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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

9.23 AM, WEDNESDAY, 9 MARCH 2016

Continued from 8.3.16

DAY 23

RESUMED **[9.23 am]**

COMMISSIONER WILSON: Good morning everyone.

MS MUIR: Good morning, Commissioner.

COMMISSIONER WILSON: I understand there's some problem with the audio system this morning. Is that affecting the Auscript receipt of what's going on in the proceedings? Can the associate get in touch with Auscript? We'd better wait, Ms Muir, until we find out what the position is.

MS MUIR: Okay. Thank you. Your Honour - - -

COMMISSIONER WILSON: We're still waiting for a response from Auscript. Is it the audio system or is it rain, I wonder?

MS MUIR: Excuse us, Commissioner.

COMMISSIONER WILSON: When counsel are ready, Auscript have indicated that things are fine from their perspective so I think we should make a start. Ms Muir.

MS MUIR: Thank you, Commissioner. Just one brief housekeeping matter; if I can hand to you the exhibits tendered on 8 March 2016. Can I tell you, Commissioner, that some of the parties have requested that the Commission produce a full exhibit list which I think is a very good idea. So we will make arrangements for that to happen as soon as possible.

COMMISSIONER WILSON: I think it's on Delium, isn't it?

MS MUIR: I don't – my understanding was that it wasn't, but one continuous document of exhibits.

COMMISSIONER WILSON: Alright. I'll leave that up to you to organise.

MS MUIR: I'll follow that up. But if I can hand – in the meantime, if I can hand this to you.

COMMISSIONER WILSON: Now, I assume this has been distributed to all parties.

MS MUIR: As per usual only just a moment ago, Commissioner.

COMMISSIONER WILSON: Very well. Unless there has been any word from anyone by lunch time, the documents will be assigned the numbers provisionally assigned to them on that list. Yes, Ms Muir.

MS MUIR: Thank you, Commissioner. I call Associate Professor Beth Kotzé.

BETH KOTZÉ, SWORN **[9.30 am]**

EXAMINATION BY MS MUIR

MS MUIR: Commissioner, Associate Professor Kotzé has provided one statement to the Commission, an affidavit sworn on 18 December 2015. The Delium reference is PBK.900.001.0001 and the affidavit has been marked as exhibit 71.

COMMISSIONER WILSON: Thank you.

MS MUIR: Professor Kotzé, your qualifications are set out in paragraph 3 and 12 of your statement and in your curriculum vitae which is exhibit A to your statement. You currently hold the position of Director of Mental Health for children and young people in the Mental Health and Drug and Alcohol Office of the New South Wales Ministry of Health. Is that correct?---That is correct.

And is it a fair summary of your CV that you have been a Fellow of the Royal Australian and New Zealand College of Psychiatrists for 28 years, and that you have worked in a number of senior clinical management and leadership positions throughout your career, and you have over 25 years' experience in child and adolescent psychiatry?

COMMISSIONER WILSON: We're not going to be able to proceed like this. I think I'll stand down and I'll ask the bailiff if he'll get in touch with court administration and see what the problem is. I'm sorry but I think it's the only practical thing to do.

MS MUIR: Thank you, Commissioner.

WITNESS STOOD DOWN

ADJOURNED **[9.31 am]**

RESUMED **[9.57 am]**

BETH KOTZÉ, CONTINUING

EXAMINATION BY MS MUIR

COMMISSIONER WILSON: I understand that adjustments have been made, but the situation is being monitored, should it recur.

MS MUIR: We'll give it a go.

COMMISSIONER WILSON: Alright. Thanks, Ms Muir.

MS MUIR: If I could take you firstly to paragraph 61(c) of your statement, Professor Kotzé; it's PBK.900.001.001 at 0014 to 0015. Just while we're getting that up, that's where you detail your involvement in the process of the development of the Draft Mental Health Service Planning Framework. So I might just refer to that as the framework when I'm asking you questions. And in your statement, you say that this process involved examining literature and databases in relation to service elements, service utilisation and best available treatment evidence, and that this resulted in expert agreement by consensus on what and how much should be provided in an ideal system. You've said that this draft framework includes a taxonomy for agreed service elements in a comprehensive mental health service system and a tool that assists with planning at different levels. You say also that there were over 200 experts from Australia who were involved in the development of the framework. Can I ask: was Dr Bill Kingswell one of those 200 experts?---Not to the best of my knowledge.

The Commission understands that there were a number of versions of the draft framework; is that correct?---There is the initial draft that has been circulated. The final document is in preparation at the moment, with a due date of about June/July this year.

Okay. So the version that I'll take you to - - -?---Yes.

- - - that the Commission has is one of October 2013; does that sound about right?---That sounds about right, yes.

Can I just now take you to paragraph 14 of your statement, at 0004.

COMMISSIONER WILSON: Ms Muir, can you slow down a little?

MS MUIR: Yes, Commissioner.

COMMISSIONER WILSON: Yes.

MS MUIR: Here, you recall – here, you say that you recall hearing about the Barrett Adolescent Centre during the development of the framework in either 2012 or 2013, and you say that your recollection is that the Barrett Centre was considered to not operate contemporary model of care, as it offered long-term residential care in an institutional setting. Just a couple of things. Is there a particular meaning that you would give to the expression cotemporary model of care?---A model of care that would

be considered modern, in keeping with, you know, currently understood standards and evidence.

So in your statement, when you say that the Barrett Centre was not considered to operate a contemporary model of care, was that your opinion at the time or was this something that had been communicated to you by someone else during the development of the framework?---It wasn't my opinion. In developing the framework, there was very detailed consideration of the evidence, but also models currently operating in the jurisdictions so that, for example, there was discussion about units in other states. There were presentations, for example, detailed presentations about some service units. There were site visits conducted by the project team to certain units. So it was during the process of those discussions, and a component of the planning process, which was looking at what was currently available, and, if you like, tagging them to particular categories of – of service within the taxonomy. It was during that process that I came to hear about the Barrett and to understand it was not operating on a contemporary model of care.

You referred to site visits. Did you have a site visit to the Barrett Centre?---No, I didn't. No.

And so your knowledge – you had some knowledge then about the Barrett Centre model of care at the time?---As a result of those discussions, yeah.

But only through speaking to - - -?---Yes.

- - - particular people?---Yeah.

Were there particular people that you can recall that were talking to you about the Barrett model of care in particular?---No. These discussions were fairly free-ranging, participative. The group's often extremely large. I don't recall anyone in particular.

And can you just explain to the Commission what is meant by institutionalisation in the mental health context?---Okay. I can certainly talk to the – the topic in the light of current experience within New South Wales. So within New South Wales, as a result of the development of a plan by the New South Wales Mental Health Commissioner, it has been determined that New South Wales will complete the process of institutionalisation – de-institutionalisation that was become some decades ago. As part of that, the definition has been defined as people staying in a hospital setting for longer than 365 days, and this setting is a – is a whole of life setting, if you like, where the person is a patient within a context, that a whole variety of their needs are met, so they don't actually need to leave that setting in order to have those needs met, and this results in an acquiring of a disability that may affect that person's ongoing life.

MS McMILLAN: Commissioner, could I – sorry – just ask the witness to speak a little more slowly?---I'm sorry.

It might be insipient age that Ms Wilson has been reminding me of that I'm taking it down somewhat slowly?---I will try. I'm sorry.

MS MUIR: We can both try.

COMMISSIONER WILSON: Yes.

MS MUIR: In paragraph 18 of your statement, you describe institutionalisation as creating the risk of enduring or even lifetime disadvantage through disruption to a young person's functioning and psychosocial development. I just – going back to your knowledge of the – well, understanding of the Barrett Centre, at this point in time now, would it be fair to say that you had a – you have a good understanding of how the Barrett Centre operated?---Yes, I do believe I have acquired an understanding. Yes.

And so are you able to explain to the Commission how institutionalism in a setting like the Barrett Centre may lead to enduring or lifetime disadvantage?---The – the significant issue for – for young people is that when their development is disrupted or goes off-track it's very difficult for them to recover that ground later on down the line. So for these young people, they were spending very long periods of time in an artificial environment where imposed on them was the role of patient, so there's the sense of things being done to them, and a relative relinquishment of decision-making and a sense of autonomy and – and responsibility. There – so they don't have the opportunities to acquire at the appropriate development stage the life experience and the developmental capacities that will enable them to then function well as – as adults. It's compounded by the artificial nature of an institution, that kind of whole of life idea, that there isn't the requirement to plan activities of, you know, ordinary living, to actually interact out in the community. Things come to you when you're in an institution. There's also the particular quality of relationships, and I think that there was certainly quite a lot of evidence in the files of the kind of regressive relationships in very high-intensity and high-dependency environments. And it is the sense that because that's such a significant part of the young person's life and it's a very long time in a young person's life, three – two to three years, that that imprint is very strong then for the young person moving into adulthood, and it's quite difficult to redress, unless it's very specifically redressed, perhaps in a program of rehabilitation etcetera.

Just to – so if I understand what you're saying – and correct me if I'm wrong – your concern is that about the setting like Barrett would be in the circumstances where young people are staying for longer than a year, where young people are not learning life skills, just doing the time. So they're not being taught how to look after themselves, and they're not getting an opportunity to, for example, go out into the – the real world as part of their – their treatment.

MR DIEHM: Commissioner, I object to that. There's a risk of a confusion arising out of those things being bundled up together.

MS MUIR: I accept that, Commissioner. I think I can slow down and take a step back.

COMMISSIONER WILSON: Take it one by one.

MS MUIR: Thank you. From your understanding of the Barrett Centre, would you accept that you understood that the young people who were inpatients there were able to take leave?---Yes.

And no doubt, given what you've said you would have understood, that was an important part of their treatment - - -?---Yes.

- - - at the Barrett Centre?---Mmm.

And you knew that there was the on-site integrated school at the Barrett Centre and was that factor something you considered was an important part of a young person's life skills and learning?---It's really – it is incredibly important to the young people when they are experiencing hospitalisation to have the opportunity to continue their education at whatever level that they're cognitively able to do so. The issue actually is that the school on-site, which is very necessary during particular phases of illness, it's again that sense of it's a whole of life service. The young person doesn't have to leave the premises to go to school. Can I just make another point that's quite important, and that is that for young people it is the dominance of the paradigm, if you like, the dominance of the experience. So for the predominant period of time the young person is a patient in an institution. Yes, they can have periods of leave, but the dominant experience is as a patient in an institution. There's quite a deal of evidence that unlike adults, for young people even experiencing quite brief episodes of illness, perhaps an episode of depression, that can actually significantly disrupt their development, such that, actually, it can be quite difficult for them to make up that ground when they've recovered from the depression or you need to address it specifically when they have recovered. So it's that mix of the predominant experience and the particular sensitivity at the developmental stage.

You referred to your knowledge being obtained from the files that you reviewed, and those files were the ones that you looked at in relation to your investigation report. So the young people's files that you were – reviewed were, really, only ones that were there at the time the closure announcement had been made? Yes?---Within the Terms of Reference, yes.

Within the Terms of Reference. So you have no knowledge of, and haven't reviewed, any of the patient files from preceding years?---No, no.

Can I ask: in your opinion, is a design specific in clinically-staffed, bed-based service for extended treatment adolescent mental health inpatients a contemporary model of care?---A purpose-built design, absolutely. A clinically-staffed, absolutely, depending on what service element what you're intending to – to develop.

Thank you. I'd like to take you to the framework - - -?---Yes.

- - - to three extracts. The first document – Commissioner, it is available on the screen but I thought it may be easier for a hard copy so I've given a hard copy to all the represented parties. And there should be hard copy for the witness as well and, Commissioner, I'll hand one to you as well.

COMMISSIONER WILSON: Yes, please.

MS MUIR: Okay. So the first – this is a document which contains a visual representation of the framework's taxonomy or classification structure. And the classification structure contains two high level groups called Population-Based Universal Services and Services Tailored to Individual Groups. I'd like to take you to the specialised bed-based mental health care services stream which sits within the high level Services Tailored to Individual Groups group. Now, I understand that the specialised – well, the Commission understand that the specialised bed-based mental health care services stream contains a number of service categories including the 2.3.2 subacute services, residential and hospital or nursing home-based service category. Is that correct?---That's correct.

So if we could then go – I'll get this up on the screen – to DBK.500.002.0620 at .0871. If we can go to 871 and over the page. Now, this contains a description of the 2.3.2 subacute services service category and if we could go to .062 – sorry 0873, the seventh dot point under Example Services?---Yeah.

If we scroll down – further down and further down – okay. The seventh dot point – if we can go further down – and you will see the Barrett Centre is listed as an example service - - -?---Yes.

