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TRANSCRIPT OF PROCEEDINGS

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MR P. FREEBURN QC, Counsel Assisting

MS C. MUIR, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

COMMISSIONS OF INQUIRY ORDER (No. 4) 2015

BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY

BRISBANE

9.31 AM, TUESDAY, 1 MARCH 2016

Continued from 29.2.16

DAY 17

RESUMED **[9.31 am]**

COMMISSIONER WILSON: Good morning everyone. Yes, Ms Muir.

MS MUIR: Commissioner, just housekeeping to start with. Can I just hand you a list of two further exhibits that were tendered that I propose be give exhibit numbers in relation to yesterday's evidence.

COMMISSIONER WILSON: Were there any exhibits tendered on Friday?

MS MUIR: Commissioner, I will have to take that on notice and check.

COMMISSIONER WILSON: Wait a moment, my Associate may know. I think these are both, actually, Ms Muir, on this schedule – both 26 and 29 February.

MS MUIR: Thank you.

COMMISSIONER WILSON: Now, I'll make sure that everyone gets a copy of this and I'll adopt the same practice as last week. If there are no comments upon it by lunchtime then the documents will be assigned the numbers provisionally shown. Yes.

MS MUIR: Thank you, Commissioner. I call Trevor Bruce Sadler but before I do I understand that my learned friend, Ms McMillan, has an issue that she wishes to raise with you.

MS McMILLAN: Yes, just briefly. This relates to the provision of the statement that arrived from Dr Sadler yesterday afternoon whilst we were in session. It's his fourth statement. I'm not in a position to be able to cross-examine about that today. I need to get further instructions from my client. Furthermore, there's one of the issues I could have put to Mr Brennan yesterday had I known. I will need to adduce further evidence from him. It mentions a nurse Kopp and he would have been able to address that issue. So it's unfortunate. I would hope not to have to recall Dr Sadler but I'm simply not in a position to be able to cross-examine about that statement. I can about other issues this morning.

COMMISSIONER WILSON: Alright.

MS MUIR: Commissioner, can I say something about the issue that Ms McMillan has raised and that is that I will discuss the matters with her further and there may be a way that we can get some further evidence in a written statement from Mr Brennan and that we can, perhaps, deal with the issues by way of further statements being adduced. But I will – it's only just been raised with me as I've come in this morning, understandably. That's not a criticism and I'll have some discussions with Ms McMillan.

COMMISSIONER WILSON: Well, that's fine, Ms Muir. We'll see how that develops during the day.

MS McMILLAN: Yes.

COMMISSIONER WILSON: Dr Sadler is here. It's expected to be a long morning anyway. I think we should get under way and I'll note what you've said, Ms McMillan.

MS McMILLAN: Yes. I'm happy to cross-examine about the matters. I just wanted to indicate - - -

COMMISSIONER WILSON: Alright. Dr Sadler, come forward. He's standing up. Does anyone else want to raise anything? No. Okay. Thanks, Dr Sadler.

TREVOR BRUCE SADLER, SWORN [9.34 am]

EXAMINATION BY MS ROSENGREN

MS ROSENGREN: Commissioner, can I say at this stage there are a few corrections to Dr Sadler's statements and if it's convenient if I could deal with those at the outset.

COMMISSIONER WILSON: Yes, Ms Rosengren.

MS ROSENGREN: Thank you, Commissioner. Dr Sadler, could I ask you to go your first statement, please. The Delium reference number is DTZ.900.001.0001 and Dr Sadler, could I take you to paragraph 21 of that statement, please, with the Delium reference number 0004?---Yes.

You have that there. If I could then take you to the second line, Doctor, where you refer to a psychiatrist from Rivendell visiting the Barrett Adolescent Centre in 2006. Do you seek to correct the year in which that visit took place?---Yes. I found another document that said she visited in 2002.

So you seek to change the reference to 2006 - - -?---Two thousand and – yes.

- - - to 2002?---Two.

Can I then take you to paragraph 51, please, and the Delium reference number is .00112. Now, Dr Sadler, you detail there the number of cases that were referred to the Barrett Adolescent Centre in the 2010/2011 financial year and you identify the number there as having been 40. On reflection, do you wish to alter that number?---I wish to change the number that was in a document that I wrote to Ms Dwyer and in

subsequent documents to the Expert Clinical Reference Group I referred to 25 to 30 as the number referred per year. And so I would like to change it to 25 to 30.

Thank you. So that's changing the reference to the number 40 - - -?---Yes.

- - - to 25 to 30. Can I then take you to paragraph 226 of that statement with the reference number at .0046. Doctor, in that paragraph you refer to your meeting with Ms Kelly and Dr Stedman on 2 November 2012 and you say there that you were verbally advised by Ms Kelly that the Barrett Adolescent Centre would close on 31 December 2012. Do you seek to correct that to any extent?---I seek to correct that. I was told that it would – it would close. A date of 31 December 2012 was mentioned. And I – so that date was mentioned but it was not necessarily the closing date.

So what would you like to change - - -?---I'd like to change it so - - -

- - - that paragraph to read on the third sentence?--- - - - the paragraph to read that the BAC would close and then a full stop – close that sentence. A date of 31 December 2012 was mentioned full stop.

And if I could then take Dr Sadler to his second statement, if I can call it that, and it's the one dated 12 February 2016. the Delium reference number being DTZ.900.002.0001 and if I could take you, Dr Sadler, to paragraph 61 of that statement at Delium reference number .0013 and, Doctor, you will see there that paragraph also refers to the meeting on 2 November 2012 and to the – that the BAC would close on 31 December 2012. Do you seek to amend your statement to reflect that which is now in paragraph 262 of your first statement?---Yes, I do.

If we can then go back to – if I could just have one moment, please, Commissioner.

Could I take you to your second statement again, please, and it's to paragraph 69 of that statement with the Delium page number at .0015 and it's over to the following page as well. Doctor, you will see there the paragraph refers to the issue of the handover between yourself and Dr Brennan. And if you go over to the second page, please, at the top there where you indicate on the second line:

> *However, it was on that day that the former Health Minister made the announcement of the closure in Parliament.*

Is it meant to say there that "it was on that day that the former Health Minister made the announcement of my standing down in Parliament"?---That is correct.

Doctor, could I take you to the final correction that I understand you have to make. And it's in your most recent statement. So it's the fourth statement with a Delium reference number of DTZ.900.004.0001 and it's to paragraph 24 on 0006, please. If – Doctor, if you go six lines down, you refer there to a view that you undertook in November 2012 of adolescents admitted to the Barrett Adolescent Centre between 2007, and it says there, to 2001. Should that read 2011?---It should read 2011.

Doctor, are there any other corrections that you would seek to make to your statement at this stage?---I'm not – not aware of any other corrections.

Thank you. Thank you, Commissioner.

COMMISSIONER WILSON: I'll allow you to make those changes.

MS ROSENGREN: Commissioner, Dr Sadler has provided four statements to the Commission. The last of these, which is the one that Ms McMillan was referring to, is dated 26 February 2016. It is DTZ.900.004.0003. This statement is not in evidence yet so will need to be formally tendered as an exhibit. So it can be added to the list overnight perhaps.

COMMISSIONER WILSON: I just query the Delium number. It was 9000040001?

MS ROSENGREN: Triple zero three.

COMMISSIONER WILSON: Triple zero three.

MS ROSENGREN: Sorry, it should be 1.

COMMISSIONER WILSON: Triple zero one.

MS ROSENGREN: Sorry, that's - - -

COMMISSIONER WILSON: Alright. That will be marked as an exhibit.

MS ROSENGREN: Thank you.

COMMISSIONER WILSON: Thanks, Ms Muir.

EXAMINATION BY MS MUIR **[9.43 am]**

MS MUIR: Dr Sadler, you have a Bachelor of Medicine and a Bachelor of Surgery and you've been a Fellow of the Royal Australian and New Zealand College of Psychiatrists since 1988. Is that correct?---That is correct.

Am I correct also in my understanding of your statement that after a period of training in adult psychiatry, you, amongst other things, provided psychiatric care to adolescents both as a registrar and then as a consultant psychiatrist and then clinical director at the Barrett Centre from December 1986 until September 2013. Is that correct?---That is correct. Yes.

Is it also correct, as I understand your evidence, that as at September 2013, the time that you left the Barrett Centre, you'd assessed and treated approximately 1000 adolescents in various outpatient settings, community clinics, private practice and hospital based outpatient services?---That is correct.

Can I start now by taking you to an email from Judy Krause to Professor Crompton in relation to the proposed Redlands model of service. This email is MSS.003.004 5222. Dr Sadler, this email attaches a document that you had sent to the working group – to the Redlands working group. And in that document you explained in some detail the Barrett Centre model of service and your observations about adolescents with severe and complex mental illness. I'd like to take you to one of the attachments to the document which is at MSS.003.004 5236. Now, in this document you express concerns about a decision to take referrals for the new Redlands unit only from CYMHS services. And the document suggests that there was either a decision or at least a discussion about excluding referrals from private psychiatrists to the planned Redlands Adolescent Extended Treatment and Rehabilitation Centre. Do you recall that?---I recall that. Yes.

Can you explain any discussions around this issue or your concerns about it?---I was concerned – I – if I can just explain the background. I was in the UK at the time visiting overseas units. So this was only email correspondence. And I – this was the only discussion I can go on. I was concerned that the referral to Child and Youth Mental Health Services or only accepting people from Child and Youth Mental Health Services meant that people who had good clinical care from a private child psychologist would then have to cease contact with that psychiatrist, begin contact with the Child and Youth Mental Health Service. They would probably see someone without the experience of the private child psychiatrist and then be likely to be referred. And I thought that was disadvantageous to the adolescents – private – well, child and adolescent psychiatrists that had extensive periods of training and ongoing professional development. And I think that needed to be recognised.

Okay. Thank you, Dr Sadler. I want to ask you some questions about the development of the Barrett Centre model of service delivery. And at exhibit A of your second supplementary statement of 17 February you've attached 11 separate versions of the Barrett Centre model of service delivery and one of the draft Redlands model of service delivery. A list with the date of each of these versions is at page – paragraph 5 on page 2 of that statement. So if we could go to DTZ.900.003.0001 at 0002. Okay. So if we go to paragraph 5 – I think that's the wrong – it's DTZ.900.003.0001.

COMMISSIONER WILSON: Do you have a hard copy in front of you, Doctor?---I'm just trying to

MS ROSENGREN: Commissioner, I think there might be some confusion. I think it was referred to a statement – his second statement, but I understand it's the third statement.

MS MUIR: It's his second supplementary statement. Yes.

MS ROSENGREN: Yes. So it's actually the third statement?---So I've got the - - -

COMMISSIONER WILSON: It's the one of 17 February.

MS MUIR: Yes. It's the 17 February statement. And if we could go to paragraph 5?---Yes.

And that's on page 2?---Yes.

And the first version you provide is identified at paragraph 5(a) and dated 1 August 2008. The actual model of service is in your statement as well but perhaps we don't need to go to that version at the moment. But to the best of your knowledge, Dr Sadler, is that the first documented Barrett Centre model of service delivery?---That was the first formal documentation. I think in two thousand and – it could've been somewhere between 2003 and 2006 there was an encouragement to develop models of service delivery at The Park Centre for Mental Health. That wasn't an official one that was anywhere outside of The Park. But I do recall there was that process to develop models of service delivery at The Park for various units.

Did you – can you recall preparing a written document at that time?---I would've prepared one at that stage.

I think from the Commission's perspective this is the first documented Barrett Centre model of service delivery that we have that's been produced?---Yes, with the mental health branch and – and outside of The Park. Yes.

And do you recall the context in which this document, dated 1 August 2008, was developed?---So there was a determination by the mental health branch or – as it was then, I think. But units would have models of service delivery to try to standardise practice across various centres so that if one person went into an acute inpatient unit in Brisbane and went into an acute inpatient unit in Cairns, they could expect a similar level of service delivery. So these documents were delivered within that context of providing consistency across the State and providing consistency across networks.

In paragraph 4, just above paragraph 5 there in the same statement you note there that the draft model of service delivery was developed in association with the statewide CYMHS advisory group and that Denise Best, who was at the time the chair of the group and the Executive Director of CYMHS, provided feedback; is that correct?---Yes.

And one of the versions you provided dated 21 July 2009 includes reference to Denise's comments?---That's right.

The model of service delivery then identified in paragraph 5(k) – if we can go over the page again, down to 5(k) – is identified as the AETRC draft model of service delivery as a template for DP dated 4 May 2012?---Yes.

Am I correct that DP stands for day program?---Day programs. Yes.

Do you recall the context for that version being produced?---They changed the templates in about late 2009, early 2010 and so during 2010 there was a – we developed a new model of service delivery within the new templates, including one for – for Barrett and then in 2012 – I think it's – yes, May 2012 that there was a need to revise the child and adolescent day program model of service delivery because it was – both Toowoomba and Townsville were coming online and so because there were a lot of similarities between what happened in day programs in terms of rehabilitation programs and also in – in – in our centre I thought it would – appropriate to make sure that the wording was very similar.

So am I correct, then – my understanding of the evidence that you're giving on this is that this model was produced to assist with the day program for Toowoomba and Townsville – for that being developed - - -?---So the child and adolescent day program was produced to assess – to – for both Toowoomba, Townsville, the Mater, and also because we had day patients it was relevant to us, so we met with a staff member for the mental health branch and at the same time when there were common things, just revise that in the Adolescent Extended Treatment and Rehabilitation Centre model of service delivery.

The last version you've provided, which is identified in paragraph 5(l), is called the AATRC Draft Model Of Service Delivery Final Draft 2005, 2012. This appears to be a version as at 20 May 2012. Does that seem correct to you?---It does.

And can you confirm that this May 2012 version was the model of service delivery for the Barrett Centre and not the draft version for what was to be the centre at Redlands?---It was the version for the Barrett Centre – Adolescent Centre at – by that time I had doubts as to whether or not Redlands was going ahead, but certainly it incorporated reference to – to a day program, as I recall, which was not to be at the Redlands centre.

COMMISSIONER WILSON: I'm sorry. I'm still a little confused. You produced this last one in response to a requirement from the mental health branch?---In association with the mental health branch, so I was sitting on the child and adolescent day program model of service delivery and commented that there were – the same programs applied to both day patients and inpatients in many respects.

Sorry. We're not on the same page?---Sorry.

The day program was number (k) – that had DP?---Yes.

I'm questioning you about number (l), the final draft of 20 May 2012. You say that was for the Barrett Adolescent Centre, rather than for Redlands, do you?---I didn't have a clear vision in my mind of – it was more applicable to the Barrett Adolescent Centre than to Redlands. Yes.

And why did you produce that one?---Because we were – I was involved in producing the child and adolescent day program model of service delivery adolescents who participated in our day program participated in the same program during the day as adolescents who were inpatients and so – and I didn't believe that the model of service delivery was reflecting that commonality of – of just some of those programs.

I think I understand now?---Yes.

Thank you.

MS MUIR: Dr Sadler, if I understand correctly, the Barrett Centre model of service delivery was never formally endorsed. Is that your understanding as well?---That is my understanding.

Do you know why that is?---I'm not sure. I – it was – sorry. It was submitted, I thought, to the child – statewide Child and Youth Mental Health Services advisory group for endorsement, but I don't know what happened there and I can't recall that process.

From your perspective would it be correct to say that you thought that you had a formal model of service delivery that properly reflected the practice at the Barrett Centre at the time?---I did, yes.

And is that formal model of service delivery – is that properly reflected in the version that you refer to in paragraph (l) – 5(l) of your – I've called it the second supplementary statement, but your third statement that we've just been referring to?---Yes, I – I believe that that one reflects the – the practice better than the 2010 version of – in – referred to in paragraph 5, sub – or (j) or - - -

So that was 5(j), did you say?---Yes.

So 5(l) reflects the practice in a better way than 5(j); is that your evidence?---Yes.

Now, if I can take you to the feedback you provided in the context of the ECRG recommendations that were being finalised around April 2013, and you sent an email to Dr Stathis on 11 April 2013 attaching four documents that you said were for discussion on Wednesday. These documents are at QHD.012.002.1351. Now, do you recall the context for that email and for the discussions on that Wednesday?---The context of that email was – was – just trying to think of the dates. I think we might've had the second last planning meeting just a couple of days prior

to that; I can't recall exactly. But, certainly, the – the final one, I think, was on 23 April 2013, and - - -

COMMISSIONER WILSON: You said – I'm sorry to interrupt, but you said planning meeting. Did you mean the ECRG?---ECRG meeting, sorry.

Yes. Go on?---The meeting was on – on 23 April 2013. So I wrote to – to Stephen, and I – Dr Stathis, because I was concerned that there were, perhaps, limited timeframes in which to do things, that the only alternatives for providing an alternate service involved acute inpatient units. I wanted him to understand the risks in – or – well, some of the – the issues involved in bed management in acute inpatient units. I wanted him to understand the characteristics of the adolescents who were admitted to the Barrett Adolescent Centre and some of the need for high levels of nursing staff, because that's not his area of expertise. He was also on the planning group, and I felt that he needed to be as fully informed of these various matters to – and help him make decisions in the planning group with the various – when the ECRG recommendations finally came about.

MS MUIR: So two of the attachments to this email concern some modelling that you did on using acute adolescent inpatient beds for extended stay patients and options for combined acute and extended treatment units. And if I could go to QHD.012.002.1357, am I correct in understanding that this document outlines some modelling that you did?---That's right.

And then the second document, which is QHD.012.002.1359, outlines three compromise options for treating extended stay patients in acute inpatient units?---Yes.

And am I correct that this is, in fact, the situation with the swing beds at the Lady Cilento Hospital?---Well, certainly, option – compromise option 1 is equivalent to the current swing beds at Lady Cilento Hospital.

So if we could go to CHS.500.0001.0001 at 0008, and if we could go to the bottom of the page, to the first recommendation, it seems to be also one of the recommendations of – in the Queensland Health – Children's Health Queensland Draft Statewide Subacute Beds Discussion Paper, that is, that most adolescents requiring extended inpatient care can be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care as per the state-wide model of service. But if we could then go back – if I could take you back to the document – your document, QHD.012.002.1359, under the heading Comments, halfway down page 1, you note that these options cannot provide a replacement level 6 extended treatment and rehabilitation service within the CSCF, which is, I understand, to be Queensland Health's clinical services capability framework?---Yes.

And you also detail a range of systematic implications and clinical implications in your document. So, Dr Sadler, what I'd – I'd like you, if you could, talk – talk us through how you arrived at these compromise options and why you think they can't

provide a replacement level 6 extended treatment and rehabilitation service?---Right. I felt that the – the first option, of – of programs being – being supplied within acute inpatient units was fairly unrealistic. The – the model of service within acute inpatient units is brief treatment, get the young person out. Psychological therapies are not predominant there because they take a long period of time and assume that psychological therapies occur in the community. So I felt that that model of then having some acute beds or – sorry – some longer-stay beds or subacute beds within an acute inpatient unit with the same group of staff would be difficult for the staff to change their mindset, and also to provide a comprehensive rehabilitation program, which I believe is, really, quite essential. The second compromise option – and I came up with these options because I thought we're going to have to close – I'll have to come up with something that's realistic – the second compromise option was the existing acute adolescent units having an allocated number of beds for long-term kids and a rehabilitation program and having nursing support coordinated with a new metro day program. So I thought that there would be a new metro day program, there would be Barrett Adolescent Centre staff which had expertise in the management of adolescents who had spent longer times within hospital, and that they would then go and visit the young people within the – within the unit. I didn't see this as a good option, because it still had the – the problems of young people within acute adolescent inpatient units, which I listed in my statements. The third option was probably my preferred option, that the existing acute adolescent units have an allocated number of beds for long-term adolescents, and then who are transported to a new metro day program for the rehabilitation component. This would be harder to integrate into the acute inpatient unit and taking them out into a – into a longer-term environment created difficulties, I felt. But I thought of the – the limited options that might be available, that that was probably the preferred option. But all of them, as I have outlined in this paper, I had felt had significant issues, and that's why I headed all of these compromise options, because I did not feel that that was the ideal solution.

Dr Sadler, I just want to take a step back in time, to 21 March 2012, and just ask you briefly some questions about a redevelopment at Springfield. Can I bring you to a letter you wrote to Dr Bill Kingswell on 21 March 2012, which is at DTZ.900.002.0001 at 0174. Now, this letter discusses, amongst other things, redeveloping a Springfield Hospital. At the start of your letter, you apologise to Dr Kingswell for writing to him privately, that you state there are no channels within Queensland Health to explore this issue. What did you mean by that?---I think that the fact that – I thought there was significant difficulties, which I outlined in the subsequent paragraph of this letter. I know that Dr Kingswell had made a comment that he privately – and it was discussed at one of the facility team project meetings – that he couldn't foresee Redlands occurring because of the protest of koalas, and there – if I went through the facility team project meetings, they were still continuing on with exploring Redlands. I thought this is not an option, so I couldn't take it up through there, through West Moreton. I felt that that wasn't – they were waiting for them to – us to move across to Redlands, so I thought I'd write to Bill privately, just because I thought we're – we're going to run out of time, we're running out of money, we need a plan B, but no one was discussing a plan B.

And so how did the Springfield site come into the mix?---That was my naivety, that I thought well, here is land that is unavailable or that might be available. I knew nothing about the development of Springfield, but I thought that it's – it may provide land – I knew that the Mater was – was building a private hospital at Springfield that – and that would provide some health facility that was fairly close by but I just suggested it.

So did you take any steps to further investigate the option?---Of Springfield?

Yeah?---I did, I think, later in twenty – probably December 2012 I had a – or an email. I can't remember the sequence but there was some discussion amongst a child psychiatry colleague of perhaps just looking at Springfield as an option. I remember writing to doctor – sorry, to Mr Paul Pasquale, I think it's – from the – from the – who was associated with the Springfield Corporation. I also approached the project manager at the Springfield who I knew through other personal channels but they said, look, it's – land is committed at Springfield.

Thanks for explaining that. Now, in paragraph 51 of your statement – and we don't need to go to that paragraph – you state that you have been unable to locate a copy of Dr Kingswell's response to your letter of 21 March 2012. Commission staff have been able to locate a copy of that document and that's at QHD.004.014.7257. Now, in this letter Dr Kingswell tells you that:

> *We're facing significant sunk costs that will be very difficult to recover by moving the project to another site at this later stage. Any proposal to shift the project now would create further delays rather than expedite matters.*

And then he says:

> *I'll forward your letter to Dr Geppert and Mr Alan Mayer for their consideration.*

And now, what did you think about this response at the time?---I knew that they had spent – I think it was a large sum of money. I – I recall about $10 million on the – acquiring the land at the site at Redlands from the Department of Natural Environment. Apart from that I thought because we had an update on the – on the budget that – that there was probably less than quarter of a million dollars or less than half a million dollars spent on the project to date. That's with architects' fees and project people – the – the commission of the fire report. So I thought that – I – I was unaware of any other costs associated with that.

As far as you can recall did you get any correspondence then from Dr Geppert or Mr Mayer in relation to this matter?---I can't – no, I'm – I did – did not receive anything.

Okay. I just want to take you to paragraph 167 of your supplementary statement which is DTZ.900.002.0001 at 0039 and then the last sentence of that paragraph

which actually is over on .0040. You say that you had discussions with Professor McDermott about coming under the Mater umbrella:

So that we were integrated with at least one major service.

?---Yes, I did.

Why were you advocating for this?---I felt that coming under the administration of The Park which was predominantly an adult mental health service often the needs of adolescents weren't clearly addressed and I thought that because we were a statewide unit being integrated with other – another major service which was going to be transitioned into Children's Health Queensland meant that we would be able to have further contacts with research, with professional development and with developing the service. I also – I spoke to him specifically about the Mater because I felt that if there was a chance of redevelopment privately it would be considerably cheaper than going through public works.

Okay. Now, I want to ask you some questions about the operation and the management of the Barrett Centre but while we have this .0040 up on the screen in paragraph 169 you say – if we can just go down – you say there that:

Many units in the UK considered a high fence a prerequisite to duty of care.

And on the other hand, your evidence is, if I understand it, that adolescents – and this is evidence that you have given in your initial statement at paragraph 128 which I can take you to – that adolescents stay because Barrett collaborated with them?---Yes.

And that there were processes to ensure the adolescents had a say in their environment. And you give the example that a member of the business unit management represented the adolescents and would present their concerns to the leadership group of the Barrett Centre at the meetings. What I wanted you to explain, Dr Sadler, is the reasoning behind collaborating with patients in this way?---We felt that collaborating with – with the adolescents was really quite an important so that we could work together towards recovery. The – the motto we had on our – on the PowerPoint slides that we showed around were together towards recovery. We felt that if a them and us environment developed adolescents would spend their time seeking to oppose us or seeking to challenge decisions rather than work on issues for their own mental health issues. So we – we helped them to identify the problems. We helped them to identify goals. We pointed out ways in which they could achieve some of these goals. We collaborated with them on developing new skills and we tried to explain things to them including being held to account for decisions we made which may be inconsistent because we felt that that environment created a – an environment of trust for the adolescents and facilitated therapeutic process.

I understand, too, from time to time that patients may have been on involuntary treatment orders - - -?---Yes.

- - - at the Barrett Centre. Can you explain how the patient was able to participate meaningfully in these sort of discussion notwithstanding their lack of capacity to consent to treatment evidenced by their involuntary status?---Yes. So there were times – I can – my recollection is going to the Mental Health Review Tribunal to – to argue that a young person should stay on an involuntary treatment order. There were often times when they had – they had consented to treatment in quite a number of areas of their life but there would be times – and particularly for those who had experienced trauma – when they would then become quite dysregulated in their emotions and so we would explain to them that the involuntary treatment order was to ensure that at the time times they – they lost that capacity to consent that they were then able – we would then step in but otherwise they were very involved in their decision-making. We also, for – for the people with – with the long history of severe incapacitating social anxiety disorder or anxiety disorders we probably had less opportunity to work with them initially because they – they – they would rather be sitting at home in their bedroom and so that collaborative process wasn't there at the – at the beginning as it was with some other groups but as they spent time and as they developed new skills we – we ensured that they had greater opportunities for leave and to show that they could – had a capacity to consent to treatment and we would then discuss with them whether or not they needed the – the involuntary treatment order. So it was a matter of continuing to discuss with adolescents what was happening, to work with them where they had the capacity to give consent to provide continuing treatment and rehabilitation and then to lift the order when that was possible.

Dr Sadler, I just want to ask you some questions now about the waitlist for admission?---Yes.

And in your first statement, your initial statement, your evidence, as I understand it, is that from at least 2006 there were always adolescents on waiting lists for admission. And as at September 2013 there was also a waiting list of adolescents. I understand too that by 2012, patients on the waiting list could be there for up to six months to be admitted to the Barrett Centre. But could I take you now to document QHD.001.003.4482. This is an email from you to – can we go up the page, please?

COMMISSIONER WILSON: Did you want to go up or down?

MS MUIR: There was just some confidential information. Sorry, down the page.

This is an email from you to the other members of the ECRG on 22 April 2013. In this email at the bottom of the page, halfway through the last paragraph - - -?---Yes.

You state there that:

> *A waiting list is useful. It sorts out those who benefit from another three to six months of community treatment and those who are truly persistent.*

?---Yes.

Can you explain, Dr Sadler, what, if any, alternative services the Barrett Centre offered the patient during this waiting period? So, for example, did you explore the option of CYMHS with – accessing CYMHS with these patients?---So if the referral came from CYMHS, they would continue to be reviewed by the local Child and Youth Mental Health Service during that period. And there were times when people got better during that period of three to six months and the need for admission was averted. So they put in supports for them to – to ensure that they can manage in the community. Our community clinical – community liaison clinical nurse would keep in touch with them to give them an update on what was happening so that they were aware of what the issues were.

So does that – so it was up to the referring agency or the practitioner to facilitate the alternate services during this period. Is that - - -?---Yes, that's right.

Okay. So at that time the referring agency or practitioner retained responsibility for the clinical care of that patient?---They did.

So at what stage then did the Barrett Centre assume that responsibility?---So once the young person was admitted, either as a day patient or as an inpatient, we then assumed that responsibility.

Thank you, Dr Sadler. Now, I want to ask you some questions about length of stay. In paragraph 55 of your statement, which is DTZ.900.002.0001 at 0012, in the third – paragraph 55, about the third sentence, your evidence in relation to the proposed model of care for the Barrett Centre is that you thought there would be a frequent need to extend the treatment beyond six months?---Yes.

And there were other adolescents who would benefit from an admission to an extended inpatient facility for less than six months. And in your statements overall, you generally identify four main diagnostic subgroups. That is, those with severe and persisting anxiety, those with severe and persistent trauma, those with persisting anorexia nervosa and those with severe and persisting psychosis. Can you explain which of these four main subgroups, or if any of them, would generally benefit from an admission of less than six months?---I anticipated, just based on our earlier referrals in the early 2000s, that the young people with anxiety disorders might benefit from a referral of less than six months. Since I have been at the – working in acute inpatient units, there are also some who have experienced trauma who I would think would benefit from a brief stay with – a stay of certainly less than six months and maybe only three months as they worked through the process of their trauma which was really quite disturbing to them and they required an acute – or they required an inpatient stay. There are some who, say, with eating disorders are not as severe who may benefit from a shorter stay. So there are subgroups of people, I believe, within acute inpatient units at present who may be staying there for four to six months but who would possibly be better in an extended stay unit for that period of time because of the rehabilitation component rather than an acute inpatient unit.

COMMISSIONER WILSON: Are you saying that – where are you now working, Doctor?---At the Royal Brisbane Acute Adolescent Inpatient Unit.

And are you saying that some patients of the acute ward are staying as long as six months?---Yes, Commissioner.

MS MUIR: When you make that reference to longer than six months, are you talking in a continued stay or is this repeated admissions?---So it would be – all of these were negotiated. So there would be times when we thought they were staying well enough, there would be times when a person might start off as a day patient, require an inpatient admission, go back to being a day patient. So we were flexible with regard to times. So it would be the total time that they spent with us, whether or not it was a day patient, inpatient or a partial hospitalisation.

And what of the – going back to the four subgroups of conditions with the young people, which of those subgroups would you, in your experience, say needed – typically needed longer than six months' stay?---I was surprised at how severe severe anxiety disorders can be and how difficult they are – can be to manage. There is often no effective complete treatment. We can alleviate symptoms to some degree. What we could do was help young people manage in spite of their anxiety through the rehabilitation program. So that was a group that I thought these – well, the group that we were seeing were taking longer than six months to manage. And I know that it's different from the Rivendell Unit. It may have to do with the different uses of the *Mental Health Act* between Queensland and New South Wales. So I certainly – within my cohort of people that I'm seeing now, I'm – or in outpatients I've seen people – they could've spent a shorter time within an acute inpatient unit. I would say the other group was the group with the severe trauma, the complex PTSD. A number of them, but certainly not all of them, required a longer admission. And, again, since working in the acute inpatient units I believe that they are a group who could benefit from a shorter – a much shorter admission.

COMMISSIONER WILSON: Sorry, a much shorter admission to the acute ward?---A shorter admission than six months. So there's spending some time in an acute ward which is – and going through the process of dealing with a trauma, it often affects their cognitive ability, it affects their schooling and they lose some of those – they just feel left behind in some of the tasks of adolescent development. And so I think that if you had a rehabilitation component to – within that setting, for that group who would take less than, well, maybe only three or four months to resolve their trauma, but having a rehabilitation setting so that by the end of it they didn't feel just shattered people but they felt that they were getting on with life, that that was – that would be important.

Thank you.

MS MUIR: Dr Sadler, if we could go to paragraph 144 of your supplementary statement; this is at DTZ.900.002.0001 at 0033. Your evidence about the eighth sentence down, just about halfway, is that:

Agency of community was a tool for change in the lives of the adolescents.

And then you say a sentence or two down from that passage, that:

The agency of community seemed to provide the courage in which social learning occurred, so necessary for many of the adolescents in which social isolation was so difficult to overcome.

