and six month contracts until 30 December 2013. Is that correct?---Yes, that's correct.

And you were employed on a part-time basis of five days per fortnight. Is that correct?---Yes.

25

After the Barrett Centre closed, I see that you worked as a clinical psychologist at headspace and that you were at headspace at Inala from March 2014 to March 2015 as well as headspace Woolloongabba from March 2014 to now. Is that correct?---Yes, that's correct.

30

As a professional who has worked both at the Barrett Centre and now at headspace, can you explain briefly to the Commission any differences, if there are any, and how you approach individual therapy at headspace as compared to how you approached the individual therapy at the Barrett Centre?---Well, I guess they're very different
35 populations of adolescents that I'm dealing with now than what I did work with at the Barrett Centre. I guess at headspace it's typically for early intervention for clients with mild to moderate mental health issues, and at the Barrett Centre, obviously, it was severe and complex. So I guess the treatment approach had to be somewhat different because of the different clientele. At headspace the way that it's
40 set up is so that it's delivered under a mental health treatment plan with 10 sessions that are given in a calendar year.

MR DIEHM: Commissioner, I object at this stage. I understood the question being posed to the witness was a question about her experience in treating patients at
45 headspace as opposed to the way – the experience she had at the Barrett Centre. I have no objection to the question. The witness's answer seems to be drifting off into

some sort of an appraisal about how headspace operates as opposed to the Barrett Centre, just in the way the answers are being framed.

COMMISSIONER WILSON: Well, Mr Diehm, I want to keep us on the straight
5 and narrow in terms of relevance as I'm sure you do, and I'm sure that's the basis of your objection. But she was asked a question as to the difference in approach to individual therapy, as I recall, and she began by saying, well, they were different populations. So I think what she's saying is surely a continuation from that. Perhaps she's leading to a conclusion as to whether or not there's any direct correlation.
10
MR DIEHM: Well, it's not just about relevance. It's about what this witness can give evidence about, and at the moment the only thing that presumably she can give evidence about is her own experience of treating patients at headspace as opposed to treating patients at the Barrett Adolescent Centre.
15
COMMISSIONER WILSON: Alright. Well, I take your point there.

MR DIEHM: Thank you, Commissioner.

20 COMMISSIONER WILSON: Ms Muir, would you ask the witness to restrict her response to her own experiences.

MS MUIR: Yes. And so, Ms Trinder, you've heard the exchange, so perhaps if you could just, when you're answering, contain your answers to your personal
25 experience, and, I suppose, taking you back to something you said in your answer, do I take it from your answer originally the cohort of young people that you're seeing at headspace you would say are a different cohort to those that you treated at the Barrett Centre?---Yes.

30 Thank you. At paragraph 14.1 of your statement, which is 00025, you say that one of the key issues that concerned you in relation to the Barrett Centre and its closure was in relation to the staffing. So I wanted to ask you a few questions around that staffing issue. At paragraph 14.6 of your statement, which is 00026, you recall that there were regular meetings and general discussions about staff issues and that you
35 say that at one of those meetings you raised that you felt there was a split between Queensland – what you describe as Queensland Health staff and Education staff, which you say affected communication between the staff. What do you mean by "split"?---I guess what I had observed following – particularly following Dr Sadler's departure – I guess he represented quite a containing – he was a containing figure, I
40 guess you could say, at the centre, and I guess he brought the teams together. So following his departure I felt that naturally there wasn't that cohesion with the staff, and the communication as a result was affected because of that.

But if we go back to your paragraph 14.8 of your statement, which is at 00026, I
45 suppose from your perspective, at least, there was frustration added into the pot about uncertainty and a general lack of uncertainty about the future of the Barrett, and that, I understand from this statement – 6 February 2013 you'd raised an ethical issue with

Scott Natho, the senior psychologist, about sufficient time to terminate therapy effectively and appropriately, as your contract was ending in two weeks. So would you accept – is it your evidence that there were – you just gave some evidence about the time of Dr Sadler's being stood down, but back before that were there – were
5 there – I will describe them as staffing issues, but for you they were personal staffing issues about uncertainty about your future. Is that right?---Yes, that's correct.

And I suspect it's a case-by-case, but in your clinical practice what do you regard as sufficient time to terminate therapy effectively?---I think your point about individual
10 cases is quite relevant, particularly at the Barrett Centre. So I think depending on their particular presenting issues at the time, it would, you know, impact on what would be an effective sort of termination date and what parts of therapy we were currently engaged in and where they're at in their treatment. So I don't feel I can give a specific timeframe.
15

No, that's fine. Did you feel – were you experiencing – in relation to the uncertainty about your contract, did that affect your ability to be able to provide the individual therapy?---I do believe that it affected elements of the therapy process, in that for – without going to individual cases, there were parts of treatment where it was quite
20 timely for us to either pursue a course of treatment or not, and at that point I didn't feel I had the certainty of my continued employment to ensure that I could support and continue to support and contain the particular clients that I was working with at the time. So it was somewhat of that ethical battle as to whether there was termination, handover, and also whether or not to commence a particular part of
25 treatment at that time.

And so that's why in your statement you've produced emails between you and Nathan – Scott Natho, where you highlight your concerns that during these uncertain times at Barrett Centre and The Park as a whole, retaining staff in their current
30 positions is crucial to continuing to provide ethical and quality care to these patients. And that was the concern about having the duration of time to treat the young people that you were seeing?---That is correct.

Now, the timeframe is February 2013, and – when I refer to the emails you've
35 exhibited to your affidavit with Scott Natho, and these emails suggest that the staff and patients at the Barrett Centre were experiencing uncertainty but there hadn't been an announcement as to the closure of the Barrett Centre yet. Is – was it a case that a closure announcement was considered by you to be inevitable, it was just a matter of when at that time?---It did feel like it was likely to be inevitable. It was
40 like a weight, I think, that was just, you know, carrying – it was over everyone's heads; when, how, what was it going to look like? So it definitely was something that – you know, that uncertainty just prevailed in every day-to-day happenings on the ward.

45 And you also refer at page 000218 – in an email you say:

> *I hope Sharon is able to appreciate the overarching need of continuity of care and stability for the unit at present.*

Do you mean Sharon Kelly?---Yes.

5

And what did you mean by the importance of continuity of care?---So I guess for Barrett there was a lot of staff that had been there for some time. And progressively over the years with the relocation or possibility or relocation, staff choosing to leave, that those that were choosing and wanting to stay, it was vital that those clinicians or
10 staff were there to continue to support the clients. What subsequently happened, or what I observed, was that as key staff were leaving, it created more distress. There was more themes of loss and abandonment. And so the idea or what I proposed was that retention was key to ensure that there was stability, that therapy could continue as best as possible under the circumstances and that there would be more resources
15 should there be a closure.

And you talk about in your statement that you felt that there was – at some point you were being asked to – staff were being asked to justify their positions and this added to the feeling of uncertainty about the future. Is that your evidence?---So that was, I
20 think, back in 2012, I believe.

The end of 2012?---Yes. That's correct.

And is this when you were saying that there were general reviews within West
25 Moreton Mental Health Services about staffing and funding?---That is correct.

Now, I just want to move forward now to 18 September 2013, just after the closure announcement. And you have exhibited at AT50 of your statement, which is at 00208, an email from Danielle Corbett about weekly meetings with Michelle Giles
30 and Lorraine Dowell. Were these support meetings?---I guess they were operational management slash support meetings. So there was a number of issues that were generally raised and discussed at that – at that time.

Can you just remind me what Danielle Corbett's position - - -?---So she actually
35 owned the full psychology position and she – I – or part of – my locum position was – so Georgia Watkins-Allen and I actually job shared Danielle's position when she was on maternity leave.

Okay. And Michelle Giles?---Well, I never really – I wasn't involved in those email
40 discussions. It was just forwarded onto myself, I believe. But allied health director. Yeah.

Okay. Now, in paragraph 14.8(f) of your statement, which is at 00027, you say on 11 October 2013 you emailed Lorraine Dowell, indicating that the Barrett Centre was
45 to close on January 2013 – I think that should be 2014. That's 14 - - -?---Yes. That is probably right. Yes.

Yes. And you were open to discussing extending your contract post December 2013. That never occurred, did it?---No.

And did you – were you given a reason for not extending your contract?---I don't
5 believe there was any specific reason provided other than funding which had been somewhat of the issue, I believe.

But – and reduced – I mean, I suppose too the Barrett Centre was about to close and there were fewer patients there at that time as well perhaps?---I guess at that point it
10 probably wasn't clear as to who would be still remaining on the ward earlier in the year, like back in October. So I'm not sure if it was quite clear as to whether or not there would be a reduced need for staff.

Now, you say in your statement there was uncertainty and speculation as to why Dr
15 Sadler had been stood down and, therefore, concerns about Dr Brennan being appointed as acting director, although she came to be better accepted as time progressed. What did you mean about the uncertainty and speculation?

COMMISSIONER WILSON: Is this going to touch on matters that ought not to be
20 in open hearing?