- - - in the description of the subacute services service category. That's correct?---That's correct.

So if the Barrett Centre was considered to not operate a contemporary model of care – which is what I understand you say in you statement – why is it included in the framework as an example service in the description for the subacute services service category?---What that means is that you could take any service example and find a compartment within the framework to put it, that it's an example of that kind of service. It's not – it doesn't go to the value of that service in providing a contemporary model of care.

Okay. So it's just - - -?---So what it says at a very high level is that is where you would put – that's the compartment you'd assign that service to.

Okay. If we could move on then to paragraph 61(c) of your statement which is at 0014. You say there that you have a comprehensive understanding of the service elements currently provided and the practice of adolescent mental health care and

other jurisdictions and obviously Queensland is one of those jurisdictions?---Yes, yes.

To what extent, Professor Kotzé, are you familiar with the alternative services which were developed in Queensland by the Statewide Adolescent Extended Treatment Rehabilitation Implementation Strategy Steering Committee or the SWAETRI steering committee. Are you familiar with those services?---There is documentation in the – on the Barrett Inquiry website in the submissions section which details some of that work and I have – I have looked at that. Prior to that, through various meetings and collegial connections including some of the later meetings of the draft National Mental Health Service Planning Framework I had some knowledge of the processes.

Okay. So these services include the subacute swing beds, day programs, the AMYOS Step Up Step Down units and youth residential rehabilitation units?---Yes.

If we could just go to paragraph 19 of your statement at 0005 and here you describe best contemporary evidence regarding mental health care. If you just take a moment to read that?---Yes.

So it's a very general question but having looked at – and with your knowledge of the services developed by the SWAETRI – it also was later called AMHETI steering committee. In your view, do those services align with best contemporary evidence?---Definitely. It's a comprehensive array of services with the – the components of a – of a specialist CAMHS and outh mental health services clearly identifiable.

Are you familiar with the subacute beds at the Lady Cilento Children's Hospital in South Brisbane?---No, I'm not.

Do you know that the – so you've never visited the Lady Cilento?---No. Not to my knowledge.

And but you know something about these beds as part of suite of services?---Yes, yes.

And you know that the beds are located within an acute ward?---Yes.

And in your opinion is it appropriate for acute adolescent inpatients to be confined with extended treatment adolescent mental health inpatients in the same ward or unit?---It really depends on the profile of clinical care need of the young person. It is certainly possible to do that and it is desirable in certain circumstances. It does have to be purposefully managed with good operational policies and good clinical leadership to ensure that the clinical care needs of both groups are met in parallel but it's certainly possible and certainly appropriate under certain circumstances.

Okay?---So for example, you might not necessarily want to transfer somebody out for the – for the last stage of a – an admission when they have established relationships, when there's an established and positive treatment trajectory in train and it might actually cause some disruption to send them to another setting where they've got to start again, essentially, in terms of establishing therapeutic relationships, for example.

You've had an opportunity to the ECRG report?---Yes.

And if we could go to DMZ.900.001 at .478 – .0475 at 478. And if we could got to – page 478 – if we go to the third dot point under the heading 2 – so down the page?---There's the target group - - -

Yes?---Yes. Yeah, sorry. I've lost it.

And the reference there is:

> *Managing these young people in acute inpatient units does not meet their clinical, therapeutic or rehabilitation needs.*

Do I take it that you then disagree with what the Expert Clinical Reference Group say here?---Not at all. It's a spectrum within – within a category and they're – they're referring to another part of the spectrum.

Okay. So – and I think you've touched on this earlier:

> *For some young people the management in the acute adolescent inpatient unit would not be appropriate depending on the condition - - -*

?---For some it wouldn't be. It may be appropriate. It may not be appropriate for others. And clearly, what this group is – is doing here is – is defining the group that you wouldn't want to manage in ongoing acute unit.

Okay. And you understood, though, from the ECRG that the target group – and I realise there's evidence of – there was no one size fits all type of patient admitted to the Barrett Centre, but the ECRG was looking at the needs of adolescents with severe and complex mental health conditions, the type of young people that had been admitted to the Barrett Centre. You understood that.

Is Western Australia one of the jurisdictions that you have a comprehensive understanding of the service elements currently provided?---Yes.

And you're familiar with the Bentley Adolescent Unit?---Mmm.

And the type of service elements offered there: are you able to describe them?---In the Bentley unit?

Yes?---It's an acute unit. I think it's about 15 beds. I think it's currently being – it may be repurposed as a result of the Western Australian Mental Health Commission plan. It's probably – if you compared it to our acute units – more on the less acute than the high acuity side.

Well, perhaps if I could – if I could take you to COI.017.0001 at 0007. This is the Western Australian Mental Health Alcohol and Other Drugs Services Plan for 2015-2025. And if we go to 0007. And here, if we just go to the second-last paragraph, you'll see there a reference there to:

> *For the first time, Western Australia has utilised evidence-based national modelling tools (the framework) that outline the optimal mix of services required to meet the demands of our population.*

And if we go to chapter 10 at 0050, at the bottom of the page, the last dot point on 50, refers to subacute hospital short stay beds, with an average length of stay between 35 days to six months?---Yes.

And then you've got that, Professor Kotzé?---Yes, I do.

Yes?---Subacute hospital short stay.

Yes, and then if we go over the page to the - - -

COMMISSIONER WILSON: Sorry to interrupt. Were you, Ms Muir, referring to the short stay or the long stay?

MS MUIR: Sorry, the long stay. That was my - - -?---Okay. So it goes over the page. Yes.

And then over the page, and they're subacute hospital long stay beds - - -?---Yes.

- - - with an average length of stay of 365 days?---Mmm.

And then if we go to 0056, if we go down to 10.6.36 – sorry, 10.6.3 – you'll see that the plan recommends that by the end of 2017, in order to plan for the future, the Bentley Adolescent Unit should be converted into a state-wide 14 bed subacute service for youth?---Mmm.

I just wanted to understand how the draft framework may have been used to propose the conversion of the Bentley Adolescent Unit, an existing inpatient faculty for adolescents, into a state-wide subacute service for youth, and do you understand the connection between the framework and then this plan for the future?---Certainly. And just to say I don't read that as necessarily meaning it's a plan to be a long stay unit. So the National Mental Health Service Planning Framework is a decision support tool. It's merely the start of a service development and planning conversation that then involves a whole lot of other processes, including stakeholder

consultation, but also including a recognition of current context and a sense of future directions that may be achieved over time. So it's not the intention of a model like this that within, you know, a very short period of time you would have extensive repurposing or redirection of its service. It's really about, well, if this is the general map that we're seeking to align to, how do we purposely prioritise, use opportunities or identify, perhaps, new sources of funding, etcetera, to align over time what we have with where we think in the future things should go. So in this process that was conducted by the Western Australian Mental Health Commission, it did use, if you like, the technical, more objective science of a mental health service planning, but it also then went through extensive processes of consultation to identify priorities and identify opportunities, etcetera.

You said a moment ago that you didn't actually read the reference to a state-wide 14 bed subacute service being for a long stay?---Mmm.

Okay. Is there any reason you say that or - - -?---Because for young people staying over 365 days, it's not a service element within the National Mental Health Service Planning Framework, and if you think about a population like the size of New South Wales, there would probably be – it's about one to two young people per year that you're thinking about, you know, might have lengths of stay of that order. That's a huge service capacity for something that should only be needed by a tiny number of young people.

COMMISSIONER WILSON: Excuse me. I wondered if I caught what you said correctly. Did you refer to young people staying over 365 days?---Yes. If – it looked like that was the definition of subacute long stay at the top of the page.

MS MUIR: If you could go back to 0051, that was – that's what I – so your understanding is that long stay – you're referring to up to 365 days?---Yes. Well, no, this – average length of stay – so some people – the high outliers within that and low outliers, but average length of stay, 365 days, is a very long time.

So when we go back to the Bentley unit, for the future that we looked at 0056, what you're saying there is that you don't think it's a suggestion that those subacute services are for longer than 365 days. Is that your evidence?---My reading, without it being spelt out in black and white, is that that is most likely to be linked with the service element before this one. So if you go back up that page to the next one, which is subacute, subacute hospital, short stay.

So 35 days to six months?---Yeah, yes.

Professor Kotzé, I just want to ask you some questions now about the investigation that you did under the *Hospital and Health Boards Act*. The timeframe for the investigation – I want to ask you some question about that. I understand that you were appointed on 14 August 2014. Is that correct?---Mmm.

Along with Ms Skippen and Ms Kristi Geddes?---Yes.

And you had to – you were tasked with investigating the state-wide transition and care planning measures following the closure of the Barrett Centre, and more specifically the matters that were set out in the Terms of Reference - - -?---Yes.

- - - which you've exhibited to your statement. The – you were initially required to finalise your investigation by 16 September 2014, and then the time was extended until 31 October 2014. Is that correct?---Yes, that's correct.

In an email that you sent to Ms Geddes on 27 October, which is exhibited to your statement, you state that the report would be a superior product had the agreement for local support to the interstate investigators been honoured. I just wanted to ask you two things about that. What was the agreement for interstate support?---When Dr Kingswell rang to ask me whether I would be willing to consider undertaking the investigation, whether I would be available, he indicated that local support would be available. It wasn't a detailed conversation, having done many investigations and reviews. What I understood that to mean was that there would be a local person available to do the needful, whatever that meant, given the particular nature of the investigation and how things proceeded.

So how would – in what way would the report have been more superior if the agreement for interstate support had been honoured?---Okay. I think that, in my mind, when I read the terms of reference and was starting to construct in my mind what would be a comprehensive report, I thought that what we would attempt to do was to develop particular chapters dealing with particular issues in great detail in a very comprehensive account. It would not be unusual, in my experience, for the local person available to support an investigation to take carriage of the particular things that are not specific to the clinical matters being raised, but things like writing the chapter on the history in context, the background to the investigation, for example; material that could be sourced from – that's not – that's not clinical. In the end, within the time available, what we prepared was a comprehensive and very succinct report.

Given what you learned during the investigation, would you – do you accept that a number of the Barrett Centre patients had – presented with very complex and complicated conditions?---Yes.

And a number of them, from what you had been provided, had already exhausted treatment options within the community?---Yes.

And did you accept that these patients did not readily fit within service systems or cross the threshold to service in the community mental health system?---Yes.

And in the model of service which you considered to be contemporary, where did these sorts of patients fit?---To answer that question it probably would be best to talk about specific examples.

In closed court?---Yes.

So I can go back to that. Thank you. I just want to ask you some questions about evidence base and outcomes. In paragraph 20 of your statement, PBK.900.001.0001 at 0006, if you could just read that paragraph?---Yes. Out loud?

No. Just to yourself, sorry?---No, no. Yep, yep. Yes.

Are you able to explain how outreach and transition support systems and intensive day patient and assertive community care teams reduce length of stay and readmission rates in adolescent mental health?---Okay. What you're really putting in place is a capacity to specifically support the young person as things are escalating to the point of crisis or they're moving out of the setting that they've been admitted to and back out into the community. So you're putting in place – you're – what you're doing is you're removing to – as far as you can, the necessity for the young person to escalate to the point where admission is necessary or to have to remain unnecessarily in the hospital setting when, with some additional support, they could be in the community. That's the length of stay issue. Readmission rates really goes to the issue that there's a natural readmission rate, if you like, which is as a result of the types of illnesses that young people may experience and the imperfect nature of our treatments or the fact that you – with, you know, an enduring and relaxing illness pattern you're not, you know, looking at cure. But there is a readmission rate that arises from that period when there's not quite the right alignment between the young person's care needs without that additional support. So things in the community are a little bit too stepped down. They don't really need to remain in the inpatient setting and you're really putting in place something to bridge that gap and to enable them to leave hospital but also enable them to be better able to manage situations as they start to escalate without having to escalate to the point where it's inevitable they end up in the emergency department and being readmitted.

And you refer to – you use the expression "have been shown to reduce length of stay"?---Yes.

Are you able to refer the Commission to the source of this information and how such outcomes have been identified?---Yes. That is from the UK. It's from the commissioning material that the NHS has developed to guide commissioners of mental health services to know what they should be purchasing to provide comprehensive services for their child and youth population.

So when you say from the UK, if we were to look for this information, where would we look?---Just Google NHS commissioning tools. You should find a link that you can then link through to other things with.

