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TRANSCRIPT OF PROCEEDINGS

THE HONOURABLE MARGARET WILSON QC, Commissioner

MR P. FREEBURN QC, Counsel Assisting

MS C. MUIR, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 4) 2015

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

BRISBANE

9.31 AM, FRIDAY, 4 MARCH 2016

Continued from 3.3.16

DAY 20

RESUMED **[9.31 am]**

COMMISSIONER WILSON: Good morning, ladies and gentlemen. Yes, Ms Muir.

MS MUIR: Commissioner, there's one housekeeping matter. If I hand - - -

COMMISSIONER WILSON: Yes.

MS MUIR: - - - to you the documents to be tendered on 4 March 2016. Copies of this document have only just gone to the respective legal representatives so if there's any issues they can be raised with me in the morning break.

COMMISSIONER WILSON: Very well. I'll adopt the usual course of waiting until lunchtime and if there has been no issue raised the documents will be assigned the numbers you've provisionally given them.

MS MUIR: Thank you, Commissioner. Before I formally call Dr Brennan, part of Dr Brennan's evidence will be in closed court. Arrangements have been made through the Commission of who will be able to be present during those closed hearings and the proposal is that the relevant family members will be present when I'm asking questions about their particular child. Insofar as the families of the three young people who died are concerned the Commission has agreed that it's appropriate for those three families to stay in together for the evidence of their particular child. Apart from that I will indicate then - when it's appropriate – when I'm about to start that line of questioning. Apart from that, my understanding is it will only be Vanessa Clayworth who will be present during the closed hearings.

COMMISSIONER WILSON: Are all counsel and solicitors happy with those arrangements? Alright. I'll leave it to the Commission staff. I see Mr Thompson is here and I'm sure he will take charge of it.

MS MUIR: Thank you, Commissioner.

COMMISSIONER WILSON: Yes, Ms Muir.

MS MUIR: Commissioner, I call Dr Anne Brennan.

MR A.T. SUTHERS: Your Honour, if I may - - -

COMMISSIONER WILSON: Excuse me, Dr Brennan. Just a moment. Yes.

MR SUTHERS: I should announce my appearance, Suthers, S-u-t-h-e-r-s, initials A.T., solicitor for Metro North Hospital and Health Service. Just on a point that came up yesterday with some evidence - - -

COMMISSIONER WILSON: Well, let Dr Brennan sit down for the moment, would you.

MR SUTHERS: Okay. Sorry.

COMMISSIONER WILSON: Sit down, Dr Brennan and I will swear you in in a moment. Yes.

MR SUTHERS: Yes, your Honour. I understand that your Honour had some concerns around a procedural fairness point as Mr Allen was not here yesterday. Learned Counsel Assisting suggested perhaps that Metro North Legal Services have an opportunity to read the transcript overnight to see if there was any questions that we would have for Dr Stedman or Dr Hoehn.

COMMISSIONER WILSON: Yes.

MR SUTHERS: I just wish to advise the Commission that we've had an opportunity to read that transcript and there's no questions and no need to recall from Metro North's point of view.

COMMISSIONER WILSON: Thank you very much for that.

MR SUTHERS: Thank you, Commissioner.

COMMISSIONER WILSON: Yes, Dr Brennan.

ANNE BRENNAN, SWORN **[9.34 am]**

EXAMINATION BY MS MUIR

MS MUIR: Thank you, Dr Brennan. You acted in the role as clinical director at the Barrett Adolescent Centre - - -

EXAMINATION BY MR DIEHM **[9.34 am]**

MR DIEHM: Excuse me, your Honour – Commissioner, I should say. There were a couple of corrections that I alerted Ms Muir to that in her enthusiasm she has no doubt overlooked.

Dr Brennan, you have provided three statements to the Commission?---I have.

Can the first statement, please, DAB.001.0001.0001 be brought up on the screen and if we can go to page 2 and scroll down to paragraph 5(a). Now, Dr Brennan, this is your first statement that is on the screen?---Yes.

Is there a correction that you would wish to make or a qualification with respect to the information in that subparagraph?---Yes. 10 September I believe should be 9 September.

Thank you. And if we can then go through to page 26, please - - -

COMMISSIONER WILSON: Wait a moment. While we're still on 5(a) - - -

MR DIEHM: Yes.

COMMISSIONER WILSON: - - - is there a typographical error in the last date there?

MR DIEHM: Thank you, Commissioner. And Dr Brennan, you will see at the end of the paragraph it says 6 August 2015 with respect to the communication of the decision to close Barrett?---That should be 2013.

Thank you. Now, if the operator can take us through, please, to paragraph 102 on page 26. Dr Brennan, perhaps if I can deal with it this way so that we don't have to close the court, that paragraph referred, you may recall, to a risk assessment for a particular patient?---That's right. I'm aware of the patient.

And it described the risk assessment as having been high. Do you recall what you would wish to say about that statement?---Yes. I'd like high changed to medium.

Thank you. Dr Brennan, with the assistance of the bailiff as need be ideally these microphones ought be able to be positioned so that you don't need to uncomfortably lean in towards them so we might see if we can have that attended to. Whilst that's being done if I can ask the operator to go to the second statement, please, which is DAB.001.0003.0001. And to go through to page 18, please. Now, Dr Brennan, again, this paragraph is partially redacted. I want to draw your attention to paragraph (c) – subparagraph (c) on that page?---Yes.

And you will recall that that paragraph deals with some evidence that – in fact – I'm sorry, Commissioner, I hadn't given this enough consideration. This particular correction cannot be dealt with other than in closed court so I might come back to that when - - -

COMMISSIONER WILSON: Come back to that.

MR DIEHM: - - - the Commission is in closed court.

If we can go through to page 35, please, and if we can scroll to (xiii). Now, Dr Brennan, that subparagraph refers to brokerage funding being secured for every patient. Should that be changed so that it reads:

For every patient requiring accommodation.

?---Yes, it should.

Thank you. And the remaining correction, Commissioner, again, probably not of any great consequence but ultimately can be attended to but will need to be done in closed court as well.

COMMISSIONER WILSON: Very well.

MR DIEHM: Thank you.

COMMISSIONER WILSON: Thanks, Mr Diehm.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER WILSON: Yes, Ms Muir.

EXAMINATION BY MS MUIR **[9.38 am]**

MS MUIR: Dr Brennan, you acted in the role as clinical director at the Barrett Adolescent Centre from 11 September 2013 to 30 January 2014 but you remained employed with West Moreton Hospital and Health Service until 9 March 2014. I just wanted to understand your role and the task that you carried out between 30 January 2014 and 9 March 2014?---In the first week of that period I remained working at the Barrett Adolescent Centre for a few days and then moved up to the administration building of The Park Centre of Mental Health and in that time I worked on discharge summaries and responding to phone calls and emails from families, carers, service providers, anybody who had queries about the Barrett Centre and its previous operation and also about its closing. There were a lot of calls relating to people wanting to obtain equipment. I then moved to Ipswich CYMHS as consultant psychiatrist leading a multidisciplinary team. That was on the basis of three days work per week but that was only for a three week period, as you say, till 9 March. While working at CYMHS I also was involved, by phone calls and emails, with Dr Stephen Stathis, Leanne Geppert and Kathy Stapley, head of social work, in addressing the patients on the waiting list and on the assessment list for the Barrett Centre. Some of that work had previously been done but it hadn't been finalised and I assisted with that at the same time, as I say, continuing to field phone calls and emails in regarding to the patients who had been discharged from Barrett.

I'll ask you some more questions about those matters in closed hearings. I want to understand fully how you came to assume the position of acting clinical director. In paragraph 5 of your first statement you say that you were telephone by Dr Steer of Children's Health Queensland in the evening of 9 September 2013 and he told you that Dr Sadler would be stood down effective immediately. Is that correct?---That is correct. I – my recollection is that I was phone on the 9th and told that Dr Sadler would be stood down the following morning and I was phoned – then I had to phone back which I did. I was – I then spoke to Dr Peter Steer and Mr John Wakefield who I think was the executive director of medical services and they explained the position to me at that point.

And you were asked to take on, and you accepted, the position of Acting Clinical Director on a part-time basis; is that correct?---I did.

And you understood at the time that you took on the position you would be assuming the responsibility for clinical care, and given that the centre would close, the implementation of the existing transition plans; is that correct?---That is correct.

On paragraph 14 of your first statement, which is at DAB.001.0001.0001 at 0004, you say that Dr Kingswell discussed with you and Dr Hoehn the need to transition all patients from the Centre as soon as possible. So if we can get our bearings time-wise, with respect to whether it was at the time you were asked to take up the clinical role of some time later down the track, when do you think this conversation took place?---I know that conversation took place as we walked towards the Barrett Centre for the first time. Preceding that visit, we had had a meeting with the executive in the administration building. So that was actually at The Park. I had accepted the position by phone on the previous day.

And so this is on 10 September. So you were with Dr Kingswell when he told you that the transition needed to happen as soon as possible?---Yes.

And did Dr Kingswell give you a reason why there was this need to transition all patients from the Centre as soon as possible?---I don't recall the specifics of that conversation or if he gave a reason for that. We had just come from a meeting with the executive, where it had been discussed, but I don't recall anything specific from him.

And when you talk about the meeting with the executive, who are you talking about?---Sharon Kelly – I think their positions are known to the Commission now - - -

Yes?--- - - - so I'll just say their names – Leanne Geppert, William Brennan and Padraig McGrath, Dr Darren Neillie – I cannot recall specifically if he was in that meeting. I know he was in a meeting the next day and I know I met him on the afternoon of, I think, it was the 11th – the 11th or the 12th, and I can't be specific about that. But I think – I thought he was in that meeting, but he may not have been.