MS MUIR: Actually, Commissioner, I might – I do have two questions in closed hearing so I might ask that again just in case. Thank you.

25 Just if I could ask you some questions about transition arrangements. Your evidence says you had minimal direct involvement and your role was to continue to provide individual therapy to a number of patients. Had you ever been involved in transitioning a patient from the Barrett Centre prior to that – the end of 2013 period? In your time there were you usually involved in the transition process?---I – partly, in
30 terms of supporting the transfer of psychological care, so to a new individual therapist. I do recall times when that would happen. But, typically, the care coordinator or – would typically – or nursing staff would usually do that.

COMMISSIONER WILSON: I'm sorry. I don't understand. Do you mean the
35 transition from one care provider within the Barrett Centre to another within the Barrett Centre? Or from someone within the Barrett Centre to someone outside the Barrett Centre?---Sorry. I thought that – yeah, that was what it was referring to, externally to Barrett. So, for instance, Ipswich CYMHS and transferring that individual therapy care to the clinician.
40
Thank you.

MS MUIR: But were you involved in the actual plans for that young person as to what services they would access after they left the Barrett Centre?---Typically those
45 would just be discussed in the intensive care case workup. So they were the two to three monthly reviews where clients would be there presenting issues and mental

health needs would be discussed with all the care members – team members. So in some ways they were all discussed together as a team.

Okay. So to that extent you had that – you were part of the team that would work on
5 the transition plan for the young person?---Yes.

Can I look – ask you to look at a document, COI.018.0002.9540. If you could go to page 9612. Okay. If you can just scroll down, please.

10 I just wanted to ask you, this is an Inter-District Transfer of Mental Health Consumers within South Queensland Health District Services document. And it's, the Commission understands, the transition policy document that was in effect from 8 November 2011. I just – while working at the Barrett Centre, did you ever see this document?---No, I hadn't.
15

In paragraph 12.1 of your statement at 00024 you note the general heightened level of concern within the Centre following the decision to close. And you say:

> *Everyone was brainstorming and trying to find solutions for transition*
20 > *arrangements.*

I'm just interested in understanding the – why brainstorming was necessary, given that at that time the Centre had been in existence for over 20 years. To your – and I'm just asking you for your direct knowledge and experience, wasn't there
25 relationships with other service providers that you could actually – that you knew to access?---I do believe there were services. Though, I think under the circumstances and where the clients were currently at in their treatment, that it was felt that that wasn't necessarily going to be sufficient. So I guess during the meetings there was this sort of invitation for other staff that weren't part of the panel, the transition
30 panel, to support them if there were additional ideas or services that they had come across or had the time to research also.

Was there a particular point in time in that year of 2013 that you realised that the Barrett Centre was closing with only – with existing services available?---Sorry?
35

So was there a particular point of time that you realised after the Barrett – the announcement was made that you realised that the Centre would be closing and that the patients would be transitioned to the existing services that were available?---I don't recall any specific time and I think it varied depending on each individual
40 client as to what that looked at.

Perhaps – I think I haven't asked the question properly?---Sorry.

I'll ask it another way. At some point after the announcement of the closure were
45 you told that there were going to be – at any point that there were going to be new services available?---I wasn't aware of any new services.

Around the time after the announcement, were there discussions about risks associated with the redevelopment of The Park as a forensic adult-only facility or in relation to EFTRU that you can recall?---Just really vague generic comments that I can't really give details about. It was just known but I wasn't privy to any specific
5 information.

You say in your statement it was your belief that responsibility for consulting with family, friends or carers in relation to transition arrangements was the primary responsibility of the transition panel or care coordinators. So does that mean that you
10 didn't deal with families at all?---There would be occasion where families were – I did have some contact with the families but typically that was not my role or responsibility.

If I could take you quickly to your CV is WMS.9000.0011.0038. Just in the – if we
15 scroll down it's just – it gives your experience at the Barrett Centre and it does include liaising and working with families and participating in intensive care reviews and case conferences. So I take it there was some liaising and working with families but you say not as part of the transition process. Is that your evidence or tell me what - - -?---I – I guess - - -
20

- - - what it is?---The individual therapy role was – was typically to advocate for the young person so there would be other staff members that would typically engage with the families. The nursing staff often had much more contact with the families and it was only if there was family therapy and the individual – or the – the patient at
25 the time wanted support I would be involved in those family therapy sessions so I would typically not have an ongoing relationship or contact with the families.

But would you be telling the individual – if you had been seeing a young person as part of their individual therapy you wouldn't be talking to their carer or the family
30 member about the fact that you were doing that therapy or even what you were doing with the young person?---There were times I would but it would vary – it would really vary.

And why would it vary?---I guess it's hard to explain just in terms of the specific
35 situation of the client whether the families were located close by or how – how much they were involved in – in coming to the Centre at the time – the families. I guess that was one challenge that we would – we would face.

So it wasn't possible to have this consultation by picking up the telephone and
40 talking to the family member who might have been up north or out west – I'm just making up locations?---Yeah. I mean – I mean, that's not necessarily the issue. I guess, as I mentioned before, there would typically be other staff members that would – would have that contact.

45 MS MUIR: Commissioner, the only other questions I have for Ms Trinder are in closed court and I have about three questions.

COMMISSIONER WILSON: Well, before I close it I'll ask how many people are going to cross-examine and are they in open or closed hearing? Ms Rosengren.

MS ROSENGREN: I only think I'll have maybe one question of this witness in open hearing.

COMMISSIONER WILSON: Anyone else? Well, let's deal with that first, Ms Rosengren.

EXAMINATION BY MS ROSENGREN **[2.25 pm]**

MS ROSENGREN: Ms Trinder, my name is Jennifer Rosengren and I appear for Dr Sadler and I just wanted to ask you to expand on some evidence that you have just given earlier and it's in relation to relationships with the other service providers – the external service providers. Are you able to tell us who those – or some of those service providers with whom you had those relationships at BAC?---Well, I mean, personally myself it was typically only the therapists through – through CYMHS that I would have that – that contact with. I – I didn't have much contact personally myself with other services.

Alright. And so with CYMHS – Evolve – were there those services as well?---There were – there were services but I – I don't recall any times where I directly had contact with them.

Alright. So there were other staff members - - -?---That would - - -

- - - at BAC who would have the contact with those service providers?---That is correct.

Alright. Thank you for clarifying further questions.

COMMISSIONER WILSON: Anyone else? Well, I'll close the hearing. The live streaming should go off. Those in the back of the courtroom who are not legal representatives or parties should leave other than Dr Brennan who may remain.

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Mr Fitzpatrick,
25 you had a question in open hearing.

MR FITZPATRICK: Yes, thank you.

COMMISSIONER WILSON: If anyone wishes to come back in, they can, Mr
30 Bailiff. Yes.

EXAMINATION BY MR FITZPATRICK **[2.37 pm]**

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MR FITZPATRICK: Thank you, Commissioner.

Ms Trinder, it's correct, I gather, that from 2009 until the beginning of 2013 you worked at the Barrett Centre on successful 12 month contracts. Is that
40 correct?---Yes.

And do you recall being taken to some email material dating from February 2013 in which you expressed some concern about the uncertainty of your tenure at Barrett?---Yes.

45

Which I think, if I've read the material correctly, you felt was impacting on your ability to maintain continuity of your therapeutic relationship with clients. Is that correct?---Yes.

5 And is it the case, Ms Trinder, that throughout 2013 your contract at Barrett was renewed on a number of occasions?---Yes.

And is it correct that it was renewed at intervals of three and six months?---Yes.

10 And do you know why those renewals were made throughout 2013; for what purpose?---So with some o the emails that I had with Lorraine Dowell, she spoke of the uncertainty and the unlikelihood that perhaps Barrett would continue post the end of the financial year, but she had no facts to support that. But I assume that with the March to June 30 contract, that the closure would then perhaps proceed thereafter.

15

Yes, but – but your contract seems to have been renewed after 30 June?---Yes, for six months.

And can you tell the Commission why that was, why the contract was renewed?
20 What did it enable you to do?---Well, to continue to support the clients and, where possible, continue with the individual therapy.

Yes, and was – were you enabled to continue un that way with clients during the earlier renewal period?---I believe that that was a little – it was more difficult to do
25 that. There were crucial stages of treatment, and that sort of period of time was not conducive to, perhaps, some of the goals that the clients had at the time. Following the six months, I was able to do some work with the clients, but then the focus did transition to how to support them with the closure.

30 I understand. Yes, thank you. That's all that I have, Commissioner.

COMMISSIONER WILSON: Does anyone else have any questions? Ms Muir, do you have any further questions?

35 MS MUIR: No, Commissioner.

COMMISSIONER WILSON: You want the witness stood down?

MS MUIR: If the witness could be stood down, thank you.

40

COMMISSIONER WILSON: Thank you very much, Ms Trinder. You can stand down.

45 **WITNESS STOOD DOWN** **[2.41 pm]**

COMMISSIONER WILSON: Yes, Ms Muir.