Just generally in adolescent mental health, how are outcomes and evaluations – and if we could perhaps focus on Australia – properly recorded?---You can think about it at the national level and the requirement for the jurisdictions to be collecting outcome measures. That's an expectation universally of services. But also for individual services, as part of the quality improvement programs, quality assurance programs of individual services, it's a common activity and – whether that's done by

clinical audit or by specific outcome measures. We, for example – and the national outcome measures are general. One of the important issues, particularly if you're thinking about developing new services, is ensuring that you're evaluating them quite specific to the intention of the service. So, for example, we have a service called a whole family team which is about providing services for children who have been identified at risk of serious harm – significant harm and that's been substantiated. So the root of entry is via the child protection system. All the standard measures of outcomes are recorded but because in that particular instance what we're doing is offering a service to the parents as individuals, the family and the child, we're developed up a suite of very purposeful, targeted outcome measures that enable us to know how that's progressing. So you can think of it at different levels. Some if it is service initiated, some of it is about demonstrating success of innovation or innovative programs. But there is also the national requirement.

What sort of systems though are used for collecting the data or recording information to then be able to base the evaluation and outcome?---There's a variety. Fortunately, for many of the routine general measures there are IT based systems. Unfortunately, for some of the service innovation developments that I'm talking about, we've actually either – we've actually either commissioned standalone databases or it's manual, manual collection, which is not ideal.

In your statement – actually, I'll take a step back. Just – and you may not be able to comment on this given you're confined with the information that you had. But did you in your review of the documents during the investigation of the Barrett Centre – did you notice whether there were appropriate systems in place for recording outcomes and evaluations of the Barrett Centre?---My understanding was that they were collecting the so-called mandatory outcome measures. I don't know whether they were systematically, you know, analysing and reviewing those or matching them for particular patient groups. As to be expected for an inpatient unit, they were not evaluating outcomes over time once the young person had been discharged, and that's the common situation for acute – or inpatient units.

You also refer in your statement to – you give some evidence that during the investigation it might have been useful to obtain a time-trended report that graphed incidents over time?---Yes.

And, for example, before and after the standing down of Dr Sadler and the announcement of the closure of the Barrett Centre. Can you just explain the relevance of the time-trended report and how this might've assisted in the investigation?---We had multiple accounts, and that was first from interviews, and it was clear from the documentation that there – of escalation in distress of the young people, and not unexpectedly for this population and increase in incidents. Kind of – in terms of face validity, that looked to be correct. We were really seeking to see if there was any objective evidence to support that. So what we expected to receive was a graph – single-page graph – which showed over time the rate of incidents on the unit, and it would've been useful to have a sense of whether there had been a change pre and post the standing down of the senior clinician and pre and post the

closure. That would've provided an objective point of data to support that part of the finding of the investigation and may or may not have assisted in getting a sense of the impact of those two events.

You may have seen Dr Sadler's supplementary statement, but I can – in that statement he had - - -?---I saw an excerpt, yes.

- - - said that he had identified – he referred to your investigation report, saying that transition should not be undertaken at a time of crisis, and Dr Sadler's comment is that given that there was a crisis at the time, which you seem to accept, that there should've been a moratorium on the closure of – or the transition. What do you say about that?---Look, I think, with respect, potentially Dr Sadler has misunderstood that reference in the literature. I think that in fact it is more referring to a sense of personal or clinical crisis for the young person, but also that it is undesirable for a young person to transition into an adult system in the crisis of acute admission. So they're not really referring to this system issue, if you like, this system context. I think that there are a couple of things to say about this issue of a moratorium. The first is that you're dealing with a population who are highly sensitive to the sense of proximity and perceived rejection in relationships and highly sensitive to the ways in which they can behave to increase the proximity of adults in their lives. One of the worst things that you can do is give an inconsistent message about the reality of that relationship and where things are headed. So I think that it would've been – there would've come a point when a stop-start approach to the closure could've potentially actually been actually quite damaging, because it increases the potential for the young person to realise that their evident distress might actually result in a change of direction and the likelihood, of course, of that happening again. The other issue, though, I think, to consider in that is that what we were hearing – and I do bear in mind that for many of the people that we interviewed the experience was still quite raw – but what we were hearing was that there was very significant levels of distress for staff and a sense of perhaps some fractures in the usual functioning of the multidisciplinary team, and in part that was also because there'd been a turnover of staff and the loss of very experienced staff, and certainly shifts were filled, but often with casual, I think, or not so experienced staff. So I think for me, there was a sense in the process of some of the ways in which the centre was able to provide therapeutic holding for these young people – and for young people with these particular difficulties, it is the skilled interaction and the quality of the therapeutic relationship that may assist them in settling and dealing with their emotions. Some of that was really, perhaps, unravelling. I don't recall anybody actually ever saying the situation was becoming untenable, but I actually think it was probably becoming tenuous. So there probably was a point where – I guess a tipping point, but I can't identify when that specifically was. I think the other issue is, too, you've got young people with significant difficulties in attachment, huge sensitivity to abandonment, and that whole kind of thing of giving the message: okay, detach, start moving on, but then reattach. And so it's just – it's not going to work.

I just want to ask you some questions about the Redlands model of care and the New South Wales Walker Unit. If I could take you to paragraph 18 of your statement,

which is at 0005, and you refer to two units there, and I assume that they're the Walker and Rivendell Units?---No, they're not. Sorry, I'm just – I can't find which page - - -

Sorry, paragraph – the model of care of the - - -?---Yes, I'm sorry. Is it in 18 or is it 17? Could you move up to 17? I think it's there. Yep. Okay. Two units in New South Wales that offer non-acute, non-declared inpatient care for young people on a four night per week school term basis with collocated hospital schools. That is actually Redbank, and that is Rivendell, which is different from the Walker Unit.

Okay?---The subacute unit declared under the *Mental Health Act* that offers medium-term care to young people with severe and enduring or treatment-resistant mental illness is the Walker Unit.

Okay. Just in relation to that Walker Unit, can I just take you to an email which was sent by Dr Kingswell on 14 March 2014 to a number of people within the Department of Health regarding the alternative services which had been proposed for Queensland. It's Delium reference QHD.004.012.9443. I realise I should say that you're not – that you're not a recipient of this email, but I wanted to ask you a matter which is relevant to the Walker Unit in New South Wales?---Yes.

On page 9444 under dot point 7, Dr Kingswell said that the National Mental Health Service Planning Framework does not support a bed-based service, and New South Wales is keen to close their Walker Unit at Concord. Was there a plan, to your knowledge, to close the Walker Unit?---Not to my knowledge.

No?---Not to my knowledge, no.

Do you agree that the framework doesn't support a bed-based service?---Look, it does. I mean, the framework – the framework supports that there are some young people who would benefit from longer stays in hospital. Now, if you just take the Walker Unit, its average length of stay is in the order of 90 days. If you add the leave beds in, it's in the order of 135 days. But its median length of stay, so the middle point of the frequency distribution, is actually 42 days. So, in fact, it recognises – and – and that's recognised within the model. There are some young people who would benefit from that longer – longer stay. What the model – and – and that – and that's, really, most particularly young people with those enduring and relapsing mental illnesses like the psychoses and the affective disorders. What the model – what you won't find in the model is, for example, the very long lengths of stay under the *Mental Health Act*. You also will not find, for example, long length of stay for people with eating disorders. Now, you have to know where to find that in – in the model, but if you take that particular group you won't find that. You also won't find, for example, extended inpatient stay supported for the group of people who have strong emotional dysregulation, which is the borderline personality disorder group in adult – in adulthood. You wouldn't actually go looking for that in this model. You would find that information, for example, from the NHMRC Guidelines

for Borderline Personality Disorders. So there's quite a lot of unpicking that has to be done beneath the general statements.

I just want to take you now, again, back to the investigation, and that – and what you actually were provided with. And in paragraph 59 of your statement – which is at 0014 – you say that the published literature which you and Ms Skippen considered when investigating and writing the report is exhibit S to your statement. And if we could go to exhibit S, which is at 01100 to 01127 – and you're familiar with this document, no doubt?---This is the large lever arch folder of documentation - - -

It's on the - - -?--- - - - of examples from literature – I'm sorry, yes. Yes, looks familiar.

And this is the key principles of transition of young people from paediatric to adult healthcare?---Yes.

I just wanted to understand the relevance of this document to the investigation and how it was used when undertaking your investigation and the report. How was it relevant?---I actually interpreted the question I was asked as what was the body of knowledge I had at the time of writing the report. I didn't interpret it as what did I go to specifically to – to use in the writing.

So this was one of the documents, but - - -?---Yeah .

- - - I was just – that you referred to and exhibited to your report - - -?---Yes.

- - - that you had considered - - -?---Yes, yes.

- - - when writing your report?---Yes.

Sorry, if I haven't - - -?---Yes.

And I just wanted to understand the relevance of this document to the writing or how you saw it?---Okay.

So - - -?---Okay. So I think the relevance is that on the one hand you have the principles of transitional care, which are quite technical and specific. They are the ordinary and usual good clinical processes of, you know, ensuring medication's being reviewed, ensuring discharge scripts, ensuring arrangements for how medication will be supplied in the community, for example. There's this other – and – and it's – it's interesting, because in some ways it's – it's so obvious and so inarguable that these kind of values and this sort of care philosophy would be brought to the process. And yet, the international evidence would suggest that, in fact, you do need to pay particular attention to sending signals to clinicians about the things that they really need to be attending to in the process and really very thoughtful about. So they do need to be thinking that the young person is at a particular developmental stage where issues of, for example, autonomy are going to

influence their health behaviours. So they do need to think okay, how practical is it to give this young person the script themselves? Does it need to be given to a carer? Is there something else, you know, that needs to be done? They do have a need for choice and control and being more responsible for self-management, but that's, of course, tempered with the – the role of the family and carers still in their lives. So it's that sense of – in some ways, it does seem to be that the most difficult components of transitional care are these more values-based philosophy of care, behaviour of the clinicians in the relationship.

Thank you. I – if I could take you to the relevant Queensland Health policy at the time, which is Queensland Health Inter-Districts Transfer of Mental Health Consumers; it's at exhibit X to your statement, PDK.9000001 at 1602. Do you remember this document?---Yes, I do.

Did West Moreton Hospital and Health Service identify this policy as the business as usual or the transition discharge practice for the Barrett Centre?---I just can't quite remember specifically whether – they certainly identified business as usual, and this policy was identified. I'm just not absolutely certain at this point in time whether they drew those two things together in their correspondence.

Maybe we could go to COI.018.0002.9540 at 9541?---Yes, the last page I think it is.

Yes. We can scroll down – at 9544, just up a tiny bit please – sorry, if we can go up to the page before - - -?---I'm sorry, yes, the page before.

Keep going up?---Yes. All staff involved in that section. So I don't read it that they specifically drew the connection to that policy, although they refer to transition practice policies and procedures. So I – actually, if we go to point 3 - - -

If we can just go up. Okay. Attachment 7?---Yes, it is mentioned there, attachment 7. Yes.

So it was identified?---Yes.

Did any of the Barrett clinicians or staff you interviewed during the investigation mention this policy?---Not to the best of my recollection.

And did you think the policy was an appropriate policy to guide transition discharge practice in a general sense?---In a – in a general sense, yes. You wouldn't describe it as – as youth-friendly, but in a general sense yes. And there was some important components of that policy that were carried forward into the – the new policy that was developed.

And I was going to ask you about - - -?---Okay.

That's the guideline?---Yep.

But – so that was my question. It would have been better to have a policy that was more specific to the transfer of patients out of child and adolescent mental health services?---Yes.

Yes. Now, I just wanted to ask you some questions about transition, the meaning of transition. Does transfer – do you draw a distinction between, in the context of adolescent mental health, transition and transfer?---Me personally?

Yes?---Yes, but I'm aware that very commonly, in common use of language, the distinction is often not drawn.

Well, perhaps if – it would assist greatly if you could explain the distinction?---Sure. The – the dominant paradigm in healthcare in North America, the UK and Australia is you have children and adolescent health services and then you have adult health services. There is some possibility of flexibility, most particularly around some of the rare syndromal illnesses in paediatrics or some of the very significant medical illnesses of childhood and adolescence. But, in the main, there's an expectation that when somebody achieves a chronological age they will shift from a child and adolescent service to an adult service. It doesn't work like that in terms of the developmental process for a young person in achieving the kind of health behaviours that are going to enable them to manage their health as an adult. That's a protracted process that may occur over many years and be quite discontinuous and, you know, at times the young person may acquire skills but then perhaps regress for various reasons. So it's because of this dominant paradigm that, arguably, there is an artefact required which is called transitional care, which is trying to ensure that – that the young person is able to leave one care system which has a distinct culture and a distinct way of dealing with young people and a distinct approach in general to thinking about the role of families and carers, to a system where the expectations are quite different. And so we have to then pay particular attention to enabling that. So it's not a natural feature of the young person's development. It's not a natural feature of the illness patterns. It's an artefact of service system organisation that is the dominant paradigm and unfortunately for mental health, of course, coincides with the period of the highest instance and prevalence of mental health issues.