And then you state in the last sentence at paragraph 144 that you saw the sense of community appear to be a necessary therapeutic component. However, Dr Sadler, you no doubt are aware that there are many question the therapeutic value of this community, given that this community was united on one view by their pathology. What do you say to those who hold that view and who advocate for this social learning to occur by reference to a more normal behaviour model within the more mainstream communities from which these adolescents came, rather than by reference to some of the challenging behaviours modelled within an institutionalised cohort, such as the Barrett Centre?---Right. I would often say to – to people who are visiting the centre, who saw adolescents when they were interacting – and the interactions were quite positive. There would be many days when they were – when they would go to and from school they'd be laughing and chatting. And I'd say there were many parts of these adolescents that really are quite well, and there are many strengths amongst these adolescents. And what we need to do is to develop and enhance these strengths. We saw people with sense of humour we would never have understood before. They were given the chance to amplify that. Certainly, there were – were the negative aspects about being on an extended inpatient for quite a length of time, and I think we were aware more than anybody else of some of those negative things and the impacts that I might have had, and particularly around the distress if someone was self-harming or the care that they developed for each other. But there were many opportunities for – for young people to – I think many more opportunities for them to – to learn from the strengths that each brought and learn from the positive aspects that – that each brought, those – that great sections of wellness within the – the quite devastating unwellness that they were experiencing, that they could use that positively.

Well, in your supplementary statement, you referred to some comments that Dr Cary Breakey made in his statement, and you say that you agree with most of these comments. Perhaps if we could go to Dr Breakey's statement at paragraph 18, which is WIT.900.021.0001 at 0004; perhaps if you could just read that paragraph:

An important feature of the BAC model - - -

No, sorry, just - - -?---Sorry.

I should said, Dr Sadler - - -?---Sorry, to read it – sorry. Yes.

- - - if you could just read that paragraph to yourself?---Yes.

Now, we might need to go up – over to the next page?---Yes.

What do you say, Dr Sadler, to those who say that adolescents developed an unhealthy dependency or attachment to staff, who had become their role models, as a substitute, as some might say, to more normal family attachments?---I think those who had strong family attachments maintained those strong family attachments. Those who were experiencing difficulties within their family: it gave them an alternative model so that they could value themselves as young people, where, sometimes, that wasn't – they weren't validated within their – their family of origin. So I think they – they could develop attachments to staff, and there were certainly attachments to staff which were – that there were certainly some staff that adolescents found it much easier to approach than to other staff. They could talk more freely to them. They felt that they understood them better. But staff went off-duty. They – they – they did their eight-hour shift, and they knew that staff had lives outside of them. So I think that whilst there were attachments and that could be used therapeutically, that there were a number of factors with a number of staff that meant that the attachment wasn't to any one staff member.

And did – were you ever concerned that there were some unhealthy dependency or attachment issues that developed at the Barrett Centre when you were there?---I'm just trying to reflect on the whole period. Certainly, I felt that there were good boundaries, and it was something that we – we tried to encourage – or we spoke about good boundaries between staff and the adolescents. And, certainly, in the last several years I can't recall feeling concerned about that issue. In other years, I think, yes, there may have been concerns, but I can't think of them specifically.

When you say other years, just so I'm clear, are you – what, earlier on in the - - -?---So in the – in the 1990s. I mean, I became aware in 2012 of an issue of – yes – staff dependency, which I wasn't happy about, but that had occurred in the 1990s. So, I mean, that's – it's – yes.

Dr Sadler, just ask you some questions about this institutionalisation expression that we've heard in evidence – in written evidence and oral evidence. In paragraph 78 of your supplementary statement – which is DTZ.900.002.0001 at 0018 – your evidence is that one of the difficulties in transitioning young adults to adult mental health services is that an adult approaches – approach continued with developmentally immature young adult, making no adjustment for the need for them to take responsibility for their management. I'd just like to understand what steps, if any, the Barrett Centre took to prepare a young adult who was required to transition into the adult – sorry – a young – well, an emerging adult who was required to transition into an adult mental health service. How did you prepare such a young person, but taking their responsibility for their management?---We would encourage them to make appointments, to be able to travel independently to the – to the place where they were going. We had little capacity, unless they were on leave, for them to take their medication independently. But if they were on leave, they were encouraged to take their medication independently and – many of the strategies that had been involved at Barrett, psychological strategies: we had encouraged them to utilise

those strategies in the various day-to-day situations of the ward. And I think that prepared them for when they went into the community, that they would be able to take the advice of – of an adult service and apply them to the – help to generalise them into their day-to-day living. So that was a process that occurred over some months.

With that encouragement or this process, how was that done? Was that role playing or – you talk about encouragement. Was that – or was it a conversation? How did - - -?---So - - -

- - - you impose or how did you guide the young people?---So, for instance, if – if someone was distressed and there were things that would be useful for their distress in – that had come out of the dialectical behaviour therapy group. Nursing staff might sit with them and get them to review the evidence that they had or the – sorry – the strategies that they had learnt in that group and how they might apply it at that time and then as time went on young people became more adept at doing that themselves and say I use this and I use that to help me cope.

Thank you, Dr Sadler. If we could go to paragraph 54 of your supplementary statement at 0012. Now, your evidence in this paragraph is that one difference between the model of service in – you were involved in developing from 2007 until April 2008 and the model you referred to as the Barrett Centre model was that you were trying to negotiate opportunities for greater self-reliance by adolescents in preparing meals, particularly breakfast and lunch?---Yes.

Why was that not already an element of the model you referred to as the Barrett Centre model?---I know that we were advocating for that from about 2002 onwards. We felt that this should be something that should be part of what adolescents did, to simply get their own breakfast and – and get their own lunches, and I can recall asking why we were still providing food that was brought down for the adolescents, but it seemed to be part of the – the hospital policy and I'm not just sure – sure why that was so, that – that we couldn't provide – we couldn't let the adolescents take that responsibility for their meals. I don't know if it was something to do with the logistics of the kitchen, the Barrett kitchen – that we weren't able to do that. I don't know. It may have been that some of the young people with – with an eating disorder, for instance, may have chosen then not to eat and that would be – we'd – we'd then have to, you know, provide special meals for them. It may be that some people with tendencies to self-harm weren't able to – to access the kitchen, but it never became an accepted part and so the – there were times when we had, for instance, barbecue days and cooking days where they prepared the evening meal and that became a regular thing, but on a day-to-day basis that wasn't the routine.

Just want to move on to a couple of budget funding issues. In paragraph 75 of your first statement at DTZ.900.001.0001 at 0016 you state that prior to the budget cuts to mental health which began in October 2012 Barrett Centre was operating below budget. I just wanted to ask you quickly what was your – at what – at that time what did you understand was behind the budget cuts?---The need to restore financial – or

to – to bring the – the health service within its operating budget. I was aware that the 2011/2012 financial year we had gone well over budget as a health service and much of that overrun was at The Park.

And if we could just go to your second statement, then, which is DTZ.900.002.0001 at 0020, paragraph 87. I just wanted to ask you about what you mean by:

After November 2012 concerns regarding ABF –

which is the definition you have used for Activity Based Funding –

were no longer relevant.

It's the last sentence of that paragraph 87?---My understanding then that – was that whatever our activity level, that we were to be closed and therefore activity levels weren't relevant to our – our future directions. Yes.

Because the Barrett was going to be closed?---That's right.

Okay. Speaking of closure, can I take you to an email you sent to Dr Kingswell on 19 November. This is exhibited to your initial statement as exhibit K and is DTZ.900.001.0001 at .0149. Okay. This email discusses, amongst other things, bed occupancy, which the Commission understands from some of the evidence was one of the justifications for closing down the Barrett Centre. In this email you give two reasons for relatively low occupancy rates, paraphrasing – if I just paraphrase, these were, firstly, staff shortages and the use of trial leave. You have addressed this issue in paragraph 41 of your initial statement and we don't need to go to that paragraph, but can you just explain to the Commission your understanding of how bed occupancy numbers are calculated.

MS McMILLAN: I object to a premise of the question, which appears to be that one of the reasons for closing Barrett was bed occupancy. I don't think that's been articulated by any witness as a reason.

COMMISSIONER WILSON: Ms Muir.

MS MUIR: Your Honour, my understanding is that there was some evidence from Dr Kingswell that bed occupancy was one of the justifications for closing down the Barrett Centre. I ask the question a different way.

COMMISSIONER WILSON: Ask it a different way. There was evidence about bed occupancy.

MS McMILLAN: Absolutely. Yeah.

MS MUIR: So we have heard some evidence about bed occupancy during the course of the hearings and in the written evidence and if you could just, then, explain

how bed occupancy numbers were calculated or how it worked at the Barrett Centre?---Yes. So bed occupancy is a standard measure that if a person is sleeping in a bed at midnight they are counted – that is an occupied bed and so if a person is on leave and they might be in the unit until 5 pm, they may be in the unit until 8 pm, but if they're not in that bed at midnight it's a – a vacant bed.

And is it correct that day patients were not included in any calculations?---That is correct.

And so going back to your email, then, how did staff shortages and the use of trial leave affect the bed occupancy statistics?---So there were times when we were managing a number of adolescents who – really quite unwell and required periods of continuous observations. That stretched our – our nursing staff capacities and the options would be to either get in quite a number of casual nurses, which would be quite difficult to maintain a full ward, or else to – to work within the establishment of nurses that we had at – at the time. It meant that to safely manage those – those adolescents we would reduce beds for a period of time until that period of high acuity was over and I can recall that there was a time when we had three young people on continuous observations for significant periods over a period of months and we reduced the bed occupancy during that time. The partial leave and partial hospitalisation was that if a person was ready to transition into the community or – or begin transition, we would then become – we would then let them go – instead of, say, Friday through to Sunday leave, they would come to – they might go, say, Thursday night and return back Monday morning, so, in effect, they were only there for three days of the week, so their occupancy was lower.

But you didn't give their bed away - - -?---No.

We've heard some evidence in particular from Dr Kingswell that he was concerned about a gray risk in relation to the location of the Barrett Centre, given the development of The Park as an adult-only forensic facility. Now, I want to ask you some questions about your knowledge of that development, but I'm correct, am I, in my understanding of your evidence, which his in your initial statement, that the location of the Barrett Centre on the grounds of the Wolston Park, in your opinion, was never ideal?---That's right.

And you say in paragraph 93 of your initial statement:

> *It was never ideal, but there had never been any adverse interactions with adolescents that had occurred.*

?---I think I meant with forensic patients in particular. Yes.

Now, can you just – I just want to understand: what did you understand, and when were you told about the proposal to redevelop The Park, and also about EFTRU, which I understand is the extended forensic treatment rehabilitation unit? Going back to 2012/2013, were you involved in discussions about the development of that –

of The Park?---No. I wasn't involved in – in discussions, but I certainly was – was given minutes, because there was a considerable redevelopment of The Park at that time. So some people were being moved to community care units, which were being established at Goodna, and there was the extended forensic treatment unit, which was going to be established at The Park. So I was well aware of both of those – of those developments and developments within The Park.

COMMISSIONER WILSON: Can you put a - - -

MS MUIR: And what did you know about - - -

COMMISSIONER WILSON: Sorry. Can you put a timeframe on that?---I'm – certainly, I think from about 2009 I became aware of the broader developments within The Park. I'm not sure whether EFTRU, as the forensic unit was named, was a more recent development of that. But, certainly, from about 2011 it would have been part of that development.

From 2011 you would have?---I would – I would have been definitely aware, but I may have been aware even in 2009 of that potential development. I just can't - - -

That's EFTRU?---Yes, EFTRU.

Thank you.

MS MUIR: And did you understand that development entailed step-down units for high and medium-secure forensic patients at The Park?---Yes, I did.

Did that concern you, if – at the time, did you think that there was a risk having such units at The Park, on the same location as the adolescent facility, the Barrett Centre?---That was a – one of the reasons why the – the Redlands facility was chosen, rather than the Wolston Park site. Personally, I knew that special notification forensic patients were going on leave, and they had been for many years, certainly – and from the high secure unit, which was located fairly – fairly close to The Park. But they had been going on leave for quite a number of times, and that included leave to any – that included ground leave or access to any part of the ground. At no stage did anyone notify that look, we have this person who is going on leave. Can you be careful of your adolescents? And I think that's because the – the psychiatrists in the high secure unit and the forensic unit assessed people very well before they gave them leave, and they were very cautious about the opportunities for things happening. Even just before we were about to close I can remember people from the forensic high secure unit being brought down past Barrett to have a – a cigarette, because they could just walk down past Barrett. They'd be officially off hospital grounds, and they would have – they could have a cigarette. But no one said look, we've got people – forensic patients coming close to your – your unit.

So I realise that you left the Barrett Centre on 10 September 2013. Up until that point though, had you been involved in any discussions about an assessment of risk with the patients remaining at the Barrett Centre, with the – with any changes that were occurring on The Park? Was there – were there discussions about risks?---No, there weren't discussions about at-risk, and, certainly – I mean, we always – we would advise adolescents just to be careful where they went on the grounds, and we would advise them, perhaps, not to go to the canteen or if they went to the canteen to go in pairs, just because the – the only adults with whom they had had difficulties were – were people from the dual diagnosis unit. So we were concerned from that perspective for the safety of the adolescent. I understood from the – from the Gantt chart, from the proposed opening of the unit at Redlands, from the latest available minutes in April 2012 that the changeover to – to Redlands was likely to occur in August 2014, and the EFTRU would not – would possibly be open in January 2014. So there was going to be a – quite an overlap, of seven months, when EFTRU was going to be open, when we'd have to co-exist with them.

COMMISSIONER WILSON: Ms Muir, it may be time to take the morning break. Would it be convenient for you?

MS MUIR: That would be convenient. Thank you, Commissioner.

COMMISSIONER WILSON: Alright. We'll come back at quarter past 11.

WITNESS STOOD DOWN

ADJOURNED **[10.56 am]**

RESUMED **[11.15 am]**

TREVOR BRUCE SADLER, CONTINUING

EXAMINATION BY MS MUIR

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

MS MUIR: Dr Sadler, just before morning tea you gave some evidence about difficulties with dual diagnosis patients. Was that – and I just wanted to understand what your evidence was about difficulties?---I remember, possibly on two occasions, an adolescent approached a person who was known to be aggressive, and I think one of them he hit in the back, the other one felt threatened and ran away.

And the other person, you mean, was an adult forensic patient?---Yeah – not a forensic patient, a dual diagnosis; so it was a combination of a mental illness and a intellectual disability.

Thank you. Now, I just want to ask you some questions about transition. So on one view, in the ordinary sense the word seems to mean moving patients from one service to another for clinical reasons, based on individual assessments. Would you agree that this period of transition is a known risk factor for mental health patients and that it could bring about a period of vulnerability?---Yes, I would.

When you're transitioning patients in the ordinary sense of the word, what procedures and plans were in place at the Barrett Centre to manage that risk and vulnerability?---So transition was a process that occurred over quite a number of months. So we would be providing the opportunity for the young person to attend outside activities, perhaps connect with a school, perhaps spend longer periods of time at home, perhaps commence a work placement. So all of those were part of the transition process. With respect to managing risk, there were a range of risks for adolescents with transition, and those that had experience severe trauma were most at risk of self-harm or injury, I believe. So that – we would help them to develop strategies to cope with the – with any distressing moments that they may have experienced in the community, we would develop safety plans with them, we would introduce them to an external provider who would then follow – thewy would be seen, and we would continue to support them after they had left the – or they were spending more time away from the centre than they were in the centre. We would be there to continue to offer support in various areas of their life, ensuring – and also ensuring that there was an adequate safety, that they had contact with a provider if they weren't able to connect with that particular provider.

Is – if I could take you to – well, firstly, in paragraph 142 of your initial statement your evidence is that there was no formal documentation about the transition process; that's at BTZ.900.001.0001 at 0028, and that's paragraph 142. can I just ask: why was there no formal documentation?---Because each transition process was separate. So there was a – just trying to think of it – it became involved in the model of service delivery, and I – transitioning to the community, but I think it talked in that – in that document about discharge. So each transition process was an individual process in which there would be continuing contact with community, there would be managing any symptoms and following through with – with who they would be followed up by once they're back in – in the community. But that would vary from patient to patient. So – and I have documented there the – the process – and I think it became part of our – our normal processes of transition that we had developed over the year. But we perhaps didn't think to document it as such.

In paragraph 43 of your supplementary statement – which his at DTZ.900.002.0001 at 0010 – you give some evidence of the process of cross-engagement with an authorised mental health service, and in the preceding paragraph you discuss the circumstances in which the Barrett Centre would resume services for a transitioning patient. And then if we go back to paragraph 147 of your initial statement – which is

at 900.001.0001 at 0029 – you say there that if the adolescent was to be transferred to a community service the phase of crossover engagement with the authorised mental health service was usually over a period of two months or more?---Yes.

What was the – what factors delayed this process?---So it depends on how the services that the receiving service had in place. It depended on the availability of the clinician, how they interacted with that particular clinician, what rehabilitation services may or may not be available for that clinician or to the – in that service. So much of what happens or happened at Barrett was built on developing relationships, and people needed time to transition to new relationships. They had found staff with whom they could discuss things at Barrett, and it's evident that whenever we – we refer someone to another person they may or may not connect well with that person when they first meet them. So they had – we had to gauge whether or not there was some capacity to engage with a new person from that service.

Just with share care arrangements, I wanted to understand your evidence, that there is a view once a patient is transferred from one service to another that the first service should no longer be involved in the patient's care so as to make room for the second service to develop a therapeutic relationship with the patient. And indeed, at paragraph 149 of your initial statement you acknowledge that this is the most common arrangement. But you do say on rare – and this is at .0029 – you do say that on rare occasions, adolescents would be discharged as inpatients or day patients, but continue as outpatients of the Barrett Centre?---Yes.

In what context would this occur?---So if they were finalising treatment, particularly – say, for instance, they had an anxiety disorder, they were able to function reasonably well, they may need to complete just some sessions with a psychologist over a period of months to complete and undertake those things with that anxiety disorder, and then be unlikely to need regular mental health care, but follow up via the general practitioner, our psychologist might see them for, perhaps, a couple of months afterwards, to allow that process to occur, rather than transition to a new psychologist and then having to – to establish relationships and maybe interrupt the process for a while.

And in what context then would a share care arrangement with another service arise in the context of the transitioning with patients at the Barrett Centre when you were there?---It would mainly occur if someone was reasonably local to our service. So we may – for instance, if they were involved with the Ipswich CYMHS we may involve them again in the provision of individual therapy prior to their leaving the centre, so that they – that became established, and they would become – they would spend more time out of the centre and have that relationship with the Ipswich Child and Youth Mental Health Service or one of the other, closer services. So where that was possible, we tried to implement that, and the person I referred to in paragraph 42: it seemed to be – offer [redacted] the best chance of [redacted] not driving [redacted] as far – which I've mentioned – and just – yeah.

We can ask those questions - - -?---Yes.

- - - in closed court. I can ask those questions in closed court. I just – there is a question that seems to – that has emerged from the hearings and the evidence, is that – and it's whether transitioning in the context of the closure of the Barrett Centre was a different concept than the usual transitioning, and – for example, was there extra planning required? Should formal guidelines have been developed? Was there a detailed evaluation and assessment of available placement and services needed? What – in your opinion, was there an issue that the transitioning of – in the context of the Barrett closing, was there a need for different considerations to be considered in the context of transitioning, in your opinion?---In my opinion, I thought that there were two aspects that were really quite vital, and they would – I was trying to consider a model of an interim service. And so that was based on that compromise option 3 that I had written with regard to utilisation of acute inpatient beds. So my feeling was that being able to just – if we could have provided a service that would have had provided some continuing rehabilitation – because I thought that was important – of some continuing contact with staff into the – into 2014, that they would have provided the context for them to then – for the adolescents to transition to other services. But when I left, that was no longer discussed.

In – I won't take you to your – a paragraph of your statement, but in paragraph 180 of your supplementary statement, you give some evidence about transition, and the focus was to ensure adolescents were as well as possible to reduce the effect of the ultimate transition. And insofar as well as is concerned, you also give some evidence that if the only services available to which adolescents can be transitioned have a lower capability to provide services, those developing the transition plans must include a component of improving wellness prior to transition so that the receiving service has the capability to manage the young person. So, Dr Sadler, when you left the Barrett Centre in September 2013, were you managing high levels of unwellness amongst the young people?---My recollection is that we were managing quite high levels of unwellness, people on continuous observations, people who had attempted suicide, people who were becoming quite distressed and withdrawing from activities in which they were beginning to engage within the community. So there was a lot of unwellness.

And we can ask these questions in the closed part of the court, but without mentioning any names at this point is it your evidence that there were patients who did not have the requisite wellness to be transitioned into receiving services without – with lower capability to provide services at the time you left?---I believe so.

I just want to ask you a question. If the witness could show you – be shown QHD.008.004.9683. Commissioner, I'm conscious of the time. I probably have another 15 minutes.

COMMISSIONER WILSON: Well, continue.

MS MUIR: Thank you. This is a guideline that was developed following the November 2014 release of the report by Associate Professor Kotzé and Ms Tania Skippen. That's the report Transitional Care for Adolescent Patients of the Barrett

Adolescent Centre. This is, I think, still a draft guideline. Have – or it might be final guideline – but have you had a chance to look at this guideline, Dr Sadler?---I had a brief chance last night, yes.

And it's – this guideline sets out principles and best practice elements for the transition of care of young people, and includes - - -

MS ROSENGREN: Sorry, just stop there. I see that Dr Sadler is looking for the hard copy of the document. I can – if I can just help in that regard, it's the – it's document 26. It's the very last document in the pile?---Thank you, Ms Rosengren.

Thank you.

COMMISSIONER WILSON: Thanks, Ms Rosengren.

MS MUIR: So you've had a chance to read this document, Dr Sadler?---I've read part of it, yes.

And it sets out some principles and best practice elements for the transition of care of young people, and includes a systematic and formal transition process, early preparation, identification of a local transition coordinator facility – facilitator, sorry – good communication, individual transition plans, follow-up and evaluation. My question is: do you agree that these matters are all very important to the transitioning process?---Yes, I do.

Are there additional matters that you also think are important?

MS ROSENGREN: Commissioner, if I can just seek some clarification on that issue, I think that Dr Sadler's evidence before was that he had read part of the document and he hadn't read the document in its entirety.

COMMISSIONER WILSON: Thanks, Ms Rosengren. Ms Muir.

MS MUIR: From what you have read of the document, Dr Sadler – and you may not be in a position to comment, and just say so – are there any additional matters, particularly of the practices that I had just set out to you – are there any other points or practice principles that you think are important to transitioning?---I wouldn't feel in a position to comment without reading and then considering the document.

Thank you, Dr Sadler. We can – I can move on. I want to ask you some questions about some of the new services. And I understand that you've now had the opportunity to review the subacute – the state-wide subacute beds discussion paper produced by – prepared by Children's Health Queensland; is that correct?---I've reviewed sections of it, yes.

And the Barrett Centre has discussed in this discussion paper at pages 20 to 23 – if we could go to CHS.500.001.0023.

MS ROSENGREN: That's document 7 for Dr Sadler?---Thank you, Ms Rosengren.

MS MUIR: And if we could go to page 20 of the discussion paper, and if you can see the last, quite lengthy paragraph on that page talks about assessment scores for Barrett Centre patients as described in a paper that you had co-authored with Paul Harnett and others in 2005, and these assessment scores are from a standard tool used across mental health services, known as a Health of the Nation Outcome Scale for Children and Adolescents, or, I think, HoNOSCA scores?---Yes.

Would you please explain to the Commission what the HoNOSCA tool measures and how it is used in Queensland Health?---Certainly. So the HoNOSCA tool is a tool with 13 major subscales and two minor subscales, and the major subscales are aggression, attention and concentration, self-harm and suicidal ideation, scholastic difficulties, physical health – yes, somatic type complaints, hallucinations, delusions, emotional symptoms, self-care, peer relationships, family life and school difficulties. There's one that I've missed amongst those, but – so it's – it's covered those – it covers a broad area of functioning of adolescents and then there – the two supplementary scales look at – consider parents' understanding of the adolescent and of their difficulties and also of the – the difficulties or – sorry – the – the information that parents have had, so – and we rate those on a nought to four scale. So nought is no difficulties, 1 is a minor difficulties, up to four where the – the difficulties are present most of the time in most situations, so whether it's emotional situation or hallucination or delusion, that'll be there most of the time if it's rated at four and then – and it's considered of clinical significance if it's rated two or three or four.

MS MUIR: So in this – the paragraph that we're at the Children's Health Queensland discussion paper notes that the overall HoNOSCA score of 15.86 at the time of the Barrett Centre admission was comparable to that of the young people accessing Australian outpatient clinics of 15.21. First, what would an overall HoNOSCA score of 15.86 generally indicate?---It would generally indicate that a person has just got a moderate disorder and so I – I would – if I can explain the context of that paper or - - -

Yes, Dr Sadler?---Yeah. So it was based on adolescents we saw between 2000 and 2002. The HoNOSCA score had just been developed in 1999 or – or published by – by Simon Gower, so it was a relatively new document and we were testing it out because it seemed to capture some of the complexity of across number – numbers of areas. The actual manual – the Queensland Health manual for – for the use of HoNOSCA was produced in 2003 and that's in the bibliography of the paper that we published. Now, when we did the training for the HoNOSCA we found that we were underrating quite a number of symptoms and so there is a document that I have in the list of documents, one of – in one of the appendices – I think it's page 100 of my second – or my first supplementary submission, which – and that was produced in 2007 and a HoNOSCA score in – in that – at that time was round about 23, 23.5 and - - -

Okay. We might see if we can find that because I was – my question was: that score from the paper that you did in 2005 did seem quite outdated - - -?---Yes.

- - - and I was wondering if there was more recent data, and you're – are you saying that there is more recent data in - - -?---There is more recent data, yes.

- - - page 100 of your – I'll see if we can get that reference up. So just while we're doing that, is a score of 15.86, then, typical of a Barrett Centre patient at the time of admission?---I would say it would be not typical. I would say most would be above 20 at time of admission.

And if we could just go to the last section of this discussion paper – sorry – of this paragraph. It talks about:

> *The total HoNOSCA scores for Barrett Centre consumers did not change compared to their intake scores when the tool was readministered at three months and six months.*

?---There was – yes.

Was that – is that a fair statement, or how would you respond to that, Dr Sadler?---That's a statement from the paper. I was just looking at a PowerPoint slide that we had and we presented to a – a seminar and there were people who stayed longer than six months and they had quite significant change over that period, so it may have been that when you looked at the whole cohort, that some of that significant change of those who would stay a longer term wasn't captured by the end of those three to six months.

You referred to a document that you – was exhibited to your statement, which was, I think, page 100, DTZ.900.002.0144. If we could just get that up and perhaps we can check that's the document that you're referring to?---Yes.

Okay. Can you explain, Dr Sadler, your reference to this page?---So my reference – these – these figures were compiled by the Service Evaluation and Research Unit at The Park and they were based on HoNOSCA scores that we were compiling as part of our outcomes measures. They – and so I – I – to – to get the figures that I mentioned I summed the – the average so the – so that first score, which is the aggression score – I thought the reasonable figure there was 1.75. I couldn't actually get a data chart to add all of these scores up, so the – the top graph indicates the changes or the – the – what the HoNOSCA score was on admission and the bottom line represents what they were on – on discharge.

What period of time are we talking that this diagram relates to?---So it would've been – I think I prepared it for the Australian Council of Health Service accreditation in about 2006, 2007. So it was probably three or four years after that – the initial data that we published.

You made a reference to outcome measure?---Yes.

What were you talking about insofar as you collected data - - -?---So – yes, routinely we – we administered the HoNOSCA score. We did the strengths and difficulties questionnaire. We did the CGAS, the Children's Global Assessment Scale, which gives a score of – a global score, a single digit – well, single figure score of where they are functioning in terms of their overall functioning and also the factors influencing health status and that often captured a lot of complexities in the young person's family environment.

And where would this – where was this information kept?---So it was entered on computer into the CIMHA system, the Consumer Integrated Mental Health Application system.

We have heard about that system?---Yes, yes.

So entered in - - -?---So it was entered in – into that at the time of the care planning meetings, yes.

So is that – how frequently do you say that that information was recorded on the CIMHA records?---So it should've been recorded on admission, and I don't think when I went to look at figures occasionally that – I don't think there was necessarily good or 100 per cent compliance with doing it on admission, but certainly every two to three months after that and on discharge when we had our care planning meeting we would revisit the – the various scores and outcomes.

And do you say that was occurring right up to when you left in September 2013?---Yes.

COMMISSIONER WILSON: So I just want to understand where those records are. I know the CIMHA records exist?---Yes.

But did you use those records to produce any sort of reports that were presented at the meetings or - - -?---Well, we could review the previous notes, so they're on – we clicked the "outcome" tab and then we could select a – say, a previous date, for instance - - -

Yes?--- - - - to look at the CIMHA record and it would – would be graphed on that for – for that date, so the HoNOSCA scores would be graphed, the – the strengths and difficulties questionnaire – there were five subscales for that and that would be graphed and so we could review if there was significant change.

So these graphs were on the computer?---Yes.

I see. And were they saved, do you know, or - - -?---That was just part of the CIMHA system.

I see. Thank you?---Yes.

MS MUIR: Dr Sadler, moving on now to paragraph 66 of your supplementary statement at DTZ.900.002.0001 at 0015, you state that:

> *My observations of adolescent wraparound service stems from my involvement with Evolve clinicians and the clinical services I provided to Logan Evolve.*

Are you aware of the eligibility criteria for the Evolve services?---Yes, I am.

And is it the case, Dr Sadler, that the Evolve services are only available to adolescents that are known to the child protection system?---That is true.

If wraparound care is only available in this context would you expect there to be a gap in service for those adolescents that are not known to the child protection system but nevertheless require a service such as this?---Yes. There would be but my – when I stated that I had the – the intention not that – that child safety would be involved or needed to be involved but that just a comprehensive array of services could be put into place for a particular person, say, as they are for – for child safety and that's - - -

Now, have you had a chance to review the business case for the development of the statewide adolescent mental health extended treatment and rehabilitation model of care, version 4, which was prepared by Children's Health Queensland and it's dated July 2014. There's no need to go to this document yet. It's document 25 but no need to go there at the moment, Dr Sadler. If I could you, firstly, to paragraph 172 of your supplementary statement of 12 February which is DTZ.900.002.0001 at 0041. Now, just summarising, you say that the AMHETI service elements individually or as a continuum are not an adequate replacement for those adolescents with severe and persistent anxiety disorders, eating disorders and complex trauma which, as you explain elsewhere in your statements, were a significant proportion of the patients at the Barrett Centre. You then go on to elaborate on your reasons for this in paragraphs 174 to 177. Just as briefly as possible could you just summarise your position on the adequacy of the AMHETI service elements individually or as a continuum for the Barrett cohort of patients?---I think, just briefly, the – it's – meeting the needs of the Barrett cohort of patients which is the – the area in which I had most difficulty because I think that either you had extensive clinical experience in that area. If you lacked that clinical experience to provide alternate services to know exactly who you're providing a service for, I mean, I think the – the services are good for different sub-populations of adolescents but the question is whether they meet the needs of the sub-population that was at Barrett. And if you haven't got the personal clinical experience you would then ask clinicians and I just would say a range of clinicians who were involved with that cohort of adolescents. Most importantly, you would sit down with the adolescents and the parents to say here is the range of – of services that we have. How would this have been for you had you been in these services and they could have provided feedback for that. I'm not aware if that happened or not. But I do think that you need to have that level of

involvement. The literature itself is not a good guide because we're talking about, say – when the literature is looking at studies, it might look at a severe end of the group and that might be the most – the five per cent most severe. The ones who attended Barrett might be the .05 per cent of the most severe so that they might be one in 100. Within the literature that one in 100 gets missed in the day to day – in – in the overall analysis in the literature and certainly when I looked at the statewide subacute beds discussion paper and I saw the literature that was referred to within that paper I had concerns that – that these – they weren't identifying the cohort that was at Barrett.