MS MUIR: Thank you. Mr Freeburn is taking the next witness, Commissioner.

5 COMMISSIONER WILSON: Thank you.

MR FREEBURN: I call Mr Rodgers.

COMMISSIONER WILSON: Thank you.

10

KEVIN RODGERS, SWORN [2.42 pm]

15 MR FREEBURN: Commissioner, there are apparently some corrections to Mr Rodgers' statement so Ms Kefford is going to take the witness through those.

COMMISSIONER WILSON: Thank you.

20

EXAMINATION BY MS KEFFORD [2.42 pm]

MS KEFFORD: Thank you, Commissioner.

25

Mr Rodgers, do you have a copy of your statement there with you?---Yes, I do.

The statement is WIT.900.014.0001. Could I take you first to page 8 of your statement at 0008. Do you wish to add the following sentence to paragraph 30 of
30 your statement:

I believe this conversation with Peter Blatch occurred around November 2012.

?---I do.

35

If we go next to page 11 of your statement, I understand that the following are corrections you wish to make to paragraph 45 of your statement. In the second line there's a reference to "seven days". Do you wish to correct that to now read "nine days"?---Yes, I do.

40

And in the fourth line there is a reference to "eight days". Would you like to make a change to that number also?---I would.

And would you like it changed to "nine days"?---I would like it changed to nine
45 days.

In terms of paragraph 46 of your statement on the same page, I understand that you wish to change the reference to "15 days" to instead be a reference to "18 days". Is that correct?---That's correct.

5 In paragraph 47 of your statement on the same page, I understand you wish to add the following words after the word "administration" in the second line?---Yes.

The words I understand that you wish to add are "during my 18 days before taking sick leave"?---That's correct.

10

At page 14 of your statement, the paragraph at the top of the page has a reference to the words "a number of telephone calls". Do you wish to replace the words "a number of" with the word "two"?---I do.

15 Finally, if I could take you to page 22 of your statement, paragraph 98. In the second line appears the word "several". Do you wish to replace that word with the word "two"?---Yes, I do.

Thank you, Commissioner. They're the corrections.

20

COMMISSIONER WILSON: Thanks, Ms Kefford. Mr Freeburn.

EXAMINATION BY MR FREEBURN **[2.46 pm]**

25

MR FREEBURN: Mr Rodgers, you talk about – alright. Well, the Commission has heard some evidence about the health and education components of the Barrett Adolescent Centre curriculum, if I can call it that, being intrinsically linked. Can you
30 explain that?---Do you mean in terms of the staff working together or - - -

Yes?---Yep. Okay. If I could just give a little bit of historical background. I started there in September 1987. And when I went there, there was a very strange culture that was occurring there. They still had the same – same types of staff. They had
35 allied health, medical staff, nursing staff and teachers. But the culture of the staff was very territorial. It was territorial in terms of the furniture and things that people possessed, it was very territorial in terms of the knowledge that people possessed and it wasn't very conducive to a team working together to the same end. And it took some, you know, 10 years of Dr Sadler and I working together to change that into a
40 team of people who shared all the resources and had everyone rowing the boat in the same direction, so to speak, and all the energy and the money that went into the place – that was the other thing that seemed to be very territorial. There was health money and there was education money. And there were battles initially about who bought this and who bought that. So those disappeared into a culture of people working
45 together for the best for the adolescents.

How did you and Dr Sadler solve those – I suppose they're silo problems, aren't they?---Well, yeah. That was – that was – I suppose we both had a – had a vision that was similar. And we had – both had very high regard for the expertise of the staff members of the various sections within the place. And I think a lot of it had to do with that. Plus, Dr Sadler and myself encouraged all of the staff. And it didn't matter, you know, whether a person was a teacher aide or whether it was Dr Sadler himself, he encouraged people to put – put their opinions forward. And everyone felt that they were valued and as important as other people's opinions in the place.

Alright?---There was also – part of the culture also was a no blame culture. So I think that was really critical too. At times, you know, things went wrong. And instead of trying – when I first got there it was, you know, a bit like the three stooges where one hits the next one, one hits the next one and there's no one left to hit after that. But – and it's all passed down the line. But, you know, in this environment it was about – if something went wrong, about a collaborative review of it to find out, well, if this happens again, how can we do it better?

Mr Rodgers, you – onto a different topic, you talk about this school, the Barrett Adolescent Centre School, being a band 7 special school. What does that mean?---Schools are banded I think from around band 6 to around band 11 in the big high schools. So it certainly depended on the number of students that you had at the school. But in special schools there was a different formula used based on the complexity of the students that were enrolled in the school. And so ours was a fairly complex school so that's the banding that the Education Department assigned to it. So according to the banding, you'd get resources to your school. So that determined, in fact, how many teachers we would get and other resources.

Where does band 7 sit amongst the - - -?---Well, it's pretty low. It's sort of second – second along. I think it starts with band 6 or something like that.

Meaning it's deserving of more resources because the students are more challenged, is that right?---Yep. That's how they determined the resources that went along to the school.

And does a school like that do NAPLAN, for example?---No, we didn't do NAPLAN.

Why not?---We didn't do – I consulted with Dr Sadler, and it was his opinion – and I agreed with him – that our students were not well enough to be able to do the NAPLAN tests, and so we found other ways of measuring their performance.

So the fact that you didn't do NAPLAN didn't mean you didn't record results - - -?---No.

- - - or progress of students?---No, absolutely. Progress of students was on an individual basis. There wasn't the possibility to have, like, a class of students. A class of students at Barrett might look like three to five students, where you might

have three different year levels, and they might be doing – and if you walked in at a particular time of day you might find they might be doing three different subjects at that time. So it was very – the programs – we called them personal education plans – were very individualised to the students.

5

Now, I just want to cover – there's the topic of Dr Sadler's standing down. Now, I want to see if we can cover that topic without going into either the details or reasons for it or the particular students involved. Now, if you need to give me an answer which involves either of those two things, can you let me know before you give the
10 answer?---Yeah, that's alright.

What I want to focus on is what were – what did you observe to be the effects of Dr Sadler's standing down on the Barrett Adolescent Centre patients and the transition process?---And the transition process. Okay. We'll start with – we'll start with the
15 staff and the students. And I think what happened was that Sharon Kelly from West Moreton arrived with two consultant psychiatrists, and that's when we knew that there was going to be, you know, a transition. There was going to be – this was going to be the closure of the centre. I hadn't been consulted about it in any way. I didn't know what was happening. I just went to work as you would normally, and
20 then we were to have a meeting, and so the teachers went across to a meeting in the morning that we were told that we were having with the consultants. They waited for 20 minutes or half an hour, and then we were told that we wouldn't be having a meeting with the consultants because they were meeting individually with the students, which was something very strange to all of us, because that's not the way
25 we did things. We always had meetings where we shared information with all the staff and all the students together. It was pretty traumatic for the staff members, and a lot of staff members expressed a concern when they – you know, this was kind of the – in a play, the last chapter for me. I was – I mean, I'd been on the ECRG, so I already knew that it was very likely that the centre would close, so for me this was –
30 this was the last act, and I – and so I was kind of resigned to it. But for a lot of the staff, I think they were very confronted and very distressed, and mostly they expressed to me concerns about the survival of not all the adolescents, but certainly a number of the adolescents who were attending the school. The adolescents themselves – and strangely enough at the time, Peter Blatch said to me you should be
35 recording any information and keep a diary. So I did submit to the Commission a diary that I kept at the time of things that were happening each day. But I suppose what – you know, when I read that back to myself, I see that what was happening was a place that was very – a very boring, mundane place, where we used to do the same things every single day, turn into chaos within just – within a few days of
40 Sharon Kelly walking in.

And is this – is this the – I don't think it's disputed that the announcement occurred on the 6th of August 2013. That's the announcement of the closure?---From the Minister.

45

From the minister?---Yep.

And about a month later, on the 10th or so of September, Dr Sadler is stood down. Are the events that you're talking about, where Ms Kelly came with two consultants – is – are those events related to that first date, the announcement, or are they - - -?---No. No, the day that – the day after – I believe the day after Dr Sadler was stood down. He was stood down, you know, in the evening, and then the next day Sharon Kelly and two consultants arrived.

I see?---That's what I recall in my mind. But, you know, again, you have to put this in historical context that from 2008 to 2012 I'd been on the planning committee for the rebuilding of a new centre at Redlands, and so there was great hope amongst the staff and amongst the adolescents that, you know, that was going to happen, and then – and during that time we lost a lot of very good clinical staff because they lived around the Ipswich area and they weren't going to travel to Redlands. So, I mean, there was a slow, you know – as far as the staffing goes and the quality of the staff goes, there were – it started in 2008. It didn't start, you know, on the 10th of September when Dr Sadler got stood down.

There was something created soon after called the transition panel?---Yes, that's correct.