I'll ask you some more specific questions in closed court about this issue?---Yes.

But just in a general sense, would you agree that the process of transition at the Barrett Centre in 2013 that you reviewed, it wasn't just a business as usual transition?---No, it wasn't.

It wasn't. So you would agree that it was really – it was the emptying out or the deinstitutionalisation of an entire centre?---When you say business as usual, I think the sense I had was that business as usual was not a particularly focused or purposeful process. That, for example, modern practice would be that from the very point of admission you're starting to focus on how well does this young person have to be and what are going to be their care needs when they're discharged? So my sense was there was probably fairly significant periods of drift and then towards the

end a focus on transitional care or transfer, whatever you like to call it. So I think it wasn't business as usual in terms of the intensity of the process, in terms of the focus required, in terms of the timeframe. But I interpreted that part of the letter to mean that it was expected that the process would be managed within the usual clinical governance processes of the unit.

Okay. So just so I – Commissioner, I'm conscious of the time. I probably have about 10 minutes of questions in open court and then I have questions in closed court. Would you be content for me to break when I finish open court?

COMMISSIONER WILSON: Well, whenever it's convenient for you. It would seem to me better to finish the open court but whenever it's convenient.

MS MUIR: Unless any other – I'm more than content if there's any other – perhaps if someone wants to adjourn now for any reason.

COMMISSIONER WILSON: Let's go on.

MS MUIR: In the context of transition that's done in – with, I guess, the young person's clinical care interests in mind in the usual sense – and I understand what you say that you considered that that wasn't necessarily happening at the Barrett Centre – would you expect though that the transition would need to be a gradual one?---I think that one of the – one of the issues in this is if you're seeking to change clinician behaviour, particularly around things that aren't grounded in objective, you know, science-like medication or whatever, you actually have to send a signal about behaviour. The risk is, of course, that the signal, it does need to be amplified in order for it to be clearly understood and influence clinician behaviour. But the risk is of literality in interpreting. So if I think about the guideline, for example, there is an example in that of it's given six months. Now, yes, you will find that figure in the literature but what you will also find and what clinical experience will tell you is that, actually, it's highly individualised and you can actually be very surprised at young people's resilience and their capacity when you perhaps felt that, you know, there's a highly significant therapeutic relationship, it will be difficult for the young person to give up. In fact, they're able to move on in a very healthy way relatively quickly. So, yes, the general principle would be – and what you're trying to send clinicians, is the message to be very thoughtful about how they're undertaking the process, what the response of the young person is. But you also need to bear in mind there's a huge variation and it does need to be individualised.

You've mentioned the guideline and I'll take you to that because that's at QHD.008.004.9683. And this is the guideline that followed after one of the recommendations of your report was that positive learnings in relation to good quality - - -?---Yes.

- - - transitional planning for the Barrett Centre be distilled into the development of a statewide policy. And it's this policy that you're referring to?---Yes.

And if we scroll down, I think you referred to an ideal period of time of six months?---That's what they put into the guideline. Yes. And they say ideal, I was thinking that it's probably an issue that you'd want to address in the education package to support the implementation of the guideline that – to emphasise that issue that a broad range of experience is entirely fine provided it's purposeful, provided it's – and I did like the component of the guideline where it emphasises where all parties are in agreement about the end of the – because that kind of captures the sense that I'm really trying to convey.

And all parties meaning the receiving services?---Yes.

And families and the young person and the clinicians?---Yes, yes, yes.

And obviously that's something – we've heard the expression cross-tapering?---Yes.

That would take a period of time to develop and establish?---Definitely for some. But, as I say, for some you can actually be surprised.

And, in fact, in paragraph 98 of your statement at 0023, there you talk about an ideal process of transition?---Yes.

And you say it would see the date set for each individual based on their individual concerns and issues and their responses to the process?---Yeah. Yep. Definitely.

And then you gave an interview with ABC local radio and you – just after the report. And you described an ideal process of transition. And you say:

> *Of course, under ideal circumstances you do like to take transition at the young person's pace.*

?---Yes.

Continuing:

> *It's not just always possible for a whole variety of reasons. But, of course, in this instance it was because a deadline had been set.*

And you agree that that's what you said in the interview?---Mmm.

So in relation to the transition of the patients from the Barrett Centre, do you think a date was set for each patient based on their individual concerns and issues and their responses to the process of transition?---I think that a date was set for closure. Within that and within the five months or so that the team had to plan and implement transition, young people left progressively as the plans were in place and able to be implemented. So within that – within that constraint, if you like – the date had been set for closure – yes, young people had their own date of discharge based on the existence of the plans and their implementation.

But it wouldn't be correct to say that transitions were taken at each patient's pace though, would it?---Well, I think that inherent within that is that you are working with a young person – I mean, I think at – at their pace it gets complicated because young people are very frequently, even with the best preparation, reluctant to move. And even with, you know, a very hopeful view about their future and a sense of all the advantages of leaving, it's quite natural to expect some – some reluctance. So it's a bit of a dance, really, when you talk about at their own pace. In this circumstance the pace was generally set because of the date of the closure but within that constraint I really do think that the – the team did attempt to – to take it as much as possible at the young person's pace bearing in mind that, of course, it was a very heightened – so it wasn't – it was an abnormal circumstance, if you like.

In paragraph 100 of your statement at 0023 you say there that the closure was seen as an administrative decision - - -?---Yeah.

- - - and an expectation of the process of transition being completed over five months. You say it was artificial in the sense that it was arbitrary across a cohort rather than personal to individuals?---Yes. That's the closure date. As far as I know the dates for discharge transition of the young people themselves was – arose from their individual transition care planning. As far as I know, nobody was instructing the multidisciplinary team about which kids to go in what order and when. With – I mean, we'll probably talk about it in closed court, sorry.

And do you recall in your interview on ABC local radio you say that:

> *It's very difficult to say that it was ideal because certainly ideal is that you take it at the young person's pace so I think there was a sense of rush because of the fact they were working towards a deadline.*

?---Yeah, yeah.

And you stand by that comment?---Yes, yeah.

Finally, in – this is my last question in open court, Professor Kotzé. I wanted to ask you about a paragraph you made in paragraph 117 of your statement. It relates to alignment between child and adolescent mental health services and adult mental health services?---Yes.

If you could just read that paragraph to yourself?---Hundred and seventeen?

Yes?---One hundred and seventeen? Is that - - -

Yes?---Yes, yeah.

Can you explain why:

For children and adolescents patterns of disease and disorder are less clearly captured within the diagnostic systems that align with standard approaches to treatment and support.

?---Patterns of – of – disease and disorder in adults tend to be more clearly captured in systems like diagnostic systems that are illness-based so schizophrenia, for example, bipolar disorder, etcetera. For children and adolescents you have – and I refer to it in another paragraph of my – of my statement – you have this – often this admixture of very troubling symptoms and – and the impact of developmental issues, of adversity, of family life, etcetera, etcetera, so that, for example, that example I was giving before of whole family teams, we can attach a diagnostic label to the – to the parent as individuals but there isn't actually a diagnostic label that describes the dysfunction in the family or the difficulties in the family. And of course, those kind of issues are highly significant with children and – and adolescents. So there has been some thinking over time that perhaps the predominant paradigms of diagnosis are – you know, perhaps we do need something that is more for child and adolescent – a more multi-axial, if you like, approach to diagnosis which is more about a formulation which draws together the symptoms in the child or adolescent and the impact of those on their life, the impact of their social environment and things that are either, you know, contributing to or mitigating, issues of – of symptoms and risk – disturbance and risk with something around, you know, family functioning so that's what I mean by that.

Thank you. Commissioner, would this be a convenient time?

COMMISSIONER WILSON: Yes. We'll break until 11.30.

MS MUIR: Thank you.

WITNESS STOOD DOWN

ADJOURNED **[11.16 am]**

RESUMED **[11.35 am]**

COMMISSIONER WILSON: Now, the hearing is closed.

Closed Hearing

ADJOURNED **[3.00 pm]**

RESUMED **[3.16 pm]**

COMMISSIONER WILSON: Yes, Ms McMillan.

MS McMILLAN: Yes. Thank you. Commissioner, can I just indicate that the first part of it will be open.

COMMISSIONER WILSON: I see.

MS McMILLAN: Yes.

COMMISSIONER WILSON: Alright. So this is a continuation of the questioning of Dr Sadler?

MS McMILLAN: Yes.

COMMISSIONER WILSON: You're still under oath, Dr Sadler.

TREVOR SADLER, CONTINUING **[3.16 pm]**

EXAMINATION BY MS McMILLAN

MS McMILLAN: Thank you.

Dr Sadler, can I ask you, firstly, it's correct, isn't it, until your standing down, generally when you went on leave, Dr Breakey covered for you. Is that right?---Yes, he often - - -

And you organised that yourself with him?---Yes.

Right. Thank you. Now, could the witness please be shown – and notice has been given of this – WMS.0011.0001.18549. Right.

Doctor, this is an email from Padraig McGrath. You know him? You know, Mr McGrath?---Yes. Yes, I do.

Yes. And he refers to some figures below about the staff profile. So can we scroll down. Now, just pausing there. The top two lines of figures are those that you provided, aren't they?---They are. Yes.

Right. And the third one, if you accept that that's Mr McGrath's own?---Yes.

Right. If we scroll down further to the bottom of the page, now, is it correct, Doctor, that to get to your 20.9 you added the NUM, the nurse unit manager, who is 1.0; a clinical nurse, 3.0; RN, 15.0; and a TNEEP, 2.9 to get to 20.9. Would that be right?---Yes.

Right. And what it didn't include was the nursing director, 0.3. Would that be right?---Yes.

Nor the clinical liaison officer, 1.0?---I am not – well, I thought that when I compiled that 20 – figures of 20.9 I looked at the nursing roster on the wall of the nurse unit manager and counted them up. And that would've included the clinical liaison nurse – officer and the enrolled nurse. And then I asked the nurse unit manager what was our staffing, and that would've included both those positions.

So you say it does. But you accept that that would add up to 22.9, wouldn't it, if you included the clinical liaison officer and the enrolled nurse?---That's true. But - - -

And nursing director is 0.3, isn't it?---Point three. Yes.

Yes?---I didn't include the nursing director because he wasn't on the staff roster. So there might've only been, say, 13 registered nurses plus – I cannot remember the breakdown of nurses. All I – that's how I arrived at that figure of 20.9.

Right. So you took it from a particular roster at a point in time?---Yes, that was - - -

Right. But Mr McGrath's evidence was to the effect that given, shall we say, the active nature of the QNU, if the figures fell below the BPF it would've been certainly something you would've heard about. Correct?---Yes.

Yes. Alright. Thank you. Did you want to add something that's relevant to the question?---May I clarify? Yes. So, initially, our staffing was raised in 2011 because the – to cover the number of people in – on continuous observations. I can recall that it was reduced again. And I'm not sure if that was at the end of June 2013 or if it was early in the year. But by the time I wrote to Ms Kelly, that was the number of people on the roster. So I know that it had been increased in line with the framework.

Yes?---But the it was reduced at some stage during the period of 2013.

But, as I say, you looked at one roster to get those figures?---But I also asked the nurse unit manager what our staffing establishment was. Now, I didn't include the nursing director because he was not clinically present on the ward. He visited occasionally.

Well, but you accept in looking at a BPF figures you do take into account, because it is obviously allocated 0.3, that they're not there the entire time. Correct?---I would say that he was there much less than 0.3. Yes.

Well, but do you accept for the purposes of calculating BPF they are counted as 0.3?---I accept that. Yes.

Yes. And so all of those staff designations are counted for the BPF. Is that right?---I was not really conversant with the BPF framework.

Okay?---I just asked about the number of people on a roster.

Right. I see. So it might have been apples and oranges, if you like? You weren't particularly cognisant of the BPF framework. You went and asked how many are on the roster, basically?---Yeah. How - - -

Right?---What staffing establishment – the rosters were fairly constant from – it included all nurses whether or not they were on leave. But they did not include the name of the nursing director, the 0.3.

Right. Okay. Now, I want to ask you, in relation to – you were part of a group that went to visit the YPARC establishment in Victoria?---I did. Yes.

Alright. And as you understood that at the time when the Barrett announcement – the closure announcement was made, that YPARC was definitely on the agenda, or a version of it?---I saw that there was a version of it in the planning group recommendations. Yes.