And my vague recollection is that there were two other people, but I cannot recall who they were.

So just taking you back to Dr Kingswell and what discussions you had with Dr Kingswell on 10 September 2013, apart from Dr Kingswell saying to you that the transition needed to happen as soon as possible, were there any other issues that Dr Kingswell raised with you at that point?---I cannot recall if he raised any other issues, but just to be clear that conversation did not occur on the 10th. My recollection is that it's the 11th. It may have – yes, it would have been 11th.

Because you had the phone call on 9 September?---I had the phone calls that confirmed the appointment on the 10th, and I spoke to Dr Sadler on that afternoon. And then I went to Barrett on the 11th, and I spoke to Dr Kingswell in person at Barrett.

Perhaps if we could just go back to paragraph 5 of your statement. I had – and perhaps it's my mistake – I had thought that at the beginning of your evidence you changed the date from the 10th to the 9th?---Yes. As I say, I think what occurred was that I was rung on the 9th and I think I wanted to check with my husband whether he thought this was a wise idea. And I recall – and I've tendered all my text messages to the Commission, so it could be checked – but my recollection is that I then sent Peter Steer a text message, telling him at what time he could phone me, as in that it was quite early in the morning, but I was happy to be phoned early in the morning. And I'm reasonably confident that was the morning of the 10th. I'm happy to be correct on those dates.

You have knowledge that I don't have about what occurred, Dr Brennan, so I just wanted to understand whether it was the 10th or the 11th. I just want to understand the extent of the conversations that you had with Dr Kingswell about the need to transition the patients as soon as possible. And if I understand your evidence, you really can't recall to any great extent what was said. But would it be fair to say that if Dr Kingswell had raised issues of concern in relation to some risks or any other governance concerns, that you would recall such a conversation with him.

MR DIEHM: With respect, that's speculative, to invite the witness to comment upon that, Commissioner.

COMMISSIONER WILSON: That's so, Ms Muir.

MS MUIR: I'll move on, Commissioner. You say in paragraph 14 of your first statement that you were under the impression that West Moreton executives wished the closure to occur quickly, subject to the safety of patients. Can I ask: what caused you to have this impression? Were there particular conversations that you had with Ms Dwyer or Ms Kelly or one of the other West Moreton executives that led you to form this impression?---Yes. The picture created in the meeting with the executive on that first morning was of a unit where there was a pattern of episodes involving risk to young people that they were concerned about. I didn't get a sense that they

needed the unit closed quickly for any reason other than that, but they had conveyed that they had been concerned for quite a period of time and that there had now been an incident that needed to be addressed and – or that had been addressed, and their concerns were of ongoing safety in the unit. But they did assure me that it was – and in subsequent sessions – that it was to be done with patient welfare considered.

At paragraph 9 of your second statement, DAB.001.0003.0001.0008, you answer some further questions in relation to the formal handover that you understood had been promised from Dr Sadler?---Yes.

And you say that the major impediment to a handover was that the staff received a written direction that they were not to contact Dr Sadler. Did you think at that time that a handover from the former long-term clinical director would have been of great assistance to you?---Yes, I did, and I was under the expectation that I would receive one, as I had had a phone call with Dr Sadler.

No doubt you considered that it would have, at the very least, given you some insight and guidance as to the staff and the resources and the patients?---Yes.

And, ideally, what would that handover have entailed?---A brief synopsis of each patient, but with, if I can say, a nuanced view of what their presentation was and what their needs were. Dr Sadler was an experienced psychiatrist and he knew this patient group very well. He had been their sole psychiatrist, for some up to a number of years. So that would have been the most critical component, in my view. I would also have appreciated his, perhaps, view of staff and their skills and who to rely on and any advice regarding potential, if you like, traps for new players. In retrospect, I can make all sorts of comments about that, but at the time I guess what I expected was a clinical summary more than anything.

Did you try and speak to Dr Hoehn or Sharon Kelly or Dr Neillie about following up on a handover or the good sense in having Dr Sadler give you such a handover?---I did. Dr Hoehn was aware of that situation; I had spoken to her of it. And as well as that, I approached Dr Neillie directly about it, and he was going to speak to Dr Sadler.

But to no avail. You didn't get the handover, did you,?---No, I didn't.

So without any handover, am I correct in understanding your evidence that it became pretty clear to you when you started on the job that, in fact, you had to devise transition plans, implement those plans and see to the clinical care of the patients more generally?---That's correct.

And in your evidence, you say that you discovered relatively quickly that there were no lists or databases or any collation of available services to which patients might transition; is that correct?---In my statement I have said that is correct, but in Dr Sadler's evidence he does mention a green folder with information about potential receiving services or community services. He also talks about the G drive on the

database. I do recall seeing the green folder in Carol Hughes' office when she was attempting to update accommodation, contacts. I am also aware that when Susan Daniel, the community liaison nurse, handed over her position to Vanessa Clayworth or handed over information to Vanessa Clayworth when Susan was going on long leave that she said in an email, at least – and I was aware – that she transferred the transition planning that she had done to date to a G drive. So I would say now that there were some documents of resources, though that was not up-to-date and it was far from comprehensive. And my recollection is that there was a particular absence of detail about any adult services which was relevant for the cohort which was being transitioned.

So just taking you a step back, you said you saw the green folder. Did you actually look through the green folder?---I'm sure I had looked through the green folder, yes.

And insofar as there was the G drive, there was a subdirectory of Barrett Adolescent that Dr Sadler refers to in his recent statement. You did know about that drive?---I knew that Vanessa Clayworth and I think Megan Hayes accessed that drive. Certainly, Vanessa Clayworth did. I did not. There were issues regarding computer access for me. My office was in a different building. It was in the school building, not the ward building. Most of my time, particularly the first few weeks, was in the ward, dealing with day-to-day clinical care and crises. So that was problematic, but by then it was clear that those two people in particular and Carol Hughes, who were trying to find resources, as were other staff, were struggling to find appropriate resources. So my recollection is that that was an inadequate resource, and I do recall that Kevin Rodgers, the principal, gave me a document which was for the south side, and it was dated, I think, 2010. So although it wasn't current, it was the most useful document that I was able to access at that time.

I think you said that, a moment ago, you had issues with computer access in your office; is that right?---That's correct.

Because my understanding is it was difficult to get internet access in some parts of the Centre; is that correct?---I'm not sure if it was difficult for internet access through all parts. There were a couple of different issues. The first was as a new employee you had to have logins and so forth, and that took several weeks for me to get any access to that. As well as that, there was the issue of – in the ward situation, I think, if I recall correctly, there were three computers. There was CIMHA, the database that was to be used for clinical records, and all staff needed to access those. At least one of them, maybe two of them, did not work for CIMHA access, and so there was – there were impediments to the use of computers at different levels.

Dr Brennan, I just wanted to ask you a couple of questions about your knowledge of the extended forensic treatment rehabilitation unit that the Commission understands opened at The Park late July 2013?---Yes.

At the time when you started in September 2013, were you aware that such – it's called EFTRU?---Yes.

Were you aware that EFTRU had opened?---Yes.

And what, if anything, were you told about EFTRU?---I was told that it had opened. I expressed my concern. I was told that the expectation had been that Barrett would have closed in December 2012, and at that stage EFTRU wasn't supposed to open until later than that date. However, EFTRU had opened, but I don't recall anything specific being said about those patients or their care arrangements. I did have some concerns, if you want me to go into those.

When you say you expressed concerns, did you express those concerns to any particular person?---It might be more accurate to say I expressed an inquiry in the executive on the first day. I asked – because I had worked there before and was familiar with the environment and there had been a lot of changes, I asked about the new buildings and so forth, and was told that this was, you know, what was in each area. And then I asked about the safety of EFTRU, and they assured – I was assured that there weren't very many patients there. It had only just opened.

And who gave you these assurances? And I realise it's a long time ago, Dr Brennan; just to the best of your recollection?---I believe it was William Brennan.

Were you told or did you know anything about adolescent patients on The Park grounds not being allowed ground access without escort from the opening of EFTRU?---Can I just give you some background about that?

Of course, Dr Brennan?---What happened was in my first couple of days I needed to get to know these patients. So apart from meeting them, I also then read the files, starting with all the inpatients. And I read the file of a particular patient who was in the habit – because I had observed it myself along with Dr Hoehn - - -

Dr Brennan, I think if we're going to talk about a particular patient I might ask you those questions in closed court. But I can - - -?---I can generalise, if you like.

That would be - - -?---I had read a chart entry suggesting that it is not wise to walk – it wasn't, in fact, EFTRU that was mentioned; it was ET and R, which is extended treatment and rehabilitation unit – another advice about being cautious. That led me to be the person who changed the conditions about ground leave. I gave a directive that as of then no adolescents from that unit were to be allowed any ground leave unless they were within eyesight of a staff member.

Dr Brennan, in paragraph 15 of your first statement, if we can go to 0005, you refer to staff morale was low when you commenced your role and that it appeared to be affected by seven matters. I only want to ask you about a couple of those matters. And, first, in subparagraph (a) – and it's probably a difficult question for you to answer given that you'd only just commenced and you've got nothing to compare the

patient behaviour with – but you say there was an elevation of the distress and behaviour of the patients at the time. Was it the case that you were being told this by the staff when you arrived?---Yes.

And, indeed, in paragraph 19 of your statement you make mention of Dr Tom Pettet, who was the registrar at the time. And you refer to him requiring a more suitable position given the closure of the Barrett. But what you do say is that – and tell me if you disagree – that the patients' distress escalated after the standing down of Dr Sadler and that you and Dr Pettet had to devote a lot of time to validating the patients' concerns with one-on-one time. Is that your understanding or your recollection of what happened?---Yes, it is.