Have you had the opportunity – they were identified as documents for you to read – the statements of Ms Myf Pitcher and Mr Ivan Frkovic from the community organisation Aftercare which provides the youth residential services in Brisbane and Cairns. They were two statements - - -?---Yes. There was two statements. I was given them last night and just trying to read to read through those – I didn't get around to reading those statements last night, I'm sorry.

You haven't had a chance to read - - -?---No. I haven't had a chance.

Well, perhaps I can take you to them. Commissioner, these statements, I think, need to be tendered. They're not in evidence yet. Could I – perhaps if I could give the numbers. The statement of Ms Myf Pitcher is at ACA.900. - - -

COMMISSIONER WILSON: Slow down, would you. ACA?

MS MUIR: ACA.900 - - -

COMMISSIONER WILSON: Yes.

MS MUIR: - - - .0001 - - -

COMMISSIONER WILSON: Yes.

MS MUIR: - - - .0001.

COMMISSIONER WILSON: Yes.

MS MUIR: And then Mr Ivan Frkovic's statement is ACA - - -

COMMISSIONER WILSON: Yes.

MS MUIR: - - - .900 - - -

COMMISSIONER WILSON: Yes.

MS MUIR: - - - .0002.0001.

COMMISSIONER WILSON: Does anyone have any objection to my receiving those statements at this stage? Mr Duffy.

MR DUFFY: Well, I'm just puzzled. I don't know whether I've ever seen them. I might have and I just can't readily identify whether I have or not.

COMMISSIONER WILSON: Well, I can't tell you for the moment - - -

MR DUFFY: I know that.

COMMISSIONER WILSON: - - - whether they're in the data rooms.

MR DUFFY: I know that. I'll just have to do some searches and see.

COMMISSIONER WILSON: Ms McMillan, what's your problem? Do you have a problem?

MS McMILLAN: No, no, no. I was just clarifying when they came into the data room. That's all.

COMMISSIONER WILSON: You have got them?

MS McMILLAN: Yes.

COMMISSIONER WILSON: Well, I'll assume in the data room, Mr Duffy, and I'll receive them at this stage. They'll be given exhibit numbers in due course.

MR DUFFY: Thank you.

MS MUIR: Were you aware of the youth – are you aware of the youth resi services?---Yeah, I am aware.

And are you aware of the service that these youth resis provide to young people?---I am aware to – to a limited extent.

Well, perhaps if we could go to paragraph 33 and 34 of Mr Frkovic's statement which is ACA.900.0002.0001 at 0007. So here Mr Frkovic explains that the youth resis are part of the extended treatment and rehabilitation continuum of care but the extended treatment and rehabilitation components are delivered separately but in a coordinated manner over a period of up to 12 months. And the resi focuses on the psychosocial rehabilitation while the clinical treatment is provided by the Queensland Health case managers mostly through community CYMHS clinics or adult mental health services so - - -

COMMISSIONER WILSON: I'm sorry, Ms Muir. I must be missing something. I thought you, in reading it, said that the components of the model were delivered

separately but in a coordinated manner over 12 months but what's on the screen doesn't say that.

MS MUIR: If we got to 33 and 34, if we go down - - -

COMMISSIONER WILSON: I can't see the 12 months.

MS MUIR: Sorry, that's – I withdraw that, Commissioner. That's my error.

COMMISSIONER WILSON: If you could take it slowly with the witness. Bear in mind he hasn't read this before.

MS MUIR: Yes. I may move forward.

Given that you haven't had the chance to read these statements, Dr Sadler, if – I know during the time at the Barrett Centre there's evidence that you were anxious to have some Step Down facilities available?---Yes.

So my question is do you think what you know of the youth resi services that such a service would have been an appropriate Step Down option for some of the Barrett cohort.

COMMISSIONER WILSON: Well, just pause there before answering it. Shouldn't you establish what he knows of the youth resis before asking a question like that?

MS MUIR: Commissioner, I had asked some.

I will go back, Dr Sadler. Can you just tell us what you do know about the youth resis?---I have experience of transitioning [redacted]

UNIDENTIFIED SPEAKER: Stop - - -

MS MUIR: Perhaps there might be – this may need to be dealt with in closed court.

COMMISSIONER WILSON: Dr Sadler, I'm sure you know that we've gone to great lengths to preserve confidentiality of patients' affairs in this Inquiry - - -?---Yes.

And any time a witness feels it necessary to deal with a particular patient, we're asking to be alerted to that - - -?---Sorry, Commissioner.

- - - so we can close the hearing. Now, if you think it would be better for you to be able to talk about a particular patient, the hearing can be closed. But if you think you can answer in general terms you can do so in open hearing?---Okay. Yes, Commissioner. I would say that I have some experience of – or some knowledge

from hearing of the program and talking with the program director of what that program involves.

With that experience in mind, are you in a position to comment at all – and you may not be – as to whether, from what you know, such a facility would have been an appropriate step down option for some of the Barrett Centre - - -?---It would have been a dream facility to have.

And are you able to comment at all whether this dream facility, as you – to have had – sorry – would have affected some of the lengths of stay of the Barrett Centre?---It certainly would have. I – when I cleaned my office, I had written my first letter requiring a facility for young people to stay who couldn't return home in 1992. I recall speaking to Mr Frkovic in late 2010, 2011 or writing an email to him, suggesting that there be a step down unit as part of a Redlands model. I – it was absolutely essential, I believe, for young people who, for one reason or other, decided that they couldn't live home to have this strong supported accommodation.

In paragraph 155 of your supplementary statement – and we don't need to go there – you say that you visited the YPARC facilities in Frankston and Dandenong with Dr Stathis and Ms Krause. And your evidence is that this model was not suitable to the Barrett Cohort. Why do you say that?---I can refer to the document, but my – the reason is that the length of stay was 28 days, the – they – they did not take people who self-harmed who were on an involuntary treatment order, which some of our adolescents did. They – they had a – relied on community rehabilitation and community contact, and that would – whilst we did that for some parts of our program, it wasn't – so for all of our program, the level of staff supervision wasn't as high. So without referring to my letter, that's the things that I recall.

And your letter is in evidence before the - - -?---Yes.

- - - Commission at QHD.014.001.0054, but I think – what I would like to take you to is paragraph 27 of Dr Stathis' supplementary statement of 15 January, which is DSS.001.002.001. Dr Sadler, just to give you some context, the Commission understands - - -

MS ROSENGREN: Sorry, it's document 20 for Dr Sadler?---Thank you. Yes.

MS MUIR: Dr Sadler, the Commission understands that in planning for the Step Up Step Down Unit, Queensland Health has made some changes to the YPARC model to make it more suitable for the younger age cohort in Queensland, and it's – Judi Krause and Dr Stathis have summarised these changes in their supplementary statement. Now, in paragraph 27 of Dr Stathis' supplementary statement he – and that's paragraph 27; DSS.001.002.001 at 0009 – and Dr Stathis notes that the Step Up Step Down Unit will have a maximum stay of three months, compared with the one month for YPARC, will have some capacity to accept referrals from outside the HHS catchment area. And without going there, can I tell you that Ms Krause also says in her statement at paragraph 26 that the younger lower age limit for the Step

Up Step Down Unit model is 16 years, and requires a higher staffing ratio, an increased focus on family visiting spaces and an increased focus on family therapy interventions. If you were to take – accept those and take those matters into account, would you reconsider your assessment of the suitability of the Step Up Step Down model for the Barrett Centre cohort of patients?---My – I can identify people who I think would be suitable for this model, but they would not have been admitted to Barrett.

Can I take you to an email from Bruce Faraday from the Mental Health, Alcohol and Other Drugs Branch to the other members of the branch and the AMHETI project team, and this is at QHD.027.001.0169.

MS ROSENGREN: Document 22?---Thank you.

MS MUIR: This email, Dr Sadler, is in relation to scoping work being done for the youth mental health commitments committee, which is considering options for implementing the government's election commitments under the rebuilding intensive mental healthcare for young people. The email indicates the committee is considering two options. Option 1 is 22-bed facility based on the aborted Redlands plans, and option 2 is to establish three smaller seven to eight-bed facilities instead, with South Brisbane, North Brisbane and Logan identified as possible sites. To the extent that you can, do you have any views on those options for the Barrett Centre cohort?---I have proposed that the – the core should be the treatment and rehabilitation program, and the focus should not be on beds. I would have concerns about a 22-bed unit; I think that is large. When I proposed a model for redeveloping Barrett in the very early stages, I proposed a model that a smaller or actual inpatient component, but a residential component for – for those people who could not access, say, a day program because of distance in their locality and just convenience, and who were safe to do so, to live in a house where they could do many of the things themselves. And so I – without looking at these models in detail, I couldn't give good – a good opinion on either of those models or which of those would be better, but I would have concerns about a 22-bed unit. I do think there is, perhaps, a third model that could be considered.

COMMISSIONER WILSON: So this third model you're talking about - - -?---Yes, Commissioner?

- - - in the broadest of terms, is that partly a Barrett-type centre and partly a youth resi-type centre?---Partly that, yes, Commissioner.

Thank you?---It would provide though the – the treatment and rehabilitation program that we provided during the day for the day programs, and – and that was a critical aspect. And – and – and I – my model was how do you access that? You know, can you access as a day program – day patient? Do you need an inpatient stay, or could you stay in a house? Are you safe enough to stay in a house? So there's a variety of ways. And so in that point of view, it may be more consistent with the – with a smaller model.

Thank you.

MS MUIR: Commissioner, I just have two more questions in open court for Dr Sadler, and that is in paragraph 187 of your initial statement – and we don't need to go there – you talk about evidence-based practice. And I just wanted to understand – and you talk about the difficulties experienced in evaluating the efficiency of the Barrett Centre. What – can you just explain what the difficulties were in evaluating efficiency? Perhaps if DTZ.900.001.0001 at 0037 - - -?---One of the - - - - - - paragraph 187?---One of the issues as to, you know, whether we were getting adolescents well as quickly as possible, whether we were over-treating, for instance, or doing over-rehabilitation, I don't believe that we were. But – and I – and the other issue, what are the facts – factors which would ensure they spent the least amount of time in hospital and we treated them as well as possible? And for that, I consider that stable staffing was a critical issue, that we must have stable staffing that knew adolescents, that were trained with adolescents to deliver the services that were needed to enhance those parts of them that were unwell.

I suppose my question is more towards the evaluation and – and it's just a difficult process?---It's a difficult process and I don't know that I have an answer to that, Ms Muir.

Was there an expectation or a requirement at least that the Barrett Centre conduct some ongoing research or outcome evaluations in order to produce an evidence based – for its model of care and to evaluate the efficiency of the Centre?---That's an expectation of a clinical services capability level 6 service. Our capacity to do research was really quite limited. And although on The Park, for instance, we had the Queensland Centre for Mental Health Research, we had the Service Evaluation and Research Unit, the – we found – I found – I approached staff from both of those on a – or several occasions about various research projects and found it difficult. We then got a research project going with the Mater child – or Kids in Mind with regard to social anxiety disorders.

That project that you're talking about, when was that?---That was 2012, if I recollect.

So if I understand your evidence otherwise, that insofar as research and evaluation was concerned, was funding an issue?---Funding and staffing were issues to conduct research. And I think certainly Dr John McGrath who is the leading researcher commented that unless you have funding for research within services, there is no – the capacity of services to fund research is very limited, or do their own research and evaluation.

COMMISSIONER WILSON: Is Dr McGrath at The Park?---Professor McGrath.

Is he at - - -?---He – sorry.

He's at The Park, is - - -?---He's at The Park. Yes, Commissioner. He's in the Queensland Centre for Mental Health Research.

MS MUIR: So any funding, do I take it, was ad hoc funding which is something like the project you talked about in 2012 with the Mater?---Well, Mater had more capacity for research and they were interested in research with children and adolescents. And I had known the Director of Research there, Dr Bill Bor, for many years. So I used those networks. And we were able to engage students, so masters and doctorate psychology students from UQ – sorry, QUT – to assist with the research project.

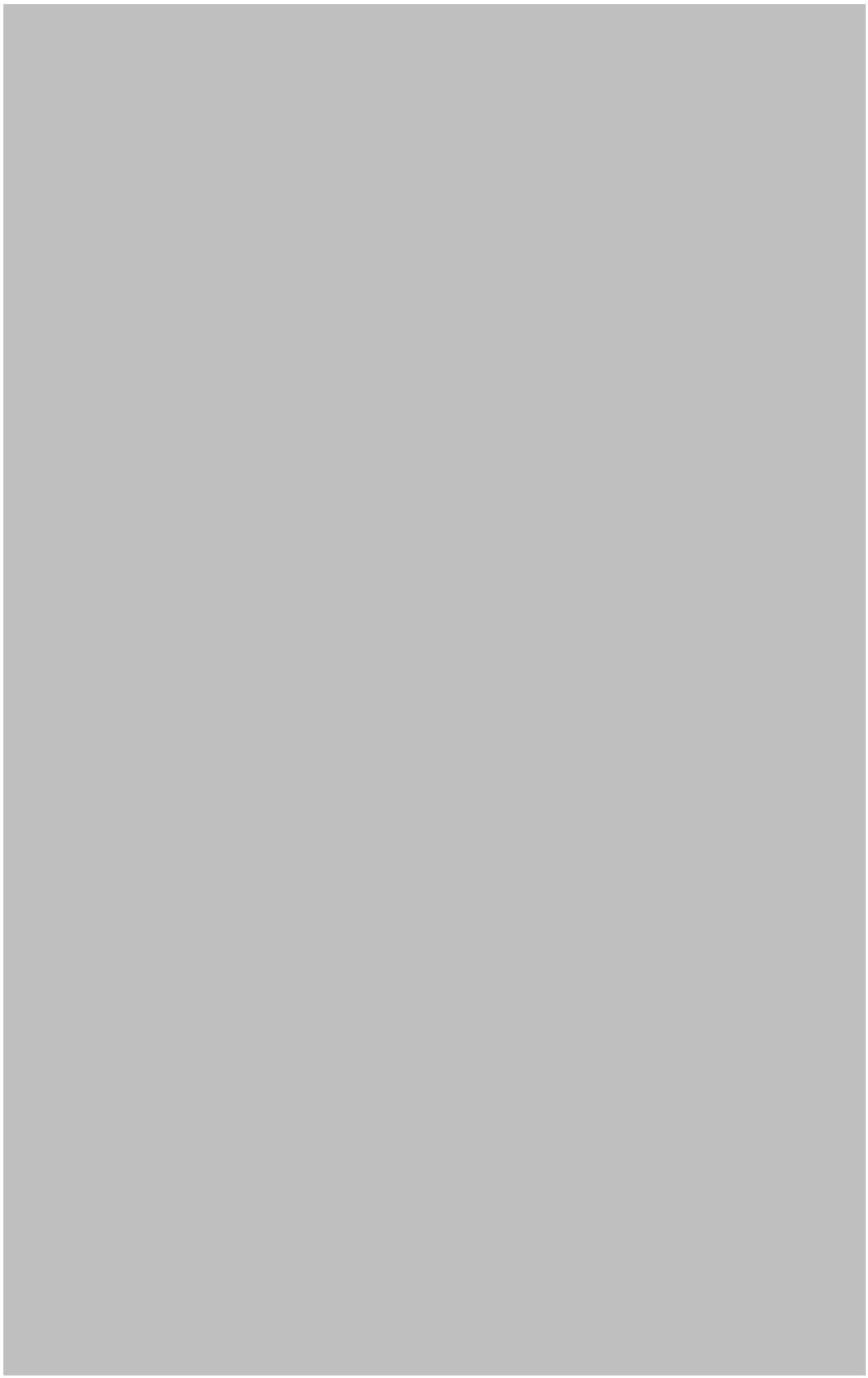
I just want to take you back to a document, WMS.0012.0001.19826. And this question is nothing to do with the services, it's just something that I wanted to clarify with you. And this is part of a – some notes from a West Moreton Hospital and Health Service board meeting dated 24 May 2013. And on the second page of this document there's reference to bringing in a senior clinician to support transition and closure, funds available for this. And the Commission has heard some evidence that the senior clinician that this document refers to is Vanessa Clayworth. And my question is – and I understand the evidence is that Vanessa Clayworth was promoted to a clinical nurse position – was promoted in October 2013. My question is simply, were you aware of any plan to bring in Ms Clayworth in May to help you with the transition?---No.

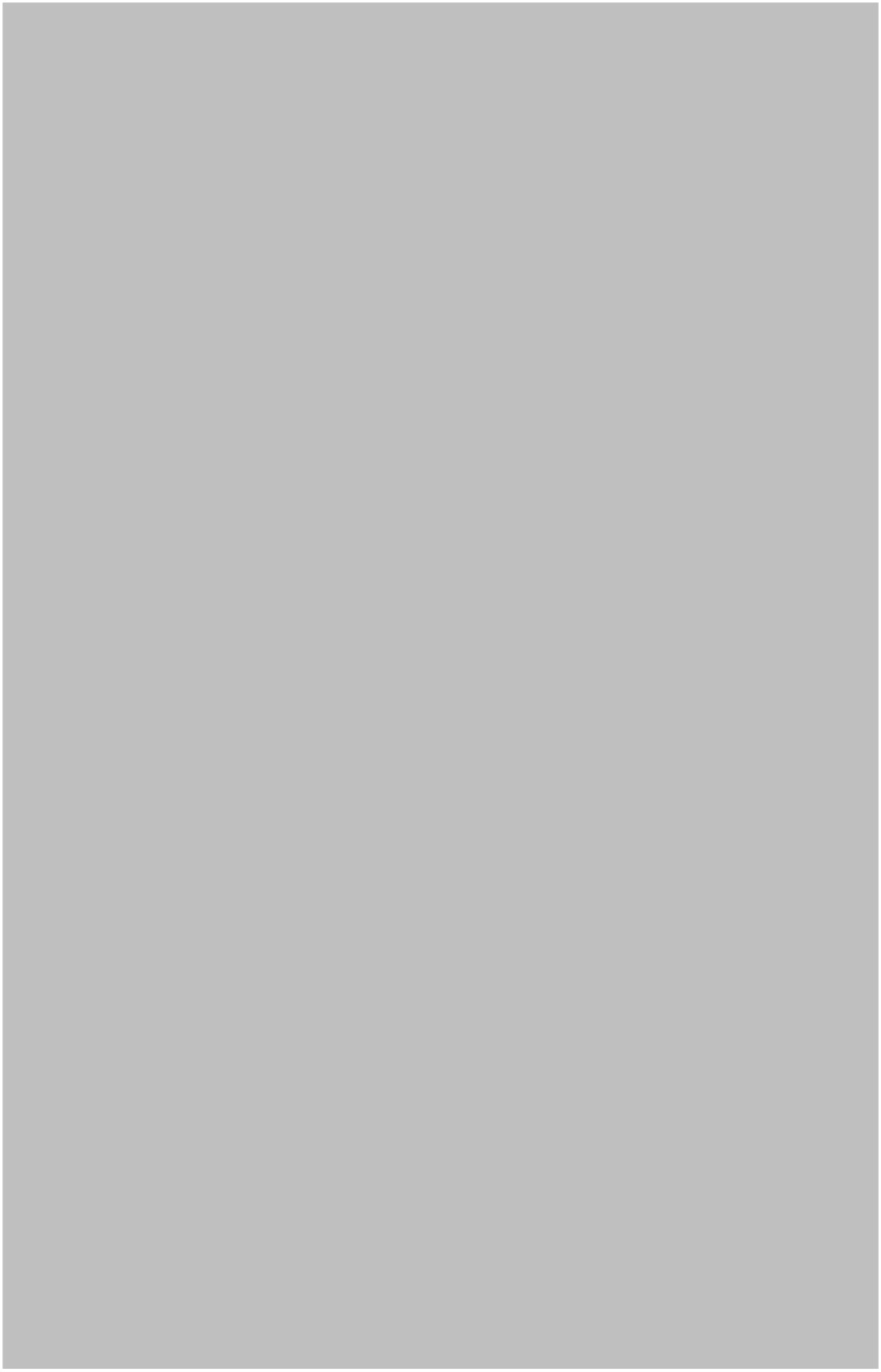
Commissioner, I have no further questions in open court for Dr Sadler.

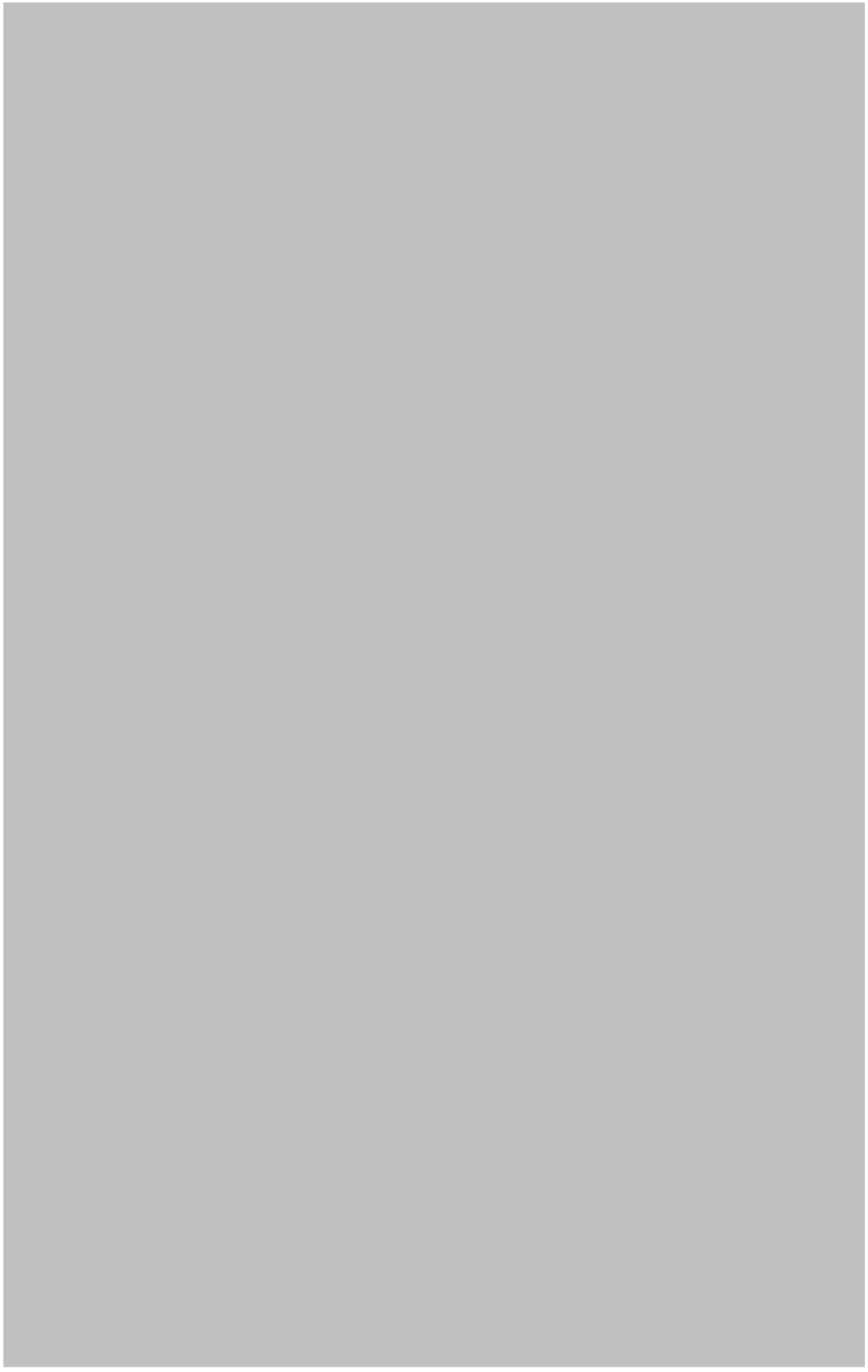
COMMISSIONER WILSON: How long will you be in closed hearing?

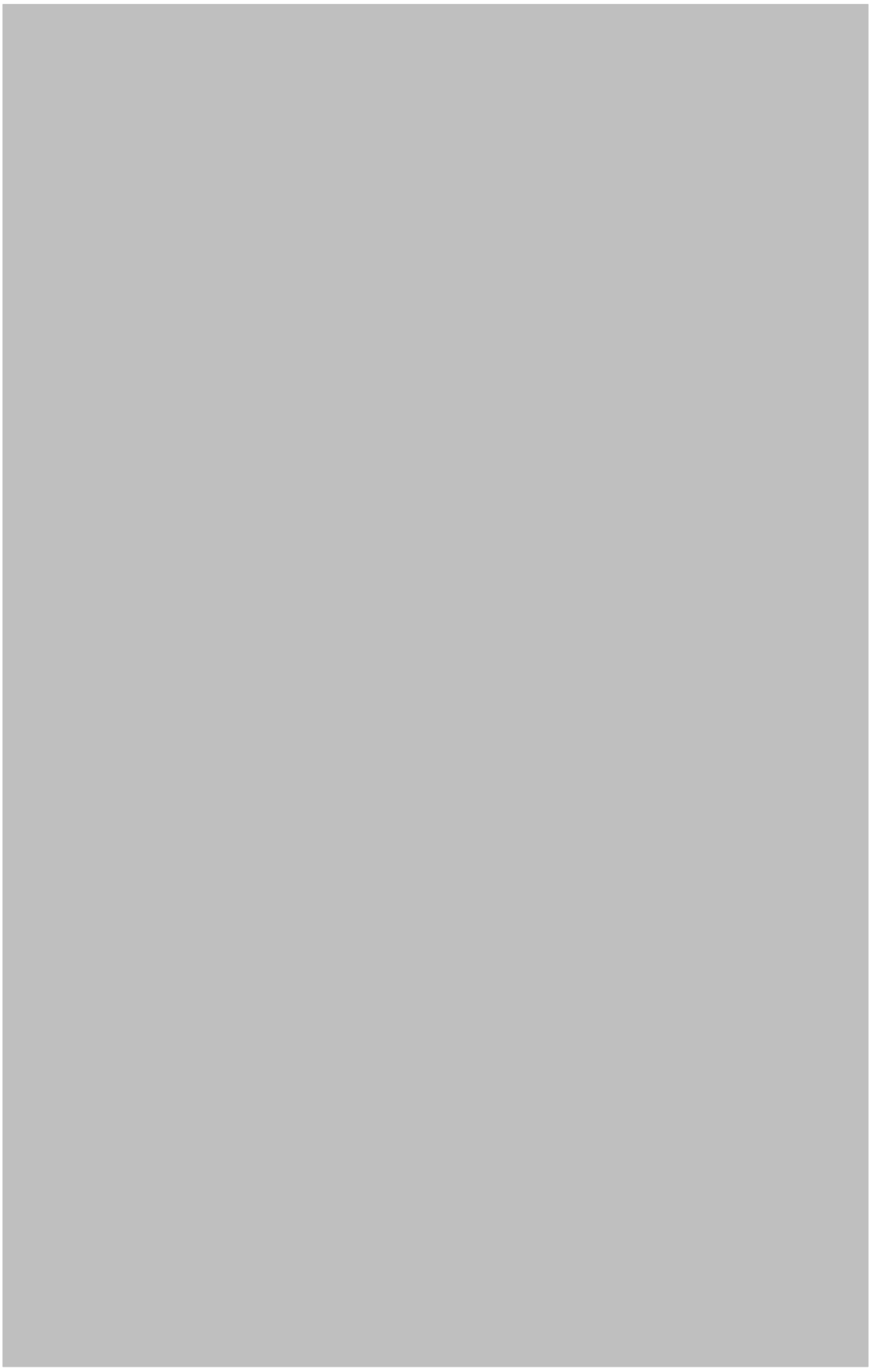
MS MUIR: I think about 15 minutes.

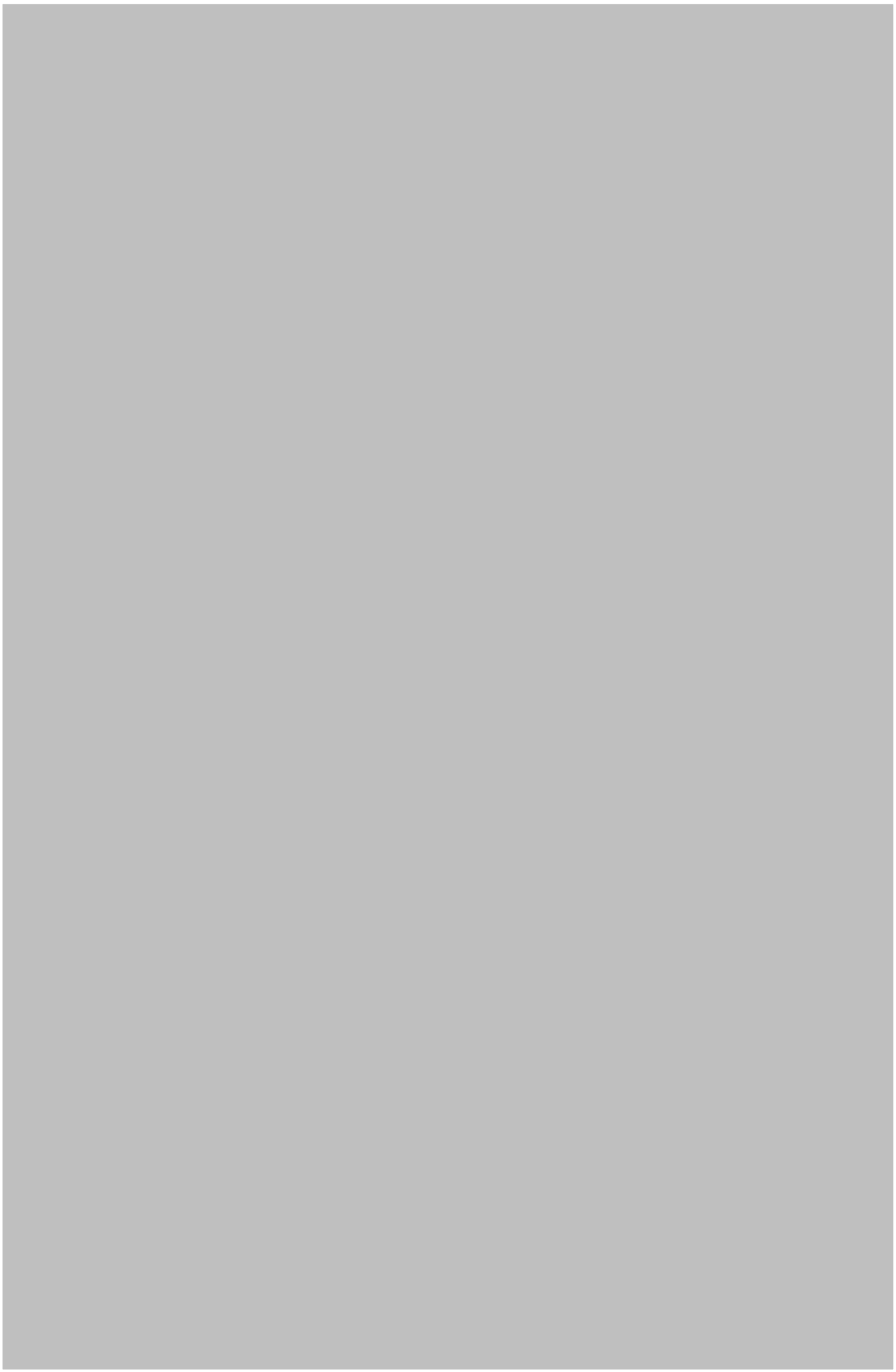
COMMISSIONER WILSON: Well, I think it's probably most efficient to deal with that now. Does everyone agree? Very well. The hearing will be closed. The live streaming must go off and those in the courtroom who are not immediately associated with the matter will need to leave, so unless you're legal practitioners or parties with leave to appear.