Alright. And you've seen emails that have come to light in this inquiry about it being – looking like it was on track, effectively, as an option?---No. I didn't - - -

With some tweaking, I should say?---I didn't consider that YPARC was on track as an option because it required a building and there was no capital works for a building. So the - - -

Alright. Well, thank you. Now, I want to then ask you some questions, please. And I think, Commissioner, they should be in closed session.

COMMISSIONER WILSON: Mr Mullins is on his feet. Mr Mullins.

MR MULLINS: Your Honour – Commissioner, would it be appropriate for me to ask my open court questions now?

MS McMILLAN: I don't mind. I'm happy to.

COMMISSIONER WILSON: I think that would be better, Mr Mullins. Yes, do so.

EXAMINATION BY MR MULLINS **[3.23 pm]**

MR MULLINS: Thank you, Commissioner.

Dr Sadler, my name is Mullins. I appear on behalf of Ms Pryde, Ms Olliver and Ms Wilkinson. You transitioned many patients from the Barrett Centre?---Yes, we did.

How many would you assess you transitioned over your 20 year period?---I lost track of the number of adolescents that we admitted to Barrett. But it would have been in terms of hundreds.

You developed a framework. May the witness please see document DTZ900.003.0197. And while that document is coming up, Doctor, you annexed, you'll remember, to your initial statement a series of documents that represented your framework for transitioning?---Yes. That was the model of service delivery and that was a component of it.

Alright. Can I just ask to go back to – I asked for 97. Can I ask just to go back to 93. And can we scroll down to paragraph 3.91. Sorry. I was right at 97. I've got the wrong number. I apologise. Go through to 97 – 197 and scroll down to 3.9.

Just to refresh your memory, Doctor. A little further. So this is the transfer transition of care section?---Yes.

And 3.9(1) there:

Disengagement with AETRC will not occur before the receiving team has made contact.

And so on. And the next page, please. Three point nine two, documentation, timely handover. Can I ask you to scroll down, please. Continue, please. Three point ten is the discharge external transition of care. That's a slightly different plan, Dr Sadler?---Yes. If we could – could I just scroll down to see 3.10 – the entire of 3.10?

The next page?---Yep.

Continue to scroll, please?---Yes.

Three point ten three:

Discharge planning will involve multiple processes at different times that attend to therapeutic needs, development tasks and reintegration into the family.

And can I go to 3.10.5, please, which might be on the next page. So part of the discharge plan involves facilitating contact between the adolescent, their family are carers and so on in the broader community?---Yes.

And then 3.10.6:

Then the discharge plan will include a relapse prevention plan, crisis management plan and service re-entry plan.

?---Yes.

Now, do I understand the case to be that the plan that you developed involved a potential for the patient to have ongoing contact with the Barrett Centre for some period of time or to re-enter the Barrett Centre?---Yes. So it would depend on the circumstances of which the adolescent was discharged whether or not a transition to another service with admissions to acute inpatient services would be the – would be preferable because they were likely to have a – just an acute inpatient admission or whether they would benefit from having a further stay with Barrett until things were stabilised. Yes.

How important was it for the adolescent to know that Barrett was still there to come back to as part of the transition process?---I considered that that was really quite important and a number of them made use of that over the years that I worked there that there were times when we would be rung up to say, listen, this has fallen through, where can I go now. So we'd support them in transitioning into another service. Yes.

So from your perspective was the transition process simply a matter of having a clinical handover and then moving away or did it involve some ongoing involvement

with at least the service that the patient had been handed over to?---The transition process involved supporting them to integrate into the new service, providing support afterwards if they needed contact or advice about things that the new service didn't provide such it might – might be advice about employment or about education. It might be advice about, say, a new mental health practitioner if they weren't engaging with that practitioner. So we – we would negotiate our level of – our involvement with the transitioning service so that we knew who had primary responsibility for their care but what our role would be even if the other service had primary responsibility we would let the other service know, look, they might still come here for this or that and provide that contact and – and support.

So this was part of a collaborative arrangement with the new service?---Yes. It was.

And the time that that might go on for would be intended – or designed for the particular individual?---Yes. It would be, yes.

What would be the longest period you would expect that would go on for?---You'd expect the initial period to be between two to six months for transitioning of care and I think that – that other – I mean, you may get intermittent calls for a year, two years after somebody had struck a crisis and they were wondering where to go.

Now, in August 2012 there was a decision made, we've heard, that the Redlands centre was not going to proceed. Did you receive any advice at that time that you were to commence transition arrangements?---No. Because we thought – I was unclear at that stage what was going to happen, whether we would stay at The Park. I remember we had a visit from Dr Kingswell, Dr Cleary and Ms Dwyer and we were looking at – they came to review the service. At that stage – I think that might have been in September, that particular visit – we had no indication of what the future of the service could look like.

You discovered on or about 6 August 2013 that the Barrett Centre was to close. Was that the first time you had been told it would definitively close?---Yes. That was the first time, yes.

And had you made any arrangements to transition patients between August 2012 and August 2013?---Well, there was a continuing process of transition so, I mean, all the time we were endeavouring to connect young people with either external schools, with – we had tried to transition a couple of those young people. Some we did. We were trying to transition them into – into employment. So transition as such is a – is what – we saw that as a – a process that began fairly early within the period of the – the young person's stay there. So once they are ready to complete and – and engage with the community we – we then began to link them up with those parts so that there wasn't a stage where you would – they would be in there full-time and then go into the community with – there would be multiple stages in which there would be linkages with the community and we tried to maintain linkages with family and linkages with referring services.

At what point in time was it made clear to you that the Barrett Centre would not be moving to another location, that all of the patients would be transitioned out and the Centre would be closed?---I became absolutely aware of that with the Minister's announcement on 6 August.

And from that time did you start to put plans in place to transition the patients that were still at the Centre?---There were difficulties because, first of all, it caused us considerable upset amongst the adolescents and so our first thing was to – to try to stabilise the adolescents. The second thing was then to consider what new services may be in place. And so my visiting YPARC was part of those – part of that looking at what other models – what type of services. I have made a submission to say that I considered that an interim service which involved Barrett Adolescent staff was important – an important component of that process but – so – and then we visited the – the Logan – a ward at Logan I think on about 30 or 31 August 2013. So I thought is an inpatient unit in the mix because I understood that it wasn't, it was a wraparound service. So I – I was – I mean, my thinking was to – to try to get the best wraparound service that we – we could and then to – to stabilise the – the adolescents to try to work with their mental health to get them as well as possible and then to look at what we needed to do in terms of accommodation and providing that support.

You mentioned earlier in your evidence on another day that the staff were very upset by what had occurred in terms of the closing down of the Centre?---Yes, they were.

And you've just mentioned now the patients were upset?---Yes.

What impact did that have, do you think, on the prospects of successful transition for any of the patients?---I think for many of them just the – well, certainly – I mean, I can only comment up until the time that I was stood aside so I can only comment to early September but certainly at that stage things seemed to be very much fluid and very much in flux. There were increased numbers of incidents on the unit and we were having difficulties managing those incidents so, I mean, I had anticipated that we would be able to – to manage that and then provide some certainty about what type of services might available that they could transition to. I thought that was important for the adolescents.

You mentioned incidents, what type of incidents?---Can I say in - - -

Not individuals just - - -?---No.

Well, I don't know whether it's - - -

COMMISSIONER WILSON: I don't know what you're wanting to say, Dr Sadler, but if it involves individual patients or very small numbers of patients such that it might be possible to identify those about whom you're speaking we should do it in closed hearings?---I think maybe in closed hearings, Commissioner.

MR MULLINS: A couple of more questions, your Honour, and then I'm finished.

You left the Barrett Centre on 10 September 2013?---Yes.

And you obviously had a good knowledge of all the patients?---Yes.

Were you willing to help in the transition of the patients even though you weren't allowed back to the Centre?---I – I – certainly, I would have liked to be able to – to impart some – my thoughts about the – the young people but also potential directions and about potential development of services

Did you ever speak to Dr Brennan about the patients that you can recollect?---I can recollect in – we were at a conference of the Faculty of Child and Adolescent Psychiatrists. We met. I was trying to avoid meeting with Dr Brennan because I knew that I wasn't to speak to any staff, but she graciously approached, and we spoke briefly at that time, and I was anticipating that we would have time to meet later during the conference.

Was there any reason, from your perspective, why, for example, you couldn't attend transition meetings by telephone?---I – my understanding was that I had no contact. I was to have no future involvement in the directions for – and providing services. So - - -

That's the questions that I have for open court, Commissioner.

COMMISSIONER WILSON: Does anyone else have any questions in open hearing?

MS ROSENGREN: I will have some, Commissioner, but I would prefer to wait till the end - - -

COMMISSIONER WILSON: Yes, I think you should, Ms Rosengren.

MS ROSENGREN: - - - if that's practical, given that I am acting for Dr Sadler. Thank you.

COMMISSIONER WILSON: Anyone else? Very well. The hearing will be closed and the live streaming should go off.

Closed hearing

EXAMINATION BY MS McMILLAN **[4.29 pm]**

MS McMILLAN: I was asking you just before that you posited, I think, a number of what you might call compromise options, didn't you - - -?---I did.

- - - as a result of the ECRG process - - -?---Yes.

- - - which you were part of?---Yes.

And one of them was – this is my paraphrasing – it was really like a mini-Barrett that you saw being included with current staff in another location; correct?---Well, I think I briefly floated that one. I – and I can't remember the date I saw the email where I had proposed that. I can't remember the date.

But in any case – so this is March 2013, where you looked at – in terms of – a compromise option to existing acute adolescent units, allocated number of beds for long-term kids, which are staffed from the existing BAC?---Yes.

Right. So can we put it this way, Doctor: you thought sufficiently highly enough of what was being done at Barrett that you were looking at it in another perhaps slightly compressed form, if I can put it that way, in terms of staff numbers at another venue; correct?---Well, I saw the relationships with staff as being key, because I felt that both they had the expertise and they had the knowledge of the young people and they had the relationships with the young people. So I thought that that was key. Now, there were some who I thought at that stage may be too unwell – this was in March 2013 – and I thought, well, the closure is probably fairly imminent, so they're probably too unwell to be able to live in the community. Can we consider acute inpatient units? But this is a way of dealing with that option.

So March 2013 you thought it was quite likely it would close and you were concerned at that point in time they were too unwell to go other than to an acute patient setting?---Some of them, yes.

Right. Okay. Thank you. So in essence, then, despite – I've taken you to the two external reviews that were critical of the operation of Barrett, weren't they?---They were.

Yes. I've taken you to what your peers in terms of the Redlands group indicated which was admission of more than six months was not supported. And you agreed with me that that was a view expressed by your peers?---That was a view that I expressed. I – I don't know if I can clarify anything about that - - -

Right?--- - - - process but - - -

There was no endorsed model of care for Barrett, was there?---No. But I'm not sure why that was because - - -

Right?--- - - - that – it was taken to the statewide child and youth mental health service advisory group and I think from there it went up to the – the statewide mental health network.

As I understood your evidence previously it was never submitted to the branch, was it?---I thought it was but - - -

I thought your evidence was that it wasn't?---Okay.

And you accepted that that needed to be done for it to be endorsed?---I'm confused – I'm sorry – because once the – the statewide child and youth mental health service advisory group had dealt with a – a thing – I think I was on the statewide mental health network at that stage but I – I just can't recall was to whether or not it was noted and endorsed. But it – it should have gone up from the advisory group up to the - - -

Right. Well, you accept that only annexed to your statement are drafts. Correct?---I was asked by the Commission to produce statements I had and – yes.

I understand that but they're only draft, aren't they?---They're drafts.

Right. And I think you agreed with me previously that the latter half of them almost seemed to relate to a process around issues at Redlands if I can put it – that group that you were on?---Yes.

Right. Okay. And if one looks at your 2013 email to Professor Martin – and I won't go into the specifics of it but I took you to it before?---Yes.

Nonetheless you posit that in another form you thought Barrett should continue?---Well - - -

That is, through an inpatient facility?---I think there were a number of processes going on at that particular stage so I had – we had the ECRG deliberations going on. It wasn't clear what the outcome was going to be but certainly there was a – a request for a tier 3 facility which had been specifically excluded from the planning group and the ECRG had thought, yes, we can't come up with an option that excluded a tier 3 service. So I mean, my mind is in flux as to what types of services might exist but I'm also interested in – as long as we're open can we look at – and – and we're going. I mean, I didn't know how long any research would take but can we look at the issues that are raised with Professor Martin.

Right. But you understood the tier 3 facility was mentioned in the ECRG and it was accepted by the planning group with caveats. Correct?---Yes.

Yes?---But not in March 2013.

Right. Okay. Because the planning group came after the ECRG, didn't it?---Yes, it did.

Right. Thank you. I've got nothing further.