In paragraph 15 of your first statement you also refer to the heavy workload due to staff resignations and lack of skills in casual and/or agency staff. So is it correct, to understand your evidence, that you did consider that there was a heavy workload? Do you agree?---For myself?

And for all staff?---Yes.

And do you agree that from your point of view, you thought there was a lack of skill with casual and agency staff?---At that stage I was advised, or the nurses themselves told me about their difficulties in coping with their workload as they felt they carried extra responsibility because of the – what they described as lack of skills of other staff. How many were casual, how many were pool, how many were agency I cannot accurately report now. I heard discussion from Padraig McGrath here the other day about the definitions of those categories of nurses and I don't profess to understand them even now. As well as that, I was also – there were many, many discussions in the first few days and it was clear that the allied health staff and the school staff had been particularly upset by and disappointed by the loss of allied health colleagues who had either not had their contracts renewed or had moved away from the Centre.

Returning to your concern about the agency staff though, in paragraph 20 of your second statement – and we don't need to go there – you talk again about your concern of the ability of agency staff to look after the patients remaining at the Barrett Centre and that you had this – well, this concern, you say, was formed definitely by December 2013. Is it fair to say then that this concern was one you developed over the few months that you were in the role?---Yes.

And your evidence is that you contacted the director of nursing at The Park, Mr Brennan, on at least three occasions. And you say in your statement that he always responded and guaranteed adequate support for nursing staff, adequate nursing numbers, and that Barrett Centre nurses would not be rostered elsewhere. And if I understand your evidence correctly you say that you raised this issue also with Leanne Geppert, Padraig McGrath, Alex Bryce, other members of the West Moreton Hospital and Health Service and Dr Hoehn. Is that correct?---Yes.

I was unclear though from your statement, Dr Brennan, despite seeking this assistance from at least six people, did you ever get that adequate support from nursing staff?---Over the four months, the nursing staff arrangements changed from time to time. For instance, at one point when they realised that the workload for some nursing staff was high, they rearranged staffing and moved Vanessa Clayworth from her position – I think, and I may be inaccurate in these titles – I think she was the acting NUM, that's nurse unit manager, and became the acting CNC. And they brought in Alex Bryce, an experienced senior nurse in The Park who although he wasn't experienced in adolescent care, he was appointed as acting nurse unit manager to provide support in terms of supporting the nursing staff, rostering and so forth and was a containing influence on the ward, which was helpful.

And that happened at about early October, I think. Would that be about right?---Yes. Early to mid October, I think it was. As well as that, there were times when nursing staff – now, I assume they are casual agency in that they weren't always rostered in Barrett but they were usually rostered in Barrett. And sometimes they would be rostered in a shift in a different area such as medium secure and their preference would have been to be in Barrett. And I guess you would say our preference in Barrett was that we would have the most familiar, experienced staff, the ones experienced within Barrett to be working there. And they would be rostered elsewhere. Sp when that concern was raised, I was assured that that wouldn't continue. And I think those promises where honoured and did happen. Nursing became, in my view, quite critical, in about mid-December. And I alerted those people that you have just listed. And, in fact, there was a meeting to address those issues in about mid-December, late on a Friday afternoon.

So by mid-December you're saying that the guarantees that you'd been asking for about adequate nursing numbers and nurses not being rostered elsewhere at The Park and getting more support for nursing staff, you were content that that guarantee was followed through and you had adequate nursing support. Is that your evidence, Dr Brennan?---That is my evidence but may I add one more piece to that puzzle?

Yes, Dr Brennan?---That is that right at the end when the numbers of patients were very small, there was a difficulty – and I am not sure that more numbers, more skills, was the answer. But the gender mix of the patients and the very small numbers made it difficult to roster adequate nursing staff in terms of, again, for them, gender and experience and being able to staff a ward which – usually, you needed two staff on a ward because even if there was only one patient, should there be an incident, one nurse was not enough. If you went on an outing, you really needed two nurses. So when the numbers of patients were very low, and I'm sure there's a formula that prescribes appropriateness in numbers to a particular number of patients, but it became a particularly difficult task to have adequate nursing when the numbers of patients were very low.

So at that point are you saying that you would've liked some more staff, some more nursing staff?---Yes.

In paragraph 21 of your second statement you say that, in your view, the support staff at the Barrett Centre during the transition process appeared to be not as good as it could've been. And you list four factors. And you say that a lot of your time was just spent listening to staff and encouraging them. Do you agree with that?---Yes.

You then say in paragraph 21(d) of your second statement at DAB.001.0003.0023 that in terms of concern for patients, many of the nursing and allied health staff had worked at the Barrett Centre for a long time and knew the patients very well. And you've identified this as a strength of the facility and that:

> *They were naturally concerned that a move to other and quite different models of care would impact adversely on patients.*

I'd like to understand further though, Dr Brennan, what you mean in the last sentence of this paragraph where you say:

> *Again, it seemed to me that the level of concern was not fully appreciated and, therefore, responded to by the executive.*

That's at the last line of 21(d). So, firstly, when you refer to staff concerns as to how a move to other and quite different models of care would impact adversely on patients, are you speaking at that point in terms of the existing services or the proposed new contemporary models of care?---Sorry, can you just - - -

If you look at what you say in your - - -?--- - - - repeat the last part of the question.

- - - in your statement - - -?---Yes.

- - - and we may need to go up further - - -?---I've got paragraph (d) there.

- - - back on to page 22 – sorry, it's the start of paragraph 21 – sorry, 23.

COMMISSIONER WILSON: I hesitate to interrupt but, Ms Muir, I'm having difficulty understanding the point of your question for this reason: it seems to me that whether the patients were to go to some existing service models or to some new contemporary models that were being devised, in either case it was a move from a model of care quite different from the Barrett Adolescent Centre and I thought that's what the sentence was directed at.

MS MUIR: Commissioner, I was unsure but I'm content. I have other questions about this paragraph that I can ask.

COMMISSIONER WILSON: Alright.

MS MUIR: Did you think the concerns were valid ones at the time?---I understood their concerns.

And you say that you didn't think the level of concern was fully appreciated by the executive. I take it you mean the executive of West Moreton Hospital and Health Service?---Yes, I do.

And people such as Ms Dwyer, Ms Kelly and Ms Geppert?---Yes.

On what basis did you form the view that the concerns were not fully appreciated?---It was a difficult time for the nursing staff. Dr Sadler had left. An investigation had started. Several of the nurses received letters asking them to appear at an investigation. Several of them were very traumatised by that request. They then became more distressed by the attendance at that investigation. Their initial, if you like, complaint that I heard of was that the person who was escorting the investigator around The Park was the HR representative who they were expecting to turn to for support. I don't know this – who this person is or any details. Following that investigation which was quite destabilising for some and many took leave and therefore weren't at work, when they did return and after some weeks they then received letters – some of them – asking them to explain certain things that had happened and they felt threatened in that setting. I'm not a HR expert and I don't know what support should or could have been provided but I was aware that the nursing staff felt that their competence and commitment was under question and yet at the same time they were expected to continue to provide care for these adolescents who were dealing with a lot of anxiety and whose behaviour at times was very difficult to manage in a nursing setting. I – as I say, I don't know what more could have been done but I was aware that the nurses expressed a sense of being abandoned by the executive in terms of caring for their needs at that time.

Did you – I suppose I was trying to understand were – did you speak to Ms Kelly or any of the executive about the matters that were being raised with you so that they were aware of these matters?---Yes, I did. And my recollection is that it was about early in November – maybe October – I think it was November. The second week of November I was in Melbourne for a conference and when not there on the ground with the staff I emailed Leanne Geppert about my concerns and I recall her emailing back and that she concurred with my view that this – or she expressed the view that this was a vulnerable group of staff and that she would discuss this further with HR.

Okay. You talk in your second statement at paragraph 17 about an administrative officer who was given to you to assist in identifying government services and departments relevant to adolescents and you say that her role was to maintain a summary of the plans and any changes that were made. And your evidence is that this was not maintained sufficiently. Was the role that Laura Johnson was given – was that different from the role that the transition panel had in relation to identifying services?---Laura Johnson was to be the project officer assigned to the transition process. Part of that role was to document the process and part of that role, as I understood it at the time, was to be a resource in terms of identifying available services and I was also under the expectation – impression that she would also be – had had experience of services in preparing for the Kotzé inquiry, it became – it seemed to me that there wasn't any documentation of the transitional care panel

meetings there were plans but I didn't feel that there was enough documentation, if you like, of the process of arriving at the decisions that ultimately were incorporated within those plans.

So you had done all this work and you say had expected that the plans and any changes that were made would be contained in that document and that the project manager would record that and it came to pass that that didn't happen?---Well, certainly, to date I have not seen any such documentation.

And so - - -

MR DIEHM: Commissioner, if I might observe, just in case there's any confusion about it, the witness's answer was about documentation of the process, the planning, whereas Ms Muir's last questions seemed to miss out the concept of process. So perhaps it ought be clarified as to whether it is - - -

COMMISSIONER WILSON: I just want to make sure I'm understanding what you're saying, Mr Diehm. I understood that there was a distinction between documenting the decisions that led to the plans and documenting the plans - - -

MR DIEHM: Yes.

COMMISSIONER WILSON: - - - and that the witness's evidence was there seemed to be an absence of documentation of the decisions that led to the plans.

MR DIEHM: Yes. Whereas Ms Muir's last question didn't focus upon the decisions as opposed to the plans.

COMMISSIONER WILSON: That's right.

MS MUIR: Sorry, that was my mistake, Commissioner.