And were you on that transition panel?---Yes, I was invited to join the transition panel by the consultant, and that was – I notice I've got that in my documents. I was invited on the 30th of September, and I would've only been back nine days after the school holidays. This was after school holidays, the September holidays. And so I would only have been back nine days, and at that stage the transition panels hadn't started. So I didn't receive any minutes, so I suspect maybe I attended probably two or three of those meetings.

Okay. So only one or – sorry, two or three?---Might be one or two, two or three. I really can't – I can only remember actually being at one meeting and, you know, sort of suggesting something that the consultant had already been discussing. That's the only meeting I do remember.

Who's the consultant you're referring to?---Dr Brennan.

Right. So your involvement in that transition panel was limited to one, two or three occasions?---Yes. Do you want to know the reasons?

Yes, please. Why did you cease on that panel?---Well, I had had a phone call from Peter Blatch after the first meeting with the consultants. We had a meeting either the day that Dr Sadler left or the following day, and at that meeting myself and other teachers challenged the consultants about a number of different issues, and I can go into those if you would like to hear them. And then I had a phone call from my – from Peter Blatch, who was my line manager, to say that he had been rung by Sharon Kelly to say that – you know, that we were being – that the teachers were being uncooperative. I do think part of this was that, you know, both Dr Hoehn and Dr Brennan, they work for the Health Department, they worked at pretty high levels,

and they probably weren't used to people challenging, you know, what they had to say, and I suppose, you know, working in the Education Department we felt more comfortable to be able to challenge them on some issues that we were concerned about.

5

Now, there's two things I need to clarify out of that. First of all, did – as a result of Ms Kelly's call - - -?---Yes.

- - - were you asked to not continue with the - - -?---No, I really haven't finished my
10 - - -

Sorry?---My last answer, because there was a second part to that, and that was that I can recall a second phone call, and it was about a transition panel meeting where Peter Blatch said that it had been reported by Sharon Kelly that I had walked out of a
15 meeting. I had a different view of that. I – I recalled in my own mind that the meeting had been – the consultant had said the meeting was finished, and I got up to walk out, and I assume that the meeting started up again after or as I was walking out. So – but I could see – to me there seemed to be a bit of a writing on the wall that it was more – I – I wanted to get the best outcomes for the students and I could
20 see that if this process was going to continue where – I didn't feel that I was trying to be difficult but if there was perception that I was I still wanted to get the best outcomes for the students so I thought it was better if I stood down from the meetings and sent one of teachers along. So from that point one of the other teachers attended the transition panel meetings.

25

And what – Mr Rodgers, what was the nature of your concerns or I think you called it your challenges – what topic and what areas were you concerned about?---There were – there were a few. The first one was that we had had over the first week that the new consultants arrived we'd had a number of – of meetings that were either
30 cancelled or had our staff sitting around for very long periods of times waiting for people to come to them without notifying us that they – they would be late. We had also – were very concerned about keeping a routine. As I said before, in a day the Barrett could appear very boring and mundane but that was really important to young people with mental health problems that, for example, people with Asperger's
35 Syndrome are kind of ritualistic and need predictability and need routine. People who have anxiety disorders need the same sort of predictability to keep calm. And so I think that, you know one of the things that made it successful was to keep that routine and the routine of what was happening there just – yes, just didn't happen. Kids weren't coming to school, arriving two hours late for school. The exact details
40 are recorded in – in my statement.

So you mentioned late meetings and disruption to routine. Any other things that you remember?---Well, I did speak with the consultants about the culture that we had within the Centre, that we had a culture of, you know, working together with the
45 adolescents. We also raised the issue of the Health Department telling us that we had to say that Dr Sadler was on leave rather than – rather than being stood down so we – and – and the consultants themselves made – made a point that we needed to be

truthful with the adolescents and then one of the staff said, well, what about, you know, we've just been directed by the Health Department to say to the kids that Dr Sadler is being on leave rather than stood down.

5 Can you recall who said that, who directed that?---In my statement I said Dr Brennan and Dr Hoehn stated that Dr Sadler had been stood down. Both of them couldn't have said it so I really can't recall who said and in fact Sharon Kelly was there as well so it could have been one of those three people but in – it was definitely a direction by the – the Health Department to the staff – the Health Department staff at 10 the Centre and the Education Department staff at the Centre to explain that to the adolescents in that way.

Can I take you to a different topic. You mentioned that you were a member of the ECRG?---Yes, I was.

15

Now, one of the ECRG's recommendations – and I probably don't need to take you to it – is recommendation 5 and it talks about education resources are essential and access to onsite schooling is considered is essential for tiers 2 and 3. Why was that? Why did you take the view that that was essential – or you as part of a committee – 20 the ECRG?---We had recognised the benefits of having a school that was part of the programs and the school was very therapeutic to the students as well. These were very damaged students in many parts of their life but for some of them school was still an okay part of their life and so it was way that they could see that part of them was okay while the therapists and other people worked with other parts so it was very 25 important to have that as part of the school. The other aspect of that was that the adolescents were too unwell to attend schools generally outside of the – of the facility that they were in. Many of the adolescents had difficult in self-regulating and at times needed staff to intervene to help them to do that. Where it was possible – where we had students who could attend school we would send teacher aides or 30 teachers with them to local schools and, in fact, with students with anxiety disorders we actually used to use – many years ago we used Oxley High School before it closed and then Mount Ommaney High School. It's kind of a practice school for them to – to go and just expose them to the anxiety of being at school. We had an arrangement with the principal there who had been a principal at the youth detention 35 centre so he had some understanding of the issues that adolescents have.

Alright. Now, Mr Rodgers, I'm going to show you a document. It's CHS.001.001.6929. Now, if we go specifically to page 6932 of that document. First of all, Mr Rodgers, I need to ask you a few questions about this document. You've 40 seen the front page and then this page. This includes, we know, ECRG recommendations on the left and something called the planning group recommendations on the right?---Yes.

Before this Commission of Inquiry had you ever seen this document?---I believe I 45 did. Yeah, I believe I have seen it.

Do you know when?---I really can't recall when I saw it.

Alright. You'll see adjacent to item 5(a) – you'll see ECRG recommendations that I took you to – mentioned a moment ago – under 5(a)?---Yes.

And you'll see – now, then there's the planning group recommendations and they
5 have recommended removing band 7 from the ECRG recommendation?---Yes.

And made some further comments. Do you recall seeing this at the time you were a member of the ECRG?---I think that the report had already been endorsed and signed off, gone to the planning group and I would have seen it sometime after that. Also
10 Michelle Bond was the – the principal who was the education representative to that group and she did ring me and discuss the changes that had been made to what was originally in the document. Would you like me to talk a little bit about why - - -

Well, can I just ask this, did you have an opportunity to comment on the planning
15 group's adjustment of your – the ECRG - - -?---No. There was no formal process to do that.

Right?---But I did have a discussion with Michelle – I – I – you know, I felt quite comfortable with that modification. The idea behind me pushing for the band 7
20 school to be part of a tier 3 service was because of the success that we'd had at the school but it was also an intention from Peter Blatch and the HR staff at – at Metropolitan Regional office to try to keep the expertise of the staff together as a whole. So if we – if we had have been able to achieve just shifting a whole school with a whole staff it meant that, you know, we're not losing that expertise. In a – in
25 one of the documents that I saw the other day I think I had made the comment to the ECRG group that, you know, it's an incredible waste of the clinical knowledge of all of the allied health, medical and teaching staff, you know, when the – when the Centre actually closed and to see them dissipate into other areas was going to be a huge loss.
30

Now, I just – Mr Rodgers, I just have one more area, and I might be able to speed through it reasonably quickly. Ms Wilson, who's next to me, is going to – has asked a lot of witnesses about a suite of different services that are either available or planned to be available, offered to adolescents with mental health issues?---Yes.
35

And I'll just quickly mention those, and then I want to ask you whether you feel that you have any direct knowledge of the education component of those. So do you know anything about – and it may be completely outside your knowledge – Assertive Mobile Youth Outreach Services, AMYOS services?---I've been to one presentation
40 about these. When I came back to work at the end of the year for the last eight days of 2013, I went with – attended with Dr Sadler a meeting with Dr Stathis and Ingrid – who's - - -

Adamson?---Adamson, the project officer, where these were presented to us, but I
45 have really no – that's about all the knowledge that I have about them.

Alright. Do you have any direct knowledge of day programs?---No, I can't speak to those.

Step Up Step Down units?---Well, only from the planning that I did with Dr Sadler
5 about the Redlands facility. Very much that would've been so useful, and at times we did – we had adolescents who were ready to go into the community, and if we had have had a house onsite – and we even looked at the doctors' houses at The Park – it would've been great to be able to have them live in a house close by and have the social workers and OTs and staff visit them at the house. It would've been a great
10 service, yeah. So that would be terrific.

Okay. And subacute beds at, for example, Lady Cilento Children's Hospital. Do you have any direct knowledge of those, or is that just outside your knowledge?---No, that's outside what I know.
15

And what about something called resis or residential rehabilitation units? Have you had any direct experience of those?---No, I haven't.