COMMISSIONER WILSON: Any other questions in the open hearing? Yes, Ms Rosengren.

MS ROSENGREN: Yes, Commissioner. I do have questions. Thank you.

EXAMINATION BY MS ROSENGREN [4.35 pm]

MS ROSENGREN: Dr Sadler, is it correct that you were contracted to work for 24 hours a week at the Barrett until you were stood down?---I was, Ms Rosengren.

And for an additional seven hours per week you were the senior visiting psychiatrist at the Mater for the Mater Health Service?---I was.

And how did this work in practice? Was it four days a week at BAC and one day at the Mater? How did that happen?---In practice it was three and a-half days BAC and half a day – I worked until late in the evening because I spent time with the extended hours team at the Mater so I could spend from, say, 1 o'clock till late at the Mater and – but doing both consultation liaison and - - -

Was there a set day each week that you weren't at the BAC?---Thursday was a day that I had typically done my private practice in. And then later as the various meetings occurred I reserved that for – most of the meetings for – for the statewide child and youth mental health group tended to be held on a Thursday so I would attend those.

And in your role as a Clinical Director am I right in understanding that you did not have any line responsibility for the nurses?---I did not. No.

They were managed through The Park?---Yes. So - - -

And was that also the case for the allied health staff?---That was also the case for the allied health staff.

If I could ask Dr Sadler to be shown a document, please, on the screen. It's WMS.015.0001.00528. I just want to ask you – you can see that it's the inter-hospital and health service transition of care of mental health consumers from one hospital and health service to the other. It's the procedure. Doctor, did you ever see this document while working at BAC?---I cannot recall it. I mean, it's dated 1 September 2013. I was only there for another eight days. I think that was the day – I'm not sure if that was the day I had the operation for my arm so I – I can't - - -

Alright. But in any event you don't recall ever seeing that document?--- - - - remember it. I don't recall that. No.

I now want to ask you a series of questions about the 2009 review and if you have a hard copy there it may assist you. The Delium reference number is JKR.900.001.0467. Dr Sadler, we know that part of that review involved a consideration of three incidents. I want to ask you, did you have any input into the three incidents that were selected for the purpose of the review?---No. Those incidents had been selected by the District Manager and the – the – sorry, yeah – and the Executive Director of Mental Health Services for Darling Downs West Moreton

Health Services District because there had been incidents of aggression and of self-harm.

I want to ask you this: were you the treating psychiatrist for each of the adolescents who were the subject of - - -?---I was, yes.

- - - involved in these incidents. Did any of the reviewers speak to you in relation to your involvement in the treatment and management of those adolescents?---There was a brief meeting on the Friday morning of the review and I thought that it would ask quite searching questions about them because they had the – the charts for them but it was only – it seemed to be not particularly searching at all.

The review makes it clear that the reviewers spent very limited time with key staff and, indeed, that the available nursing staff in the unit were predominantly new staff and casuals?---Yes.

Now, you explained in your evidence the other day that when the reviewers were at BAC conducting this review that many of the staff were attending a recovery intensive offsite workshop?---Yes.

You indicated in your response to questions from Ms McMillan that this workshop had been organised some months earlier - - -?---Yes.

- - - and was that prior to it becoming known that the reviewers were coming out to the BAC?---Yes. It had been organised at the end of 2008.

And do I understand from your earlier evidence that it would have been very difficult to have rescheduled the workshop, one of the reasons being that there participants travelling from North Queensland and other more remote areas?---From North Queensland. We had booked the Bardon Professional Centre. We had – it had been advertised to Child and Youth Mental Health Services throughout the state and so – and we had a couple of invited speakers to that review. So we – it was – it was a significant event and it was also a significant financial outlay for that particular event.

Okay. Now, you also indicated in response to questions from Ms McMillan last week that you have – or had significant concerns about the review. Can you explain for us what those concerns are?---Yes. First of all, the timing of the finalised report. It was – the – the review occurred at the end of February 2009 and I asked Dr Terry Stedman when the report was coming out. He said that they were chasing up Dr Walters but it didn't come out until September 2009 so there's a gap of seven months. I was concerned about that delay. I was first shown the report at the beginning of January 2010 and by that time it had been circulated to Associate Professor David Crompton from Metro South, to Dr Aaron Groves, and I had – I thought that – and I thought there was one other person involved to whom it had been circulated prior to being – my being able to review the – the review and provide comment about it. I spoke to Ms Michelle George, who is noted as being one of the

reviewers and one of the authors of that report. She said that the other reviewers didn't speak to her during that process. They didn't – they didn't consult her about the draft report, nor had she seen the final report, and yet it has matters to do with nursing matters, and she's – she was the Nurse Unit Manager at the Mater Chid and Youth Mental Health Service. Sorry.

COMMISSIONER WILSON: Ms Rosengren, I should make it clear that I'm prepared to receive this evidence as to what Dr Sadler's understanding of the position was, but not as evidence that that was the position.

MS ROSENGREN: No, that is correct. Yes, Commissioner?---Sorry, yes.

COMMISSIONER WILSON: So I don't know what, if any, weight I will attach to it in the circumstances, and I'm a bit surprised there hasn't been any objection from any other barrister. But if you want to proceed with it, be as efficient as you can.

MS ROSENGREN: I wasn't – the issue was raised by Ms McMillan the other day, and I haven't – I hadn't been able to clarify it with Dr Sadler because he was under cross-examination, so it was really just exploring what that issue is, and now that I know that I'm happy to move on.

COMMISSIONER WILSON: Very well.

MS ROSENGREN: If we go to the first – if I can take you to the review – do you have a hard copy of that there with you, Dr Sadler?---Yes.

You'll see at the bottom of the first page there, under ACHS Review, and it's – there are four dot points there at the bottom. And if we go to the third dot point there, it states there that in The Park hospital redevelopment the BAC had lost access to the – to facilities. Do you know what that referred to?---So we had lost access to the – both the tennis grounds, the – the oval that was directly opposite. In the – in another part of The Park there was a significant – there was a building which provided indoor recreation for evening. All of those were quite significant, I thought, in providing young people with opportunities not only to interact, to have physical exercise, but to also defuse and to – to help regulate emotions. Although they – they still accessed the grounds of the oval on occasions, it was not a – a regular thing, and we had to gain permission for it.

The fourth dot point there refers to the aspects of Barrett's configuration and relating building issues that were dangerous. Do you know what that refers to?---I think it – I mean, it refers to – to the layout of the bedrooms, of the bathrooms, just having shared bedrooms, having people not in direct visual observation. There was a blind corner from the nurses' station which adolescents could go around and – and – and I think, at that – no – sorry – the ACHS report, yes. It had said to the – it failed to credit West Moreton because it hadn't provided a high-dependency unit which had been there in previous reports. So in the 2008 ACHS report, they said to be

accredited one of the issues that must be addressed was providing a high-dependency unit to meet the criteria for other - - -

Alright. Can we go over to page .0473 of the report, please, under the heading Clinical Model, and if I – if we just scroll – and if you could just take a moment to read to yourself the second paragraph there, saying – where it says "the review has had a number of interventions"?---Yes.

Can you take a moment to read that, please?---Yes.

What do you say to the suggestion that these two therapies encapsulated the clinical approach of the therapeutic program at Barrett or were a cornerstone of the therapeutic treatment offered at Barrett?---The two-day recovery intervention was detailing the multiple interventions that occurred at the Barrett Adolescent Centre, and staff were available to talk to them when they came to visit us at the lunchtime to talk to them about any of those interventions.

So can I just stop you there - - -?---Sorry.

- - - because if you can just answer my question - - -?---Sorry.

- - - the question is – it says – it indicates here that Malua Therapy and Adventure Therapy were the two overriding interventions. Do you accept that these therapies encapsulated the clinical approach at BAC?---I definitely do not, no.

And why do you say that?---Because they were only – certainly, the Adventure Therapy program only occurred on occasions. I mean, there – there were other interventions that were occurred, multiple – there were group interventions, individual interventions. There were the – the – the family, when it could proceed. So there was a range of interventions that occurred at multiple levels, and – and there were multiple types of groups that were occurring. So – and the Malua Therapy, certainly – I think that might have been present at the talk that Mr Aludin gave on the importance of the Malua or just the – the environment. I didn't place a lot of importance on that. In my response to this review, I outlined my concerns about just using the term Malua Therapy and that it was – living in the community and adjusting in the community, but not an overriding part of it.

Okay. Now, can I then ask if you go to page .0480. Dr Sadler, you may recall that Ms McMillan took you to some of these recommendations last week, and the first recommendation she took you to was number 2, that clear inclusion/exclusion criteria be formulated. Did you consider that this criteria had been clearly formulated prior to this review?---I thought that it had been clearly formulated, but there were times when we – we may – there was one particular patient of – of the – that was potentially an issue for whom that may not have applied, yes.

Okay. So do you consider that that recommendation had been implemented?---I believe that it had.

If we go to recommendation 5, was the next one, and it was agreements with local acute hospitals for assistance in the management of the physical sequale of self-harm. I understand from your evidence last Tuesday that you had reservations with this recommendation. That was your evidence;; is that correct?---My reservations when I thought about it in the intervening period is that I very low-level carriage of – of anything, that the agreements from higher levels. And – and, certainly, for West Moreton that agreement had to come from the Executive Director of Mental Health Services and the Director of the Ipswich Hospital, for instance. But all of these recommendations were then subject to an external review from the – I mean, the implementation of the recommendations then became part of the process of the Darling Downs, West Moreton Health Service – or mental health services. They undertook to review these recommendations. They undertook to implement them and then to say what actions had been taken with regard to these recommendations, and I'm sorry I didn't make that clear when I spoke last time.

Can I then take you to the next recommendation that you were taken to, was number 8, which was agreements with local acute mental health facilities with regard to the transition of older adolescents from care at BAC to care in adult mental health services?---Yes.

Can you explain whether that recommendation was implemented. Well, it would have been implemented as part of that implementation process.

And are we correct in understanding that there were only two adolescents at BAC at that time who were looking at being transitioned into adult services?---My recollection is that probably – was so – sorry, I can't remember at the beginning of 2009. Yes.

The next recommendation was recommendation 10, which was that the length of admission and planned discharge date for prospective admissions be agreed upon by the refer and BAC staff prior to admission. Do you consider that to be feasible?---I considered it to be difficult, and, I mean, we – because we never – because these young people had been engaged with services for quite some time prior to coming to BAC, and the services had already struggled to provide services for them, I felt that we couldn't give a clear indication of what was involved in their treatment. May I just come back to the previous question too? You asked about those two young people. In fact, they had gotten the ages wrong of two of the young people involved in that particular review. So – and they had stated that they were close to 18, and this was not in fact – I – in my response to this review, I corrected the fact that the ages were wrong.

Okay. The next recommendation that you were taken to was recommendation 11, and you indicated in your evidence last week that you didn't consider that it was feasible to implement that in relation to all cases. Can you explain what the difficulties were in that regard?---The difficulties were that – and, again, this would be part of the implementation report when we finally submitted that. We would've discussed those particular difficulties, and I didn't have that implementation report in

my mind when I was answering these questions. But at that stage the difficulty that I envisaged was that a person may transfer out of the catchment area of a mental health service. They may decide not to go back to a certain private provider with whom they had been. So these agreements, while important, may need to be flexible, and there were times when an occasional adolescent had most of their care in an acute inpatient unit with very little involvement with a community child and youth mental health service. So whilst we were trying to keep the local service involved, they – there may be a number of variables which then made that not feasible.

The next recommendation you were taken to was 13, the concept of step-up and step-down facilities and halfway houses. Can you just read that one to yourself?---Yes.

Were there any impediments to implementing that recommendation?---Well, I hadn't approached Mr Ivan Frkovic, and I can't remember if it was just before this or just after, but there was a meeting in the state-wide mental health advisory group in which he spoke about step-up step-down units, and I subsequently wrote to him with regard to the potential for providing that type of model and also supported accommodation on leaving the unit after they left, for those people – young people who wouldn't have accommodation after they left Barrett. Now, nothing – I didn't – Ivan might have replied, but it didn't proceed, and this had been something that I had been seeking for many years.

Recommendation 14. If you can read that to yourself. Perhaps if it could be scrolled - - -?---Could it be scrolled down, please.

- - - so Dr Sadler can see the rest of it. What do you say there to the part of the recommendation that any adolescent who is there for longer than 12 months should've been intensively managed to find alternative clinical placement, including for older clients placement within adult mental health services?---That proved to be really quite difficult in practice because of the different nature of adult mental health services, the focus that they provided, the – I mean, they provide services for a limited group of people, predominantly with schizophrenia and psychotic bipolar disorders and some people with brief acute admissions for borderline personality disorder. They didn't provide at that stage treatment for complex trauma nor did they provide treatment for people with severe social incapacity – incapacitating anxiety disorders.