So when you talk about the plans and changes that were made to those plans which is the language you used in your statement, what were you expecting that ought to have been recorded that wasn't recorded on the planning documents?---When attempting to analyse the process that led to transition as in this inquiry or others it would be very helpful to be able to read a document which outlines, for instance, the particular services that were approached and their responses. In terms of at the time and being able to progress the transition plans such documentation of the process wasn't critical. I don't think it impacted negatively on those transition plans. The people involved in developing those plans were very committed, involved and aware of all changes that occurred and the communication between the team was intense, I guess, is the word.

COMMISSIONER WILSON: Can I ask a question to make sure I understand what you're staying, Dr Brennan?---Yes.

Are you saying, on the one hand, that there is an apparent absence of documentation of approaches to lots of services which were unable or for reason didn't feature in the ultimate transition plans but nevertheless in your assessment the absence of that documentation did not impact adversely on the planning?---That is correct. But also, and referring back to Ms Muir's question, there was also, I think, the absence of a single one-page document that encapsulated the entire transition plan for each patient that could have been handed on.

I see?---So there are two different - - -

Two different things?--- - - - areas. Yes.

I understand that now. Thank you.

MS MUIR: Dr Brennan, I just want to ask you some questions about the concept of transition. In paragraph 35 of your second statement, you draw a distinction between transition and transfer?---Yes.

And your evidence is that transition needs to be gradual. Can you expand on what you mean by gradual in a timeframe sense?---I think transfer is a little bit like discharge and then arriving at another service. It's just a point in time. In my view, transition is a process which should start early – and we could discuss that timeframe – but it starts early, it is individualised, if you like patient-centred – by the way, if I use the word patient, could be adolescent, young person, emerging young adult. I don't mean to categorise these people as ill. But it is centred on the patient, it involves their wishes and their best interests. It involves looking at a range of options, seeking to identify those that they are happy with and that are appropriate for their needs, communicating with those services, and then providing some kind of transition process where there is a gradual introduction to that service. And depending on the particular person, their particular, if you like, disorder and their range of family or community supports, that transitioning into a new service may need to be gradual in terms of a kind of cross-tapering of care or it may be different. There may be some in-reach into the new service. But, overall, I view transition as a process rather than just a change at a point in time. And in terms of when it should start, I guess I had done – I had an interest, actually, in transition of adolescent to adult health care prior to ever going to Barrett, and I think it varies enormously, depending on the particular conditions. However, I think the guidelines around transition for adolescents or children to adolescent to adult services indicate that it really does need to start either at the point of admission into whatever service they're going to be leaving or very soon afterwards, and it certainly would need to have been in place, I think, for some months in this particular case.

And your evidence in relation to transition in your statement is that, if possible, involve parallel streams of care?---Yes, when appropriate.

And that's a different thing to cross-tapering?---No. You could have parallel streams of care and cross-tapering. I would just add one proviso, and that is there are some

conditions in which some aspects of the care may be cross-tapered or parallel, but some other aspects of the care need to be quite clearly delineated into ending with the referring service and starting with a receiving service.

And you would say that just depends on the condition and the patient and just the general circumstances?---Yes.

Was the work that you undertook at the Barrett Centre in September 2013 through to January 2014 – is it more accurately described as overseeing a transition or a transfer?---Overseeing an attempt at transition that for most was a transition and for a few, at least one, but a few – and I won't – sorry – I shouldn't go into small numbers – was more like a transfer.

And would you agree insofar as there was a transition process for some of the young people that the task that you were given perhaps could be described as much more than a business as usual transition, and by that I mean in the sense that it was done in the context that you were closing down an entire centre?---That is correct.

And given what you've said in your statement and said here today about what is required for transition, you know, gradual, parallel streams of care – you also talk in your statement about good communication – would you have expected then from those charged with the decision for the closure and oversight of the transition process that there might have been some of the following matters that might have been attended to – and tell me if you disagree – so you would think there would be detailed, careful and lengthy consultation and communication with families?---Yes.

The same with staff?---Yes.

And the same with the patients?---Yes.

And you would think that there would be early preparation in relation to all aspects of the closure of the centre. So, for example, early assessment of the available services?---Yes.

And you'd want to have some consultation about the timing of any replacement services?---Yes.

And you'd want skilled and consistent staff?---Yes.

And just much more of a lead time to prepare staff and to work with families and patients?---Yes.

And a process that, if I understand your evidence, is very important is, really, liaising and consulting with the receiving service?---Yes.

And are there any other processes that you think are important as part of a transition in the context of the transition being not so much a business as usual transition but in

the context of the closing of the Barrett Centre?---In the particular case of closing of the Barrett Centre, I think if there had been a shared narrative about why is Barrett closing it may have helped. It may have allayed some anxiety for some if there had been a clear understanding of when new services would come online and what would they be. And in particular, I think – as I understood it from the concerned consumers and their supporters, I think the perception that services weren't available was highly relevant. Whether those services in fact – and we can talk about this, perhaps, in different – in a closed session – whether those services, in fact, would have been appropriate services for particular young people is another issue. But the fact that some, particularly tier 3, were seen not to be available, I think, contributed to the perception of abandonment and I think that made the transition process very complex in this particular case. So it certainly wasn't business as usual.

Just while we're still on the topic of transition, if I understand your evidence you didn't receive any documentation from West Moreton Hospital and Health Service or Children's Health Queensland about transition. I'd just like to show you a document, which is WMS.015.0001.00528. This is an inter-hospital and health service transition of care mental health consumers from one hospital and health service to another procedure document. Am I correct that you had never seen this document until the Kotzé and Skippen investigation?---I have not seen this document. I don't recall seeing it; I may have, for the Kotzé and Skippen investigation?---I have not seen this document. I don't recall seeing it – I may have – for the Kotzé inquiry. I saw it at this Inquiry a few days ago.

Thank you. You talk in your statement, at paragraph 18 in your second statement, about the lack of transition literature that had been provided to you. And you exhibit four articles that you received through a contact that you had tracked down. And looking at these articles, Dr Brennan, I'm just wondering: were they relevant?---Not particularly.

So do you accept that developing transition plans, matching patients to services requires two things: first, as you put it in your evidence, to get to know the young person to ascertain their mental health problems and other associated difficulties?---Yes.

And to identify what the available services were at the time?---Yes.

And your evidence is that the transition process was fluid and iterative?---Yes.

And so does it follow that it was necessary to undertake both steps at the same time?---Yes. Perhaps in a different setting those two phases could have been somewhat sequential but as I was new to these patients I didn't know them and a transition process was to start or had started in that a closure date – or a closure announcement had been made. So they definitely needed to run concurrently because, really, for that entire four months I was still getting to know them, I would say.

And insofar as ascertaining services were available the Commission's got evidence from Vanessa Clayworth that these services were recorded in community contact forms prepared for each patient?---Yes.

And without going to the forms in open court – so I want to suggest to you that you were required to identify services that touched upon was it vocational needs?---Yes.

Educational needs?---Yes.

General life skills, money management, meal preparation, hygiene?---And other areas, yes.

Leisure, recreational - - -?---Yes.

- - - activities, access to transport?---Yes.

Accommodation?---Yes.

Financial support, medical and mental health services?---Yes.

Family support?---Support of the family for the young person, not necessarily supporting the family independently.

Yeah. And the preparation of service handover documents?---Yes.

And so to understand the enormity of the task, in order to devise effective transitions you had to not only clinically care for these patients during the transition period but you had to identify services that could meet as best as they could that continuum of needs. Is that correct?---That is correct.

So by way of an overview were the following services identified as possibilities: private psychology and psychiatric and other medical providers?---Yes.

Local CYMHS networks?---Yes.

NGO services?---Yes.

Headspace?---Yes.

Community care units to provide accommodation for young people?---Accommodation and mental health care, yes.

Family homes to the extent that it was a possibility?---Absolutely.

And acute inpatient units?---Yes.

On acute inpatient units, what did you know about the availability of some longer-term beds in the acute unit at the Mater in late 2013/early 2014?---I did not know anything of them in late 2013 or early 2014.

So you weren't told by Dr McDermott or anyone else that there were some longer-term beds available to Barrett patients if required?---No.

I want to ask you briefly about the SWAETRI process proceed in parallel with the transition panels chaired by you?---Yes.

Could we have WMS.0018.0001.00510. Before I ask you some questions about this document, is it correct that most of the patients admitted to the Barrett Centre were young people with severe and persistent mental health problems with associated comorbidities and emotional and life skill developmental problems and often with periods of acute sickness. Is that a broad description that you would agree with?---No. I think that is a description of several. I think there are several who in the past may have met that description but they had had long-term treatment and were doing quite well and so the domains of morbidity for them were much more confined. They were quite functional in many aspects of their lives and so that description wouldn't have fitted them.

Thank you, Dr Brennan. At the time, though, when you took on your role as clinical director and in dealing with the young people at the Barrett Centre was it your understanding that many of these young people had exhausted the services available in the community?---Many had, yes.

So just in relation to the SWAETRI process, this is an email chain of 17 October 2013 involving you and the original email is sent by Ingrid Adamson, the chair of the SWAETRI strategy meetings calling for a discussion?---Yes.

And you respond and say:

> *In mid-September Elisabeth –*

I mean Elisabeth Hoehn?---Yes.

Continuing –

> *and I decided that it was best to keep two separate streams going. You would be committed to care of current patients and Elisabeth and others would work on strategies for new models of care and development of such services.*

And you see immediately above the email you will see Elisabeth Hoehn describes herself as a bridge between the SWAETRI and the transition panel process?---Yes.

Is it the case that you knew that replacement services were still being developed at the time you were transitioning patients from the Barrett Centre?---Yes, I was aware they were being developed and that they were not ready for this cohort.