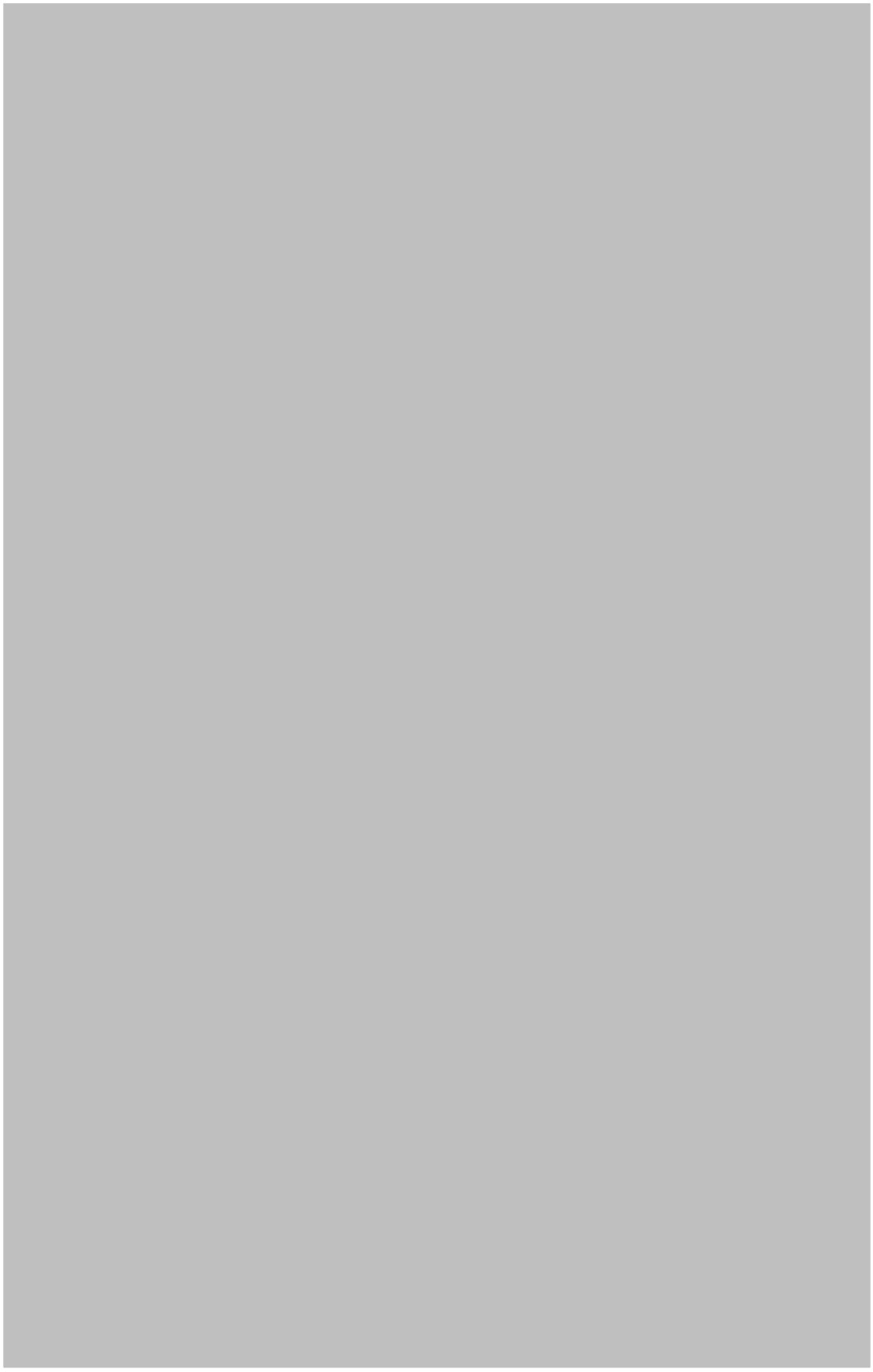












COMMISSIONER WILSON: Alright. Could the hearing be opened, please, Mr Bailiff. The livestreaming can come on and people can come back into the courtroom if they wish. Just give them a moment, Ms Wilson. There's usually a bit of disruption while they come - - -

MS ROSENGREN: Can I just alert you at this stage – there may be one question that I do seek to explore in closed hearing with Dr Sadler.

COMMISSIONER WILSON: Well, you're acting for Dr Sadler - - -

MS ROSENGREN: Yes, I am.

COMMISSIONER WILSON: - - - so you'll come at the very end.

MS ROSENGREN: That's right. I was just concerned about opening and closing and opening and closing the court to make sure that you're satisfied with the process.

COMMISSIONER WILSON: Well, save it up and don't let me forget.

MS ROSENGREN: Thank you, Commissioner.

MS McMILLAN: I have matters in closed, as well – as well as open so I'll alert you.

COMMISSIONER WILSON: Thank you. We'll deal with your questions first, Ms Wilson.

MS WILSON: Thank you, Commissioner.

EXAMINATION BY MS WILSON [12.34 pm]

MS WILSON: Dr Sadler, my name is Elizabeth Wilson and I represent the State of Queensland. Can I – I just wanted to clarify a matter. Ms Muir took you to your third statement which is DTZ.900.003.001. Okay. So that's your third statement and can we go to the second page which is paragraph 5 which we'll – now, you see this – and you were asked some questions about, you know, these were the models of service for the Barrett Centre. Do you recall that?---Yes.

Now, can we just go down to (l), which is paragraph 5(l), which is the ATRC draft MOSD, final draft, and it looks like that is 20 May 2012?---Yes.

Okay. And correct me if I'm wrong: I think you suggested that that draft that we see in paragraph – that's set out in paragraph 5(l) best – that you suggested that that draft best reflects what was the model of service for Barrett?---Yes.

Okay. Now, can I take you to this document to see if that's the document you're referring to, and that is it's attached and marked A, the following copies, and there was one – there's one exhibit A and there's just a whole lot of documents in order, Commissioner. So I just want to make sure this is the document you're referring to, which is DTZ.900.003.0174?---Yes.

Okay. Now, you've seen that document before, Dr Sadler?---Yes.

Now, perhaps if we can – just so we can get a wide view of the document, so the doctor can see what the whole front page looks like, can we just go – okay. Now, is that the document that you're referring to in paragraph 5(l)? You might need to scroll further just a bit. Now, we've got a date down here: 17 February 2016 in the footer, but, obviously, must be when it has been accessed or something in the recent future – in recent times. Doctor, does that - - -?---Yes, that seems similar. I mean, there was a lot of wording in each document, and that looks familiar.

Right. The draft model of service – we can go to the footer – the draft model of service, which is the CNY sub-network BAC review work group: is that the name – is that what the AETRC was called?---I'm not sure what – because if we look at the footer, we see here:

> *BAC Review Work Group: Additional Questions for Trevor Sadler by Bernice Lindic.*

?---Yes. I – I – I mean, I wouldn't know if that was – that was presumably on the original document. I – I can't remember it. I can't remember who Bernice Lindic is. And – yeah – I didn't understand the coding used for a lot of documents.

For the group which is titled the BAC Review Work Group, is that the work that Judy Krause's group was doing?---No. I don't know – I'm not sure. Like, whether this was the child and adolescent day program and that's – that was a child and adolescent day program review work group, and then the same people reviewed the BAC model of care. And whether they called it a different name I – I really don't know.

Okay. Perhaps have a look – is this the document that you drafted? Do you say this is a document that you drafted?---Well, I had a considerable input - - -

Okay?--- - - - into it, yes.

Is – I'm just trying to make – to sure, because I don't see any reference to BAC in the document, except at the footer, and I don't want to take up a lot of time of the Commission for me to go through it. So I'll just see if this rings a bell – in fact, you can assist the Commission – was this document not developed specifically for – as a Barrett Adolescent Centre model of service, but rather in relation to the Redlands program?---It was developed for whatever program would be there in the future. These documents were visionary. Certainly, it reflected better what happened at Barrett, but the general term was adolescent extended treatment rehabilitation centre, and if Barrett did close at any stage, Redlands seemed unlikely, this would still be a document that applied to that.

So perhaps we can get clarification. Now, do you have any view that there is a gap in the alignment of adolescent and adult mental health services in Queensland?---I believe there is.

Okay. And is the best way to address any gap that we – that a process needs to be undertaken to determine what services may be required to address this youth patient group in Queensland, that is, a service mapping exercise?---I think that is a good idea, as long as it's broad.

As long as it's?---As long as it's broad, of - - -

Broad?---Yes.

Well, an exercise, just for example, which could identify the similarities and differences between current services available in child and youth mental health services vis-à-vis adult mental services; do you - - -?---Yes, I think that those things – what I think is – is really necessary is – is – is just to identify what is it that – that your patient needs, what type of service does - - -

Yes?--- - - - your patient need, and then build up from there.

Identifying the service needs for specific age groups, for example 13 to 18, 16 to 21, 18 to 25?---Not only that, but I've got a patient with these characteristics. Is this service suitable for them or not?

Okay?---And I think – yes.

But this is a service mapping exercise, to be able to take a holistic view to be able to look at what services may be required vis-à-vis need. Do you accept that that service mapping exercise is a good idea?---I'm – I'm distant from policy things, and I come as a clinician. And so when I think of services that needing to be developed, I start off with a patient, not with the types of service.

Okay. Now, do you have any view about whether there's any potential gaps with respect to young people who experience mental illness with a co-existing disability, like a dual diagnosis in the services available?---May I ask when you say dual diagnosis, the term is used in two contexts: one is a mental illness with either intellectual impairment or developmental – neuro-developmental difficulty, or the other is used of a mental illness with substance use.

I'm looking for the former?---And I think there are difficulties for both of those populations. I think services could be better developed for both of those populations, particularly those with neuro-developmental difficulties.

And then in the same light then, perhaps then a service-mapping exercise would be useful to look at these issues as well?---Yes.

Thank you, Commissioner.

COMMISSIONER WILSON: Yes, Ms McMillan.

EXAMINATION BY MS McMILLAN [12.43 pm]

MS McMILLAN: Yes. Thank you. Dr Sadler, can I just ask you some questions initially. If we look at – and I'm asking you in a general sense – handover or a date of handover, I take it that is part and parcel of a process, isn't it?---Yes.

And what I mean by a process is, isn't it, that it happens progressively, so it involves imparting of information to, obviously, a receiving service, doesn't it?---Yes.

It also includes issues related to the referral, correct, to them?---Yes.

The acceptance by them?---Yes.

And that transition process?---Yes.

Right. Okay. So is that a fair – and please tell me if it's not – summation of what a handover is?---I would include an introduction and support to attend the service as well.

So, if you like, a referral, in a sense, to say this is this patient and they need these types of services?---Yes.

Is that what you mean?---Yes.

Right?---So - - -

Okay. Thank you. Now, Doctor, you heard Dr Breakey's evidence, I take it, did you?---No, I did not.

Right. But if I tell you, in effect, his evidence was that you start planning for discharge with patients – and I'm talking about the adolescents here at Barrett – from day 1; is that correct?---I didn't do that, partly because – (1) is that we had to know about them and the more we understood them, the – the more we understood what were the difficulties that they were facing, so I couldn't envisage – I – I – I mean, my process of transition was we will get these people well and what do we need to get them well, but - - -

Right. But as I understand it it's correct, isn't it, that on, effectively, admission and even in the pre-admission there should be some foundation laid, say, within your intake in relation to their eventual discharge. Now, it may not be detailed because, as you say, that may evolve over time, but you would have some foundation, wouldn't you?---We – we absolutely have some expectations that this young person will be discharged and that they are likely to go back to a certain service.

And that would be done at admission?---That's our – our expectations. We don't have a formal plan at admission - - -

Right?--- - - - because that plan can change considerably.

I understand things can change?---Yes.

But did you hear Professor Hazell's evidence?---No, I did not.

Right. But as I understand, say, with the Walker and Rivendell, part and parcel of any admission is that transition is immediately planned for back into services that can scaffold around the patient. Would that be a fair understanding of it?---Well, that – that's certainly our expectation and that's what – yeah, that that transition will occur.

Right. But are you saying that transition will occur, but you wouldn't have, at least at around the time of admission, specific services in mind?---We – we would have specific services in mind.

And they should be present in patient records?---I think in – in most instances the – referring services, the – is the most common – is – is the one that's there and there should be a – an initial care planning document drawn up. Yeah.

Right. So someone such as in Dr Brennan or Ms Clayworth's position should be able to pick up a patient record, to looking at transitioning a patient and say, "Right. I see that the services being looked at", for instance, "are identified"?---I think by the time they had been there a while that that would – that original document would not be of any particular relevance. I mean - - -

Right. And what do you mean by a while; over a year?---Well, some – some of them had been there for six months, some over a year by that particular time. Yes.

And some, we know, were there up to four years, weren't they?---I can't remember any of the last group of adolescents being there four years.

But it was the case, wasn't it, that the longest stay of any patient there was four years?---Yes.

Thank you. Now, I want to ask you some questions about the – excuse me. And I take it that if the initial admission details about supporting services became out of date there would be updates through the notes, wouldn't there?---Yes.

Right. So that would – that would be found in the patient records?---So there were – prior to the intensive case work-up or care planning work-up there – there were notes from all of the clinicians compiled to look at the summary and then there was a record of that contact with the receiving service.

So there would be updates, what, regularly in the records about appropriate services that - - -?---There should be updates every two or three months.

Every two or three months?---Yes.

Right. And they would be updated, as I understand, as, for instance, more services became available?---Yes, or - - -

That would be one example?--- - - - plans changed for a particular adolescent.

Right. And that might have to do with their family of origin or other issues – that you might need to change that?---Might have to do – it might have to do with a change of location.

Yes. Alright. Thank you. Now, I want to ask you about the models of service delivery. This is annexed to your statement on 17 February 2016. My learned friend Ms Wilson took you to this. Paragraph 5, please, which is DTZ.900.003.0002. Now, you say these are what you term as copies of the various models of service for Barrett; is that right?---Yes.

Right. But as I read down, after (g) the terminology is AITRC; correct?---Yes.

And would you agree that the import, that is, the contents and the direction of the documents from 2009 are quite different from those contained in (a) to (g)?---They are.

Right. And is it quite likely that they were being worked up in terms of the process associated with, at that time, Redlands?---Most of the reason for the change was that there was a new template from the Mental Health director - - -

Right. And so, just so I understand, is from (g) on what was being worked up in this new template, as you've referred to it?

COMMISSIONER WILSON: It would be from (h) on, wouldn't it?

WITNESS: (h) on, I thought - - -

MS McMILLAN: (h). I'm sorry, Commissioner. I misled you by that – my lines [indistinct] sorry?---I think from (h) on was the start of the new template.

Right. Well, so, for instance, at page 0073 of that document – and if we scroll down to the bottom, please – you'll see this appears to be the 2009 plan, that is, (h). Would you agree with that?---Yes.

And you'll see the author is L. Geppert. That's Leanne Geppert, as you would know it?---Yes.

And she at that time wasn't part of Barrett or West Moreton, was she, in 2009?---No, she wasn't.

She was part of the Mental Health branch, wasn't she?---Yes.

Alright. So again so I can just clarify this, (a) to (g) are specific Barrett related?---Well, they – they were models – yeah, they – they were models of service for Barrett.

Barrett?---But they – the – at that stage, by the time of – they were being finalised we – we had been through the site options plan. It was known that Barrett was going to be rebuilt and – but a final site hadn't been decided on, so I think it was round about this time that the site option was chosen and it became clear that we needed to drop the name Barrett.

Right. So but you don't contend, do you, that Redlands was Barrett transplanted?---There were many aspects that Barrett – no, I mean, certainly we – we lacked the day program.

Well, but apart from that there were – because the whole point, wasn't it – there was a template being worked up for what was a more contemporary model of care for Redlands, wasn't it?---I believe that what was worked up was – was, in actual fact, a

– was a process of continuing improvement. I mean, I don't think that it was a more contemporary model of care, for – for example.

Right. So – alright. Well, you just say it was an updated – was it an improved model that was being worked on; is that right?---We were required to put it into a new template, so that required discussion and there was this broader discussion about – okay, now that we're moving to Redlands and – and I – if I put it into some context, it was after the Walter report came out, and you'd be aware of that.

The 2009 review?---2009 report.

Yeah. Doctor, can I just bring you back to my question. I'm just not clear. So, as I understand it, the documents (a) to (g) are largely authored – they're authored by you, aren't they?---In conjunction with – I'm just trying to think of her name from the Mental Health branch. I mean - - -

Is this Ms Best that you referred to before?---No, no.

Right. But – yes, and so from (h) onwards that was part of a process that you're aware Professor Crompton's given evidence about, this model that was being contemplated for Redlands?---Yes.

Right. Okay. So in terms, then, of these models of service, if I could go to, first, page 0005. And just satisfy yourself that appears to be the first draft model of service; correct? If I tell you it's immediately after your *Oaths Act* declaration - - -?---Sorry?

Sorry, Doctor. Did you say something?---No, I was just trying to page that it was located on.

Yes. It's page 1 of the annexures to your statement?---Right.

COMMISSIONER WILSON: This is the third statement, and it's exhibit A; is that correct?

MS McMILLAN: This is – no, it's not the first statement. It's the statement of 17 February.

COMMISSIONER WILSON: Yes.

MS McMILLAN: Third statement, I believe?---Yes.

Right. Have you got that, Doctor?---Yes.

Now, that was a model of service of which you were the author?---I can contributed to it, but as I said it was this person from the mental health directorate who wrote a lot of this, I think.

Right. So if we go onto page 6 of that document – and it'll be page 2 for you, Doctor – please go down to planning, the heading Planning, if you scroll down. So just read that to yourself, "Currently, BAC"?---Yes.

That was your view, was it, that BAC did not feature in the glossy view of the Queensland Plan for Mental Health?---Yes.

Right. If we go over two pages, to page 9 – or I should say three pages; page 5 of the annexures – if we go down to expected clinical outcomes and we scroll down to the last line, "Chart below gives blah blah blah", there's not a chart that I can find following that, is there?---I'm not aware of a chart.

No. If we go to the - - -?---And that's not my style of writing.

Sorry?---That's not my style of writing.

Alright. But this is a document that you annexed as being models of care for Barrett, isn't it, models of service?---They were all the documentation that I had.

Thank you?---So I provided that to the Commission.

Can we go to page 10. This is the second iteration, it seems, B, which is 12 February 2009. Page 10. So it's 0014, I'm sorry; I gave you the annexure number, rather than – so this is the 2009 iteration, it would seem; correct?---Yes.

Right. Over onto page 15 – which is page 11 for you, Doctor – scroll down, please, to planning, and it's still – it contains that again, doesn't it? Doesn't accord with the – doesn't feature in the glossy version; correct?---Yes.

Right. That was still your - - -

COMMISSIONER WILSON: Sorry. Where are you, Ms McMillan?

MS McMILLAN: Page 15 of the Delium document.

COMMISSIONER WILSON: I've got it. I've got it. Thanks.

MS McMILLAN: Yep. And could we go back up to the top, please. You see average length of stay to be filled in, wasn't it?---Yes.

And so – just so I understand, this – these documents – you understand for a model of service to be endorsed needs to be endorsed by the branch; correct?---Yes.

And the reason – is this your understand, that it needs to be – apart from anything else, is that it's consistent with state-wide appropriate practices?---Yes. Yes.

Well, that would make sense - - -?---Yes.

- - - wouldn't it - - -?---Yes.

- - - because you're meant to be – Barrett was meant to be part of a continuum - - -?---State-wide, yes.

- - - or a state-wide - - -?---Yes.

- - - service. So the mental health branch is, if you like, the gatekeeper in terms of understanding and having policies that are consistent with a state-wide rollout; correct?---Yes.

Right. So that there's nothing here, is there, that this was ever forwarded to the branch, any of this iterations for endorsement, is there?---Perhaps not that it was - - -

No, but is that true?---The iterations for endorsement may not have been. It was developed – I remember meeting in the branch with a staff member.

And prior to it being sent to the branch, it would be quite usual, wouldn't it, to have any model of service peer-evaluated, wouldn't it?---That's right.

Right. And so if we look, by comparison, with the panel or committee, I can call it, in relation to, loosely-termed, Redlands, that was – and you were one of them – a group of eminent clinicians, wasn't it, amongst other people?---There were eminent clinicians among those people.

Yes. Yes. And that's the sort of thing that you would expect to be worked up, if I can put it that way, for a model of service?---Yes.

Right. So that, again, you had the learning, and again, some consistency of practice from an array of clinicians; correct?---Yes.

Right. Thank you.

Keep an eye on the time, Ms McMillan.

MS McMILLAN: Thank you. I'm happy to stop at that point for the moment.

COMMISSIONER WILSON: Now, I seem to recall Ms Mellifont wanted us to return at 2.30 today. Is that still the case?

MS ZERNER: Your Honour, I can respond on her behalf. It would be after 2.30, so it doesn't have to be. It was just that she wasn't available until at least 2.30, your Honour.

COMMISSIONER WILSON: Well, we'll adjourn until 2.30 then.

WITNESS STOOD DOWN

ADJOURNED **[1.01 pm]**

RESUMED **[2.31 pm]**

TREVOR BRUCE SADLER, CONTINUING

EXAMINATION BY MS McMILLAN

COMMISSIONER WILSON: Ms McMillan, before you proceed with your cross-examination, I'd like to get some idea from all of the parties as to how long they think the cross-examination will take this afternoon. I say that, because there is the discussion to take place about the Terms of Reference, and I think it's important that adequate time be allowed for that and that it be done today, even if the - - -

MS McMILLAN: Yes.

COMMISSIONER WILSON: - - - cross-examination's not finished.

MS McMILLAN: I will probably be about another 30, 35 minutes. I understand the only other person to cross-examine is Mr Mullins for the patients. I'm getting a hand raised by - - -

MR McMILLAN: I expect I have about five minutes as well, Commissioner.

COMMISSIONER WILSON: Thanks, Mr McMillan. How long, Mr Mullins?

MR MULLINS: Ten minutes, your Honour.

COMMISSIONER WILSON: Alright.

MS ROBB: I'm on the list, Commissioner, but at this point I don't have anything. But something may arise.

MS ROBB: Thanks, Ms Robb. Now, what about you, Ms Rosengren? How long do you think you'll be?

MS ROSENGREN: I – it's a little bit difficult to estimate at this stage, but I'm going to say 10 to 15 minutes.

COMMISSIONER WILSON: Well – and I don't know whether Ms Muir will have any questions. We could say an hour and a half, roughly.

MS ROSENGREN: I would imagine certainly, that will accommodate.

COMMISSIONER WILSON: So that will take us until 4 o'clock. How long is the discussion on the Terms of Reference going to take?

MS McMILLAN: We're trying to narrow it further, so for our purposes 10 minutes. I mean, we're hoping it might be basically resolved, but don't want to get too optimistic.

COMMISSIONER WILSON: Is everyone of the view that there's a prospect of it largely being resolved?

MR O'SULLIVAN: I think you'll have to exercise your own judgment about it. I think you will have to hear some submissions and turn your mind to it, but there's no doubt about that. We're attempting to reduce the issues to a document that you can engage with and make decisions about, and what we're hoping is that – I think what my learned friend is thinking: if we can give that to Ms Muir and she can turn her mind to it, it may be that the parties can come to you with only very narrow issues that separate them. But you still will have to exercise your judgment, Commissioner.

COMMISSIONER WILSON: Thanks, Mr O'Sullivan. Mr Diehm, what's your attitude?

MR DIEHM: I've got a couple of issues that arise out of what – the document that was circulated last night via email. They will only take about 10 minutes to deal with though, I think, Commissioner.

COMMISSIONER WILSON: Is everyone still of the view that that needs to be dealt with this afternoon?

MR DIEHM: I think it should be, Commissioner. Yes.

COMMISSIONER WILSON: Very well. On that basis, I'm going to stop the cross-examination this afternoon at quarter to 4 to allow a short break, and then start the discussion of the Terms of Reference at 4 o'clock. I understand from what Ms McMillan said earlier in the day – and I think someone else – that the cross-examination couldn't finish today anyway.

MS McMILLAN: It's possible, yes. As I say, I need to obtain some instructions.

COMMISSIONER WILSON: Alright. Well, let's proceed for the moment - - -

MS McMILLAN: I'll do the best I can, yes.

COMMISSIONER WILSON: - - - but it finishes at quarter to 4, and we'll see where we go at quarter to 4.

MS McMILLAN: Thank you, Commissioner.

MS MUIR: Commissioner, could I just ask – raise one thing, and that is if there is a document that Counsel Assisting should look at before 4, Mr Freeburn is coming across for the argument, so perhaps if it is ready earlier, before 4, then we can – if it could be provided to us that may assist.

COMMISSIONER WILSON: Alright. I can see Mr O'Sullivan nodding, so I'm sure he'll do his best. Yes, Ms McMillan.

MS McMILLAN: Yes. Thank you. So, Doctor, I was asking you just before the lunch adjournment about the models of service delivery. So I just want to make sure I understand. So there was never an endorsed model of service delivery for Barrett; correct?---I believe not.

No. And, in fact, the most it got to was a draft?---That may be right.

Well, that is right, isn't it?---Right.

I mean, that's what you've annexed to your statement, and I've taken you to it. That is right, isn't it; they were marked draft?---I'm not sure what – I can't recall what was taken to the state-wide CYMHS advisory group, for instance. But, certainly, the second one, the 2012 one, was just a draft.

Yes. But you accept that all of them are marked draft, aren't they?---Yes.

Right. Thank you. Now, Doctor, would it be correct to say that, looking at your statements, that you see yourself, really, as an advocate for the Barrett model?---I worked there for a long while. I see myself for an advocate for adolescents at the most severe end of the spectrum.

Right. But you became involved yourself in Save the Barrett campaign, didn't you?---I – I had some – well, I – I signed a – an online petition.

Yes?---Yes.

Alright. So – but you'd accept, wouldn't you, reading your statements, they very much appeared to promote what you regarded as the Barrett style of care; correct?---The best parts of that style of care.

Okay. Thank you. Now, you say in your statements that you attended to – that is, you implemented – recommendations of both the 2003 and 2009 reviews;

correct?---Well, certainly, I implemented the 2003 reviews. I had significant concerns about the 2009 reviews.

Alright. Well, we'll come to that in a minute. Can I just take you to 2003. Can the witness be shown DTZ9000020184; Doctor, it's annexure K to your – I believe it's your second statement, and it's at page 140 and following.

MS ROSENGREN: Yes, that's the document. Thank you.

MS McMILLAN: Doctor, you have that there?---Yes.

Alright. So this is – am I right in saying that, according to your statement, this is your response to the 2003 review?---Yes.

Right. And I see that – so you're familiar with it, obviously, the document?---Yes.

And so recommendations are down the left side, response, action items, responsibility and timeframe. Now, responsibility, obviously, indicates, does it, who at Barrett was to have responsibility for implementing those recommendations?---Yes.

And in the – timeframe appears in the last column, doesn't it?---It does.

And that was when it was to be actioned by, was it?---Yes, I imagine so.

Right. So, for instance, recommendation 1: the response was qualitative and experiential evidence has been collective and shows that young people with conduct disorders do not have good outcomes within the BAC environment, but that conditions such as – and it's blacked out – do have good outcomes. So that was a response, was it, in part?---Yes.

But, Doctor, you'd accept, wouldn't you, that, in fact, after recommendation 6 there is no one attributed with a responsibility to carry out the recommendations, is there – I'm sorry – down to recommendation 11, and then it only appears for two recommendations; correct?---Yes.

And there's no timeframe, is there, given after recommendation 1?---No.

Right. So that's the document that the Commissioner should look at in terms of understanding your implementation of the review; correct?---Yes.

Thank you. Now, I want to take you, please, to the 2009 review; that can be found at JKR.9000010467. Would you like the document number again? Document 21, Dr Sadler, I'm told you should have?---Thank you.

And it's at point 0467. Right. Thank you. Doctor, do you have it? No?---No.

Alright. Well, I can ask you some questions about it. Doctor, just have a look at that and perhaps if it's scrolled down to the bottom. Do you recognise that as being the 2009 review?---I do.

Right. Thank you. Now, you say you had reservations about that review. Correct?---I did.

Right. And was it, in fact, that you took your staff offsite while that review was being conducted?---Our staff were booked to do a recovery intensive when that - - -

Yes. But can I just ask you - - -?---Yes.

They weren't onsite for the review?---Most of our staff weren't onsite.

Okay. And I take it you made no alteration to their schedule to ensure that they were there?---The recovery seminar had been booked for some months. And that review was decided upon, I think, just several weeks beforehand. To have altered the seminar would have been very difficult because people were coming from North Queensland and other places.

Alright. Now, can I take you to page 0480 of that document, please?

COMMISSIONER WILSON: Ms McMillan, before you take the witness to the document I want to clarify which copy of it you have. I say that for this reason: my understanding is that the report itself is about 18 pages. But there are various copies in circulation that have commentary inserted.

MS McMILLAN: This is just the 18 page one.

COMMISSIONER WILSON: Alright.

MS McMILLAN: And it's the one I'm - - -

COMMISSIONER WILSON: If it's just the 18 page one, it's okay.

MS McMILLAN: Yes. And I'm referring to the annexure to Ms Krause's statement.

COMMISSIONER WILSON: Alright. Thank you.

MS McMILLAN: That's the Delium reference I've given. So if we then go to page 0480, please. Right.

Doctor, if we just scroll down so you can see, these appears to be the recommendations of that review. Would you agree?---Yes.

Now, can I just take you to some of them:

(2) That clear inclusion and exclusion criteria be formulated.

Now, that was a theme, perhaps not worded in the same way, that was present in the 2003 review, wasn't it?---Yes.

Right. Number 8, please:

Agreements with local acute mental health facilities with regard to transition.

So that was a recommendation. Did you act upon that?---Where it was appropriate, yes.

And will we find that in a document somewhere?---No. It was on a case by case basis.

Continuing:

(10) That the length of admission and planned discharge date for prospective admissions be agreed upon by referrer and BAC staff prior to admission.

The length of admission was an issue, wasn't it, in terms of the 2003 review?---Yes.

Right. And was that attended to, this recommendation?---No.

Eleven, read that to yourself. If we can just scroll down. Was that implemented?---I didn't think it was realistic to be implemented.

Continuing:

A firm agreement which will have an ongoing role in the patient's management.

Well, I asked you some questions before lunch. You understand that that's a feature, for instance, of the Walker and Rivendell Units?---Yes.

Paragraph - - -

MS ROSENGREN: What number was that one, sorry?

MS McMILLAN: Eleven. Thirteen, if you read that to yourself. That would seem, one would think, a sensible recommendation?---Yes.

Was that implemented?---No.

No. What about 14?---It was certainly our aim to limit the stay but there were circumstances beyond our control at that time which made it difficult.

Right. So that recommendation itself wasn't implemented? Sorry, I'm just – I asked you, is that right?---No.

No.

MS ROSENGREN: Is that 15?

MS McMILLAN: Fourteen. Fifteen, was that implemented?---Part of that was implemented in the care planning workups.

And I take it from what you said earlier in your evidence that it was your expectation there would be some record in the patient's notes about issues related to discharging. Correct?---Yes, at times.

At times. Sixteen, was that recommendation implemented?---No. I certainly tried to meet with key staff from the Statewide Child and Youth Mental Health Service. I addressed forums and that was the – I mean, those statewide networks were the main networks at which these issues could be addressed.

But, Doctor, it's not just for you, is it? It says the staff. So it's the staff with key referring agencies. It's not just you, is it, that recommendation?---It's not just me.

No. And that would be important, wouldn't it, for other staff to know what other agencies are available and obviously have a dialogue with them, one would have thought?---It is important. And, certainly, on a case by case basis the - - -

Right?---Yes.

Seventeen, was that recommendation implemented?---No.

No. Then can we go down to treatment evaluation. Can I ask you to read recommendations 1 to 5?---Yes.

Yes. And were those recommendations implemented?---Routine use of standardised measures was already in place at the time of the review.