And then if we go to recommendation 15 which is that planning towards and documentation regarding a patient's discharge should be undertaken throughout the admission. Was that being done prior to this recommendation?---Yes, it was. I think that during the time – and I mean, in part – as part of the care planning work-up there was a continuing – we sought the young person's point of view and what was likely to happen, what was going to – to – where – where they could go, their goals for the next period of – of intervention and part of that was that discharge – included discharge planning and what they would need to achieve and the processes they could undertake to achieve that discharge planning so that was in place.

Were issues in relation to patient's discharge – the discharge of patients regularly discussed at the weekly case conference meetings?---Yes. I mean, certainly we would discuss – because it was a – a longer-term unit we would discuss predominantly at the care planning meeting which occurred every two or three months matters in relation to discharge but at – at any time in the interim at a care – at a placement – or at a case conference there – there would be meetings or discussion about – or for a particular person, are they ready for discharge, are they ready to transition to a different phase, for example, from inpatient admission to – to partial admission to day patient or – so there would be discussions of that nature depending on what had happened during the week. So those would be regular considerations that we would given.

Would they also be the subject of the discussions at the six weekly case work-ups?---Yes, they were. Yes.

Okay?---That was very much a focus of the – yes. Well, sorry, at the end of the time we intended – referred to them as the care planning meetings rather than case work-ups but at this stage it was case work-ups. Yes.

Recommendation 16 you were also taken to and if you can just read that to yourself. In your evidence last week you told us that you tried to meet with key staff from the child youth mental health services. Can you expand on that for us?---Well, it was predominantly my meeting but – so there would be meetings with the statewide child and youth mental health service – that's advisory group – I attended that on a monthly basis. And there things like admission to acute inpatient units were discussed. We would discuss admissions to Barrett. I would give feedback about what had occurred to – to Barrett at that particular time and because we were in transition – or I thought in transition to Redlands that – that process continued but it was part of the main process that continued at that time.

Okay. Now, can we then go the heading on the same page here – treatment evaluation – and it's the – it's noted there that appears to have been negligible evaluation of treatments delivered by BAC?---Yes.

What do you say to that?---Well, I mean, we did regularly use standard – standardised outcome measures - - -

Well, can you just – if we just go to that paragraph - - -?---Sorry.

- - - there appears to have been negligible evaluation and then – I'll deal with those recommendations - - -?---Recommendations, yes.

- - - in a moment?---I mean - - -

What do you say to that statement?

MS McMILLAN: Well, I've already asked this and he gave an unequivocal yes that there was negligible evaluation.

MS ROSENGREN: I differ. I don't recall that answer being given but if I can just explore that further with Dr Sadler - - -

COMMISSIONER WILSON: I'll let you explore it.

MS ROSENGREN: Yeah?---Okay.

Was there negligible evaluation done of the treatments delivered by BAC?---There was some evaluation done. I mean, there was some evaluation done at the beginning, at the end. There was not evaluation done, say, three months post-discharge or six months post-discharge. And I couch that in – in terms of the answers I gave and responses to recommendations 1 and 2 last time. Yes.

What do you mean by there were evaluations done and the beginning and the end? What are you referring to there?---So – I mean, in terms of the routine outcome measures, we did those at the care planning work-ups. We did that at the beginning – admission to the unit, and we did that on discharge from the unit. So that was a – outcome measures that were followed through. There – when they were being assessed by the psychologist or the speech pathologist they would then do routine standardised measures to look at things like depression, anxiety and aggression as part of their – both pre- and post-interventions. They would also consider intervention – measures looking at the effectiveness of some groups, and – so there were measures to evaluate the outcomes.

And if we go to those recommendations – I think you've addressed with the first one; do I understand that, that they were in use prior to the review?---Yes.

And what are some examples of those?---So the – the standard ones are the Health of the Nations Outcome Scales for Children and Adolescents, the HaNOSCA scale, the strength and difficulties questionnaire, the factors influencing health status and the Children's Global Assessment Scale.

Okay. The recommendation 2, in relation to additional specific measures be used, can you read that one to yourself?---Yes.

The example there was the depression rating scale for those adolescents with depression. Do we understand from your earlier evidence that that was already being used at Barrett at the time?---So that was – yes – being used, and it had been used for quite some years prior to this review, the depression and anxiety, aggression and – I think – and we introduced another one later, but they were already routine measures.

Recommendation 3 there: if you can read that?---Yes.

And in your evidence last week, I think you explained that you looked on the quality network for inpatient - - -?---CYMHS.

- - - child youth mental health service forums from the UK - - -?---Yes.

- - - to see if they had any instruments available. Why did you do that? What was the purpose in doing that?---Because the – I felt that the Royal College of Psychiatrists, their quality network of inpatient CYMHS, which is part of – of that and is a multidisciplinary forum, has probably developed the best types of measures to evaluate children and adolescents. Many of the – the – those units have young people that are equivalent to those in young people staying at Barrett, and I felt that – that they gave good thought to these measures. They had, in fact, a HaNOSCA scale that was filled in by the child or adolescent – or by the adolescent. And – for instance – so that – and we didn't have a facility to do that on the CIMHA because it wasn't listed. But I would have found that quite useful to compare their – their view of where they were at compared to what clinicians' ratings were and see what the disparities were.

Okay. Then recommendation 4, if we can go to that, the affiliation with the academic unit: do we understand that it did occur with the Mater Kids in Mind Research Unit?---Yes, I – yes.

Okay. And the last one, the introduction of a regular meeting to specifically address the process of outcome measurements at BAC?---I mean, in the care planning work-up we would review the outcome measures for an individual adolescent to get an idea of, say, the change in HaNOSCA scores over time, if that was readily available. And – and in a paper that we developed for mental health services conference in, I think, 2004 we looked at trajectories of adolescents, and the young people who – who were there with different disorders had different trajectories, and so you'd expect different outcomes at the beginning and the end of an episode for someone with, say, social anxiety, compared to the trajectory and the outcome scores for someone with complex trauma.

Okay. Now, Dr Stedman was your direct line supervisor at the time?---He was, yes.

Did he ever raise with you any concerns in relation to the adequacy of the steps that had been taken by you to address the recommendations in the 2009 review?---Well, he – he spoke to me when the review came out, and – and we discussed the adequacy – we just did a brief look-through in January. And then I – I'm – I said that I'd write a response, which I did, I think, by – by April – well, 2010 I finished my response to the review, and I – I sent it then to Dr Stedman and Ms – Ms Katrina Matthews, who was the executive director at the time, and met with Dr Stedman just to discuss the – you know, the – my response to the review. And following that, there was a process of the implementation, in which they set up a process to look at the various steps which things needed to be addressed based on both the – my response and also the issues of the review.

Can I ask Dr Sadler to be shown document QHD.005.001.3152. Can you see there, Doctor, that the subject is Update and Finalisation External Review Report of the Barrett Adolescent Unit?---Yes.

And paragraph 3, if we can scroll down, please, refers to the review there at paragraph 3?---Yes.

And then if we go over to paragraph 10, please, to the next page, it says:

> *Key issues: the recommendations arising from the 2009 review have been substantially actioned.*

?---Yes.

And then it refers to some outstanding recommendations?---Yes.

Can I then just ask you then to go to – it's part of this document: it's .3173.

MS McMILLAN: Commissioner, I object at this point in time. This isn't the witness' document. Ms Lane has given a statement about it. She is the author of it. What's the relevance of asking this witness about a document that he is not the author of?

COMMISSIONER WILSON: Ms – sorry.

MS McMILLAN: Asking him to read paragraphs doesn't exist - - -

MS ROSENGREN: All of those questions were directed at the setting the background to it, and I just wanted to then take Dr Sadler to this document, the final report of the 2009 review of the Barrett Adolescent Unit, to ask him whether this was the outcome of the process to which he had been referring to in his evidence.

COMMISSIONER WILSON: Ms McMillan's point, I think, is that he didn't writ either the briefing note or the final report that Ms Lane, who was – I've forgotten her title – the executive director of the West Moreton District at the time – wrote these documents - - -

MS ROSENGREN: I - - -

COMMISSIONER WILSON: - - - or is responsible for them. So - - -

MS ROSENGREN: I understand. It was really just to say is this the process that he had been referring to in his evidence, where it was looked at on a district level.

COMMISSIONER WILSON: Well, you can go that far.

MS ROSENGREN: Yeah. So that's all – that was the question for you, Dr Sadler: is this the process that you've been referring to in your evidence?---That's the process, yes.

Okay?---And - - -

Alright. If we can move away from that report then, please, I just want to ask you that when you were stood down in September 2013, did you consider that there were appropriate services for all of the young people to be transitioned to? In other words, were you concerned that there were gaps in services?---I was concerned that there were gaps.

And what did you consider those gaps to be?---I considered that for those who might need ongoing hospitalisation – and I thought there might be some who would require ongoing hospitalisation – that there was – acute inpatient wards were not really suitable. I was also aware that some had their 18th birthday come January, come February, and that would mean that they couldn't access Child and Youth Mental Health Services, and certainly the adult mental health services had different – quite different approaches to people than we would have taken. I was concerned that there weren't adequate accommodation facilities. I was concerned that there weren't adequate schooling facilities. I – and I was concerned – well, one of my things was the development of an interim service to provide contact for the young people and aid the transition to care, and so all of those things - - -

COMMISSIONER WILSON: Sorry, I didn't catch what you said. You said one of your concerns was the development of a what service?---Of an interim service, sorry, Commissioner.

Interim service?---Yes. The – yes. Because I had strongly believed that that was going to be an important component of service, and I didn't necessarily have confidence that there would be seen the need for that interim service. I felt that the school – the Barrett Adolescent Centre School, which provided a lot of services to the adolescent, wasn't being included at the Statewide Adolescent Extended Treatment and Rehabilitation Implementation Group planning meetings, and therefore they would be left out, and I was concerned that the working groups could be quite separate in their function.

MS ROSENGREN: Now, when you were stood down, you were the treating psychiatrist for every one of the adolescents at the Barrett Adolescent Centre?---Yes.

Now, from your perspective, why do you consider it would have been valuable for the ongoing welfare of those adolescents if you had been able to provide a handover to Dr Brennan? Now, if I can give you some background. There's other evidence that Dr Brennan was provided with a file and with the clinical notes in relation to each patient?---Yes.

And there was also – Nurse Clayworth was able to provide her a verbal handover as well?---Yes.

Do you think that in addition to that, that you could have provided some value had you been in a position to give a handover?---I think if you can provide direct verbal handovers – my feeling is that you can communicate in written form but having the opportunity for a verbal handover was important because then you can clarify questions. You might have different perceptions about what is meant by different terms or different interventions, and having the opportunity to actually discuss things so that there's clarity would have been really quite important.

And what further input do you consider that you could have provided that, for example, Nurse Clayworth wouldn't have been able to as – in her capacity?---I think the – I – Nurse Clayworth, I believe, was a thoroughly professional nurse and I had very high – I still have very high regard for her. I think perhaps the thing that I would have provided extra was that long-term synthesis and integration of a lot of the information that had occurred over the period of time, what we had tried, what we had – where we had failed, where the obstacles were, and she could provide a lot of those details, but there was, say, for instance, a period of time in I think it was about May 2013 when she took up a secondment elsewhere – or I forget when that was. So there was breaks in the time that she was there in which I would've been able to provide that synthesis and longer-term perspective of the issues.

Did you consider that it was an important component of the Barrett Adolescent Centre was the ongoing involvement of referring agencies?---Yes, I believe that was - - -

So it wasn't – so can we take it that it wasn't the case that the agency would refer and then effectively be removed from the process, if I can call it that?---Absolutely not. We – no.

And can you speak in general terms but without reference to any particular young people how you sought to maintain, you say, ongoing involvement with referring agencies?---So, in general terms, we'd invite them to participate in the care planning workup so that they either – if they lived fairly locally, they would come directly. If they lived some distance away, they would participate by either video conference or teleconference. The community liaison nurse would be in contact with – with key workers, and often the care coordinator would be in contact with the nominated person from that particular agency. I would provide follow-up to – or feedback to colleagues if I saw them about what was happening at meetings of child and adolescent psychiatrists. So there were a number of avenues. If a young person could access, say, individual therapy or family therapy with another – with – with a referring agency and that could continue, we would continue on with that, and so that happened on a number of occasions.

Was it routine practice at BAC to inform the referring agency of what treatment goals would be for particular adolescents?---Absolutely.