And in those circumstances, given your significant workload at the Barrett Centre, you didn't think it would be useful for you to be involved in those discussions?---I thought it would be counterproductive not just because of the workload but because I had perceived within the first few days – weeks – that there was significant distress on the part of several people connected with the Barrett and of some of the patients and their families about the provision of new services, the delay in providing them and what they would be and I thought it best that I not align myself in any way with a process that was causing them distress, as my focus was their young people.

So is the case, then, that while Dr Hoehn was reporting to the SWAETRI the news of the transition panels SWAETRI didn't assist you by identifying any new services that were opening to which Barrett Centre patients might transition?---Towards the end of December 2013 SWAETRI and others were developing the – and just started to recruit for the YRRU at Greenslopes – the residential facility – and there was some introductory discussions about that but otherwise, no, they didn't identify any other services.

I'd like to ask you some questions about that but I'll do that – sorry, about the youth resi – in closed court. What was your understanding of the SWAETRI steering committee's brief? Did you know that – or think that the committee was tasked with developing and implementing new replacement services to support your task of transitioning patients out of the Barrett?---I had read the ECRG report. Not – not the one that reads starting with a preamble but just one that I had downloaded from the net and that I think I recall that there was a suggestion that's what they would be doing but my understanding was that they were developing the new services which I did not think were going to be available for this cohort. So they weren't really developing services for these people though there were some of this cohort who may use other services in the interim and when new services developed by SWAETRI came online, yes, they may have been appropriate for them.

So am I correct, because you were focusing on the patients at the Barrett you weren't being consulted in relation to types of services that might be needed for the young people you were transitioning?---Not officially.

You say not officially but I think in your statement you talk about you were at some point – your opinion was sought in relation to the development of models of care and that you did give an opinion but this was in the context of the faculty meetings and peer review process and not in the context of SWAETRI. Is that right?---More particularly not in the context, really, of my position as acting director of Barrett but just as a child and adolescent psychiatrist with an interest in that area.

So what timeframe are you talking about that your opinion was sought?---Shared may be a more accurate word rather than sought. I would discuss several times a

week with Elisabeth Hoehn what was happening at Barrett, but also what was happening with new services. If I ever spoke to Stephen Stathis, I would also discuss new services with him. In terms of the timeframe for faculty meetings or anything else, it was starting from September 2013, but extended well into 2015, and, really, ongoing in those settings.

When you came to your role as clinical director, would it be fair to say – and, again, correct me if I've misunderstood your evidence – that there are probably three broad categories of young people that you needed to transition or transfer on the closure of the Barrett Centre. So the first would be – there was a group of patients who had markedly improved such that they could be discharged from the Barrett Centre in the ordinary course of their care and they could go to their family home, often with follow-up supports from a psychologist or psychiatrist. Was there a category of young people at the Barrett that fitted that description?---They fitted that description, with the caveat that they had, for some of them, an identity as being part of the Barrett cohort who felt abandoned, and they had endured Dr Sadler's standing down.

And it would be fair to say then those issues of abandonment: we go back to some of the earlier evidence you talk about in relation to transition, and that's, you know, early preparation, more consultation, and that then assists in dealing with those issues of abandonment?---That's right. I guess I would add though that it depends where we look at transition. If you're looking at were they well and able to return to their families and have outpatient care provided either publicly or privately, yes, there was definitely that group. However, with the passage of time and the events that have occurred, that group may look different now to what they appeared to be then in terms of, if you like, their preparedness for transition.

COMMISSIONER WILSON: Sorry, I'm not sure what you mean by now. Are you saying but for Dr Sadler's standing down and the reaction to it they may have been ready for transition, but given what had happened they had a different appearance from the one they had before the Sadler incident? Is that what you're saying?---I probably I didn't express that very clearly. I think that the seed had been sown for them to feel vulnerable in a way that they perhaps didn't need to, and that was by the standing down of Dr Sadler.

Just a moment. Some of this evidence could perhaps be given later, I think.

MS MUIR: Yes?---I think that would be better.

COMMISSIONER WILSON: Yes.

MS MUIR: Yes, Commissioner. Dr Brennan, in paragraph 36 of your first statement you give some rationale behind wanting to have a small clinical care

transition panel, and you talk about wanting to have a good understanding of the new facility or service and whether the young person met the criteria for accessing that service, and most critically, whether the young person was emotionally and psychologically ready to consider such options. And so when you say that it was critical that the young person was emotionally and psychologically ready to consider such an option, again, you're talking about timing and preparedness; is that correct? Have I understood correctly what you're saying?---Yes, but where preparedness may also include an understanding of their past traumas or life experiences that would inform their capacity to adapt.

But isn't the problem that you didn't have the luxury of time in being able to wait for a young person to be ready, to be prepared, because you had been given instructions that the transition needed to happen as soon as possible?---I think there was a significant amount of work done that actually had – that bore fruit in terms of getting some of the young people more ready to transition by addressing those underlying issues. Does that make sense?

So are you talking work that had been done up to when you took on the position - - -?---No.

- - - or from when you took on the position?---From when I took on the position and transition actually was on the table, and there were frank discussions with patients about transition, but also addressing their own particular difficulties that made it possible to transition some who initially looked like it would be a very difficult task, given the timeframe.

So some were emotionally and psychologically ready to transition?---Yes.

But – and correct if I'm wrong – you're saying some weren't emotionally and psychologically ready?---Yes.

You also have the difficulty – you didn't have a level playing field, would it be fair to say, because you had very distressed and anxious families?---Yes.

And you had some staff who you felt were undermining you?---Yes.

And you had young people who had heightened anxiety and stress and some of whom were not ready to transition, as we've said, at least in the usual sense?---Yes.

Okay. And you had to transfer patients to services that you had great difficulty locating?---Yes.

Given your role as a child and adolescent psychiatrist in Brisbane for a number of years, I just wanted to understand: weren't you not aware of many of the existing services available to this group of young people?---I was aware of several services, but I think the services that we found very difficult to identify were accommodation services, and I guess I would say, from my experience particularly in private

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

Thank you, Dr Brennan. I will. If I could go to paragraph 5(e) of your second statement, which is DAB.001.0003.0006, here, you say that many of the Barrett patients are able to be treated with the services currently available, such as CYMHS and AMYOS day programs, and treatment in acute beds in local hospitals. But what you also say, that there are some who will require a medium-term residential facility which provides not only nursing observation and attention to reduction or prevention of self-harm, but also education and vocational training and socialisationYour statement was sworn on 24 December 2015 – your evidence is that there are no such services currently. Is that still your view?---Did I say there were no such services? There are such services. I am not familiar with them. I know the names of them. I have not visited them. There are some of those services – maybe I'm referring to – I don't think there is a medium stay inpatient facility or the tier 3 service - - -

If you go to paragraph 5(e) - - -?---Yes.

- - - just take your time and read that paragraph?---Yes. What I'm referring to is I don't believe there's any medium stay facility. I have subsequently become aware from discussions with Dr Stathis before this inquiry started, some time last year, that there are subacute beds available at LCCH. I'm not aware that there is any facility that is focusing on vocational, educational issues with a recovery focus. Now, that may be part of the tier 3 service being developed, but I'm not aware – I don't have intimate knowledge of that service.

So in your statement, when you do say – and I take it it's still your view – that there are some young people who require a medium-term residential facility?---Yes, I do.

Do you have a view about the number of young people such a medium-term residential facility should have capacity to look after?---I think that is beyond the area of my expertise. I have not researched the area, but I hope it's not huge. It should be a small number.

Do you have a view about whether or not such a facility ought to be attached, for example, to a hospital or be in a non-medicalised environment?---I think there needs

to be a balance. Such a facility – and I'm not talking about a residential facility; I'm talking about one where you can get the young person out of an acute bed but they can still be very closely monitored in terms of managing risk, particularly self-harm, but also there may be patients who require a medium stay while medications that are being trialled become effective. I think the research is clear, that, for instance, antipsychotics take quite a long period of time to kick in. And those people, I think, are best cared for not in an acute facility. I don't think a long stay in an acute facility is beneficial. So whether that's a Step Up Step Down facility or whether there's some standalone, medium-stay facility, I think I would leave up to the experts in the area.

Dr Brennan, before I ask the Commissioner to close the court and perhaps we have a morning break, I just want to ask you a couple of questions arising from some evidence that Dr Kingswell gave during the course of his oral evidence last week. The evidence was that the Barrett Centre was a violent and very, very difficult place. I just want to understand: did Dr Kingswell – from your evidence earlier, he was with you on your first day at the Centre. Did he visit much during the time that you were the clinical director?---He did not visit while I was the clinical director.

And when you took on the role you said that you had conversations with Dr Kingswell. Did he warn you of his concerns at this time or at any other time?---I was not surprised to hear in evidence that was Dr Kingswell's impression, as that was what I understood his view was. But I couldn't, as I said earlier, give you the specifics of that conversation as to what he said.

So you were a medical officer at the Barrett Centre under Dr Sadler in 1993 and then in 1994, and then you were the acting clinical director from September 2013 until January 2014. Given your firsthand experience of the Barrett Centre in either of these periods, does the description of the Barrett Centre used by Dr Kingswell accord with your experience of the Barrett Centre during either of the times that you were involved with the Centre?---I think the terms for me are emotive, and perhaps extreme. I think that at Barrett there was a level of self-harm that to a layperson would be highly distressing, and I think that for incoming new patients it was very confronting. And I think for many of them they adapted, but I know that for some they did not and it remained traumatising. So if that constitutes dangerous, then it was dangerous, and if those episodes are violent then it's a violent place. But I guess I wouldn't have characterised it with those terms myself; it was high intensity.

Commissioner, the rest of the questions I have for Dr Brennan are in closed court. Is that a convenient time for a morning break.