Thank you. That's all I have, Commissioner.
20

COMMISSIONER WILSON: Cross-examination, Ms Wilson? Mr Diehm.

EXAMINATION BY MR DIEHM **[3.14 pm]**
25

MR DIEHM: Thank you, Commissioner.

Mr Rodgers, my name's Diehm and I appear on behalf of Dr Brennan. You've said
30 in your statement and you've referred in your oral evidence to the circumstance that you had worked at the school at the Barrett Adolescent Centre for 26 years?---Correct.

Over that period of time, as you've described in your oral evidence here today, you
35 were of the view that many very good things have been able to be achieved in the partnership that you formed with Dr Sadler?---Correct.

And you were very proud of those achievements?---Very proud, yeah.

40 And considered that the continuation of that combined service that you'd put together, education and health, was vitally important for the adolescents who came through the Barrett school and the hospital facility?---Yes, I felt the survival of the students was at risk.

45 Indeed, you were, I suggest, very passionate about the need to continue that service?---Absolutely.

Can the witness be taken to paragraph 57 of his statement, please. Just while that's coming up, Mr Rodgers, in that passage of your statement you may recall that you describe that after a short period of time following the September school holidays in 2013 you went to your family doctor with a range of symptoms that you believed
5 resulted from your new work situation, and that you were given leave through to the end of the year?---That's correct. And I think it also says that he is prepared to write a report. In fact, I was asked by the Commission to supply a report. I'd asked the doctor for it, but before he had finished writing it the Commission didn't require it any further.
10
Alright. Is it, in effect, in short, the circumstance that you were off on stress leave?---I had a cardiac condition and high blood pressure, and it was being affected by – well, in the doctor's opinion it was being affected by the work situation.

15 Alright. Were you suffering psychological distress at that stage from the work circumstances?---Certainly.

Was that affecting you in ways of making you anxious?---Yes.

20 Causing you to be agitated?---I can't really answer that question.

Alright. Was it affecting your concentration?---Yes, I imagine so, but I have no firm evidence to know that it did.

25 Alright. Can the witness then be taken to paragraphs 8 and 9 on page 002 of his statement, please.

Now, in those paragraphs, Mr Rodgers, you detail the period of time that you had extended sick leave, so that occurred in 2013, 2014 and 2015?---Yes, that's correct.
30
But they weren't one continuous period, as you describe in paragraph 9. They were from time to time across those years?---No, not from time to time. I went back to work at the end of the year, and after the meeting with Dr McDermott I really felt that I couldn't continue any further in my career.
35
Alright. I'm sorry. And - - -?---And then I haven't been back to work since then.

I apologise, I'm not paying attention enough there. You have detailed the terms that you were absent across those years, and they were - - -
40
COMMISSIONER WILSON: What was the meeting with - - -

MR DIEHM: - - - substantial periods of time.

45 COMMISSIONER WILSON: I'm sorry. I'm sorry, I cut across you.

MR DIEHM: Yes. They were substantial periods of time, as you've detailed in paragraph 9?---Yes.

Thank you.

5

COMMISSIONER WILSON: Mr Diehm, I'd appreciate clarification about what the meeting with Dr McDermott was.

MR DIEHM: Yes, thank you, Commissioner.

10

The meeting with Dr McDermott you were speaking about: is that a meeting that occurred after the school had moved to Yeronga?---Correct.

Alright. And that was about the provision or the school's view or your view,
15 perhaps, that it would be helpful to have some further mental health services available to students there?---Yes, but that wasn't the actual event that caused me to go back to the doctor. It coincided with the serious self-harm of one of our students the day that we went to that meeting.

20 Thank you. It's just a coincidence that it was at that time?---Yeah, absolute – some irony, I suppose.

Thank you. Now, the Commission has evidence before it that you in fact had a period of leave in late 2012. Do you recall that? I'm sorry, do you recall, in fact,
25 having a period of leave in late 2012?---No, I don't.

You recall that in November of 2012 there was an incident where Professor McDermott was giving evidence before a public inquiry, and he said something of a plan that he was aware of for the Barrett Adolescent Centre to close?---Yes.

30

And that was reported in the media?---Yes, it was.

You recall that?---Yes.

35 Yes. And according to evidence that Mr Blatch has given to the Commission, shortly after that announcement you took a leave of absence. Do you recall that being the case?---I don't – I'm sorry, I don't recall that. I know I was there on the day that the announcement was made, because I got a phone call from the ABC that afternoon. We'd just been doing our quadrennial school review and planning the
40 next four years. So it was out of the blue that we heard that, in fact, the place was going to close.

Mr Blatch has said in his evidence to the Commission that after returning to your position for a short period from the leave that I've just suggested to you that you had,
45 that you ended up taking another leave of absence?---Have you got any - - -

You don't have a recollection of that?---I don't have any recollection of it. Have you got any dates or something to help me?

Well, it seems to be in November of 2012?---I'm sorry, I – I don't recall that.

5

Alright?---Or the reason why I would've been away.

According to Mr Blatch's evidence, the teachers of the school knew at this time that you were unwell and were concerned about you. Do you have a recollection of there
10 being knowledge amongst your staff of you being unwell at that time?---I had a heart attack probably in 2008. So it could've – you know, teachers could've been concerned about my unwellness.

Alright. Well, you - - -?---But I don't recall taking any leave at that time.

15

And you don't have any particular recollection of the teachers being concerned about your health at that time, in November 2012?---Not specifically. No.

No. Alright. You said to – in answer to questions from Mr Freeburn just a few
20 minutes ago, earlier in your evidence this afternoon, that on the occasion that Ms Kelly arrived at the school in the company of two consultant psychiatrists, coinciding with the event of Dr Sadler being stood down, as you were to learn soon thereafter, you came to know that the BAC was going to be closing?---I think I described that before as what I understood to be the final act, you know. I already knew from the
25 ECRG meetings that the plan was to close the Centre and that new models of service delivery were to be developed. So I already knew about that. I already knew about it in 2012 as well.

Yes?---So I don't think it was anything new.

30

You say you saw it as the final act. Is what you're saying that despite the Minister's announcement on 6 August 2013 that the BAC was going to be closed or was to be closed, that you believed or hoped that there was a prospect that that outcome could be avoided?---I don't think so. I think I was resolved to the fact that it was going to
35 close.

Well - - -?---And that we wanted to get the best outcomes for the students out of the processes that were being put in place.

40 You see, Mr Rodgers, you said just a moment ago, consistent with the evidence that you gave in answer to questions from Mr Freeburn, that you saw this development as being the final act. So by that you must have meant, I suggest, that you saw Dr Sadler's being stood down as being a step in the process of the Barrett Adolescent Centre closing?---I don't agree with that.

45

See, I suggest to you that when Dr Brennan came onto the staff in place of Dr Sadler, you viewed her as being a person who was facilitating the closing of the BAC in

circumstances where you considered that it ought not to close?---I think that's reasonable. I mean, maybe not from your point of view but I think that would be, you know, what I would have probably thought at the time, that the two consultants were there to do the work in closing the unit. That's what we were told.

5

And that was a different process than what you had envisaged was going to happen whilst Dr Sadler was still there?---No. I think I said before that in the ECRG group we already knew that the place was going to close and the Minister had already made the announcement. So I was already resolved to the fact that the Centre was going to

10 close.

Mr Rodgers, you're aware, I take it, that since the time that you prepared your statement that's before the Commission, that Dr Brennan has put a further statement before the Commission in which she's given a different version about certain events

15 that you had referred to in your statement. Are you aware of that?---Yes. And my legal representatives have explained that to me and we've already spoken about one of those things which was Dr Brennan believing that I walked out of a meeting that I don't believe I walked out of. So we have a difference of opinion. That's okay.

20 Yes. I think your evidence in answer to questions about that earlier this afternoon was that the meeting had finished but then started up again as you were walking out. Is that the effect of what you were saying?---Yes, exactly.

But you didn't return to the meeting?---No.

25

Even though you knew that the meeting was continuing?---The meeting had been closed by the consultant – this is as I recall. I mean, we're talking about three years ago. But as I recall, I have a different point of view to Dr Brennan about the end of the meeting. I recall that we were told that the meeting was finished and then it

30 started up again. At the time I walked out, or even after I walked out – I can't even recall – I was told about this later on. So, you know - - -

I'm sorry. I thought your evidence earlier - - -?---Yes.

35 - - - in answer to the questions you were asked by Mr Freeburn was that you were aware that the meeting was starting up again – to that effect?---I think I've made – I've certainly said that in my statement. But, you know, when I sit here and try and recall exactly whether I walked out and then it started up and someone told me later that it had started up again, or whether it had started up as I was walking out and I

40 didn't go back, I can't recall. I'm sorry.

Mr Rodgers, on reflection, do you think it's likely that you have been somewhat unfair on Dr Brennan with respect to observations you've made about the difficulties that you had working with her?---On reflection – and I've had time to read through,

45 you know, the minutes that I kept at the time – the only thing that I'd really be saying as a summary of those is that the Centre became very chaotic and the staff became

very distressed. And if you want to sort of start pointing fingers, I mean, I don't think you can point the finger at one person. And I'm not trying to.