Right?---Additional specific measures for specific disorders, as I mentioned in my response, eg, depression rating scales were already in place at the time of the review. Regular use of patient and parent carer satisfaction surveys were not used. I was looking on the Quality Network for Inpatient CAMHS forum from the UK to see if there were instruments that they had that were available.

Okay. What about otherwise, three to five?---Affiliation with an academic unit. As I've mentioned, I tried to establish connections with the Queensland Centre for Mental Health Research. I tried to – well, I wrote to Professor Graham Martin with regard to self-harm and suicide and I was eventually successful in linking with the Mater Kids in Mind research unit.

Alright. What about five?---No, we didn't.

What about:

Regular use –

at number 3 –

of patient and carer satisfaction surveys.

?---That's the one I explained. I was looking for satisfactory survey from the Quality Network for Inpatient CAMHS to get a reasonable survey.

In the UK?---In the UK.

Did you contact the mental health branch here for assistance?---No.

No. And you see above there it says:

There appears to have been negligible evaluation of treatments delivered by BAC.

Would you accept that?---Certainly in terms of formal evaluation, it was one of the issues that we continually had a difficulty with. We would have liked to have been able to review the HANOSCA scales and see what was happening and undertake with those. We would have liked to have post-discharge reviews so to get an idea in three months and six months of what was happening.

Now, those about nine recommendations I put to you in the page before, continuing onto that page, you say they weren't implemented. At first blush, they would seem to be pretty sensible, pragmatic recommendations, wouldn't they?---Sorry, you'll have to take me back.

The recommendations, if we scroll up the page before. For instance:

Clear inclusion and exclusion criteria be formulated.

That had been a thing in 2003?---I believe that that was done, that we did have clear exclusion criteria.

I thought you said that hadn't been implemented?---Well, it hadn't been implemented inasmuch as it was already in place. So I had significant issues with this review, which I address.

Where are your reservations documented, Doctor?---There's - - -

Sorry, the inclusion criteria. Where is that documented?---So that was subsequently documented in the model of service delivery. But there were documents within Queensland Health that were developed in 2003 which clearly outlined the inclusion criteria.

But sorry, I – perhaps we're at cross-purposes. I'm asking you in terms of a clear inclusion and exclusion it was raised in 2003, you've agreed. Is it correct that you can't point to a particular document that would indicate that that was formulated?---There is a particular document. There is a document within – that was submitted to the statewide child and youth mental health – I think it was the – it wasn't a – a clinical meeting at that stage. It was documented in 2003 and there was an acute beds model and a – an extended treatment model with an admission and – or - - -

This was Queensland Health?---Queensland Health.

But – right. But I think you'd already agreed that your iterations of the model of service delivery up to and including 2009 did not sit aligned to the Queensland Mental Health Plan, did it?---The Queensland – sorry, I'm unsure of the question because is that the glossy brochure that you were – referred to.

Well, you've termed it that way. That's the Queensland Mental Health Plan. I took you to that before.

MS ROSENGREN: I object to that. I don't he did say he termed it as that. I think he indicated that the document – there was someone from the directorate who was involved in compiling it and he had some active input into it but he never has – he hasn't given any evidence to say it was – that was his terminology of it.

COMMISSIONER WILSON: Ms McMillan.

MS McMILLAN: No, he accepted that that was a term he would use. He may not have authored - - -

COMMISSIONER WILSON: I don't recall that - - -?---No.

- - - I'm sorry.

MS McMILLAN: Sorry?

COMMISSIONER WILSON: I don't recall that.

MS McMILLAN: Well, I do. Very well. I'll put it to the witness again.

The glossy Queensland brochure as you've just termed it, that was a term you were comfortable with, that you had used?---It was a term that was there. This was a draft model and there was some - - -

Can I just - - -?---Probably – I mean - - -

Would you just answer that question?---Yes. Well, I – I don't know if I was comfortable with it or not. There was some light-handed – light-hearted stuff in developing the draft model.

There was a what?---This was 2009. I - - -

Alright. So what we read in those model service delivery – what that included light-hearted statements such as:

> *Currently BAC does not feature in the glossy version of the Queensland Plan for Mental Health.*

?---Yes. That – that's right. And then you'll notice that comment blah, blah, blah. These were draft models. They weren't intended to be the final model but they were models that I had on my – that I was asked for by the Commission.

Now, in terms of the 2009 recommendations I've just put to you, would you accept that the ones – as I've put to you – they seemed pretty sensible and pragmatic recommendations, don't they?---Certainly, the – I mean had reservations about recommendation 5 – agreements with local acute hospitals for assistance in the management of the physical sequelae of self-harm. That was certainly an agreement that we tried to put in place on numbers of occasions with numbers of hospitals but to do that required a higher levels of agreement than I could – than I was responsible for. Recommendation 6 – agreements with local - - -

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

Five, did you seek those agreements with local acute hospitals?---We sought them but I mean I'm only a low-level person within the hospital.

Right. So – but in particular I took you to two, eight, 10, 11, 13, 14, 15, 16 and 17. Do you want to say anything about those recommendations?---Two - - -

MS ROSENGREN: Can you say the numbers again, please.

MS McMILLAN: Yeah. Two, eight, 10, 11, 13, 14, 15 16 and 17?---Could I just scroll up to eight, please. Thanks. So the agreements with the local acute mental health facilities with regard to the transition of adolescents in the care of BAC to care in adult mental health services. At the time of this review there were two adolescents who would go into another adult service. Those - - -

Perhaps - - -?---Sorry.

Are you going to be talking about particular patients?---No. But I'm just saying it was an uncommon thing that we needed to have agreements with acute mental facilities. There were - - -

Although – yes. Sorry, finish your answer?---There were times when on a case by case basis we negotiated the transfer of a patient into an adult mental health facility and – but in terms of formal agreements all I can do as a clinician is – is make arrangements with the ongoing clinicians. I am not in a position to be able to draw up agreements. That occurs at a higher level.

Although if you wanted to I take it you could escalate that through to the mental health branch, couldn't you?---If we needed to, yes.

Yes. If you wanted to seek their assistance to implement, for instance, these recommendations that was obviously open to you to do so?---Yes. I would have taken that up to Dr Stedman.

You would have – up to who?---To Dr Stedman, the – my - - -

So you say - - -?--- - - - director of clinical services.

- - - you have or did?---If – if there were issues, I would have.

Alright. Thank you. Right. Now, you were involved in what might be called the Redlands project – perhaps that's one way of terming it – weren't you?---Yes.

And you formed part of – and I'll be going, Commissioner, to document JKR900001.0455. Just while I get that up there, you remember, don't you, this was a number of meetings that you see from the document on the screen, Doctor, to review models of service delivery. These took place in 2010, didn't they?---Yes.

And you see the chair was Judy Krause. You were an apology for the meeting on 10 February but if we just scroll down we have Penny Brassey. She's obviously a similar position to yourself albeit at Townsville?---Yes.

Present we have the statewide principal project officer CYMHS, Judy Krause, Dr McDermott. You'd accept he's an expert clinician in this area – child and adolescent services?---Yes.

Dr Scott, similarly so?---Definitely.

And Dr Michael Daubney?---Yes.

Alright. So can we just scroll down. Now, just as this time while I'm asking this, you went overseas for some holidays, didn't you?---I went overseas to look at – at adolescent inpatient units - - -

Alright. Okay?--- - - - in the UK.

In any case, you still had contact with them via email, didn't you?---Yes.

And you had your feedback incorporated. Correct?---I believe so.

Yes. Alright. Now, just scrolling down the minutes, you got copies of these minutes, didn't you? You were sent copies - - -?---I – I would have imagined so.

Right. Okay. Now, in terms – you have read Ms Krause giving an overview in terms of the review of Barrett and what that had effectively turned up. You see that at the bottom of the page?---Yes.

And then over the page. Correct?---Yes.

Alright. And then I want you to go to JKR900.001.0458. You've seen this document before, Doctor?---I may have. I can't remember.

Then if we go to document 0461. This was another meeting of that panel or committee in relation to 19 February. You were still overseas, I gather?---I was.

Alright. And you've seen those minutes before?---Presumably. I – I cannot honestly remember seeing the minutes. I may have.

Alright. And I want you to go to .0463. Scroll down a bit, please. See James Scott? You read that before?---Yes.

Would you accept that as being correct – that proposition?---No, not necessarily.

No. Right. Okay. Thank you. Now, could we go to the document 0485. Doctor, this is a letter sent by Ms Krause to Dr Crompton. You know who Dr Crompton is, don't you?---Yes, I do.

And you would've seen this letter, I take it, which enclosed the draft model of service delivery for the AETRC?---Yes.

You've seen this before?---I believe so, yes.

Right. Just if we scroll down and where it starts "there are a range of recommendations" – just read that to yourself. That's, then, consistent with your understand of the process – that there'd been a range of recommendations about a continuum of care?---Yes.

And to that effect, a six month period in most cases?---Yes.

And if we look over the page, please. Scroll down to the paragraph "as you're aware" . Now, just read that paragraph to yourself, please, Doctor?---Yes.

Yes. So down to the words:

Trevor is critical of the six month treatment timeframe.

Does that – that addresses what your concerns were?---I felt by that time the adolescents we were seeing were more complex and that they were taking longer than six months - - -

Sorry. Can I just stop you there. Does that reflect what your input was?---Yes. Yes.

Thank you. And then it says:

The group notes is, equally, no evidence for a one to three year admission.

Now, do you accept that that was discussed and you understood that to come from, if you like, the deliberations of that group?---Yes.

Right. Did you take that on board – that there was equally no evidence for a one to three year admission?---I did.

Alright. So I take it you would've addressed that quite seriously, given the eminence of the other clinical clinicians on that panel or committee; correct?---Yes.

Thank you. And it is correct, is it not, that in relation to the Barrett site itself at The Park you referred, I think, early in your evidence to the site – you understood it not to be appropriate. You've had a look at the site options paper for the redevelopment of the Barrett Adolescent Centre, October 2008?---Yes.

Could the – could it be brought up, please. It's QHD.020.001.1122. Doctor, while we're waiting for that to come up I might read to you – this is under The Park site options conclusion:

Although the existing and planned forensic services at The Park significantly impact on the feasibility of this option, there are understandable incentives to retain the current adolescent centre location. The service has enjoyed the development of an experienced cohort of staff, formulation of effective local partnerships.

Does this sound familiar to you?---Yes.

Continuing:

Both are critical to the service model. They key strength of redeveloping in the same location is the inherent support this offers in sustaining the existing culture, expertise and partnerships.

Do you remember reading that?---Yes.

Now, over the page – and this is .1123 – it says:

> *As stated, the close proximity of the site to the growing high security and extended treatment forensic programs compromise this option. Redeveloping the unit in close proximity to mentally ill offenders is likely to pose clinical and practical challenges and may become a matter of public interest.*

Do you remember reading that?---Yes.

Right. So from October 2008 or close to it you were aware that that was promulgated in the site options paper?---Yes. Yes.

Right. Thank you. And EFTRU was, in fact, opened after – around the time you were stood down, wasn't it?---It was, yes.

Yes. Thank you. Now, you made some mention about Springfield being an alternative site, didn't you?---I did.

To your knowledge, that wasn't opened until October last year; correct?---Correct. I had no idea of the time it - - -

Right. And, to your knowledge, it doesn't offer mental health services, does it?---No.

No. You have visiting rights at the Mater, don't you?---Yeah, I do.

You do. Alright. And it's private hospital only – that goes without saying, doesn't it? It's not Queensland Health?---No.

Right. Logan – you've seen Dr Crompton's statement, haven't you? You've read it in this Inquiry? I'll paraphrase it. There's recommendations. He obtained advice about Logan as an alternative and you haven't read what that advice to him was?---No.

But, in any case, you understood that wasn't viable; correct?---Excuse me, Ms McMillan, is that Logan as in 2013 Logan or Logan as a site option back in 2008?

Well, 2008 it wasn't an option; you understood that?---Right.

And in 2008 – perhaps I'll put it this way: it's correct, isn't it, that one of the things you need to look at if you're establishing mental health unit is it's inadvisable, for instance, to have a number of storeys, isn't it - - -?---Yes.

- - - storey building? Because of the risk to the patients; correct?---Yes.

That's why something called a green fields is usually looked at; correct?---Yes.

So that you don't have those issues, if I can put it that way, that you would have with existing structures in a hospital or other health facility?---Yes.

Right. And that was, I suggest to you, one of the attractions or one of the major attractions initially with Redlands – that it was a green fields site?---That's right.

And there were other issues. I think you'd had some input that you didn't want it to be in an area that might pose other dangers to young people?---Yes.

So in an, perhaps one might say, undesirable part of town, etcetera. Those sorts of things?---Yes.

Right. Thank you. Now, in relation to the ECRG it's correct, isn't it – now, Doctor, you deposed to a discussion with Sharon Kelly in October 2012; correct? This was in relation to an issue she raised about what if, effectively, Barrett were closed. Do you remember the meeting?---If it was - - -

MS ROSENGREN: The evidence is 2 November.

MS McMILLAN: Sorry. I stand correct.

MS ROSENGREN: 2012

MS McMILLAN: 2 November?---2 November. I do, yes.

Yes. And you understood that discussion to be confidential, didn't you?---I did.

Notwithstanding that, you sent an email to quite a number of people about that, did you not?---I did.

Alright. Can the witness see DTZ.002.001.0028. Doctor, I'll start putting to you while we get the document up. This is an email from QFCAP to – at Google – I'm sorry – it's to Google Groups and you informed them on 2 November at 6.42 pm about there being an issue of the Barrett closing and that a date of 31 December was mentioned. Do you remember that email?---I do remember that.

So Google Groups was clearly a considerable number of people, I take it?---It was a number of child psychiatrists, yes. The QFCAP stands for Queensland Faculty of Child and Adolescent Psychiatrists.

So that would be to all of them in the faculty?---To those who were on that group.

Yes?---So not all of them were on the group.

Alright. And you followed it up, did you not, 7.13 on the same date:

This information is confidential at the moment.

?---Yes.

And you were then aware, weren't you – sorry, just excuse me – and on 5 November you sent further email to other people: Mr Sean Hatherill, Jeff Beams and Victoria Gladwell; do you remember that?---That's right.

And, further, another one to Brett McDermott; correct?---Yes.

And William Bor?---Yes.

Right. And you then – and you didn't mark any of those emails as confidential, did you?---No, I didn't.

No. And then we're aware, are we not, that Professor McDermott made his statement at the inquiry; correct?---Yes.

You're aware of that. You then corresponded with Dr Stedman, didn't you, and told him by email on 8 November 2012 at 3.23 pm:

> *I did contact Brett McDermott.*

You said at the end of that email:

> *This was not the outcome I expected. I did wrong in contacting Brett, but did so on the understanding that he was being contacted by the directorate.*

Do you remember writing that to Dr Stedman?---Yes.

But, in fact, you had nowhere indicated there that you understood there was – to communication by the directorate with him?---My understanding was, from what Ms Kelly said, is that the – the – there would be a – a meeting with senior people, including other people from acute – from adolescent inpatient units about adolescents being transferred across to – to their units and alternate services being developed, and that I thought that he would be one of the ones, as the director of a major CYMHS service, he would - - -

But – yes, go on?--- - - - and he had been previously in the – consulted with regard to Redlands, that he would be one of the ones – key ones consulted.

But – couple of things. The first lot of emails you sent was to this QFCAP, which you said was a group of child and adolescent psychiatrists?---Yes.

It wasn't to Professor McDermott, was it?---Well, he could have been on the QFCAP.

In fact, it wasn't until 5 November you sent him a specific email; correct?---A specific email?

Yeah. And at that time, you say that you accept that it was meant to remain confidential?---Yes.

So do you accept you were being somewhat disingenuous to say to Dr Stedman that you understood Professor McDermott, in any case, was being contacted by the directorate?---No, because that was my – well, my understanding: that, eventually, he would be contacted by the directorate.

Eventually, you say. But he wasn't specifically mentioned, was he?---No, he wasn't.

No. And you didn't tell Dr Stedman either that you had broadcast it to a great many more people than simply Dr – Professor McDermott, did you?---No, I didn't.

No. Thank you. Now, the ECRG: you were on that committee, chaired by Dr Geppert; correct?---Yes.

And you endorsed the recommendations, did you not?---Yes, I signed off on them.

Yes. And you were clearly aware at that time that there were not necessarily what might be termed a tier 3 facility, as in building, in place; correct?---Yes, correct.

And you were aware from that document what was being suggested as – to be put into place in terms of servicing a tier 3 need; correct?---It was agreed.

Yeah?---There are qualifications about that and about the process. I had written on 22 April because I couldn't see that there would be a tier 3 service put into place. Therefore, I wrote the document with the compromise options 1, 2 and 3, because I felt that patients were at risk unless there was – or some patients would be at risk unless there's a clearly-developed service.

Right?---Now, I – that – our final meeting of the ECRG was 23 April, I think. The document was circulated in some time in early May, and I think we had to have sign-off on 7 May so that it could then go to the planning group the next – for the next week. My concern was that – well, I was glad that the document did mention about the – the risk. I believe that that was essential. I believe that that was toned down compared to what we had discussed in the ECRG. I felt that there were differences in the – some of the content compared to the ECRG recommendations. But I felt that this process has got to be signed off because it was an imperative to do so.

Alright. And you did endorse it, as you say?---Yes. I gave my final approval.

Alright. Now, it was clear, wasn't it - - -?---Excuse me. Sorry.

Yes?---May I just add I gave my - - -

Is it relevant to the question?---Yes.

Alright?---Because my – I gave my approval because I knew that I was then on the planning committee and able to address some of these issues on the planning committee.

Which you in turn did on the planning committee?---Yes.

Right. Thank you. Now, in terms of – once the Minister announces the closure of Barrett in August 2013 – you'll recall that?---Yes.

You were aware, you were not, that there would be a bricks and mortar, if I could put it that way, at that time to effectively take up the slack, if I can put it that way, with Barrett closing; correct?---Correct, with reservations.

Well – but that was the position as you understood it?---On 6 August, that was the position.

Right. And does a Ms Daniel work for you or worked with you at the Barrett Centre?---Ms?

Daniel, D-a-n-i-e-l?---Yes.

Right. Could the witness be shown, please, a document, WMS.6006.0002.37693. Thank you. Doctor, have a look at that. That's an email from Ms Daniel to, amongst other things, to you?---Yes.

Now, I'd like you to read down to, particularly, the second paragraph?---Yes.

Yes. And then could I ask you, please, to look at another document. WMS.6006.0002.38249. This is, it appears, a generic letter sent, again, by – this is sent by Ms Daniel. Do you recognise that letter?---I don't specifically recognise either of these letters. I accept the first one had included me as a copy.

Could you scroll down, please, to the paragraph saying "I wanted to reassure you". So you don't know that you've seen that letter before?---I'm not sure that we'd seen the letter before. I know that when I met with Ms Dwyer and Ms Kelly and the announcement was made they said you can still continue to take patients.

Right, but I'm particularly interested in the – a site – they will be transferred over to the wait-listed service at the new site, and the letter talks about the new site has not yet been determined. Now, firstly, in relation to that email sent from Susan Daniel, did you comment upon that in there about there being a new site being mentioned?---May I look at the date of that email?

Yes. If we scroll back up to the previous document, it's 9 August 2013, Doctor?---Right.

Both on 9 August.

COMMISSIONER WILSON: I think the witness wants to see the email, not the letter.

MS McMILLAN: Yes; the document before that, please?---Yes.

Yes. Alright?---Yes.

Yes. Alright. So did you have any knowledge of her corresponding about with potentially, it seems, consumers and carers about a new site?---I can't recall anything like that because in my mind I had no clearer indication of what we might be transitioned to.

So you weren't – you have no knowledge, necessarily, you say, and you certainly didn't authorise her to send out that letter?---No.

No. Alright. Thank you. Now, the balance of the questions I wish to ask are in closed session, Commissioner.

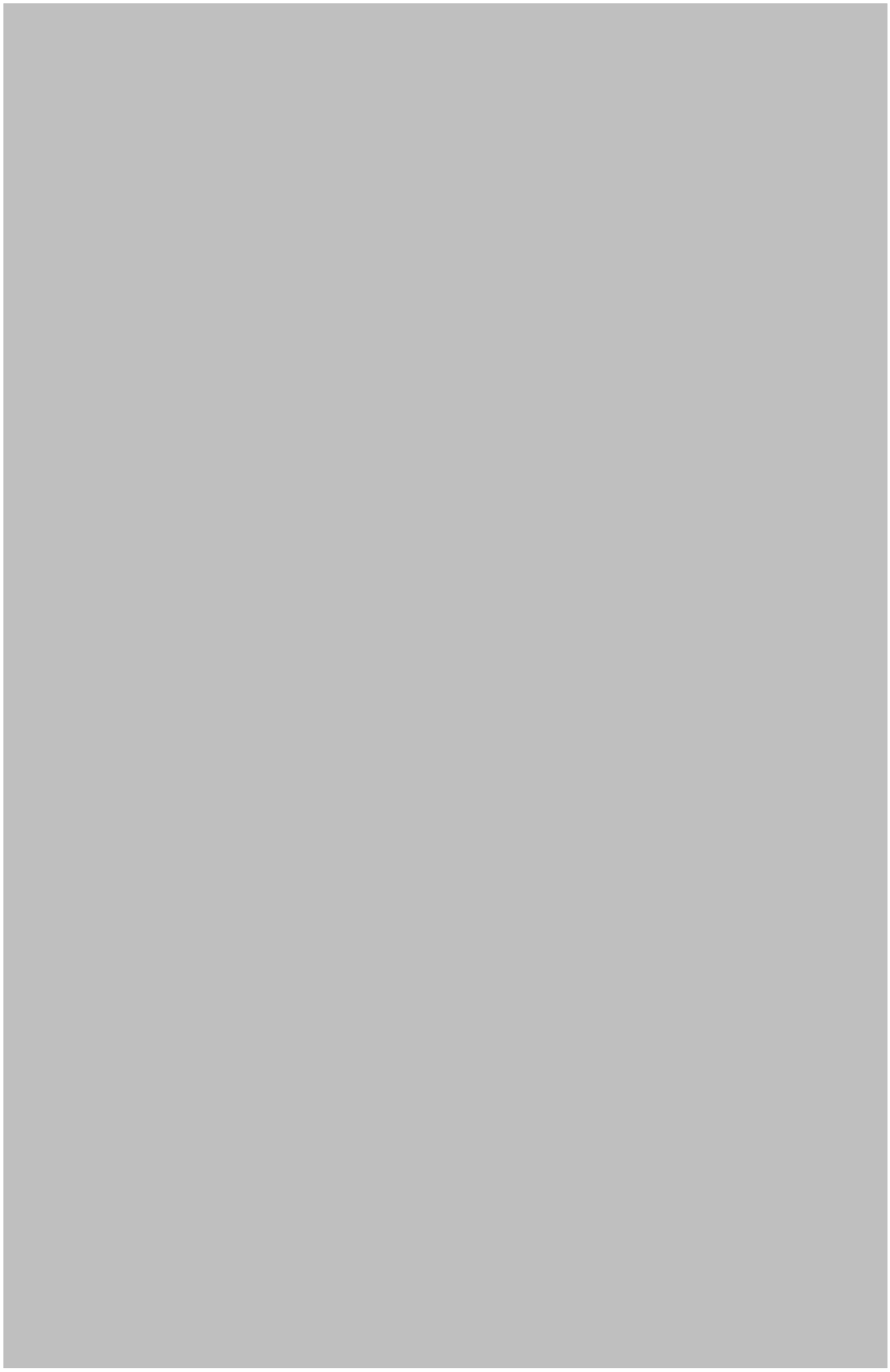
COMMISSIONER WILSON: How long will it be? How long?

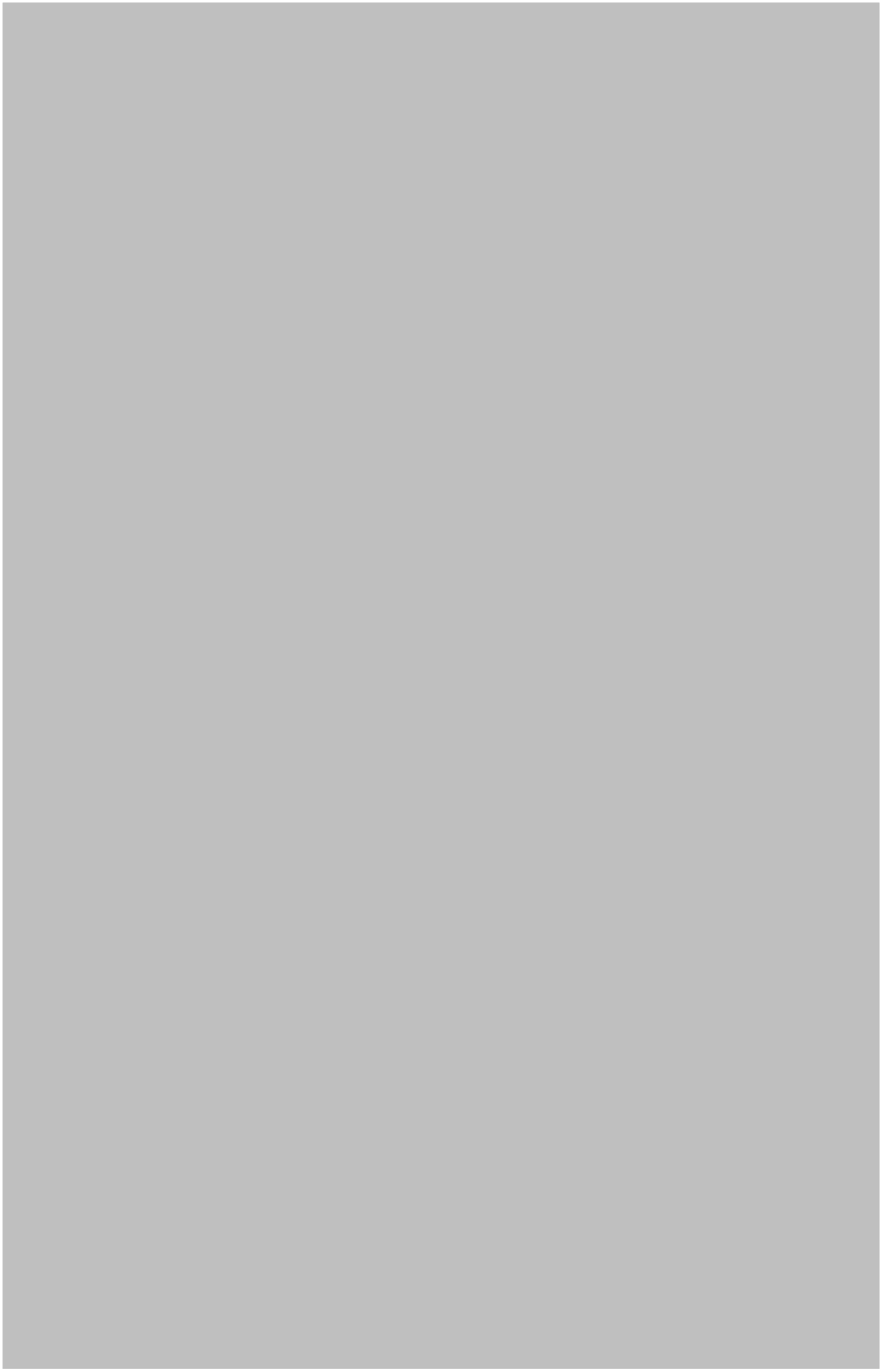
MS McMILLAN: Ten – 15 minutes at most.

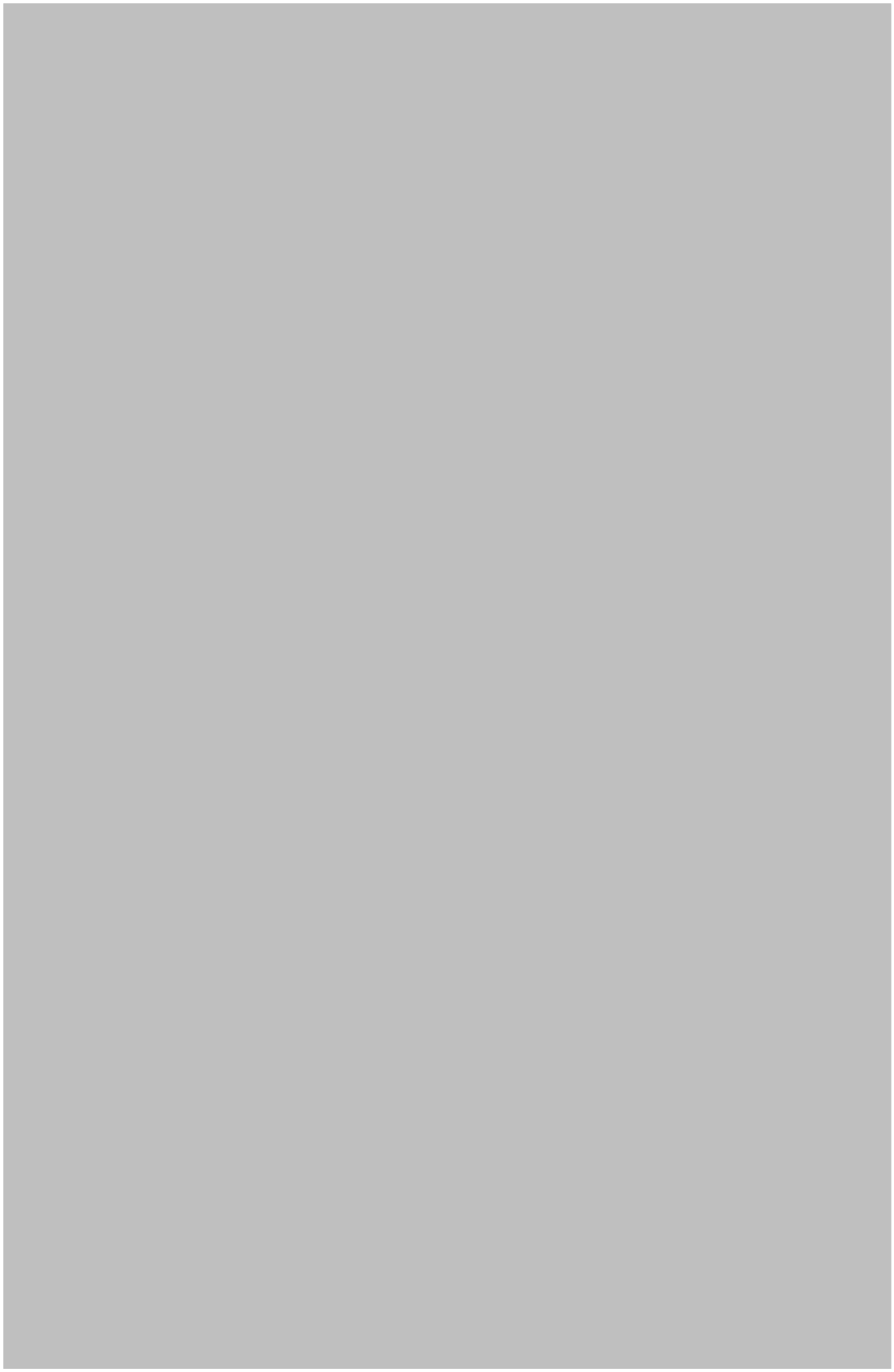
COMMISSIONER WILSON: Alright. Now, someone else had something in closed session. Is that right?