COMMISSIONER WILSON: Yes, it would be. I have something else to attend to for the Commission, so I'll have to take a half hour break. 25 past 11?

MS MUIR: Thank you, Commissioner.

WITNESS STOOD DOWN

ADJOURNED **[10.56 am]**

RESUMED **[11.28 am]**

Closed Hearing

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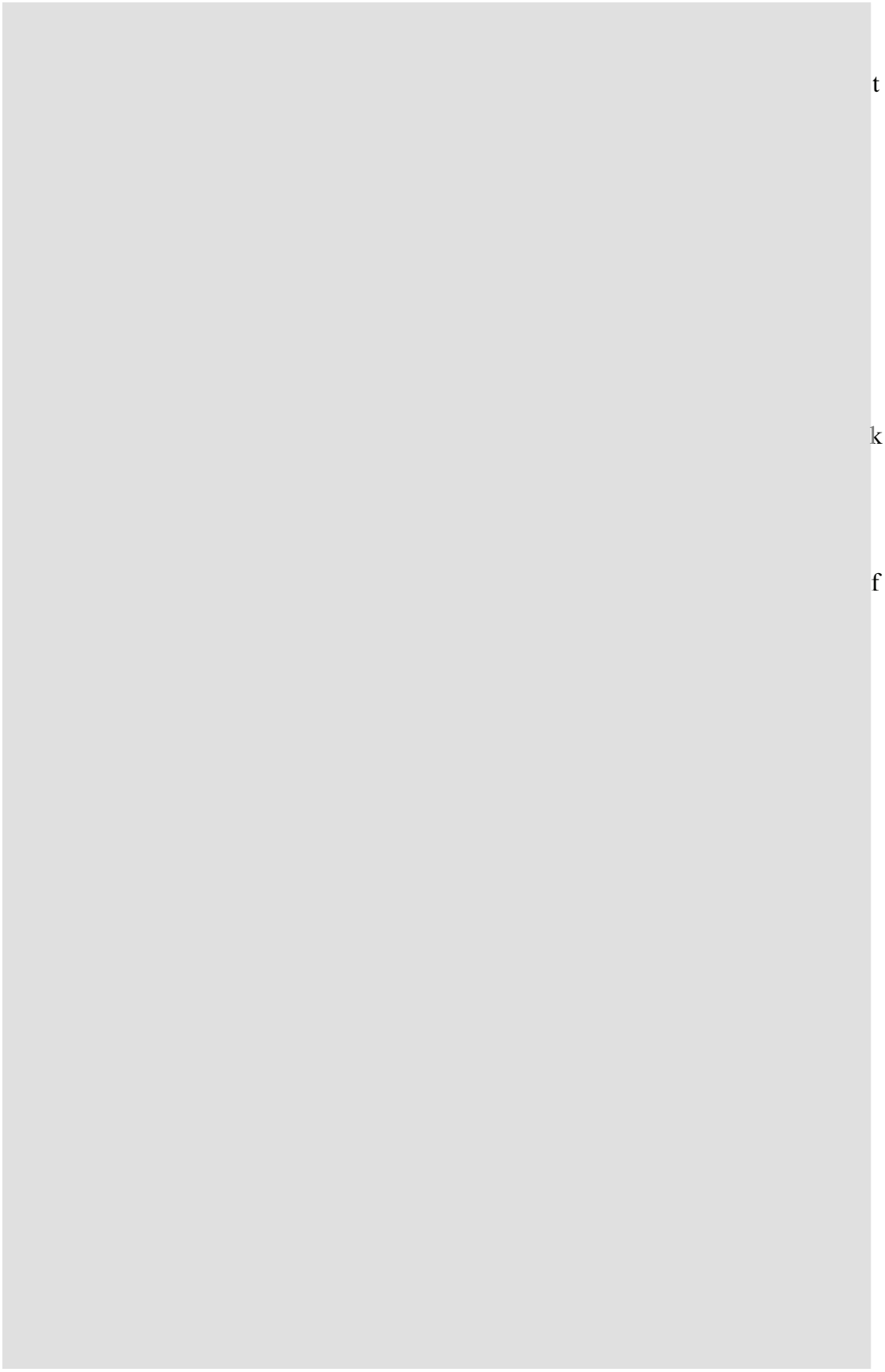

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COMMISSIONER WILSON: Alright. Well, the live streaming can come back on and the hearing room can be opened. Who wants to go first with their questions in open? Ms Wilson?

MS WILSON: Thank you, Commissioner.

EXAMINATION BY MS WILSON **[4.19 pm]**

MS WILSON: Doctor, in response to Ms Muir, you said that the Pine Rivers CCU was an old building. Did you go and visit that building?---Yes.

Was it your view that it was an old building? I suppose that's a matter of view and judgment, I suppose?---I guess it is. The building where they held their case conference, where there were communal activities and so forth was not an old building.

Yes?---The residential wing where Talieha's room was – was that old? I thought it was a little – maybe it was the foyer area, you know, the sort of little garden area leading into it felt a little bit old with wooden fences. That's all.

Yes, yes. Okay. Can I take you to your statement, which is DAB.001.0001.004, which is paragraph 12. That's where you refer to that Dr Elisabeth Hoehn provided supervision initially in her role?---Yes.

You sat through her evidence yesterday. And do you accept that the scope of your relationship was that it was no clinical supervision provided?---I listened to Dr Hoehn yesterday and I felt that at some level that perhaps under estimated the extent of the input she had into clinical advice for me.

She wasn't your line manager though, was she?---No, she was not.

And she provided support for you to bounce ideas off. That's the case, isn't it?---That's right.

And we can see that in some of the emails where you two get together and you consider things and then you present the view?---Yes. That's right.

But - - -?---She didn't have the role of supervisor either in the sense that within psychiatry or psychology the term may be used.

And that's the point that I was getting at because there is a meaning for that in that world, isn't there?---There is.

And she didn't perform that?---No, she did not.

Okay. Now, in terms of SWAETRI, that group was responsible for the development of statewide services?---That's right.

And if I understand your earlier evidence you were aware that those new services were not specifically – were you saying that those new services were not specifically – perhaps if I put it this way: that was in terms of providing statewide services?---Yes.

And they weren't specifically directed to providing services just for the BAC patients?---For the current cohort of BAC patients.

For the current cohort?---That's right.

They had a much wider role to play?---They did.

Okay. Now, you've probably heard me ask these questions a few times. Do you – and this is really in relation to whether there is a gap in the alignment of adolescent and adult mental health services in Queensland. Do you think that there is a gap in the alignment of adult – adolescent and adult and mental health services?---Yes, I do. And that was – but that is - - -

And if you are going into any - - -?---I have heard you ask these questions - - -

If you are going into any patient – well, you must be - - -?---No, no. I'm not going into any patient. I would just say that I think there is a lack of alignment between child and adult services and I feel confident that some of the new initiatives at least addressing that in part in that the age range, for instance, for the Greenslopes residential unit is, if I'm correct, 16 to 21 whereas child and adolescent services have all stopped at 18. And there's been some discussion very recently that maybe that top age range needs to be flexible.

Are you aware - - -?---So that's already a change.

And are you aware that Logan mental health services has commenced a youth unit serving young people up to age 24?---I am.

And you've heard me ask the questions because you sat in the back of the court - - -?---Yes.

- - - about a mapping service being undertaken to determine what services may be required to address any gap?---Yes.

Looking at the similarities and difference between the current services available in the child and youth mental health services against the adult mental health services - - -?---Yes.

- - - do you – would you think that is a good idea to have that mapping exercise?---I do. And I think the mapping exercise needs to extend to covering comorbidities and dual diagnosis when the dual part is either substance use or intellectual disability.

Thank you. Thank you, Commissioner. Thank you, Doctor.

COMMISSIONER WILSON: Ms Rosengren.

EXAMINATION BY MS ROSENGREN **[4.24 pm]**

MS ROSENGREN: Thank you, Commissioner. Dr Brennan, I understand that when you were asked to take on the role at BAC that you weren't given any formal job description apart from the position title?---That's correct.

And were you aware that that had also been the case for Dr Sadler, that he, too, hadn't been give a job description?---No.

I just want to ask you some questions regarding the gaps that there were in services, if I can call it that, when you arrived at BAC. From what I understood of your evidence earlier you identified that one of those gaps was the lack of availability of services for those young people at BAC who had not yet turned 18 years of age but were unable to live at home for whatever reason?---Yes.

Is that right? Is that one hole or one gap that was in the services - - -?---Yes.

- - - at that time?---And where they're unable to live at home either because of distance or family function or their own, if you like, psychopathology that precluded that.

And do I understand that another gap that you identified when you arrived at – so when you were at BAC in terms of the availability of services was in relation to

supported residences if the young person was over 18 and had ongoing mental health issues?---Yes.

Can you identify other gaps in services which were relevant to that patient cohort at BAC when you were doing the transition process or when you arrived?---Can I just go back to your – the first of those categories – I don't know if we covered it. So that would be young people under the age of 18 who are not in the care of the State, who are unable to live at home for those, perhaps, three reasons and then over 18s with a mental illness or over 18 where they don't have the skills for independent living and need to learn those which is not necessarily that they are mentally ill but their mental illness may have impacted on their normal trajectory in life but I think also in our society these days a lot of 18 years olds don't have skills for independent living so I think we do need residential support for them.

Okay. So – no, the lack of availability of those services made transitioning all the more challenging for you?---Yes.

And did you have any concerns regarding the capacity of NGOs to care for young people in terms of having sufficiently trained staff and those sorts of issues?---Yes.

And what were your concerns in that regard?---And we're still closed? Yes.

UNIDENTIFIED SPEAKER: No?---No.

MS WILSON: No, we're not closed.