Alright. Perhaps we can – I can put it to you this way, Mr Rodgers: as you've
5 acknowledged, there was considerable distress amongst patients and staff at the time that Dr Brennan started?---Absolutely.

That distress was shared by you?---Yes.

10 That distress from your own point of view was how you felt about the events that were unfolding or as a result of how you felt about the events that were unfolding?---Yes. But I think my distress was more inside me than outside me. Well, that's what I thought. But, you know, as I said, as there was a perception that, you know, I was in any way being unprofessional or obstructing what was going to
15 happen, I wanted the best outcomes for the students. So that's why I went to my doctor and, you know, got away from the situation for my own benefit and the benefit of everybody else there.

Yes. I was going to suggest to you that part of the distress you were feeling was also
20 because of what you were observing about others and how upset that made you feel, about their distress?---That would be very true. As the principal of the school, I mean, you have a responsibility to the staff where you have a responsibility to the adolescents as well. And because of our close involvement with all of the staff at the Centre, there were a lot of people to support. I suppose the senior people are the
25 people that others look to to support them at that time.

It is the case, isn't it, that on reflection you can see that the distress that you were experiencing may well have affected the way in which you behaved towards others, including Dr Brennan?---I don't believe it did. But I believe that there was a
30 perception that that was the case, and I'd be interested in other people's evidence about that – about my behaviour.

Alright. Do you recall that there was an episode – I'm sorry, I'll rephrase that – that there was a time shortly before you went on leave where there was a plan that had
35 been developed by teaching staff to conduct a forum or meeting for patients and their families to discuss personal education plans for the patients?---Yes, I do.

And the plan was to, in fact, have the discussion about the individual patients' personal education plans with the group, the cohort of patients and parents
40 together?---I can't – I would've thought that might be an element of it, but certainly if we're discussing an individual plan, I would've expected that that part of the evening would've been just with the parent/carer and the adolescent themselves, yes.

That plan for – with respect to that meeting came to be discussed in a meeting of the
45 clinical care transition panel that was held on the 16th of October, I suggest. Does that recall generally with – or reflect generally your recollection?---I can't recall

being at a meeting like that. I do recall Dr Brennan speaking with me about this forum, though.

Alright. And she raised concern with you about the idea of those discussions going
5 on other than through individual sessions with families and their children?---That's correct, so I therefore cancelled the meeting, and in any case there was little interest. There were only three parents who were interested in coming.

Alright. Well, I suggest - - -?---I did – I did follow Dr Brennan's direction about that
10 and her concerns about that.

I suggest that as that conversation continued, you said to DR Brennan words to the effect, "If you think things are bad now, they are only going to get worse"?---I can't recall.

15

And that you told her that there would be union involvement, in that there was an intention for union delegates to visit The Park together with some politicians?---That is incorrect. Can I explain further?

20 Yes?---Yep. I actually only can recall speaking with Dr Brennan on two occasions. One was in the hallway – this was before I went on leave. One was in the hallway, when I asked her about the job and, you know, why she was doing the job, and the second was when I went to her office, when I – the Queensland Teachers' Union had been in touch with me. They wanted to have a meeting of the staff, and so I thought
25 that I needed to let Dr Brennan know about that meeting. So I actually went to her office and sat down and discussed that with her. There were other matters raised about there. If you want me to go into those I can. But it was at – you know, in her office at that time that I spoke to her about the QTU meeting.

30 See, I suggest to you that Dr Brennan asked you if Sharon Kelly had been informed about the union visit and that you advised her that Ms Kelly had not been told?---I would think that would be correct.

And Dr Brennan asked you whether she could inform Sharon Kelly about it, and you
35 advised that that was okay as far as you were concerned?---Yeah, that's fine.

In the same conversation, you told Dr Brennan that any communication sent to you from Dr Brennan would be provided to the young people and their families?---No. I never said that.

40

You would agree that if you did say such a thing, it would've been inappropriate for you to have done so?---Absolutely.

See, I suggest to you, Mr Rodgers, that from very soon after, if not immediately on
45 Dr Brennan's arrival at the Barrett Adolescent Centre to take over from Dr Sadler, your communications with her were characterised as – to use the term – confrontational?---I disagree with that. When Dr Sadler – Dr Brennan arrived at the

centre, I went up and gave her a hug and a kiss. I'd worked with her in '95 very closely, when she was a registrar there. Before the end of the first week I'd gone and given her documents about the school so that she could familiarise herself with the school, and I wouldn't describe my behaviour towards her as confrontational.
5 Certainly we raised some issues in the first meeting with her, with other people present.

Well, that first meeting was on the 13th of September, wasn't it?---I'm not sure, but I'd – yeah, probably agree with that.
10

Well, it's - - -?---I didn't think – I thought it was, yeah, probably that date, yeah.

Yeah. If you go to, please, page 53 on Delium of the statement, is that the meeting that you were speaking about earlier in your evidence, when you spoke of - - -?---I
15 think this was a meeting – I thought it was earlier in the week than this, but it makes reference to the meeting on the 11th of September, yeah, not the 13th of September.

I see. Well, if you go back – if we can go back to the previous page, there's a reference there at the bottom of the page to the 12th of September, but then about the
20 fifth paragraph down a reference to the 11th of September. They appear to be the entries that cover the first few days after Dr Brennan's arrival?---Yes, they do.

The concern that you mentioned to Mr Freeburn before that affected the – your role with respect to the transition panel meetings was about the teachers being treated –
25 I'll use these terms, to summarise the effect of your evidence. You can disagree with me if it's wrong. But being treated disrespectfully by being made to wait for a meeting to which they've been invited to attend with the psychiatrists?---Okay, yeah.

Well, okay. You accept that that's the characterisation of what the complaint
30 was?---Yes.

And that was about a meeting that was intended to happen on the first day of Dr Brennan's arrival, wasn't it?---I'm not sure if it was the first day or second day.

35 Alright. First day or second day?---Yeah.

Either way, that was something that was a continuing cause of concern as far as you and perhaps other teaching staff was concerned, wasn't it?---What was?

40 The fact that you had been – you and the staff had been kept waiting for that meeting?---That was only one occasion, yep.

But it was one occasion that continued to be a source of irritation, wasn't it?---We used to have to wait a lot for clinicians.
45

I see?---There would be events that would occur that caused things not to happen on time.

See, what I suggest to you, Mr Rodgers, is that you had been feeling the effects of stress and strain with respect to the potential closure of the Barrett Adolescent Centre from as far back as November 2012?---That may be the case. I really don't know if it was back that – and, as I say, I can't remember taking any leave at that time.

5

And that the feelings that you experienced as a result of your great passion for this centre, in the circumstances in which it was about to be closed, did affect the way in which you conducted yourself towards Dr Brennan?---You may be – you may be right, and that's why I say I would be very interested in others' point of view on this.
10 I don't believe that I did. I thought I acted professionally and in the best interests of the students.

But you accept that that's something difficult for you to say given that it's an observation about your outward behaviour towards others?---It's an observation from
15 one person. That's why I said I would like to hear what others would say about my behaviour at that time towards Dr Brennan.

Thank you. Thank you, Commissioner.

20 COMMISSIONER WILSON: Any other cross-examination? Mr Fitzpatrick?

EXAMINATION BY MR FITZPATRICK [3.41 pm]

25

MR FITZPATRICK: Yes. Thank you, Commissioner.

Mr Rodgers, I'm Chris Fitzpatrick and I'm acting for West Moreton - - -?---Yes.

30 - - - one of their counsel. Now, Mr Rodgers, your situation as at 2013 regarding the Barrett Adolescent Centre was that you had worked there continuously for 20-odd years. Is that correct?---Since September 1987, yes.

Correct. And you may not know this and tell me if you don't but your employment
35 at the Barrett Centre was preceded by Dr Sadler, wasn't it, by one year?---Yes. He wasn't – he wasn't the director at the time. He was still in his training and – yes, he was there then.

I understand. And so was he there before you or you there before him?---No, he was
40 there – he was already working there when I first arrived.

I understand. And you worked together closely and collaboratively as you've described from 1987 until 2013 – September of 2013?---Yes. We had – it was – it was a very professional relationship. He's not the sort of guy you go and have a beer
45 with at the pub sort of thing so we didn't mix socially outside be had a very close working relationship and I - - -

Yes?--- - - - and I think he's a terrific psychiatrist.

Yes. Now, I assume that from the time when you first met Dr Sadler it took some time for you to gain each other's confidence and respect as you've just described to
5 the point you characterised him as a terrific psychiatrist?---I – in terms of time, yeah, I don't think it would have taken a long time but, yes, I suppose it does take time to build up that kind of respect.

Yes. An ordinary human experience, Mr Rodgers, is that it takes some time of
10 varying lengths to build a rapport. Is that correct?---I've not read any literature about that but I – I accept what you're saying.