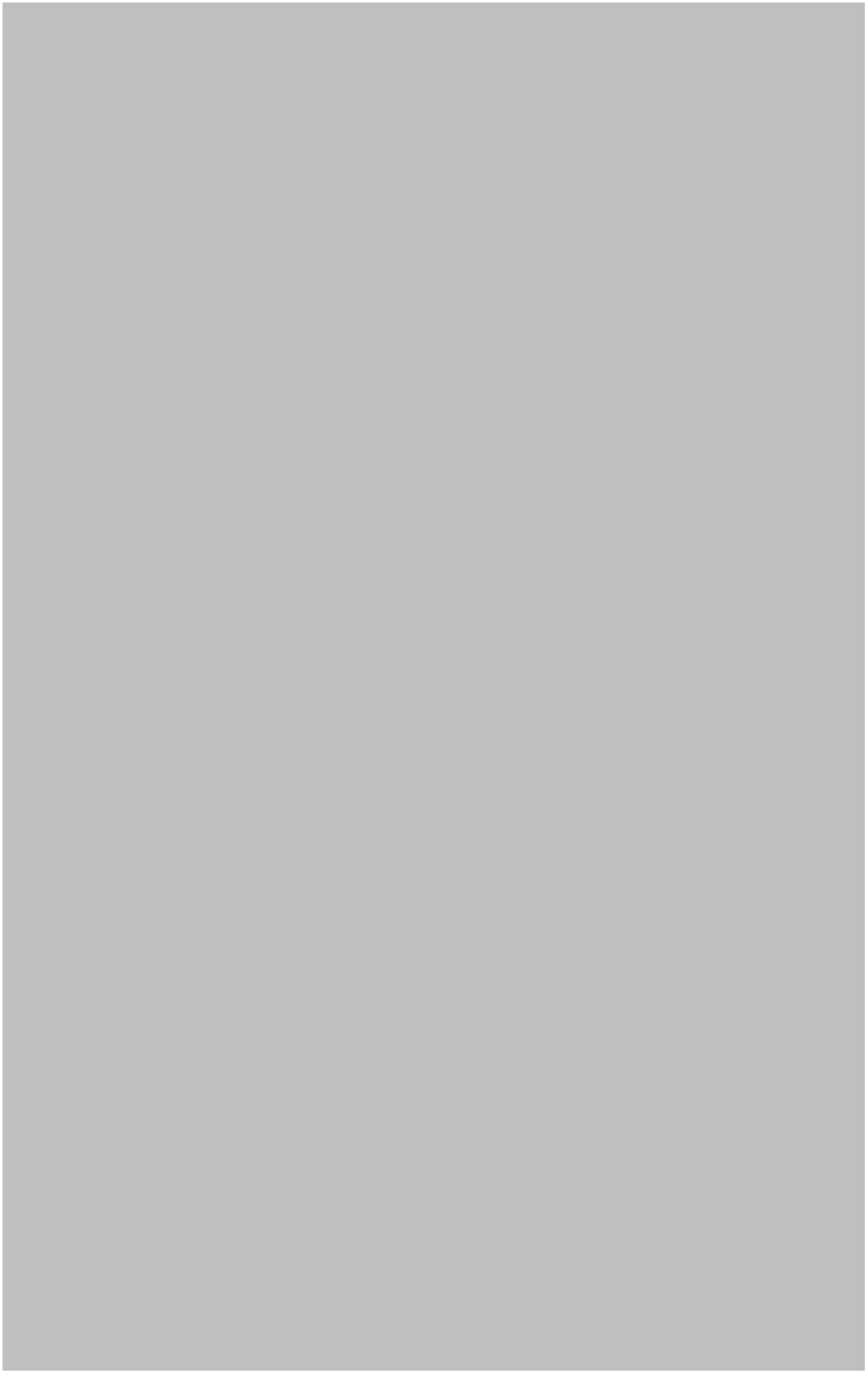
MR MULLINS: I have a few questions in closed session, Commissioner.

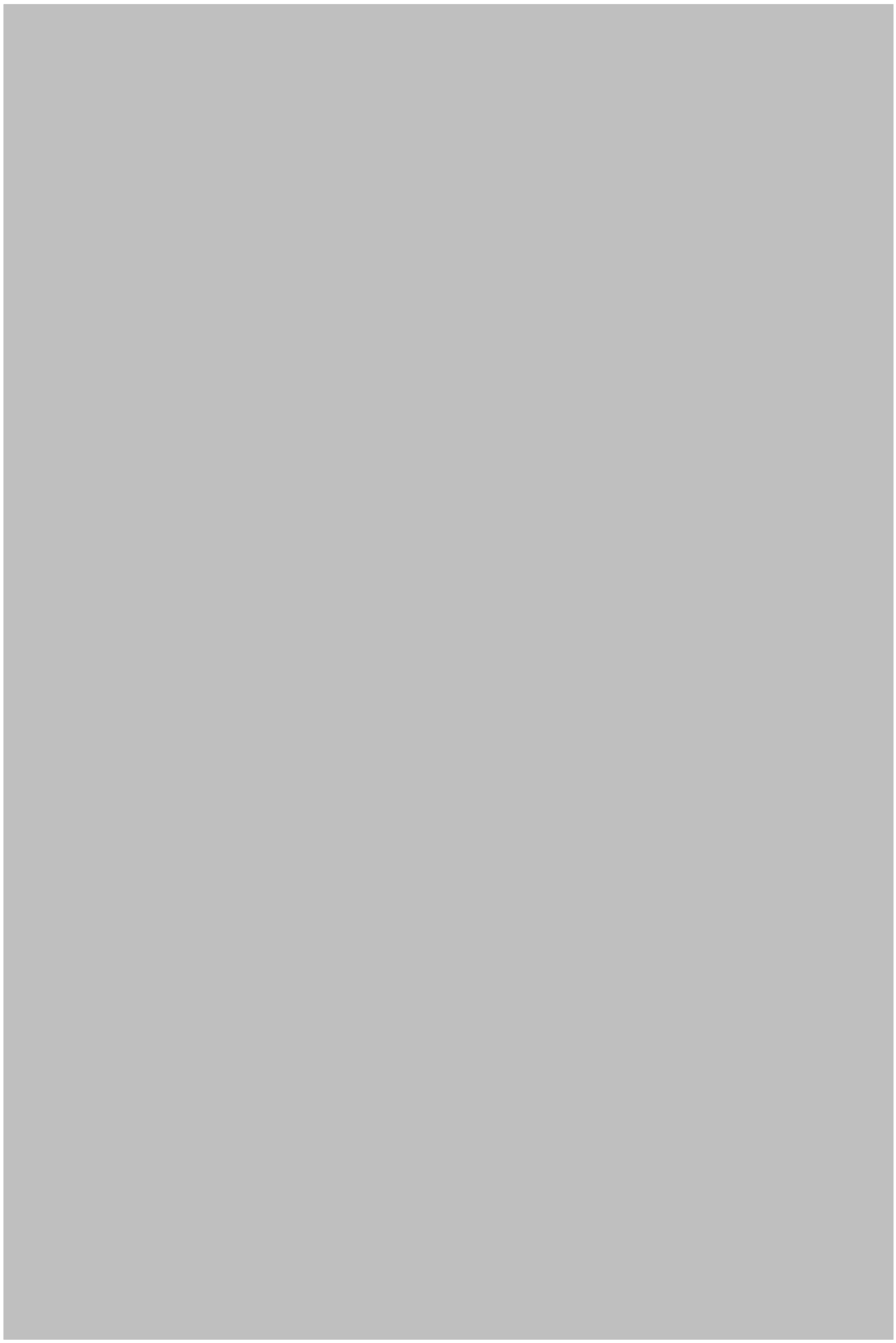
COMMISSIONER WILSON: Alright. Well, I'll close the hearing at this stage, deal with yours, Ms McMillan and hopefully also with Mr Mullins. The livestreaming must come off, please, and those in the back of the court who are not parties or legal representatives should leave.

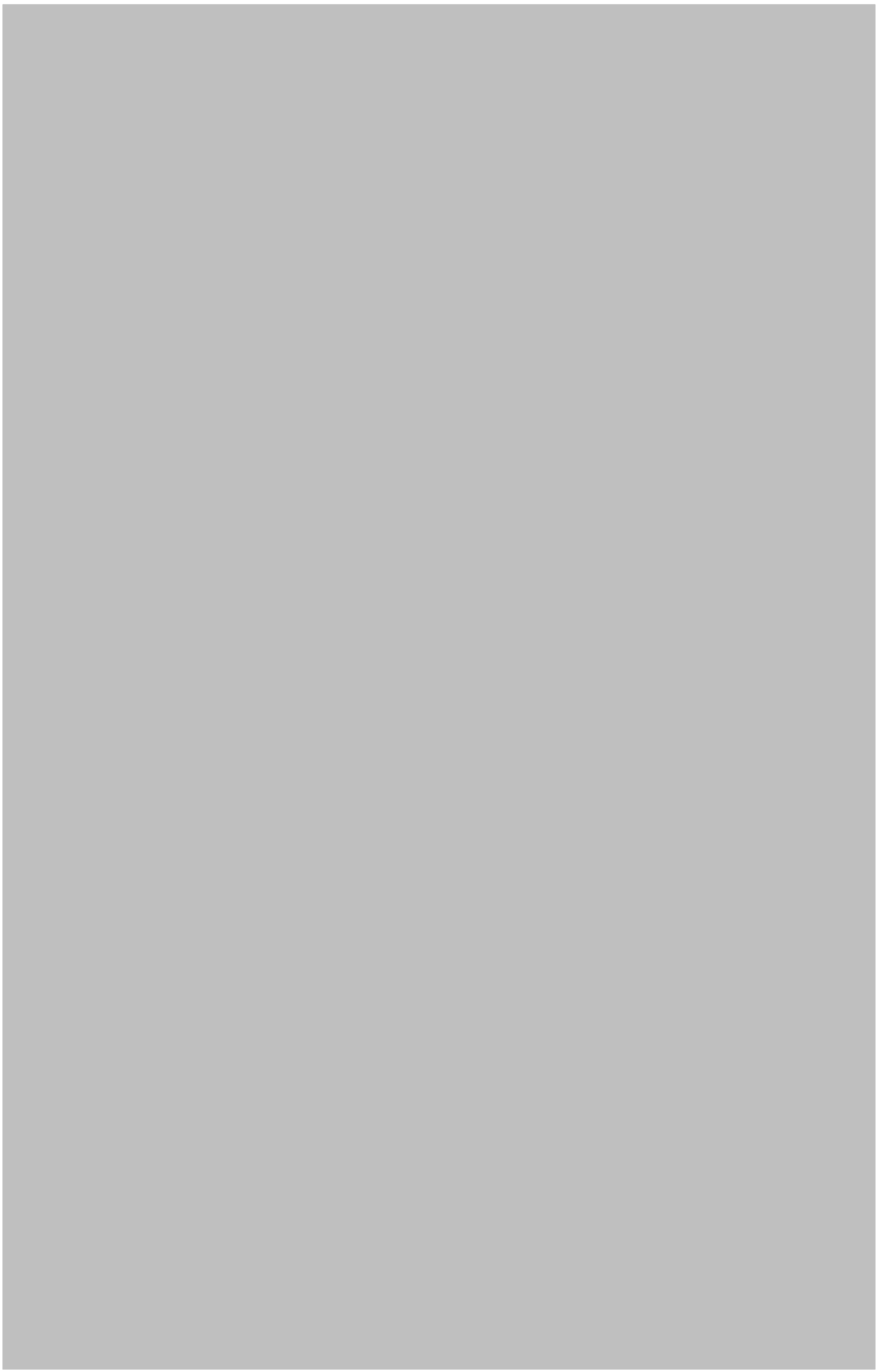


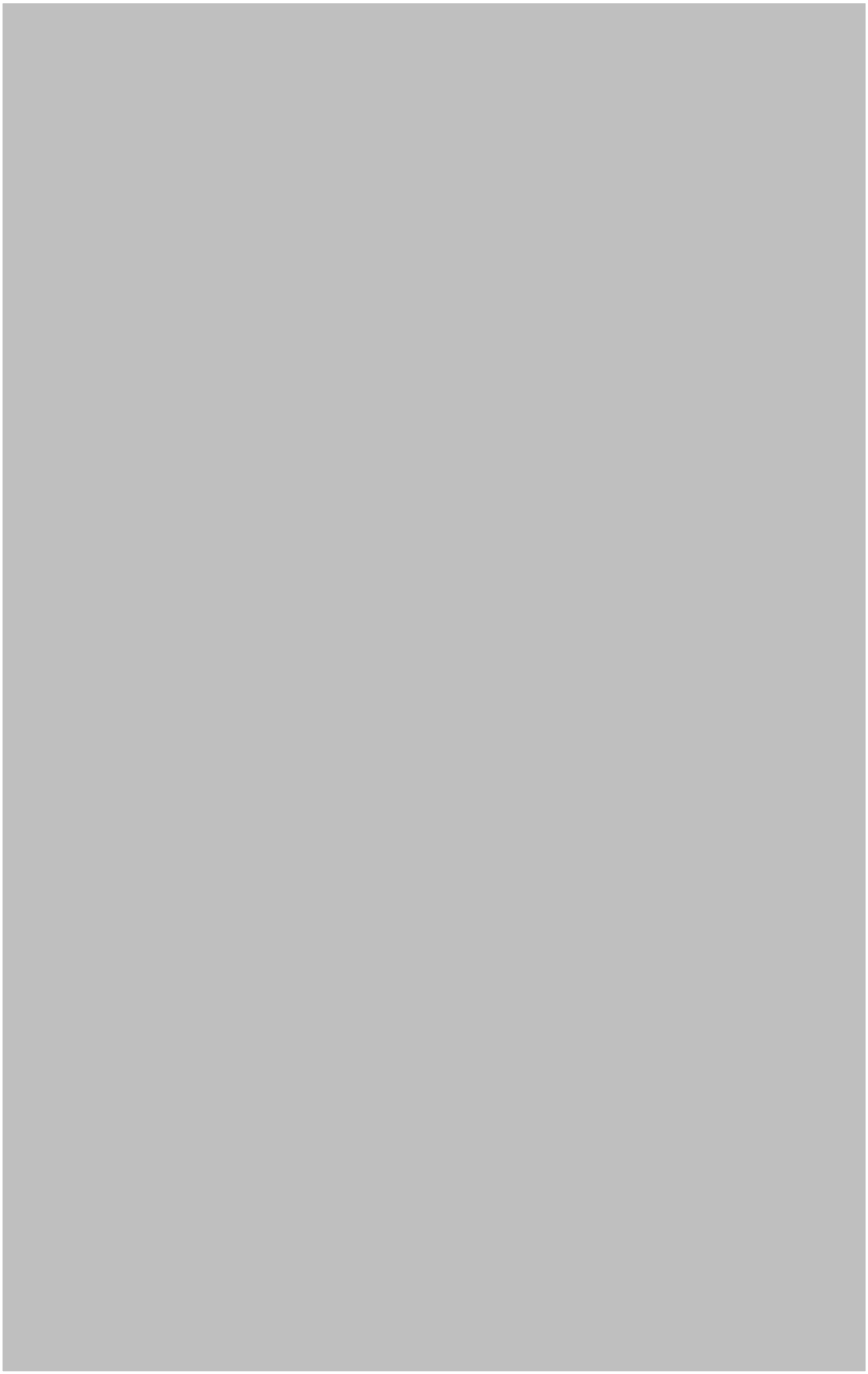


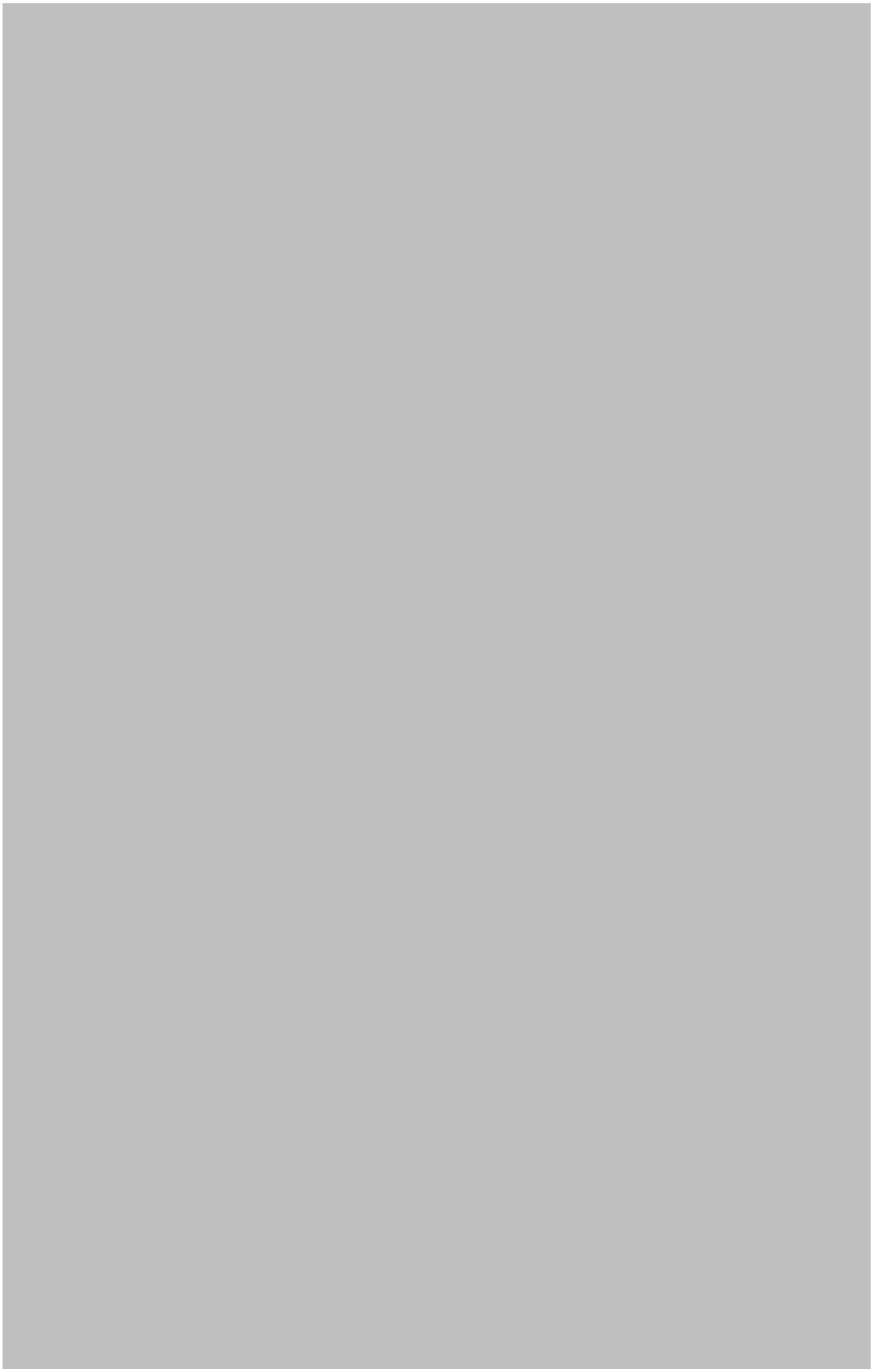


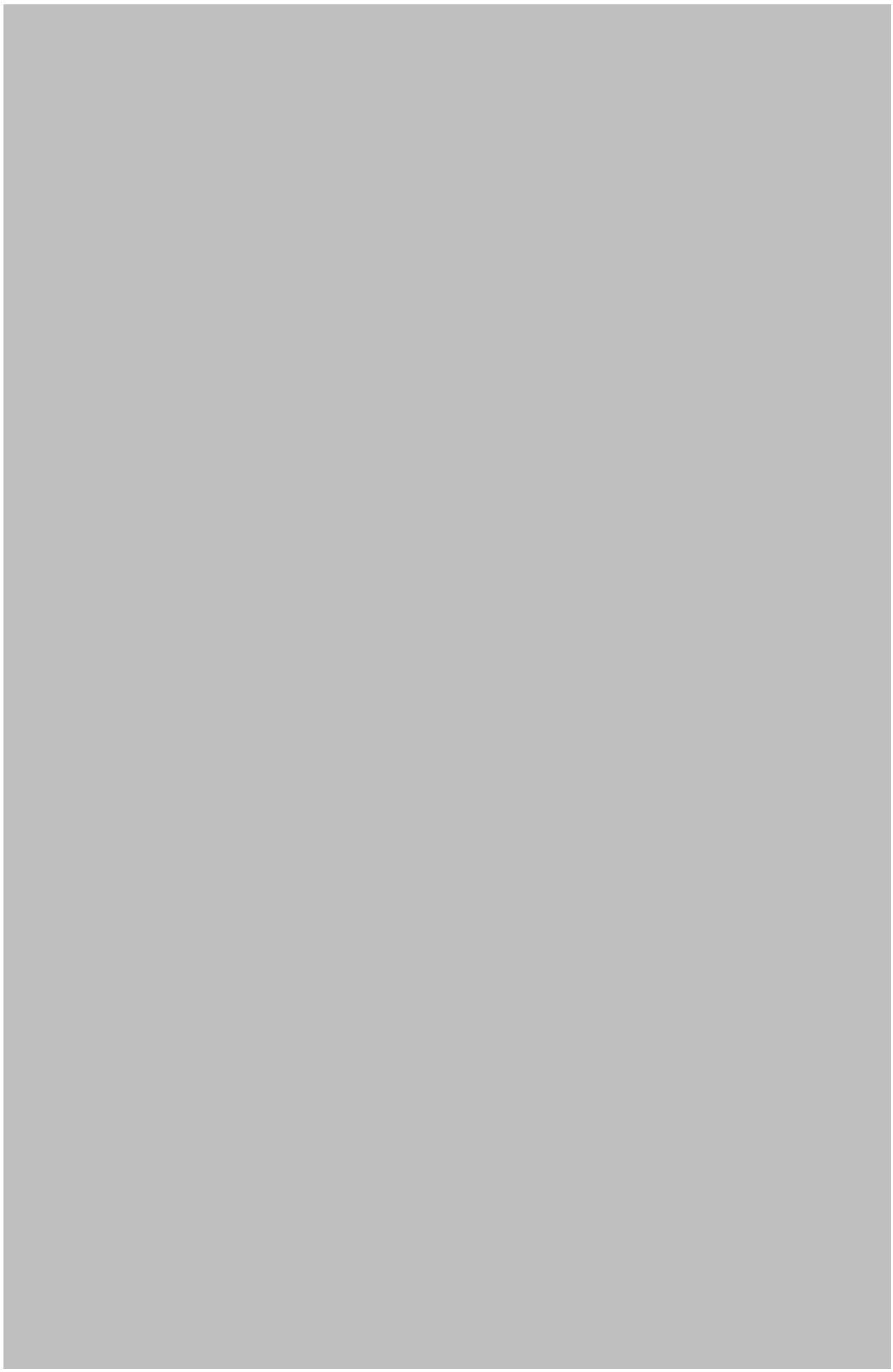












ADJOURNED **[3.46 pm]**

RESUMED **[4.04 pm]**

COMMISSIONER WILSON: Now, before we commence this discussion is it going to be in closed hearing?

MS McMILLAN: Yes, Commissioner.

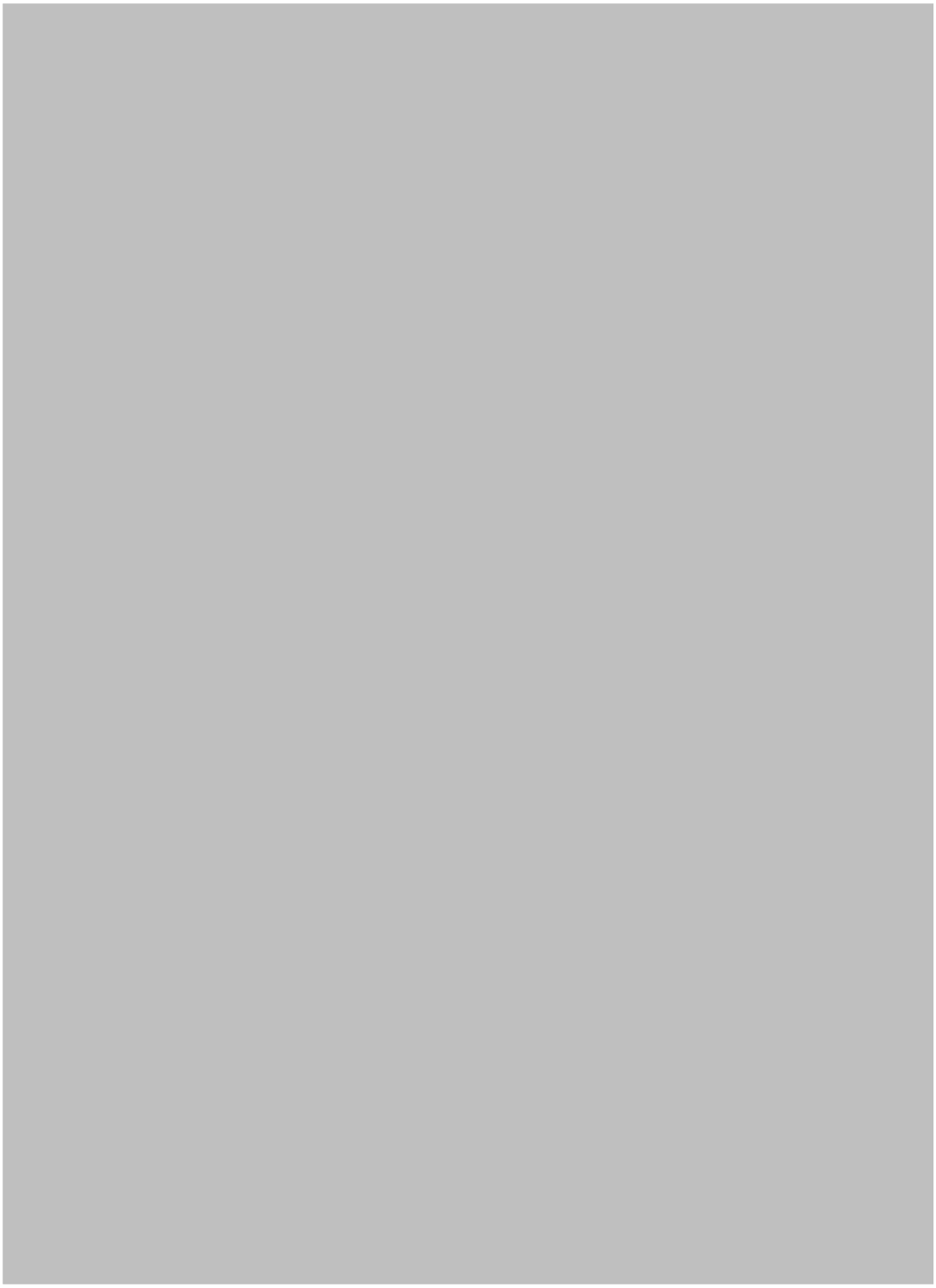
COMMISSIONER WILSON: Does everyone – you obviously want to raise that matters that relate to particular patients?

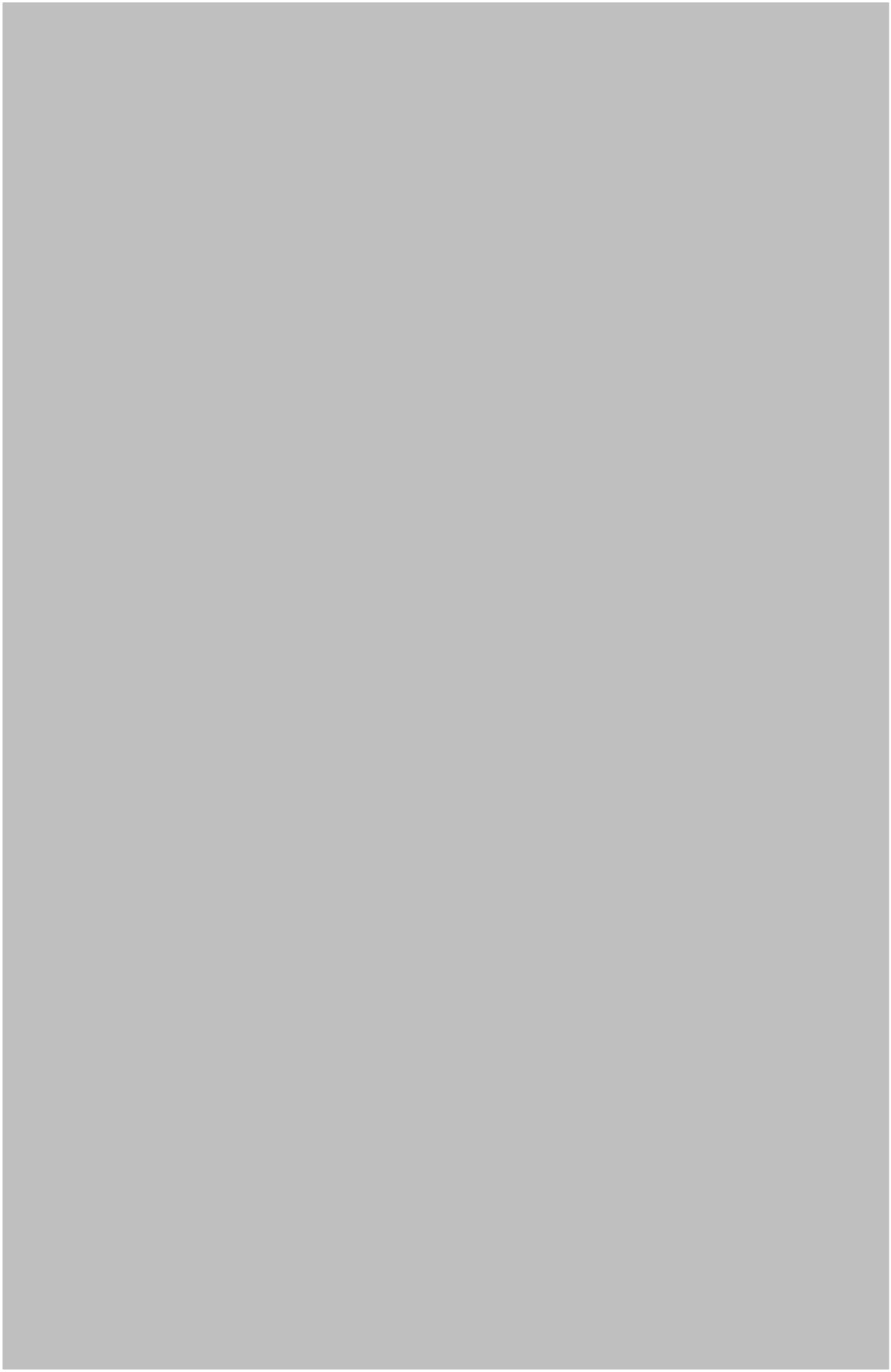
MS McMILLAN: Yes, because - - -

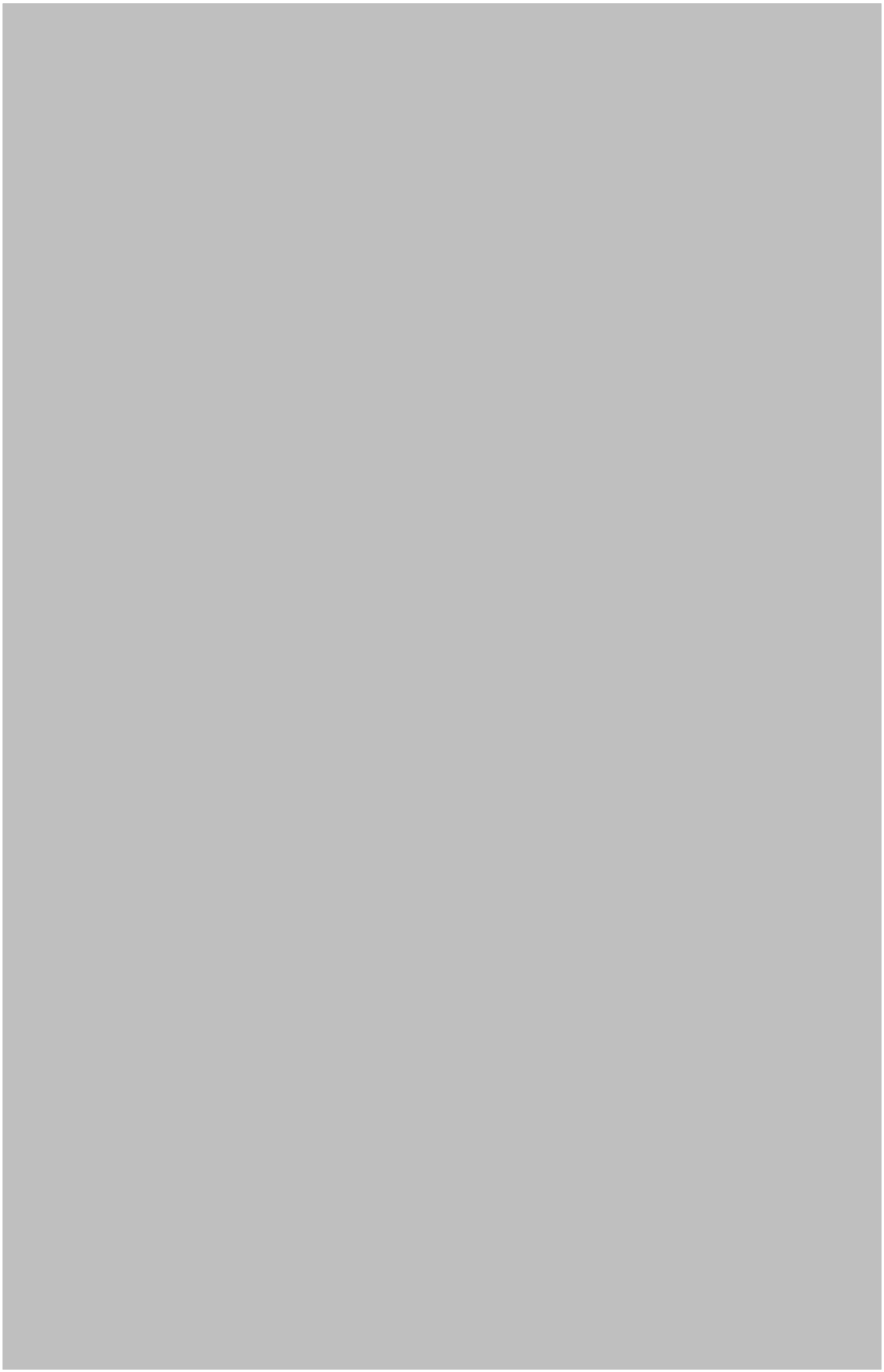
COMMISSIONER WILSON: Alright.