WITNESS: Okay. I won't name patients. For some patients where we were selecting NGOs to provide additional support within accommodation settings it became clear to us that they may not have what we considered would have been adequate mental health training or expertise and we would have wanted to provide that were they to be the carers. Now, that doesn't become relevant because that particular NGO was deselected by another service and another one put in place. But I guess as mental health providers, if you're going to transition somebody and you as the current carer feel that it – or it is your responsibility to be caring for them, you've – to select an NGO you do need to understand whether they have the capacity to do what you are expecting them to do. And that's difficult when there are all kinds of NGOs and I'm not aware of any formal way of knowing what their capacities are.

MS ROSENGREN: And was one of the other challenges that you were confronted with that there were some young people who simply didn't fit in neatly to any service so what that involved was trying to get the service to change their rules, if I can call it that way, to try and accommodate these young people?---That's right.

If I can turn very, very briefly to the issue of the handover, you've given very clear evidence – am I correct that it was your expectation that you would have received a handover - - -?---Yes.

- - - from Dr Sadler?---Yes.

And you said in your evidence earlier that you regarded him as a very experienced psychiatrist and someone who knew the patients well?---Yes.

And you also indicated in your evidence that had you been able to get a handover from him is what you would requested was a brief synopsis in relation to each adolescent and I think you said there with a nuanced view. Can you explain for us what you meant by that?---I guess you'd get a shorthand version of what's really going on here for the young person. So to just give somebody a label of a diagnosis really doesn't convey a lot about a young person. To say whether mum and dad are married or separated or how many siblings they have or where the family home is – all those kind of demographic details are really – they're important, but they really don't paint the picture. But to have an insight into what the young person's kind of – I don't know, kind of psychopathology is or what their defence mechanisms are like and so forth or their usual patterns of behaviour or kind of, if you like, clinical gems of how to manage somebody. It's those kind of things that, really, only, I think, psychiatrists can give you. I'm sure other staff – and some of them are very skilled and, as I learnt, some of the nurses at Barrett had been there a long time. There were some who were very skilled and could convey some of that information. But I think – I thought at the time it would have been helpful to have that from Trevor Sadler.

Okay. You also gave evidence that as part of that handover that you would have appreciated his input in relation to staff, the skill mix and your words were – and I hope I'm summarising it correctly – any advice for the traps for new players?---Yes.

I think that was the phrase you used. Can you expand on what you mean by that and why you considered that that was important information that you had available to you?---Well, for instance, in regard to the education staff, I, I think, somewhat naively thought that – well, the mistake we made on day 1 is we kept them waiting and we've kept them out of a meeting and their reaction seemed a little bit in excess of what you might expect for that, but we shall soldier on. Now, it was a good idea to soldier on and see if we could repair those relationships. But I guess if I had understood that there was already some existing tension between education and health which, as I understand it now and I didn't then, perhaps had already been brewing as a result of education feeling that they weren't consulted about the closure, that they were informed in the same way that health was informed about the closure and aspects like that – I think would have made it perhaps a little bit easier. I'm not sure that it would have had any material impact on the transition for patients. It may or may not have. It might have made my work easier at the time.

I hope I'm being fair in summarising this, but I understand that when you arrived in the Barrett Adolescent Centre that a lot of these young people were, I think, really, really distressed. A few of them had very high levels of self-harm. There were suicide threats from some of them. And you went on to explain in your evidence today that there was intense distress in that the impending closure of the BAC had made many of them feel abandoned and that they were having everything taken away

from them. I guess against that background that in those early days that what you were predominantly preoccupied with doing was attempting to defuse crises situations and also to stabilise the young people---That's right.

Would you – did it come to your attention that that was the situation that Dr Sadler was also confronted with after the announcement of the closure on 6 August 2013 – that that was what his days were spent doing, as well: attempting to defuse crises and to stabilise very, very distressed adolescents?---No. I didn't speak to Dr Sadler about what his experience was in that month.

Okay. In some questions from Counsel Assisting about mandatory reporting, you indicated that you weren't given any guidance by the health service about this issue. Is it correct, though - - -?---Can I clarify that?

Please do. Yes?---No, no. Can – did you say I said - - -

I thought that was your evidence that you – with the mandatory reporting obligations?---Yes. I didn't require – I may have said that incorrectly. I don't think I required advice from the health service to tell me what I had to do about mandatory reporting. I reported the incidences that I chose to report, obviously. I reported one incident, at least, that was, in my view, not of the sort of severity that would necessarily mean that you should report or that you would be obligated to report under the legislation. However, Barrett at that time was, as you now understand, under an investigation which was critically focused on staff's obligations to report, and that included nursing staff. So when a nurse had documented something in a chart, the senior nurse advised me this had been documented, and therefore I needed to do something about, and I did.

What I want to understand though: from your understanding, was it that a doctor was required to make a mandatory report under the *Public Health Act 2005* if the doctor became aware or reasonably suspected that there had been a detrimental effect on the young person's physical or psychological or emotional wellbeing of a significant nature caused by different sorts of abuse, including sexual abuse or neglect or exploitation?---Yes.

And would it be right to say that this involved some judgment call – that involves a judgment call by the doctor as to, first of all, whether the young person has suffered significant harm to their physical, emotional or psychological wellbeing?---Yes.

And also involves a judgment call as to whether it had been caused by one of the various sorts of abuse, including sexual abuse?---Yes.

And you went on to explain that your judgment would be informed by the context in which you were working?---Yes.

Do you recall giving that evidence?---I'm sure I should – it's only today – but it's been a long day.

Can you explain about what you mean by that?---Obviously, you make the judgment in that context. So if, as I learned when I was referring to some patients – I'll be just careful what I say publicly – just being cautious about this – because I had learned from their charts and things I was told by staff about the past histories involving them, and then there was an incident involving them, and the nature of that incident was such that I knew it was of a nature that had previously caused a particular person distress, to my way of thinking that is harm, and I had the context from the history of what had gone before. If that was, on the other hand, a one-off event in a playful manner amongst adolescents in the open with no apparent harm, psychologically, physically, whatever, then that would be different. So, I guess, that's what the context is.

Okay. And you provided an example, where there was an occasion where you made the – you exercised your clinical judgment not to make a mandatory report [redacted] --No, I did make the report. I was saying that - - -

COMMISSIONER WILSON: This is something which, I think, was dealt within closed hearing, Ms Rosengren.

MS ROSENGREN: I'm sorry about that. Actually - - -

COMMISSIONER WILSON: Well, I think you should move on. If you want to ask the question I'll close the hearing.

MS ROSENGREN: I'm happy to leave it at that. That's fine.

COMMISSIONER WILSON: Alright.

MS ROSENGREN: Thank you. I have no further questions.

COMMISSIONER WILSON: Alright. Mr McLean-Williams.

EXAMINATION BY MR McLEAN-WILLIAMS [4.38 pm]

MR McLEAN-WILLIAMS: Yes. Thank you, Commissioner. I did circulate a list of eight topics that I was going to pursue with Dr Brennan. Particularly for the benefit of Mr Diehm, I should indicate that topics 1, 2 and 7 I will not pursue in light of the evidence that has already been given. Dr Brennan, my name is Andrew McLean-Williams. I'm counsel for Justine Oxenham?---Yes.

I'd like to ask you some questions, please, particularly in relation to some education-type issues?---Yes.

Could I please take you, firstly, to paragraph 3A in your supplementary statement; the Delium reference is DAB.001.0003.0002. Now, Doctor, just have a chance to read just the first sentence in paragraph 3A, and you talk there about some instances where appropriate boundaries had not been maintained. Do you see that?---Yes.

Could I please take Doctor Brennan now to paragraph 68 in the statement of Deborah Rankin; the Delium reference is DRA.900.002.0016. It's just taking some time to come up. But in all events, Dr Brennan, in that paragraph in her statement, Ms Rankin, who, as you know, was the deputy principal - - -?---Yes

- - - and at one time acting principal of the Barrett School, talks about a relational model?---Yes.

Being the school environment and says that that is an environment which is built on developing relationships between the students and staff?---Yes.

Now, in light of that evidence, might that go some way towards explaining why educational staff may have developed a closer relationship between themselves and students than perhaps might be considered appropriate in a specifically clinical context?---Yes. That does go some way. I guess I would say it explains – the other comparison I would make is that the teachers at the Barrett School were very devoted – I have no doubt about that – to their students. And their relationships were more – they were probably closer than you would expect of teachers in a mainstream school with their students.

Yes. Alright. Thank you. Perhaps we might then go to paragraph 19(c) in your supplementary statement. That's the statement dated 27 June. Delium reference DAB.001.0003 at 0018. Now, we'll go specifically to subparagraph (c), Doctor?---Yes.

Now, I don't wish to descend into any detail about particular students or patients?---Sure.

But therein you do say that you observed that there were insufficient developmental skills being imparted to students in the context of the education of they were receiving at the Barrett Centre. Do you agree that you have said that?---Yes, I do.

Look, just in light of that comment that you have made, could we please have a look at Delium reference DTZ.900.001.0021, which is paragraph 110 in Dr Sadler's statement. It was Dr Sadler's statement dated – you've got it there. I'm sorry. Yes.

COMMISSIONER WILSON: Mr McLean-Williams, don't feel pressured for time. I intend stopping at 5 o'clock and starting at 9 o'clock on Monday morning.

MR McLEAN-WILLIAMS: Have you had a chance to read that, Dr Brennan?---Which paragraph am I to read?

Paragraph 110?---I can only see to 109.

It starts:

As part of their daily routine.

?---Yes. I can read the first part of that paragraph.

It would seem that Dr Sadler accepts that the school program needed to be tailored in relation to the specific needs of individuals?---Yes, it did. I would agree with that.