Alright. In fact, I think you told the Commission that when you commenced at Barrett there was some territorial issues. Is that correct?---Absolutely.

15

And I think you said that it took you and Dr Sadler working collaboratively more than 10 years to address those. Is that correct?---Yes. I used the 10 year term, you know, loosely. You know, it could be five, it could be 15, you know, but it takes – it takes a very long time, I think, to turn around a culture that's in a – in a place.

20

Now, you've said that with the – by the way, I take it that from your membership and participation in the Expert Clinical Reference Group you had insight into the fact that the Barrett Centre was likely to close?---Yes.

25 And that there was a model of care that was being developed around that?---Yes.

And I gather from your participation in the ECRG and your reading of its report that you understood that it was accepted by all that an important aspect of the redevelopment was the educational component. Is that correct?---I believe all of the
30 members felt that – all the members of the ECRG.

Yes. In fact, I think it was expressed in the ECRG that the education resource was essential?---Yes. I think that was agreed by everyone.

35 You would have taken notice of that?---Well, I probably would have proposed but, you know, these were very experienced and eminent people in the adolescent psychiatric area and most of them had experience in units where there were schools attached and had seen the benefits.

40 Yes. And am I right, also, that it was known from an education perspective that whatever may become of the Barrett clinical unit the Barrett School would not close?---We were assured of that by Peter Blatch and the HR people at Metropolitan Regional office.

45 Yes. And your Minister had made some statements to that effect, didn't he, in August 2013?---I didn't see those but, you know, I think it was fairly consistent in

the Education Department that they wanted to keep the expertise of the group together.

Yes. Alright. Now, you've given evidence that when Dr Sadler was stood down the
5 effect on the patient cohort was, I think, you've described it as chaotic?---Yes.

And you said that you – there was an occasion when Sharon Kelly and two consultants arrived at the unit shortly after – if I've understood correctly – Dr Sadler was stood down. Is that correct?---Yeah. I believe it was the day after.
10

Yes. And were the two consultants – are you able to identify them as Dr Brennan and Dr Hoehn?---Yes.

Alright. And you've said that, in your observation, the consultants went into a
15 meeting with the students. Is that correct?---We were told that we were to go to a meeting - - -

Yes?--- - - - and we went across to go to the meeting and we stood outside our meetings room that we met in every morning with the students and then the
20 consultants came and told us that we weren't invited to that meeting. We had been told that that was the meeting we were to go to and then we were told that there would be a separate meeting for the education staff.

Yes. And am I right to think that you were offended by that?---Yes. It was not part
25 of our culture to be meeting like that and it seemed to me that there was a definite – and in subsequent meetings that there was definitely – seemed to be a situation where people would come and meet with Health Department staff, people would meet with Education Department staff and people would meet with the students so that everyone was kind of divided up into little parts, if you like.
30

Yes. Now, Mr Rodgers, I don't want to be unfair to you because as you've said you weren't a party to the meeting that occurred between the consultants and the students but as I understand your evidence your central concern throughout your time at Barrett including to it closure was for the welfare of the students?---Absolutely.
35

You would regard their welfare as a matter of utmost priority?---Yes. And in the 26 years I was there despite several attempts at suicide no one had ever completed an attempt at suicide.

40 Yes. Well, can I suggest to you that that was how Drs Brennan and Hoehn looked at things when they first went to the Centre on that day, that is, that the student welfare was of utmost importance and it necessitated them meeting the students even if it meant that the teachers were kept waiting for some short period of time.

45 COMMISSIONER WILSON: Mr Fitzpatrick, how can this witness answer a question about what was foremost in the minds of Drs Brennan and Hoehn?

MR FITZPATRICK: Yes. I withdraw that, Commissioner.

COMMISSIONER WILSON: How much longer do you expect to be? Mr Fitzpatrick, how much longer?

5

MR FITZPATRICK: Yes. Commissioner, I'm finishing.

COMMISSIONER WILSON: You're finished?

10 MR FITZPATRICK: Yes. Thank you.

COMMISSIONER WILSON: Alright.

MR FITZPATRICK: Yes. Thank you.

15

COMMISSIONER WILSON: Does anyone else wish to ask any questions? We haven't had an afternoon break but if we can conclude this fairly promptly I won't break.

20 MR McMILLAN: I only have a very few questions.

COMMISSIONER WILSON: Alright. Mr McMillan.

MR McMILLAN: Thank you, Commissioner.

25

EXAMINATION BY MR McMILLAN [3.51 pm]

30 MR McMILLAN: Mr Rodgers, as you know, I act for Debbie Rankin?---Yes.

I only have a very few questions for you. You were asked some questions by Mr Freeburn about the importance of the onsite school for the model of care that was delivered by the Barrett Adolescent Centre when it was at Wacol?---Yes.

35

It is the case in your experience – in your long experience as the principal of the Barrett school there that the students, when they came to the Barrett Adolescent Centre commonly had been disengaged from education for extended periods of time before their admission?---Yes, I think the average was something like six months,
40 but it was probably – you know, in some cases, up to two years that adolescents hadn't engaged in school.

And unless they were acutely unwell, it was generally expected that the students who were inpatients at the Barrett Centre attended school every day?---Even students who
45 were acutely unwell – like, we had had students who were on suicide watch with two nurses beside them 24 hours a day, who would come over to school and do activities

at school, and, in a way, this was very therapeutic because it took their mind off the dominating theme of killing themselves.

Is it the case that one of the advantages of the school being so proximately located with the health service, if I can put it that way, is that students could, if necessary, go back and forth between the school and the hospital as required during the day?---Yeah, well, that went both ways, you know, that if they had heightened anxiety or problems with self-regulation they could go back to the ward, but it also meant that for students who had a lot of anxiety who were school refusal, they really only had a short way to get to school, so it really helped them to take advantage of the school that was there.

The Commission has heard some evidence that for adolescents with mental illness attending school is a normalising experience. In your experience at the Barrett Centre, was the attendance of patients at the Barrett school a normalising experience for them?---Yes, but where possible, I mean, you know, you always work with the principle of least restrictive environment, so where adolescents could, we wouldn't want them to be at our school; we'd want them to be at local schools or attending education programs at TAFE or outside the centre. But yeah, certainly it's a normalising experience for them to come to school and, as I said, you know, makes part of them feel that, okay, well, I've got lots of these parts of me that aren't okay, but, you know, I'm okay at school. Another thing I do want to mention that I haven't been able to yet is about – you know, one of the things that we really tried to do was to promote mindfulness with the kids, that it was part of the dialectic behaviour therapy, but we understood that, you know, with kids with post-traumatic stress disorder, they were concerned about past experience. For those who have anxiety, they're worried about future experience. So if you can provide activities in a school that, you know, put them in the place of now and not worry about the future and the past, that is very therapeutic.

Is it the case that you as principal and the school teachers tried to develop situations where the students at your school could experience some successes in their lives?---Absolutely. I mean, the question about NAPLAN was, you know, around that, that to be able to sit tests where, if they hadn't been to school for two years and we know that they're not going to do well in those tests, it's only going to reinforce failure for the students. So it was all about finding the things that they – an individual student was good at and working through those to try to get improvements in other areas.

Thank you. I want to ask you a question about the meeting that's been referred to earlier in your evidence with Professor McDermott in 2014?---Yes.

Is it the case that after the Barrett school relocated to Yeronga, you initially approached Dr Stathis with a request for the provision of some hours for a consultant psychiatrist to come to the school to assist you there?---That's not quite correct. I think I referred earlier, when I was speaking about a meeting that I went to with Dr Stathis and Ingrid Adamson – it would've been in the last eight days that I was at the

school in the year previously, so it wasn't that I spoke to Dr Stathis in early two thousand and – where are we now?

2014?---2014. I was at school in that first term, and I do remember the two things
5 that were on my mind to get across to people – to the parents and carers and the students – was that whilst we could look after educational needs, we couldn't look after their mental health needs. And the parents were saying that they needed more care – mental health care for the students. Dr Sadler had actually offered to give his time free of charge and come a couple of hours every two weeks. We put that to Dr
10 McDermott at the meeting and he didn't think that was appropriate.

Can I just take you back a step, please?---Yes.

When the school moved to Yeronga, at that stage you understood, didn't you, that
15 each of the students from the – that were formerly inpatients at the Barrett Centre had been transitioned to the care of another psychiatrist for their ongoing psychiatric care. You understood that, didn't you?---Yeah, I wasn't part of the transition panels, but I did understand that their mental health care – I don't know if it was under – everyone was under psychiatrists. It may have been a different type of service, but
20 everyone had a mental health transition plan that was done by the clinicians to – you know, to look after their needs.

So why was it that you thought that the school would benefit – the school or the school community would benefit from those additional psychiatric hours at the
25 school?---We had a range of students. As you know, there were 11 students who were transitioned out of the Barrett Adolescent Centre, and there were clinical meetings to decide which of the students could be enrolled at the Barrett Adolescent Centre. So that we only had five enrolled – six enrolled, and we saw five in an outreach way, and those - - -

30

COMMISSIONER WILSON: Excuse me. Would you pause for a moment?---Yes.