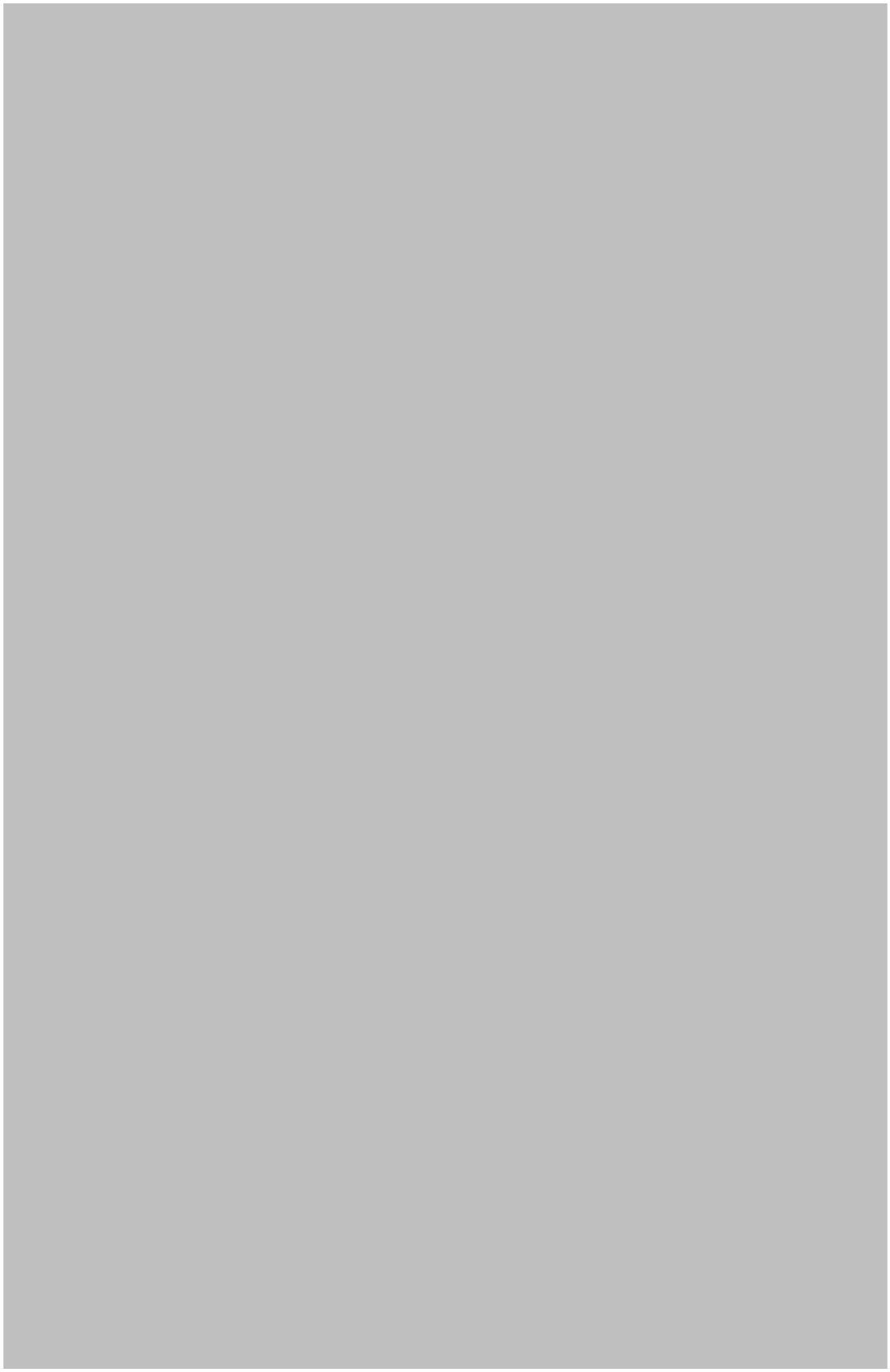
MS McMILLAN: - - - there's a particular document that I think will be central to this issue that needs to be discussed. So I can't see how it can avoid [indistinct]

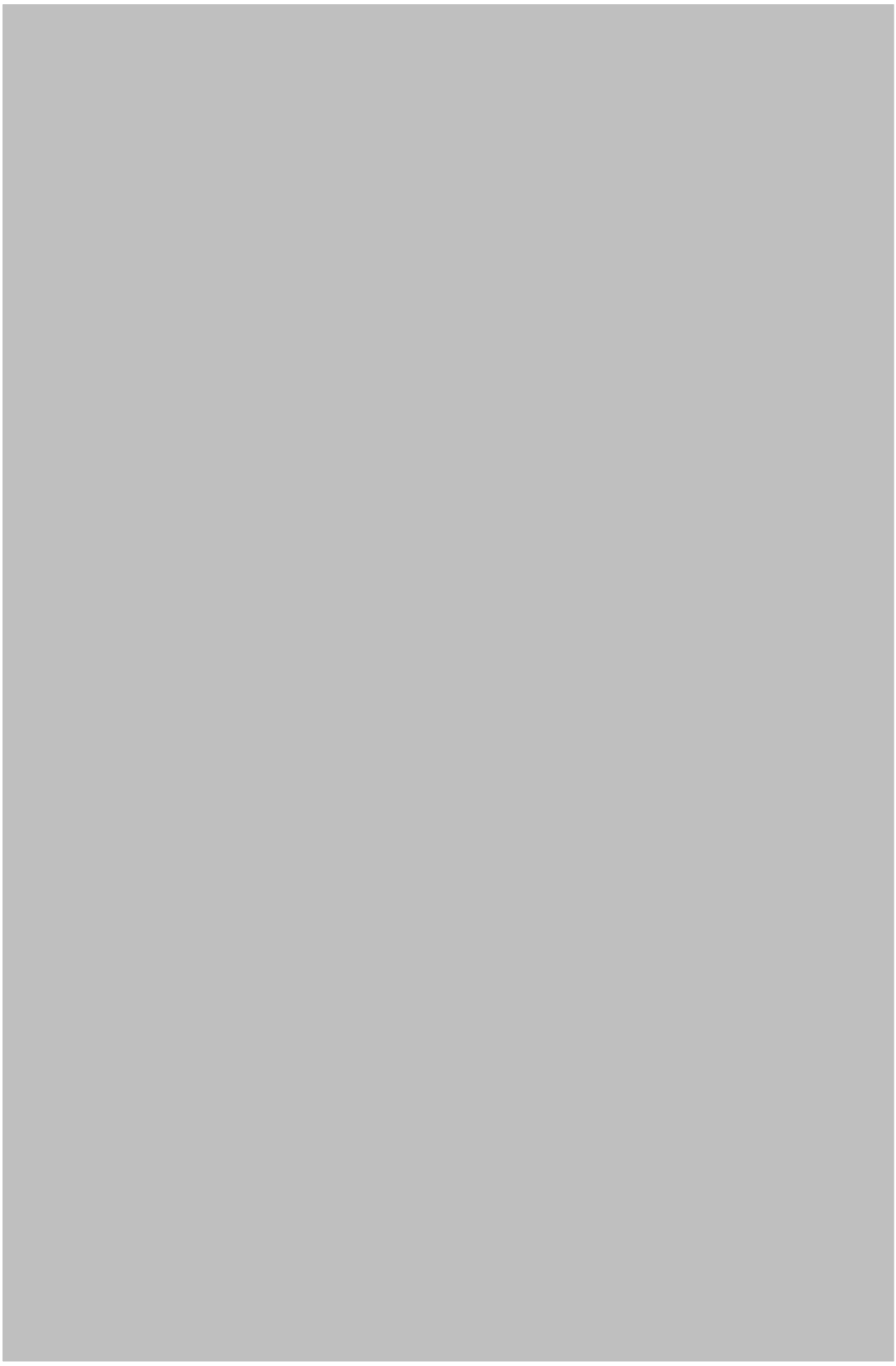
COMMISSIONER WILSON: Very well. It will be in closed hearing. The live streaming will have to be off, and no one in the courtroom except legal representatives and parties.