And would you keep the referring agencies informed, for example, as to how successful particular treatments were?---So that was part of that intensive care planning workup that we – we would describe the process that had occurred over the period, where they had advanced, where they were having difficulties, the interventions. We'd invite feedback from them about the process and about the – their involvement. Yes. So they provided a bit of external peer supervision in some ways, because they – they knew the young person. They knew the issues involved and they could comment on the appropriateness of – otherwise of interventions.

Okay. Now, if I can just turn to the – a different topic now. It's the period around the 2nd of November 2012 when Ms Kelly told yourself and Dr Stedman that BAC would close and that it could be as early as December 2012?---Yes.

Now, can you recall that Ms McMillan asked you some questions last week about the emails that you sent to child and adolescent psychiatrists?---Yes.

Yes. If you could just be – they could just be put on the screen, please. And it's DTZ.002.001.0028. And if we can go about halfway down the page, please, you'll see the emails – the email that you sent to your colleagues at 6.42 pm?---Yes.

If you read the first paragraph to yourself there?---Yes.

So what you've done there is you're informing your colleagues that BAC is closing and that the closure date could be as early as the 31st of December 2012?---Yes.

At that time, were you very concerned that there was talk about the BAC closing within this timeframe?---Yes. I was really quite concerned, because I thought – I have over – over many years given considerable thought as to what alternative services could be developed. We had a forum to discuss what alternative services could be developed, and I just felt that there wasn't an immediate option that was available, and so I wrote that in my email to the colleagues, that I can't think of alternative services that could be developed within that timeframe.

And were many of the psychiatrists, your colleagues to whom this email was sent, were they working at community in inpatient services to which these adolescents would be potentially transitioned to?---Yes. So I emailed all the directors of the inpatient services and on the Queensland Faculty of Child and Adolescent Psychiatrists, there are numbers of colleagues who are both in community child and youth mental health services and also in private practice.

Okay. And if I can ask the screen be scrolled down to the beginning of the next page, please. And if you go to the third line where it says:

> *I thought, however, that I needed to let you know ahead of the official announcement so you can carefully consider the alternatives.*

Can you just read from there to the bottom of the email to yourself, please?---Yes.

And does that summarise the reasons why you considered it necessary to inform your colleagues of the closure within such a potentially short timeframe?---Yes. That's my – they were my concerns.

Okay. If I can now turn to the planning group and ask you some questions about that. How many meetings of the planning group did you attend?---I think possibly four. I can't – yes.

And was the last of those in May 2013?---Last of them in was May twenty – yes.

And did you attend that meeting by telephone from Townsville?---I did.

And at that meeting were there discussions regarding the tier 3 service which had been recommended by the ECRG?---Yes, there were.

And did those discussions include whether wraparound services would be an adequate - - -?---Yes. It was - - -

- - - solution in the circumstances?--- - - - quite a concern of mine.

And you expressed concerns about that at the meeting?---I expressed concerns at the meeting and subsequently I emailed Dr Kingswell so, yes.

Okay. And by the conclusion of the meeting had the issue of the adequacy of wraparound services for the sub-cohort of adolescents at BAC remained unresolved?---I thought it was totally unresolved.

Okay. And if I can just ask Dr Sadler to be shown – it's – the Delium reference number is DTZ.004.0001.0202. And this is some email correspondence between yourself and Dr Kingswell following that meeting in mid-May 2013?---Yes.

And in those emails you raise your concerns regarding the wraparound service?---Yes.

Were you invited to any further planning group meeting subsequent to this time?---No, I wasn't.

And did you have any involvement with the planning group subsequent to the May 2013 meeting?---No. I saw no minutes of that particular meeting nor did I see any further invitations to further meetings.

Now, I want to now ask you some very brief questions about the categories of patients that were treated at BAC. You've explained in your second statement - - -

COMMISSIONER WILSON: Excuse me, before you go on. Does this need to be in closed hearing?

MS ROSENGREN: No. It shouldn't need to be in closed hearing because it is a question of a general nature. But Dr Sadler if you feel the need to talk about a small number of patients or - - -?---Yes.

You've explained that there were four broad categories of adolescents with whom BAC interventions appeared to benefit. And one of those categories was young people with persistent and severe psychosis?---Yes.

You've also explained in that statement that as your best estimate if BAC had 15 inpatients and you've just taken a hypothetical scenario there would be about a two in three chance that one bed would be occupied by an adolescent with severe psychosis?---Yes. I thought there might be perhaps one every 18 months or so.

What I want to ask you is this: you'd be aware, no doubt, from having read Professor Hazell's statement that while he never visited BAC it is his impression that one of the key differences between the patient group treated at the Walker unit and those treated at the BAC unit, that the Walker unit appeared to be a step up from the BAC facility in terms of the severity of the mental health issues being managed. He gives an example of that of the fact that the Walker unit had a much higher proportion of young people with psychosis as compared to the BAC?---Yes.

Are you able to explain the disparity there in terms of the number of patients being treated at the BAC compared with those being treated at the Walker unit with the diagnosis of unremitting psychosis?---Okay.

MS McMILLAN: Well, I object to the question. How can he make the comparison with Walker?

MS ROSENGREN: Well - - -

MS McMILLAN: What's the basis for that question to be asked? He can talk about what's contained at Barrett but there's no evidence he has any particular knowledge of Walker, that he visited or anything of that nature. I don't see how any of this would assist you at all.

COMMISSIONER WILSON: Thanks, Ms McMillan. Your response, Ms Rosengren.

MS ROSENGREN: It's simply to explore with Dr Sadler if he can give an explanation for the relatively low numbers with the psychosis. I guess my question was really to say are they being treated elsewhere, are you able to explain - - -

COMMISSIONER WILSON: Well, I think your question is really a bit too general and a bit too vague. You can ask about the makeup of the Barrett cohort but that's about as far as you can go as I see it. Dr Hazell has given evidence of the makeup of the Walker cohort and what follows from that seems to be a matter for submission.

MS ROSENGREN: I'm happy to move on, particularly given the time of day. What I want to ask you now is a related question, but not that question. Do you accept, Dr Sadler, the proposition that young people with psychosis are necessarily the most severely mentally unwell?---No. Certainly, they can be amongst the most severely, but, certainly, it is recognised that people with other disorders can be quite severely mentally unwell. But it's much more likely that young people with severe psychosis – a greater proportion of them are severely unwell compared with, say, those with an anxiety disorder. But for those with a severe anxiety disorder or those with complex trauma, they will be – can be severely unwell, but there's a spectrum up until those who are functioning a lot better. But they can have the same degree of impairments as those with psychosis and – and – and find the distress of their mental illness equally as severe.

I now want to take you – to ask you some questions about two statements that have been provided. One is by Kimberly Sadler, who I understand is not related to you, but if I can just – her – the Delium reference number is WIT.900.012.0001, and if we can go to paragraph 17 of that statement, please, which is on page 0003. Could I ask you to read that paragraph to yourself and then ask you whether you agree with what is there, the opinion expressed there?---That's paragraph 17?

Yes?---Yes. I – I – I would disagree that it was extremely stigmatising, it did not teach the clients resilience. For instance, they – they needed to learn the skills to be able to do that, which she mentions, for example, the booking and attend appointments with psychologists in the community. As for the public, some of them needed to be taught those skills to be able to do that. And some of them – you know, for planning ahead, for being involved, they had – these were young people who often had been, really, quite isolated and had suffered significant impairments. And so our task was to empower them as much as possible. I would disagree with that statement.

I then want to take you to paragraph 19 on that same page, and then can you read that paragraph to yourself?---Yes.

What do you say to the suggestion that you ever prayed over a client on continuous observations?---I've never prayed over a client on continuous observations.

What about laying your hands over a patient as a form of clinical treatment?---I've never laid my hands over a patient. No.

Paragraph 22 can you go to – if we can go to, please, and it's over the page. If you can read that to yourself?---Yes.

Is it correct that the only therapy being provided at BAC was from a mindfulness perspective?---No. There were multiple interventions provided, both individual, group and, when we could, family.

Okay. Paragraph 29 on 0005 – can you read that to yourself, please?---Paragraph 29? Yes.

Yes. And the paragraph rather suggests that you tended to favour some nurses over others. Do you agree with that?---I spoke to the nurses who were in the nursing station who were on for a shift, because I thought it was really quite important to – to try to get a consistent model – consistent approach to the various adolescents, and certainly I can recall speaking to Kimberly Sadler on numerous occasions about young people.

Can you then go to paragraph 30, please, and can you read that to yourself?---Yes.

Do you consider Ms Sadler's perception correct, that you gave more attention to female adolescents in the unit than the male adolescents?---I think there was possibly a perception of that. Certainly, I – I would review them more regularly, because they would be on continuous observations more often because of high acuity, and therefore I – I – to be able to manage risk was really quite important for that group, whereas the – the – and it would be for those reasons that I would be – perhaps review them more frequently, or anyone whether on high – on continuous observations. Our approach was to encourage them to facilitate engagement in processes even while on continuous observations, and therefore that sometimes involved an element of risk, and I thought as the treating psychiatrist I should be the one who took that element of – took the final decision on that.

Paragraph 36, please, is the next one, and it's on the – page 0006. Would you just read that, please?---Yes.

That relates to the conduct of some nurses, including Nurse Kopp. As far as you're aware, was this issue addressed by the nursing hierarchy from The Park?---Yes, it was.

If we go to then paragraph 41 on the next page, please. It's redacted. Maybe I can go to that in closed hearing. I didn't - - -

COMMISSIONER WILSON: Ms Rosengren, what do you want to do?

MS ROSENGREN: Yeah. I would've thought that I could've dealt with this in open hearing in that there's no reference to any patients at all.

COMMISSIONER WILSON: Well, I don't know for the moment what it said. It's - - -

MS ROSENGREN: Perhaps if I could read it out to Dr Sadler.

COMMISSIONER WILSON: Well, what are you reading from?

MS ROSENGREN: It's – it is just the unredacted version of Dr - - -

COMMISSIONER WILSON: Of what, the statement or the supplementary statement?

MS ROSENGREN: No, it's the statement of Ms Sadler.

COMMISSIONER WILSON: Of Kimberly Sadler?

MS ROSENGREN: Yes, and it's her first statement. Your Honour, I'm happy to move ahead and deal with that in closed session very briefly.

COMMISSIONER WILSON: How much longer do you think you will be?

MS ROSENGREN: I don't - - -

COMMISSIONER WILSON: I know it's been a very upset day today. It hasn't been your fault.

MS ROSENGREN: Yes.

COMMISSIONER WILSON: We've had the technical problems. But everyone gets very tired in the afternoon.

MS ROSENGREN: I imagine I've only got a few more – I've only got a few more questions before I go into closed – the closed hearing questions.

COMMISSIONER WILSON: And how long will you be in closed session?

MS ROSENGREN: I would have thought no more than 20 minutes.

COMMISSIONER WILSON: This really is getting out of hand.

MS ROSENGREN: I might be 15 minutes.

COMMISSIONER WILSON: I can feel that you're rushing and I wonder whether you're doing the job that you would like to do. I mean - - -

MS ROSENGREN: I am very conscious of the time and keeping people waiting.

COMMISSIONER WILSON: What's the program for tomorrow, Ms Muir?

MS MUIR: Commissioner, I was just going to say, there has been – there is one witness that we won't be calling, and that's Dr Allan, and he's down for 3 o'clock tomorrow afternoon.

MS ROSENGREN: Yes.

COMMISSIONER WILSON: If we started early tomorrow morning, would half an hour wrap it up from your perspective?

MS ROSENGREN: Half an hour would wrap it up, I would imagine. I would just have to check with Dr Sadler's availability, that he doesn't have patients booked in.

COMMISSIONER WILSON: What's your position tomorrow morning, Doctor?---Tomorrow morning is better for me than tomorrow afternoon.

Now, will you have many questions?

MS MUIR: At the present, I have no questions.

COMMISSIONER WILSON: Well, I think it would be better if we started at 9 in the morning.

MS ROSENGREN: That would be my preference, rather than rushing through it this afternoon, because it probably is - - -

COMMISSIONER WILSON: Well, I don't want you to rush through it and not do justice to your case or the evidence that Dr Sadler may be able to give, but, obviously, I am concerned about the programming. Dr Sadler won't know, but we had a number of technical problems this morning which slowed us down for quite some time. So not without some reluctance, I think 9 o'clock in the morning. It's going to be another very long day for everyone, but we'll finish this witness first.

MS ROSENGREN: Thank you, Commissioner.

WITNESS STOOD DOWN **[5.35 pm]**

MATTER ADJOURNED at 5.35 pm UNTIL THURSDAY, 10 MARCH 2016