We're starting to talk about very low numbers. Once we start to speak about low numbers, there's a possibility of identification. If you want to lead this evidence, Mr
35 McMillan, I think it should be in a closed hearing.

WITNESS: Maybe you could ask me the question. I can answer it without - - -

MR McMILLAN: Well, Mr Rodgers, if you think you're able to explain why you
40 sought additional psychiatric input without discussing the numbers of students or the individual students you can, but otherwise, if you wish to do that we can close the hearing, as the Commissioner has indicated?---Yeah. The simple answer is that the parents or carers expressed a concern that they needed more help for the adolescents, and also we had some students there who, in our perception – and we weren't trained
45 in any clinical sense, but certainly from my 26 years' experience, I could see that there were some adolescents that were attending the school that needed additional help, so we tried to seek that for them.

Do you recall whether – when you first raised this issue with Dr Stathis, whether he was the person who referred you ultimately to Professor McDermott?---Yes, I raised the issue with Dr Stathis, and it wasn't any formal meeting. It was at the meeting where Ingrid Adamson was explaining the different services that were coming
5 online, and at that meeting I just had a quiet word with Dr Stathis and said that – you know, that we were going to be at this school and that we needed some extra mental health input. I don't know if I mentioned that Dr Sadler had offered at that stage, but he said this would come under Professor McDermott's umbrella. So he was the person to talk to.
10
You sought a meeting with Professor McDermott, and that meeting ultimately occurred in April 2014; that's correct?---Yes.

And for reasons that we don't need to go into, that meeting was ultimately overtaken
15 by discussion of another event other than the initial purpose of that meeting, wasn't it?---Yes, it was.

Did you make any further inquiries with Professor McDermott or Dr Stathis about getting additional psychiatric support at the school after that initial meeting?---No.
20 At the meeting Debbie Rankin and I had gone with the agenda of getting some extra assistance for our students. But it was – Professor McDermott took over the meeting and asked us about the services that students were receiving. And I - - -

And then there was some discussion of another matter that is not relevant to my
25 question. That's - - -?---Right. Yep.

That relates to a particular patient?---Yes.

Thank you. Finally, Mr Rodgers, you were asked some questions about leave that
30 you took following Professor McDermott's evidence in another public inquiry in late 2013 – sorry, late 2012?---Yes.

It's the case, isn't it, that you had some planned holidays in early 2013, two weeks when Stephen Marriott acted as the principal?---I should be able to recall but I just
35 can't recall what happened.

Alright?---You know, I can't - - -

If you don't remember, that's alright?---I can't recall taking the leave. Sorry.
40
Thank you. That's – I have no further questions. Thank you, Commissioner.

COMMISSIONER WILSON: Is there any other cross-examination? Ms Kefford?

45 MS KEFFORD: No.

COMMISSIONER WILSON: I'm sorry? Mr McLean Williams, is it?

MR McLEAN WILLIAMS: Yes. With your leave, Commissioner.

COMMISSIONER WILSON: How long will you be?

5 MR McLEAN WILLIAMS: One question.

COMMISSIONER WILSON: Very well.

10 **EXAMINATION BY MR McLEAN WILLIAMS [4.02 pm]**

MR McLEAN WILLIAMS: Mr Rodgers, my name is McLean Williams. I am counsel for Justine Oxenham. Just in terms of understanding the chronology of
15 events, you received – or the education staff received an assurance from Mr Blatch in relation to the future of the Barrett School. Was the assurance received before or after the commencement of Dr Brennan in the position of acting director?---Definitely after but maybe even before.

20 Definitely after?---Definitely after but maybe even before. That was consistent that both Peter Blatch and Judith Duncker in their visits to the Centre – to the school spoke with the staff and assured them of continuity.

Conceivably it could have happened before Dr Brennan commenced?---It could have
25 happened before Dr Brennan commenced, yes.

Could it have happened before the official announcement of the closure of the Barrett Centre in August of '13?---I don't think so because in my understanding Peter Blatch had no knowledge in the end of the 2012 that the place was going to close and I
30 believe in his evidence when I saw him presenting the other day was that he only learnt about that after the Minister had announced it so I don't know he would be talking to me about that before – before the Minister announced it. I think – I think he may have talked to us and been a consistent visitor and saying that to us after.

35 Yes. Thank you. No further questions, Commissioner.

COMMISSIONER WILSON: Alright. Ms Kefford, your turn.

MS KEFFORD: Nothing, Commissioner.

40

COMMISSIONER WILSON: Alright. Does anyone else have any questions? Mr Freeburn, do you have any questions?

MR FREEBURN: No, I don't.

45

COMMISSIONER WILSON: Alright.

MR FREEBURN: May Mr Rodgers stand down.

COMMISSIONER WILSON: Yes. Thank you very, Mr Rodgers. You can stand down?---Thank you.

5

WITNESS STOOD DOWN **[4.04 pm]**

10 COMMISSIONER WILSON: Are there any housekeeping matters, Mr Freeburn?

MR FREEBURN: I think there's a matter that Ms Wilson - - -

COMMISSIONER WILSON: Ms Wilson.

15

MS WILSON: I've got one, Commissioner. Considering some of the evidence and some of the issues [indistinct] that it canvassed this afternoon you're – the Commissioner may consider reciting some of the words from Mindframe guidelines.

20 COMMISSIONER WILSON: I'm not sure about that.

MS WILSON: It's a matter for you, Commissioner. I just thought - - -

COMMISSIONER WILSON: What you have on this page – have you distributed it
25 to others?

MS WILSON: No, I just – I keep it – I just have it on the bar table in case that something like that occurred. I wasn't expecting it.

30 COMMISSIONER WILSON: No. If those guidelines are on the table outside I might leave it at that.

MS WILSON: Certainly, Commissioner.

35 COMMISSIONER WILSON: Does anyone else wish to say anything? How are we travelling? We've caught up with one witness. I take it there are still inquiries being made about when the other witness we passed over on Tuesday should give evidence. Is that correct?

40 MR FREEBURN: Yes.

MR FITZPATRICK: Yes, Commissioner.

COMMISSIONER WILSON: It seems to be you, Ms Wilson.

45

MS WILSON: Well, I did think that. It's my aura, Commissioner.

COMMISSIONER WILSON: Alright. Now, I just want to check on tomorrow. Mr McGrath, 9.30. That's still the case, is it?

MR FREEBURN: Yes, thanks. Yes. I think that's - - -

5

COMMISSIONER WILSON: Ms Daniel at 10. Dr Hoehn at 11 and Dr Stedman in the afternoon.

MR FREEBURN: I think there is some moves afoot to – I hesitate to use this
10 expression – but get rid of Dr Hoehn, that is, that it may not be necessary to call her. So if that happens we can move people up the batting order or it may be that we can organise that replacement.

COMMISSIONER WILSON: Well, before I say anything Ms Robb has been very
15 anxious to say something. I don't know what it is. Ms Robb.

MS ROBB: I don't think this will be news to Mr Freeburn but my understanding – we've received a formal notification this afternoon from the Commission that Susan Daniel won't be required because the two parties that had indicated they wished to
20 cross-examine her no longer do. That would be counsel for the family and counsel for the State. So there's another hour freed up there.

COMMISSIONER WILSON: Alright. So no one else wants to cross-examine Ms Daniel. Well, I'll assume then that Dr Hoehn will be coming forward to about 10
25 o'clock. Dr Stedman – is that evidence ready to be presented? I ask that because I recall from a couple of days ago he was going to be asked some questions about research into outcomes.

MR FREEBURN: The only thing I can say about that is that we haven't yet
30 received the research but I'm told that there's a meeting arranged at the Commission with Dr Stedman for 8 am tomorrow.

COMMISSIONER WILSON: Alright. Well, we'll assume for the moment that it will be able to proceed in the afternoon.

35

MR FREEBURN: Yes.

COMMISSIONER WILSON: And then there's the argument about privilege at 3.15.

40

MR FREEBURN: Yes. I had thought that was 4.15.

COMMISSIONER WILSON: At one stage it was shifted to 4.15. It hasn't come back to 3.15 - - -

45

MR FREEBURN: I don't think so.

COMMISSIONER WILSON: It was to suit – well, to fit everyone one in and not to keep Mr Dunning waiting given his other commitments.

MR FREEBURN: Yes.

5

COMMISSIONER WILSON: So I will assume that's 4.15.

MR FREEBURN: Yes.

10 COMMISSIONER WILSON: Alright. One thing at a time. We'll leave it at that, I think.

MR FREEBURN: Thank you, Commissioner.

15 COMMISSIONER WILSON: No one else wants to raise anything? Very well. 9.30 in the morning, then.

MATTER ADJOURNED at 4.09 pm UNTIL THURSDAY, 3 MARCH 2016