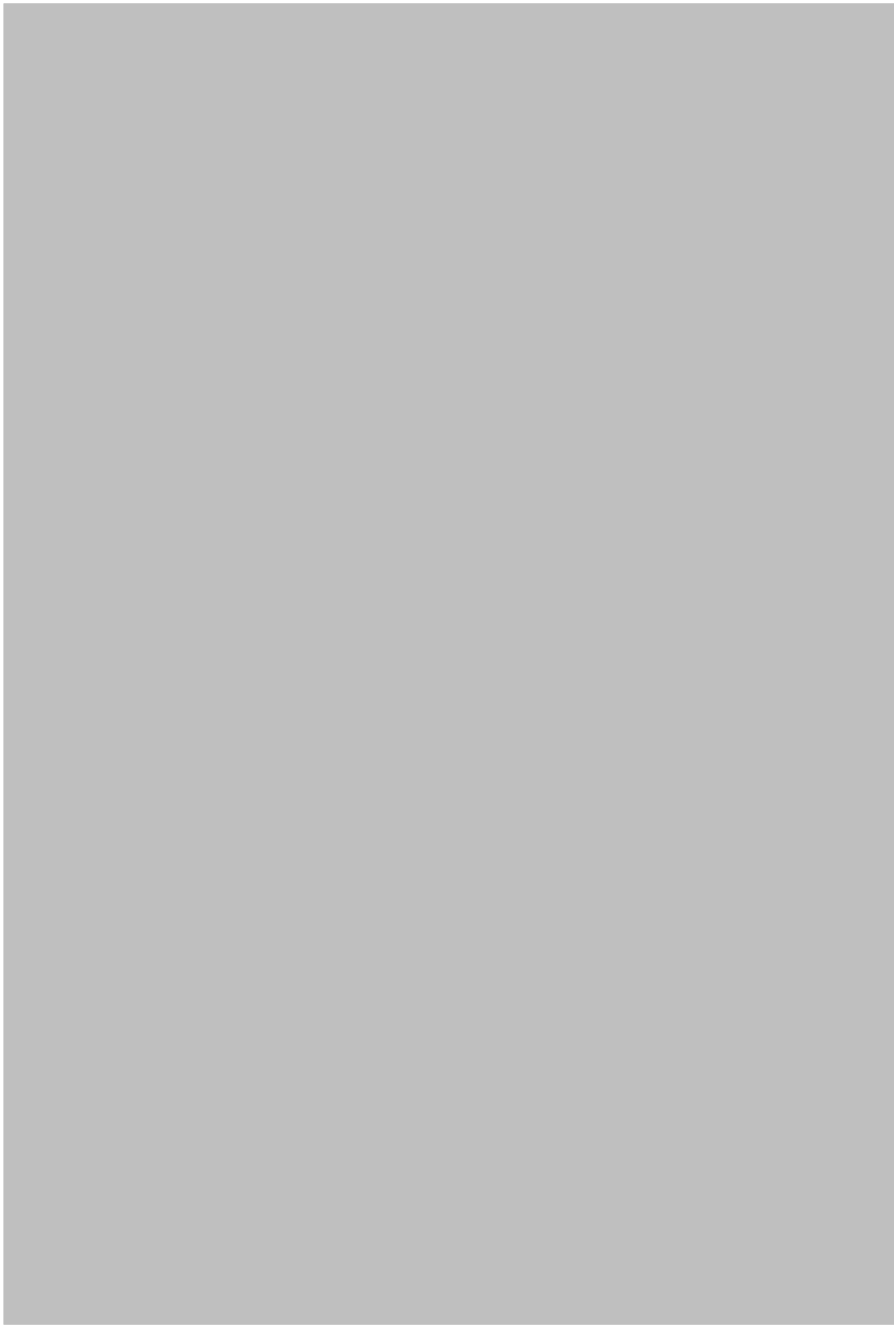


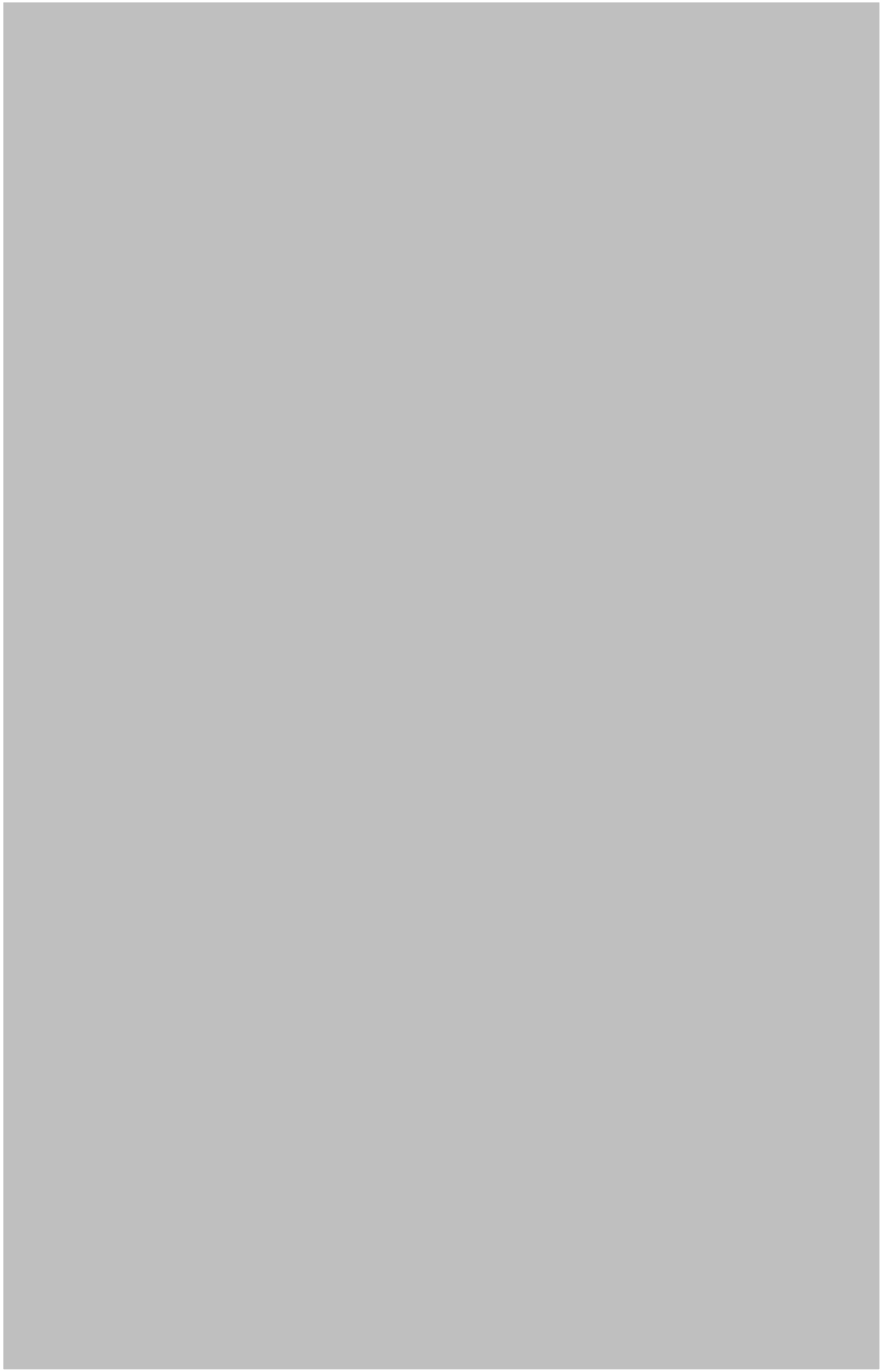


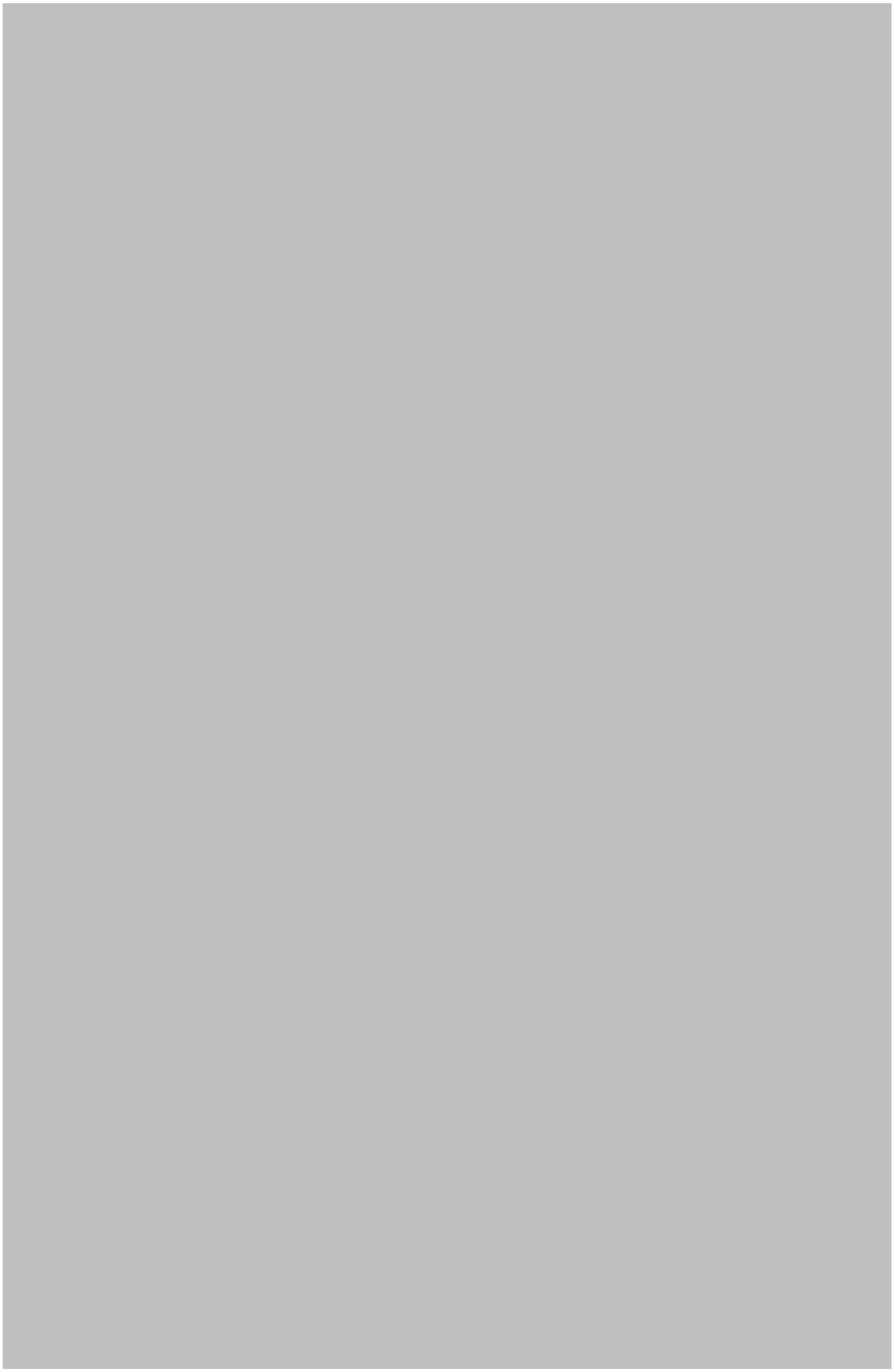


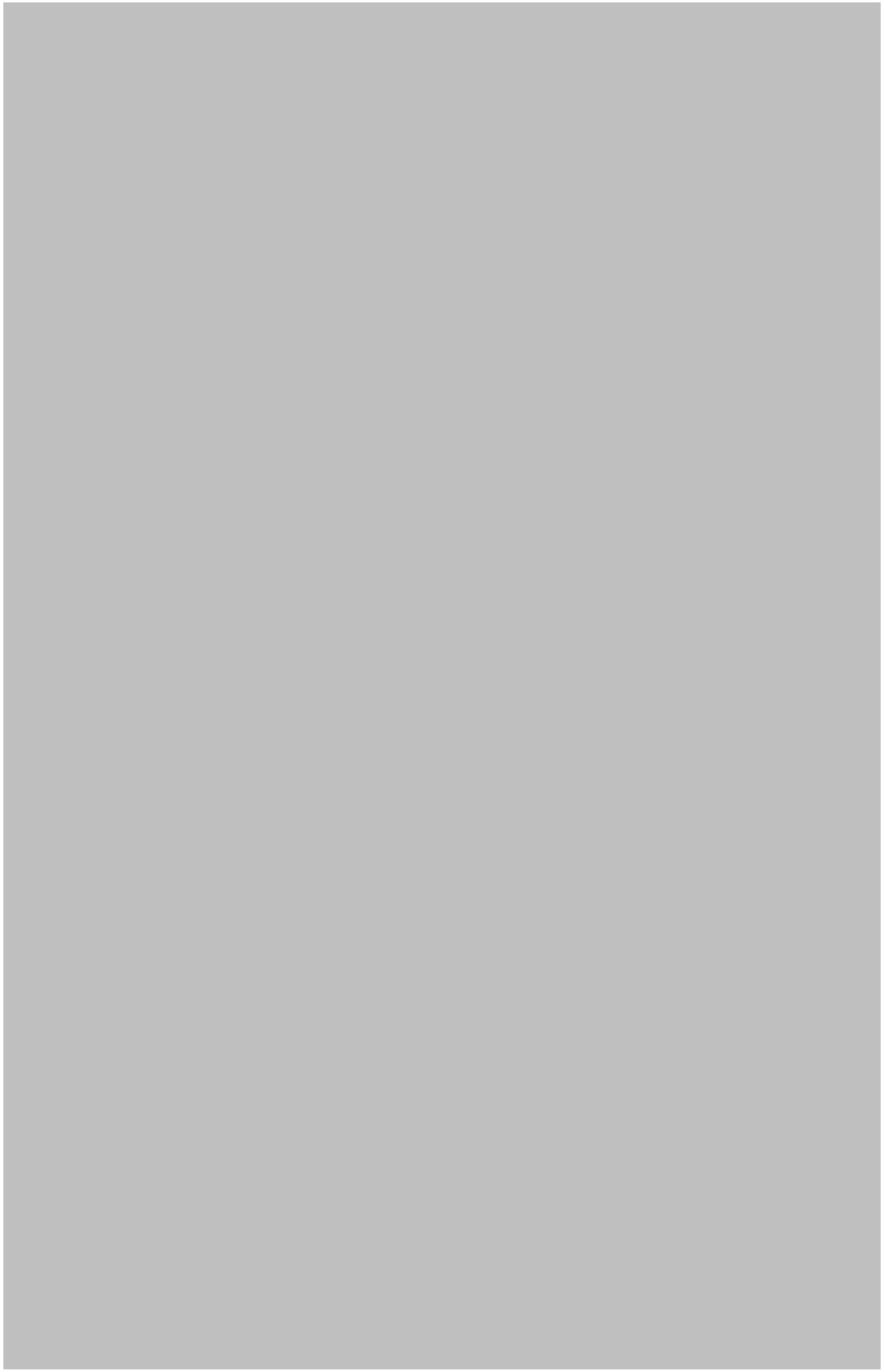


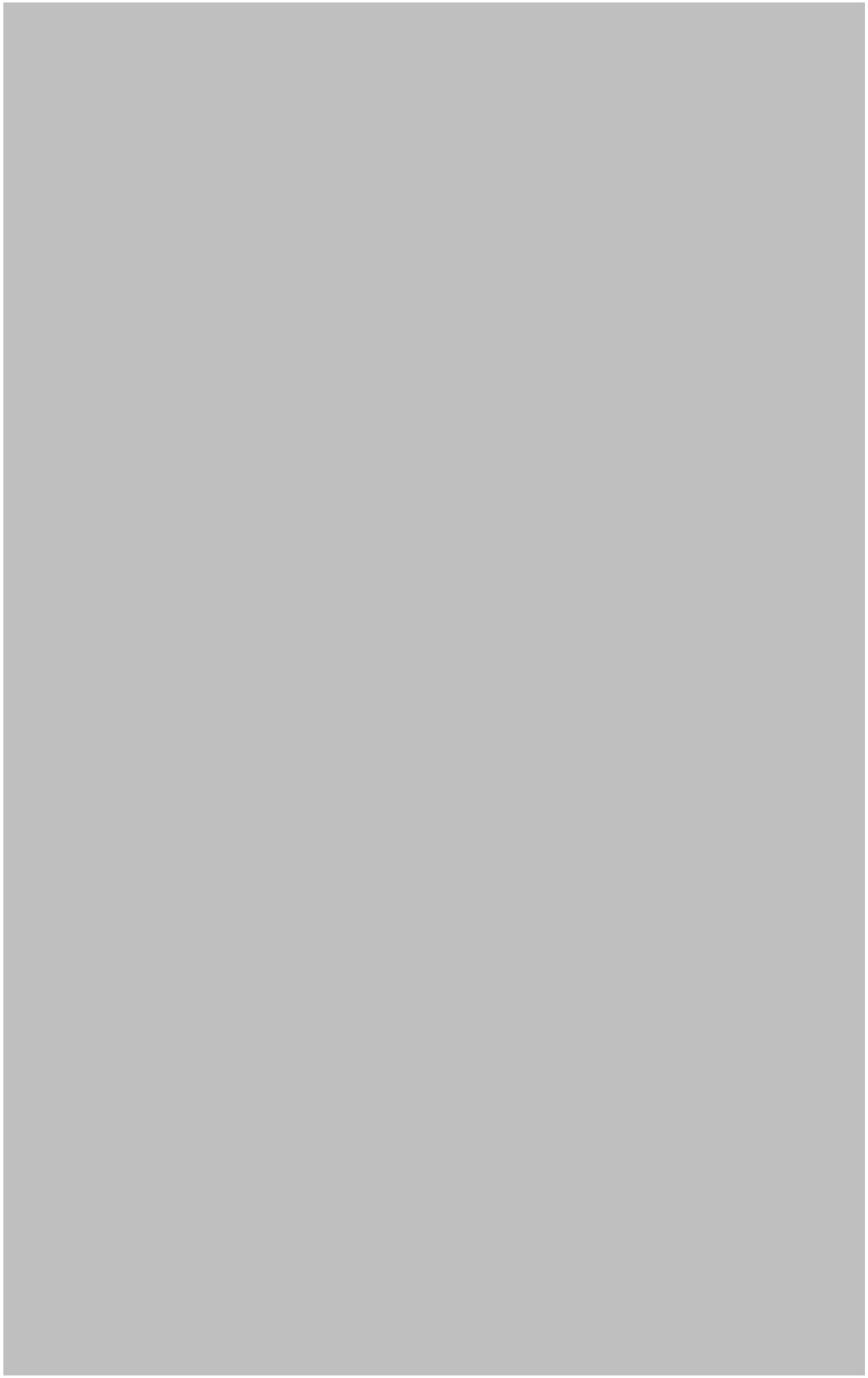


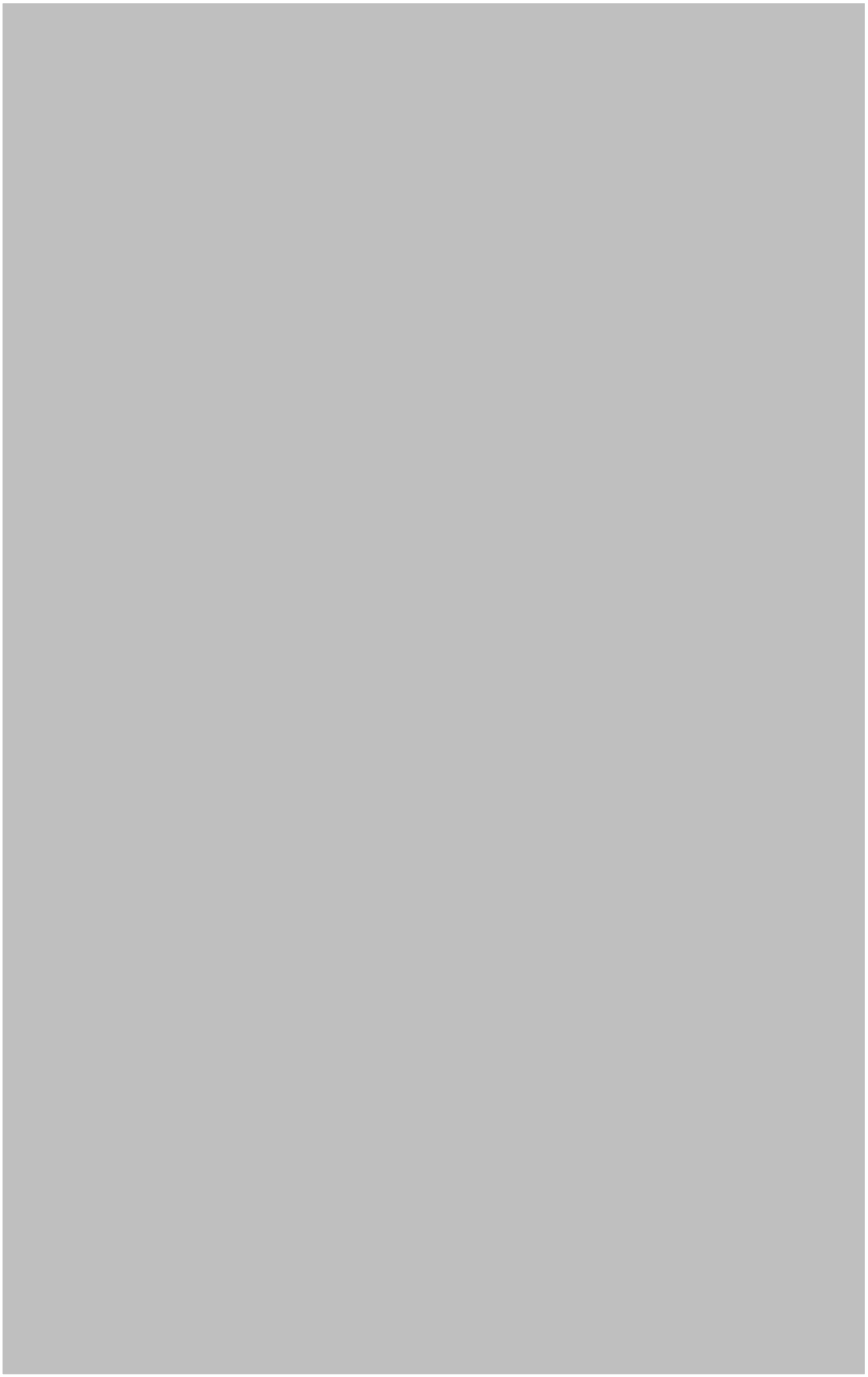


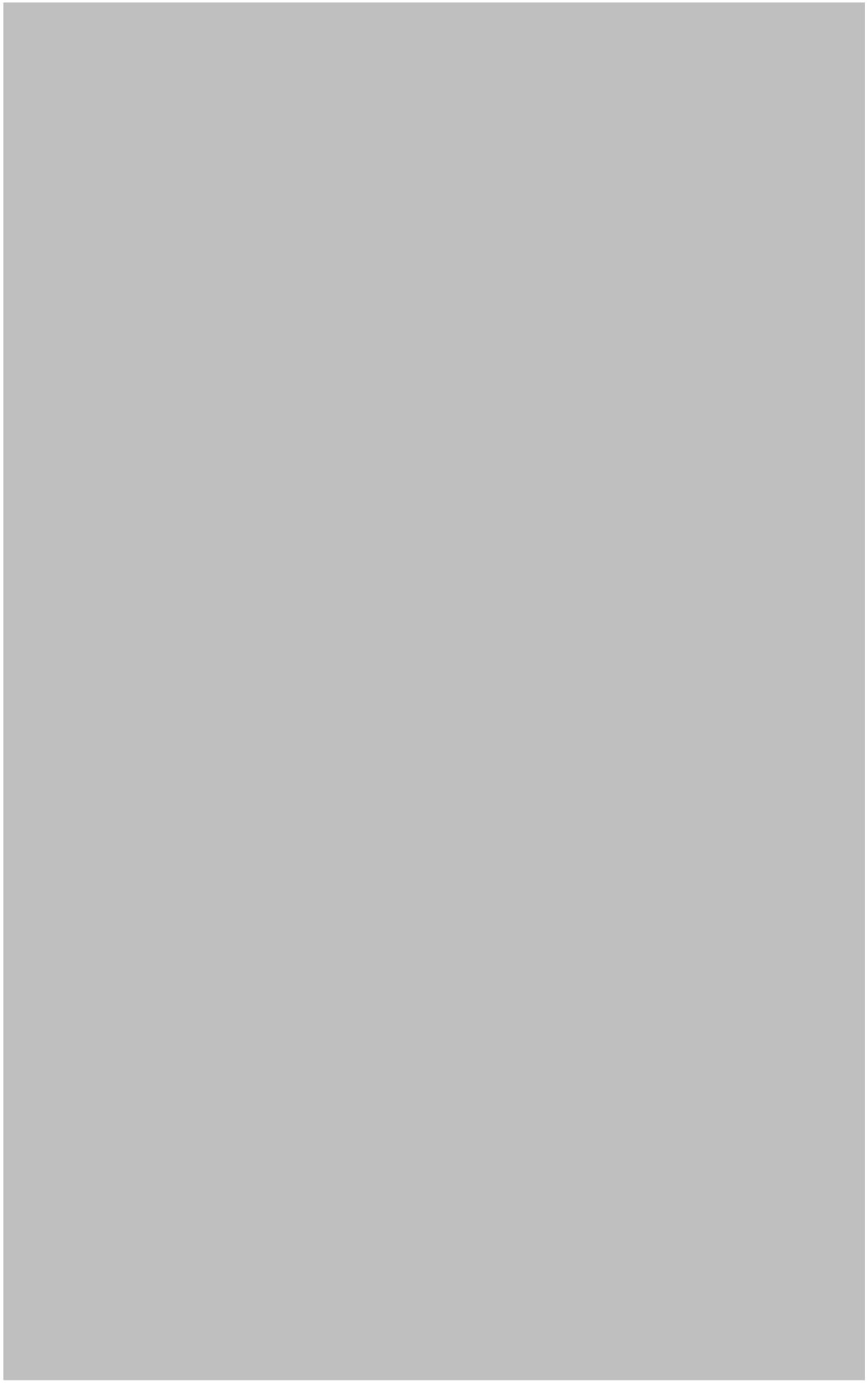


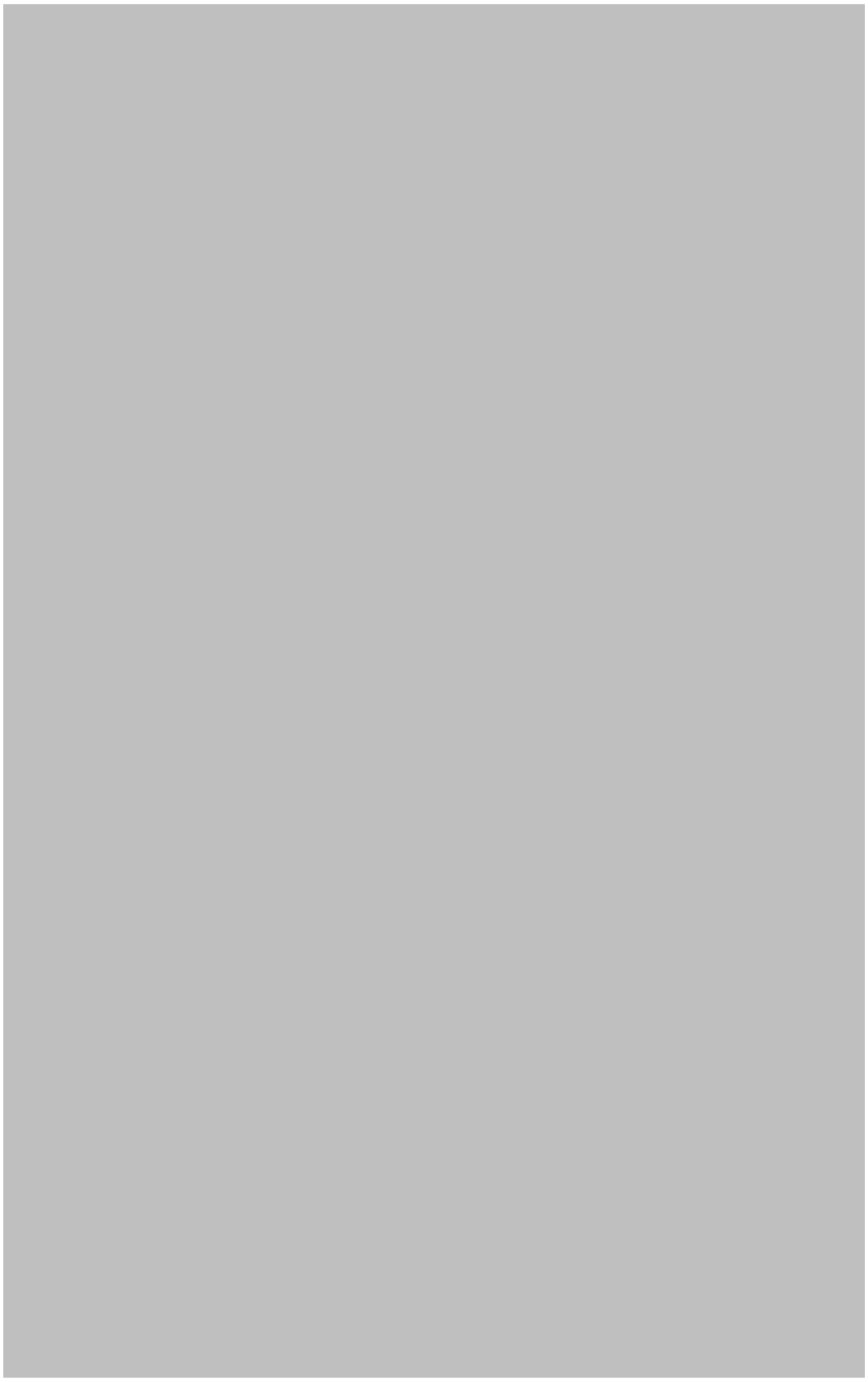


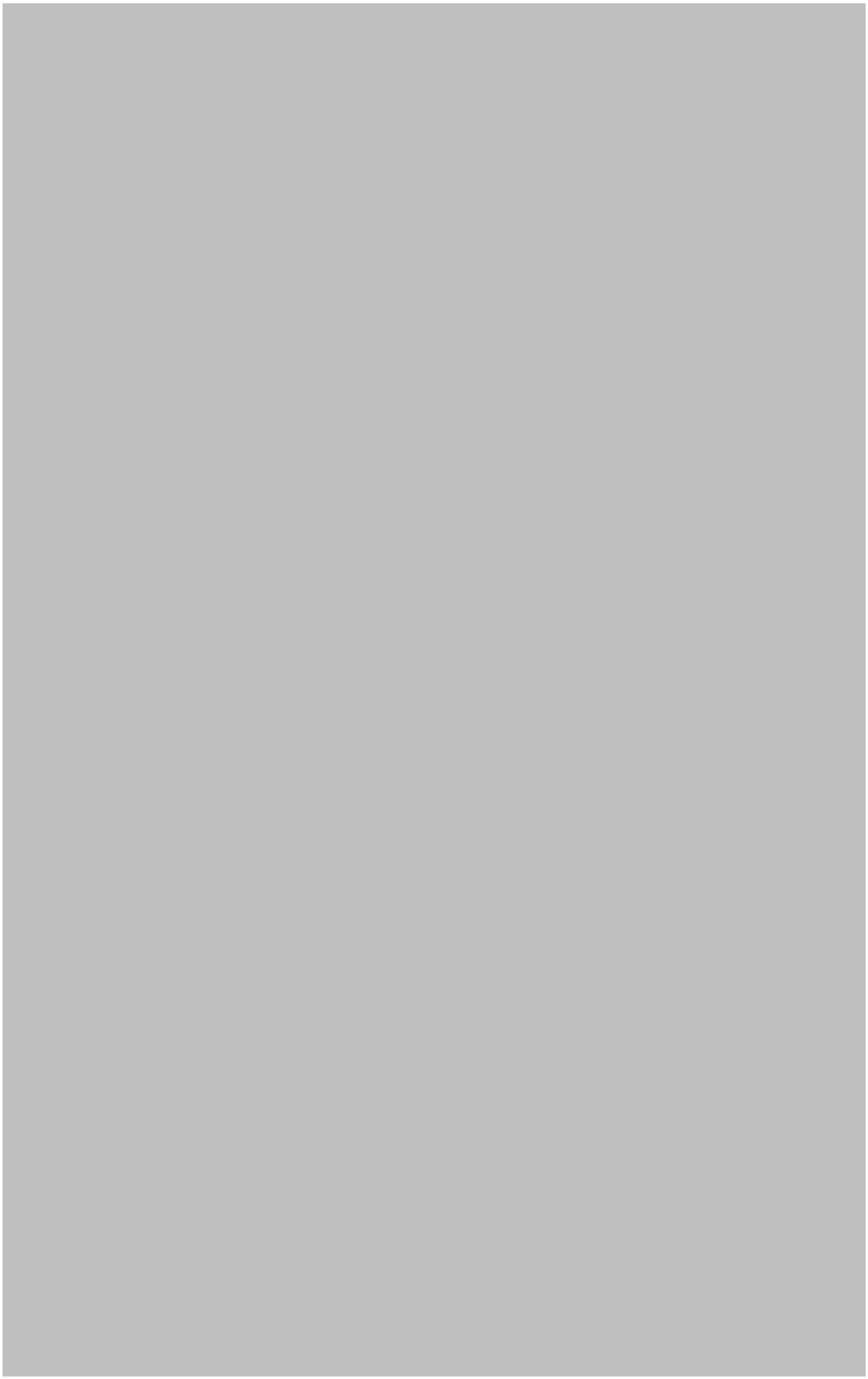


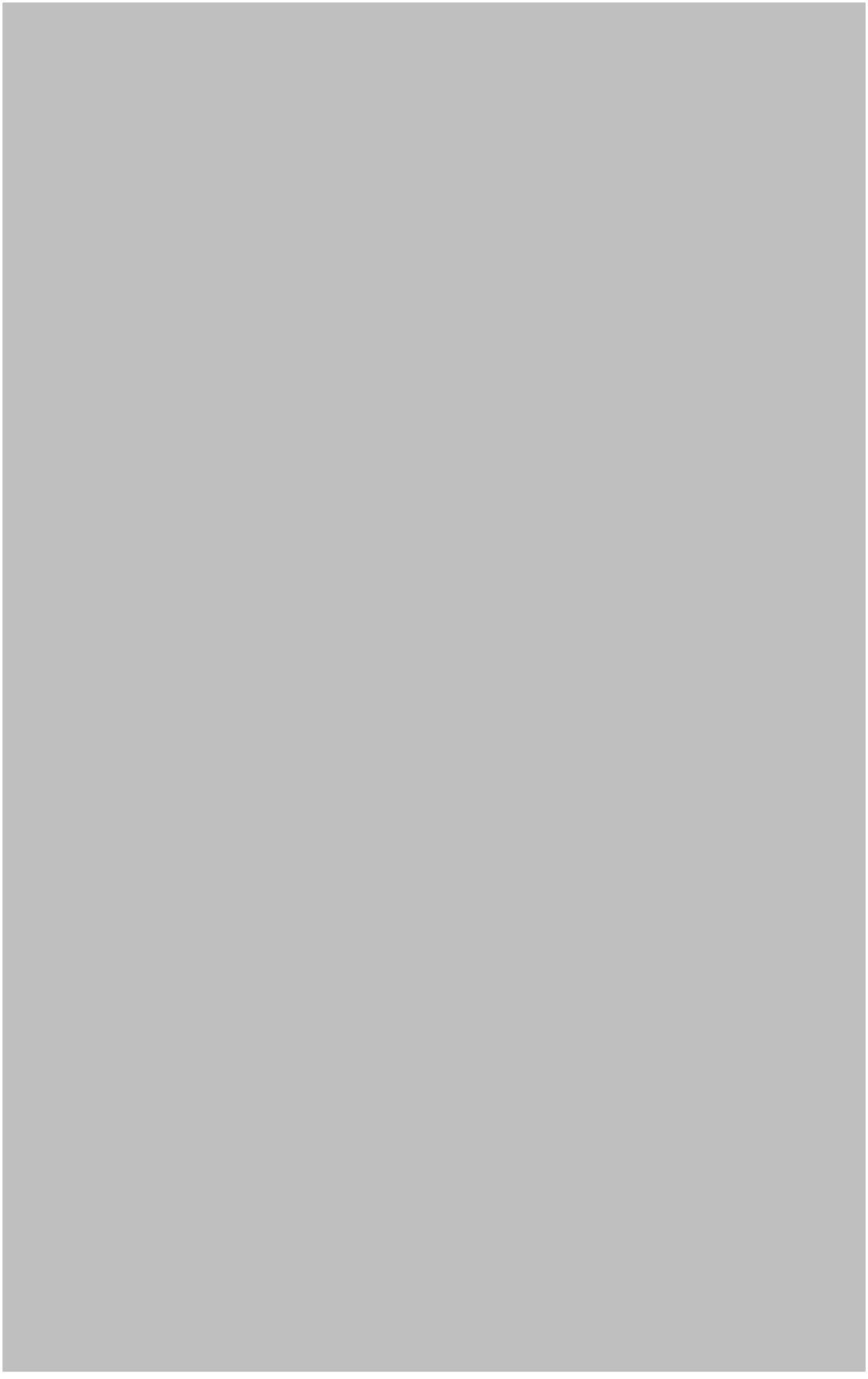


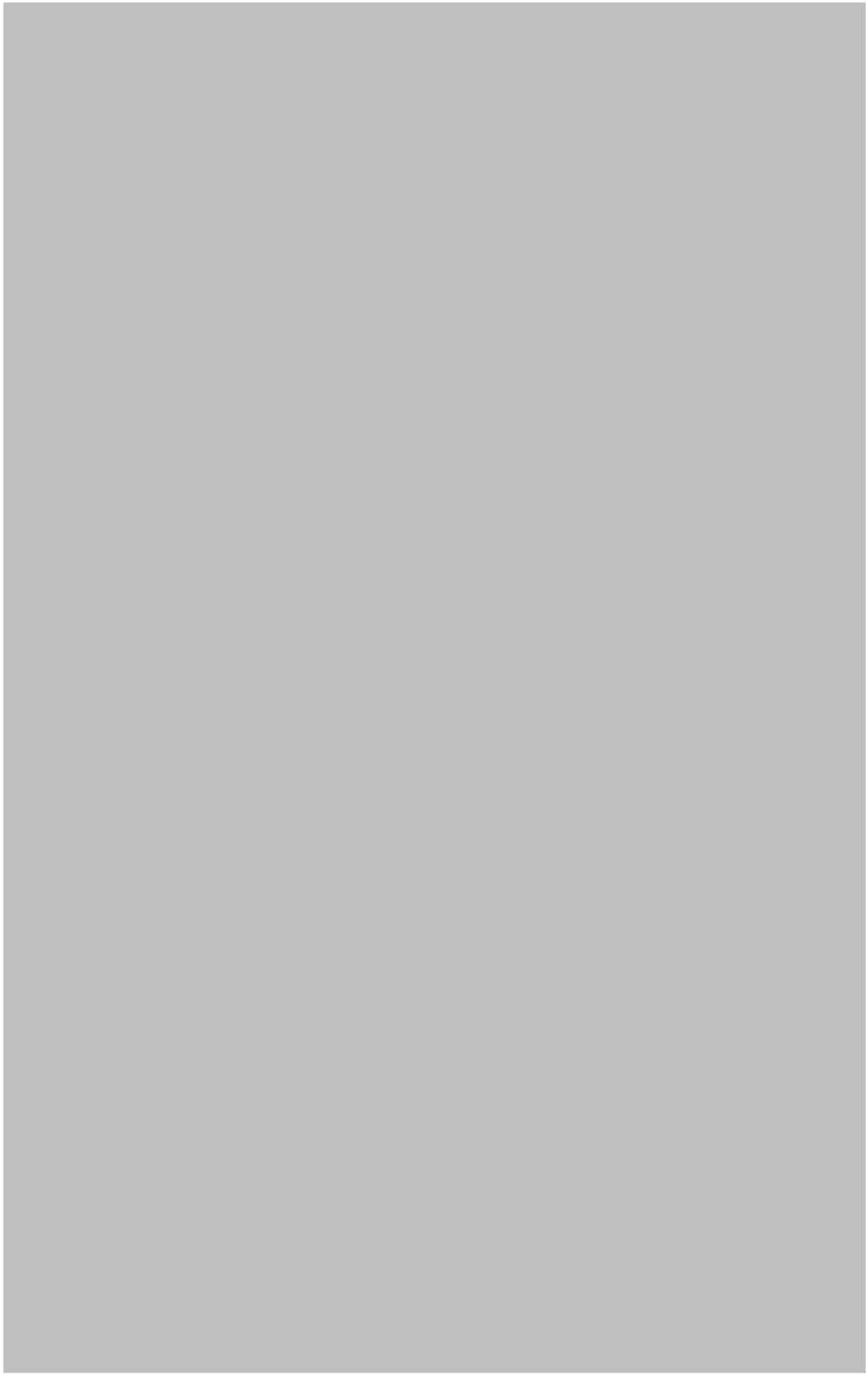


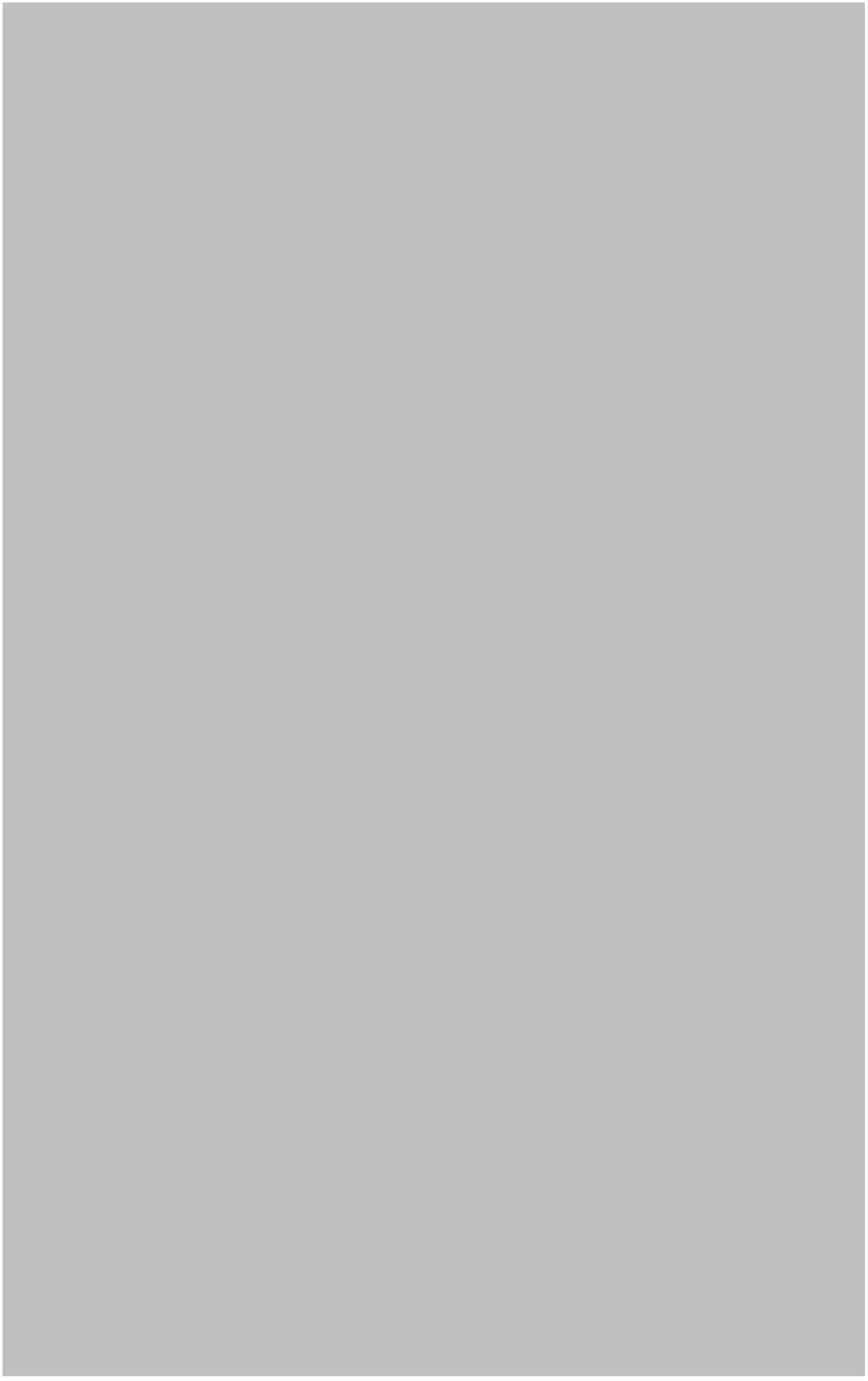












COMMISSIONER WILSON: Alright. Well, just let me collect my thoughts. The remarks that I'm about to make can, I think, be made in open hearing, so the live streaming can go on and if there are people outside who wish to come in, they may. It's so late they've probably all gone home. Mr Bailiff, are there people out there wanting to come in or not?

BAILIFF: [indistinct]

COMMISSIONER WILSON: Thank you.

BAILIFF: [indistinct]

COMMISSIONER WILSON: There has been quite lengthy discussion of the meaning of the Terms of Reference in relation to transition. I have been asked by some counsel to give clarity to the meaning of these Terms of Reference. Others have submitted that I ought not to do so. The issue which seems to have – I'll say that again – the issues which seems to be of particular interest is whether the Commission considers that the causes of death of the three young people who died between April and August 2014 are within the Terms of Reference. With the agreement of all counsel I'm going to make the following statement in this open hearing, which follows a draft put before me by Mr O'Sullivan with the agreement of some other counsel. It is in these terms. The Terms of Reference do not extend to and the Inquiry does not extend to consideration of the following matters: (a) the immediate cause or root causes of the deaths of the three young persons who died during 2014 who had formerly been patients of the Barrett Adolescent Centre; (b) an inquiry into whether those deaths were caused by or contributed to or affected by the closure of the Barrett Adolescent Centre in early 2014; (c) an inquiry into whether

those deaths were caused by or contributed to or affected by the transition arrangements or the adequacy of care provided by the various receiving services.

There is a definition of "transition clients" in Term of Reference 3(d), that is:

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

Who fell within that definition is a question of fact. I am concerned not to prejudge that question of fact. I appreciate that some parties would like me to give an indicatio of who were the transition clients because the question affects their approach to the evidence called by Counsel Assisting the cross-examination of witnesses. Counsel Assisting have provided all other parties with a document headed Confidential Working Draft Potential Transition Client List which is said to be current as at 29 February 2016. It contains about 10 columns including the identities of certain former patients of the Barrett Adolescent Centre, the dates of their discharge from the Centre, their diagnoses at discharge, the dates upon which they were handed over to other services and a "transition period" transition arrangements, witnesses being called and issues.

This table is, as I understand it, a statement of those Counsel Assisting presently submit come within the definition of transition clients. I note the preparedness of Counsel Assisting to provide updates on all of the information in this document on an ongoing basis. In the document under Period of Transition, they have set out their views of the commencement and completion of transition with respect to each of the patients listed in the document. In some cases, the same date. In other cases, a dates – in other cases, the completion date is stated as a date one month after handover, and there may be other dates in other cases. This reflects what I understand to be the true position that the period of transition has to be determined as a question of fact on a case by case basis.

Term of reference 3(d)(ii) requires the Commission to inquire into the adequacy of the transition arrangements for transition clients. Term of reference 3(e) requires it to inquire into the adequacy of the care, support and services that were provided to transition clients and their families. Counsel assisting have indicated their willingness to provide in writing a statement of their present approach to these issues and to update it if that approach changes. I consider that that is an adequate response to the concerns that have been raised by some of the other counsel. I'm not prepared, in effect, to decide even provisionally what is encompassed by the terms of reference about transition. Again, I think there are questions of fact which will have to be determined on a case by case basis, and they will have to be determined in the light of all the evidence and submissions I may receive.

Mr Diehm on behalf of Dr Brennan has identified some inconsistencies between issues in this document I have been referring to and the statements of areas of interest which counsel assisting have been providing in relation to witnesses to be called to

give oral evidence. Again, counsel assisting have undertaken to look into such inconsistencies and make any necessary amendments to either or both documents forthwith. Insofar as any party may wish issues to be added to or varied in the chart of potential transition clients, they should raise the issues with counsel assisting as soon as possible. Mr Ben McMillan who acts for Deborah Rankin has queried whether the educational transition of the transition patients is within the terms of reference. I have been told that there have already been some discussions with counsel assisting in relation to this. Again, it is not a matter which I can or should try to determine today, and counsel assisting is prepared to – or are prepared to indicate their attitude as soon as possible.

Any changes to the chart relating to potential transition clients or to the areas of interest forms or to the statement counsel assisting are going to provide of their present approach to what is encompassed by the relevant terms of reference including whether educational transition is encompassed should be circulated to all parties by the relevant document or documents being placed in the online data rooms as soon as practicable.

I am concerned, as I'm sure all counsel are, that we are falling behind what is a tight schedule. I ask all counsel and in particular Counsel Assisting to review the questions they propose asking in oral evidence to determine whether they're really necessary or whether they can be reduced in their scope. The batting order – as the order in which witnesses are called has been colloquially called – will require further review. Ms McMillan, how much longer do you think you'll be with Dr Sadler?

MS McMILLAN: Fifteen minutes.

COMMISSIONER WILSON: And that encompasses everything?

MS McMILLAN: Well, I'm still awaiting instructions on the other matter.

COMMISSIONER WILSON: Could you let the Commission know as soon as possible - - -

MS McMILLAN: Will do.

COMMISSIONER WILSON: - - - how long you will be - - -

MS McMILLAN: Yes, will do.

COMMISSIONER WILSON: - - - so that that can be taken into account.

MS McMILLAN: Yes, of course.

COMMISSIONER WILSON: I can foreshadow to all that I will be calling for written submissions at the end of the oral evidence and in the week leading up to Easter – probably the Wednesday and Thursday – there will be an opportunity to

speak to these. I do not anticipate full oral submissions. It is critical that all written and oral submissions be concluded before Easter. The only caveat to that relates to potential adverse findings which will be notified in due course with an opportunity for written submission in response and needless to say that will have to occur after Easter.

Is there anything anyone wishes to raise?

MS WILSON: Can I just raise one matter?

COMMISSIONER WILSON: Yes, Ms Wilson.

MS WILSON: I beat you to the mark. In terms of written submissions, is the Commission going to set out a timeframe about when we are required to comply with those, that is, with Counsel Assisting providing the written submissions, a date and then for when we need to respond to those. It's just that arrangements need to be made so that we can adequately set aside time to deal with those and appreciating between the finishing of evidence and the starting of oral submissions is something like 10 days or something like that so - - -

COMMISSIONER WILSON: Well, there's one clear week and then there's the week leading up to Easter and I've indicated that the Wednesday and the Thursday – and I apologise to those who would like to go away but there's I can do about it – Wednesday and Thursday will be set aside to give people an opportunity to speak to their submissions. I don't want to give a final timetable but at this stage I am anticipating Counsel Assisting submissions by the Thursday of the week before Easter and all of the parties' submissions by the Monday of the week leading to Easter. Does that answer your question?

MS WILSON: Well, that is a timeframe so thank you, Commissioner.

COMMISSIONER WILSON: Alright. Thanks. Mr O'Sullivan.

MR O'SULLIVAN: Commissioner, you directed – one issue you – you've disposed of the transition issue. There's that parliamentary privilege issue that you have yet to dispose of on Thursday and you will do it on Thursday. Your direction was I was to put in submissions on Friday which was done and that any other party would put in submissions on Monday. We've seen some very detailed and helpful submissions from the State but we've seen no submissions from anyone else and no submissions from Counsel Assisting. We then are proceeding on the basis that you're not going to get any submissions from Counsel Assisting but if that assumption is wrong we would like it to be clarified. If a particular timetable applies to them as it applies definitely to other parties we'd like to know because - - -

COMMISSIONER WILSON: There's certainly no intention to treat them differentially.

MR O'SULLIVAN: No. No, well, that's why I say we're proceeding on the basis there is no submissions. That may cause you - - -

COMMISSIONER WILSON: Well, just a moment. I should ask Mr Freeburn whether he is proposing submissions.

MR FREEBURN: Yes, I am.

COMMISSIONER WILSON: So are you asking for leave to provide them late?

MR O'SULLIVAN: Yes, please.

COMMISSIONER WILSON: And when are you asking for leave to provide them by?

MR FREEBURN: We can provide them by lunchtime tomorrow.

COMMISSIONER WILSON: Alright. Well, I will give you that leave.

MR O'SULLIVAN: That will be helpful. I think we should try and confine the oral argument to make it as short as possible. It's – I mean, we're put in some submissions. The State has. It seems to me that the proper approach is to try and confine the oral hearing. It's a difficult and messy area and hopefully we can get something that's a workable, sensible way forward.

COMMISSIONER WILSON: Alright. Well, I'll need to look at those submissions. I have read your submissions, Mr O'Sullivan, over the weekend but that's as far as I've gone.

MR O'SULLIVAN: Thank you, Commissioner.

COMMISSIONER WILSON: Alright. Anything else? 9.30 in the morning? Alright. Thanks.

MATTER ADJOURNED at 5.39 pm UNTIL WEDNESDAY, 2 MARCH 2016