Would you accept that that, again, goes some way towards explaining why what you were observing briefly during your short time at the school perhaps didn't reflect what you might expect to see in a more ordinary or mainstream schooling environment?---No, I don't agree with that. I did not expect in the Barrett School to see what I might have expected to see in a mainstream school. I would add I am not a teacher or an education expert and I don't spend time in mainstream schools very much. But what I was commenting on was about even though there were individualised programs for each student, my general and somewhat lay observation, though I am a child and adolescent psychiatrist I – and I am interested in what young people are doing educationally or vocationally and think it's very important – I didn't observe a level of activity that I expected to see there in the three months that the school operated while I was the acting director.

Could I please take you to paragraph 24 in your supplementary statement, that dated 27 January 2016. The Delium reference DAB001. Now, you say therein that your experience was that the almost universal view of the education staff that the decision to close the school was wrong?---Yes.

Was it the closure of the school or the decoupling of the school from the Centre – the clinical Centre?---It was initially the closure of the Barrett Centre. Sometime after I started there, there was an assurance, I think, from Peter Blatch that the school in fact would then remain intact. Prior to that there had been an – a fear amongst the teachers that they would be uncoupled themselves in that they wouldn't remain as a unit together. They didn't think that was a good idea. They wanted to remain as a unit.

But that assurance was also given by Mr Blatch, wasn't it?---Yes. Eventually it was given and that allayed their fears. Yes.

Thank you. If we could go, please, to paragraph 25(b) in the supplementary statement which is at page 0025. Now, I accept that there was a degree of cultural dissonance that was making it difficult to deal with the education staff. Would that be a fair assessment?---Yes.

Notwithstanding that difficulty did you not feel it was important to try and unpack what their concerns would be to better inform the transition planning and decision-making?---Yes.

In hindsight, what further efforts could have been made, do you think, to re-engage with the education providers in that environment?---I don't know that I could have made any more efforts than I did.

Finally, I'd like to take Dr Brennan to some passages from the transcript of the evidence of Mr Kevin Rodgers and they are pages 18-54 of the transcript at about line 20, and over the page to 18-55, at about line 3. Could you also have a look, Doctor, please, at pages 18-56 and 18-57 - - -

MR DIEHM: Commissioner, I'm not so sure the way in which that was presented on the screen, given that it went over a page, that witness had an opportunity to read it, let alone absorb it.

COMMISSIONER WILSON: Well, I confess I was writing when the first part went up, so I don't know how long it stayed it up.

MR DIEHM: It seemed not to be very long. The witness can say for herself?---I have not read the first page. I can only read the last sentence.

MR McLEAN-WILLIAMS: Well, we can pause to allow Dr Brennan further time.

COMMISSIONER WILSON: Do you have – Mr McLean-Williams, do you have hard copies of the pages you're referring to?

MR McLEAN-WILLIAMS: Yes. I can provide those.

COMMISSIONER WILSON: I think it would be better if you did. Take your time to read them, Dr Brennan.

MR DIEHM: Commissioner, I wonder if whilst that's happening I can asked for the page on the screen to be scrolled at so I can see what we're looking at too.

COMMISSIONER WILSON: Is that better?---I have read that reference.

MR McLEAN-WILLIAMS: Doctor, you see that Mr Barrett in particular talks about the – I'm sorry – Dr Rodgers talks about the importance – Mr Rodgers talks about the importance of having clinicians in close proximity to the classroom?---Yes.

Do you accept that that is an important facet of education provision to this cohort of students?---I do.

No further questions.

MS PHILIPSON: Your Honour, I have four - - -

COMMISSIONER WILSON: Just a moment, would you? Four questions: will they really be over in under 10 minutes?

MS PHILIPSON: Yes, your Honour.

COMMISSIONER WILSON: Alright. Well, go ahead with them - - -

MS PHILIPSON: Okay. Thank you.

COMMISSIONER WILSON: - - - Ms Philipson.

EXAMINATION BY MS PHILIPSON **[4.52 pm]**

MS PHILIPSON: Thank you. Dr Brennan, my name is Kay Philipson. I'm representing Professor Brett McDermott. I just have a few questions for you. The first one's in relation to child youth mental health services?---Yes.

Now, is it correct that – known as CYMHS – are generally – that they generally only accept patients and provide services to those residents within their own geographical catchment areas?---That is correct.

And that's consistent, isn't it, with the National Mental Health Standards, that as far as possible access to treatment and support for people with mental health problems should be close to home?---Yes.

If I could take you, please, to your third statement, DAB0050010001 at 0027, paragraph 79. Your Honour, perhaps some of that – if that could be taken off, actually, because I think it refers to a specific patient.

COMMISSIONER WILSON: Would you take it off the screen, please.

MS PHILIPSON: In that paragraph it refers to certain things, but one of the things you say in there is:

> *I recall having some discussions with Professor McDermott and appreciated his support throughout the time I worked at WMHHS.*

Do you recalling making that - - -?---I do.

What support were you referring to? Are you able to speak to that support in general terms?---If there were really difficult – or I found difficult circumstances or things I couldn't resolve or I wanted some advice, I would often ring Professor McDermott, as he is now, and speak with him.

And he provided that support to you?---Yes, he did.

And just one last question: I suggest to you that prior to you commencing your role as acting clinical director at the Barrett Centre on 11 September 2013, that Professor McDermott told you to think very, very carefully before taking that position?---No. I have a very clear recollection of what happened. I was asked if I would take the position. I knew that it was a very confidential matter. Dr Sadler himself didn't know he was about to be stood down, as I understood it. The following morning, at 8.30, I had a coffee date with Brett McDermott that had been arranged on 20 August. It was to discuss future employment in a new service that he was establishing that he and I had discussed on many previous occasions. I met him. We discussed that service, where it was going, what I may or may not be doing in it down the track. As I went to leave that appointment, I said to him guess where I'm going now and I told him – I said I'm covering Trevor for a few weeks. I can't tell you what it's about. It's a big secret. He then disclosed to me that he knew exactly what it was about because of his involvement to date in that process, which I won't go into in open court. That conversation ended. The next day or later that day – no. The – I think it was the next day. It was when the announcement was made in Parliament. I texted him and said I'm very concerned about Dr Sadler. And he said I'll go and check on him. And we stayed in touch over that. And then when he rang me back that night, he said words to the effect that I was very silly for taking on that job. So he did advise me then as to his concerns but not before I had accepted the position and not before I'd actually physically gone to Barrett.

Thank you. I have no further questions.

COMMISSIONER WILSON: Thanks, Ms Phillipson. I am going to adjourn now. Just before I do so, can I ask the Associate something. I'm going to adjourn until 9 o'clock on Monday morning. How long do you think you will be, Mr Diehm, on Monday?

MR DIEHM: Commissioner, I think only 10, maybe 15 minutes.

COMMISSIONER WILSON: Alright.

MR DIEHM: Can I raise one matter. I understand that everybody has cross-examined now that wishes to do so. These circumstances are different, of course, than they are in civil or criminal trials with respect to communications with witnesses who are under cross-examination, as it were. Might I inquire as to whether there's any objection from the Commission or any other party to my instructing solicitor, my junior and myself communicating with Dr Brennan over the weekend?

COMMISSIONER WILSON: About the matter of her evidence?

MR DIEHM: I'm sorry?

COMMISSIONER WILSON: About matters of her evidence?

MR DIEHM: Well, yes. About the proceedings to the extent it's necessary to do so, I should add.

COMMISSIONER WILSON: Alright. Well, first of all, I'll ask if any counsel has any objection. No. There won't be any difficulty, Mr Diehm.

MR DIEHM: Thank you, Commissioner.

MR McMILLAN: I'm sorry, Commissioner.

COMMISSIONER WILSON: Yes, Mr McMillan.

MR McMILLAN: I noticed – Mr Diehm has just advised you that as far as he was aware there was no further cross-examination. That's so subject to me reserving my position in relation to cross-examining of Dr Brennan. Counsel Assisting have very generously given me an indication that they expect to formally announce their position in relation to educational transition, but they haven't done so as yet. And on that basis, I indicated to them and to Mr Diehm that I didn't seek to cross-examine Dr Brennan subject to that position being confirmed. In that case, I don't seek to cross-examine her, but I do formally wish to note that I reserve my position in that regard.

COMMISSIONER WILSON: Alright. How long do you think you'll be in reply, Ms Muir?

MS MUIR: Not very long at all, Commissioner.

COMMISSIONER WILSON: What does that mean?

MS MUIR: I have no questions at the moment.

COMMISSIONER WILSON: Alright. Can I say there is a very full day planned for Monday. I'm starting half an hour early because I think this evidence of Dr Brennan's has got to be concluded. But I do urge all counsel very carefully to consider the time estimates they provide to the Commission. If questions are important, obviously they should and can be put. But it does throw out the planning not just for the Commission but for all the parties and for all of the witnesses if we run over time like this. It really has not been very satisfactory from that aspect today, and I make no criticism at all of Dr Brennan. I want her to understand that. But I am concerned about the scheduling of witnesses when days such as Monday are ahead of us with a number of witnesses, some of whom may be short but at least one of whom I expect to be quite lengthy. Alright. Adjourn till 9 o'clock.

MR DIEHM: Sorry, Commissioner. I might just add one thing. To be clear, with respect to communications with Dr Brennan, they won't be about her evidence but they will be with respect to obtaining instructions about any other necessary matters for the conduct of the proceedings.

COMMISSIONER WILSON: There will be no difficulty with that, Mr Diehm.

MR DIEHM: Thank you, Commissioner.

WITNESS STOOD DOWN [4.59 pm]

MATTER ADJOURNED at 4.59 pm UNTIL MONDAY, 7 MARCH 2016