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# TRANSCRIPT OF PROCEEDINGS

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**THE HONOURABLE MARGARET WILSON QC, Commissioner**

**MR P. FREEBURN QC, Counsel Assisting**

**MS C. MUIR, Counsel Assisting**

**IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950**

**COMMISSIONS OF INQUIRY ORDER (No. 4) 2015**

**BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY**

**BRISBANE**

**9.03 AM, THURSDAY, 10 MARCH 2016**

**Continued from 9.3.16**

**DAY 24**

**RESUMED** **[9.03 am]**

**TREVOR BRUCE SADLER, CONTINUING**

5

COMMISSIONER WILSON: Thank you. Yes, Ms Muir.

MS MUIR: It's the continuation of Dr Sadler's evidence this morning. I understand
10 Mr Duffy has one question that arose he wishes to ask at the outset. He's discussed
it with Ms Rosengren, and she has no issue with that. So it's proposed that Mr Duffy
ask a question.

COMMISSIONER WILSON: Is the hearing closed or open at the moment?

15

MS MUIR: It's - - -

MS ROSENGREN: It's still open, Commissioner.

20 COMMISSIONER WILSON: And is the question one that can be asked in open
hearing, Mr Duffy?

MR DUFFY: In open hearing, yes. With your leave, Commissioner, of course.

25 COMMISSIONER WILSON: You have my leave. Yes, Mr Duffy.

**EXAMINATION BY MR DUFFY** **[9.04 am]**

30

MR DUFFY: Dr Sadler, my name is Duffy. I appear for Dr Kingswell. You'll
recall that yesterday afternoon your counsel took you to an email that you wrote to
Dr Kingswell on 21 May. Do you remember that one?---I do.

35 And the copy of the email that was shown to you, in fact, contained a copy of Dr
Kingswell's reply to you, also dated 21 May?---Yes.

Do you remember that? And you were asked some questions then about that email
chain. And you were asked whether after that you were invited to any further
40 planning group meetings?---Yes.

And you said, "No, I wasn't"?---No.

And you said that you saw no minutes of that particular meeting nor did you see any
45 further invitations to further meetings?---No.

Alright. Now, this is, just so that we're clear, meetings of the planning group?---Yes.

And the planning group was the group that was set up to consider and report on the recommendations of the ECRG?---Yes.

Alright. Now, do you know when the planning group, in fact, reported to the board?---No.

Can I suggest to you that the planning group reported to the board and the planning group's report was considered by the board, that is, the board of West Moreton, on 24 May?---Yes.

Do you accept that?---I accept that. Yes.

Alright. And that the planning group's report was included in the board papers for the meeting of 24 May?---I accept that.

And that it appears that the agenda – or the board papers were completed prior to 24 May?---I accept that.

Alright. Does that not suggest to you that, in fact, there were no further meetings of the planning group after 21 May?---It could do.

Alright. Well, you're not suggesting that you know that there are?---Well, I saw the recommendations of the planning group, and they included recommendations that – including Y-PARC which hadn't been brought up at that planning group meeting, so I thought there must have been another meeting.

Alright. Well, you thought there must have been, but you don't know that there was?---I have no idea.

Alright. Thank you?---Thank you.

Thank you, Commissioner.

COMMISSIONER WILSON: Thank you. Ms Rosengren, in open hearing?

MS ROSENGREN: In open hearing, please, Commissioner.

**EXAMINATION BY MS ROSENGREN [9.07 am]**

MS ROSENGREN: Dr Sadler, if I could ask you to be shown the statement, please, of Nurse Glubb. And the Delium reference number is FAM.900.019.0012 – sorry – 0001. And I could – if the screen could be scrolled down. It's to .0003 and paragraph 17 there, please. Could I ask you to read that paragraph to yourself?---Yes.

Was it correct that some adolescents hadn't been given a diagnosis for the reasons suggested there?---No. It was a requirement of CIMHA that – well, entering the outcomes, we record a diagnosis at all times. So we could not record outcomes without recording a diagnosis.

5

Can we then go to paragraph 21 on that same page. If it could just be scrolled down, please. So to paragraph 21. And just the first sentence in that paragraph, please. Would you read that to yourself?---Yes.

10 What do you say to the suggestion that BAC over that period of time failed to broker in community services?---We continually tried to establish links with community services for adolescents both for their transition out of the – out of the Centre and for possible placements if any should require placements. We had links with the community CYMHS.

15

Okay. So do you disagree with what is there?---I disagree with that. Sorry.

Okay. And the last paragraph I want you in that statement in paragraph 22 on the same page and to the last sentence in that paragraph. And it might be over the other
20 – the next page. Just – oh, no. So if you can go back – just scroll – yeah. At BAC – if you can just start there – should have been doing?---Yes. I mean - - -

Do you consider that BAC was doing whatever it could to encourage family involvement and to transition patients out?---Certainly to transition patients out there
25 were times when we could have encouraged – well, I was trying to – and the nurse unit manager were trying to ensure that family involvement was kept at a high level.

So do you – is it your position that given the constraints within which you worked in that BAC did do whatever it could to encourage family involvement?---We did do
30 whatever we could. Yes, yes. We did.

And it's also your position that, once again, with the constraints within which BAC worked that it did everything it could to transition patients out?---Yes.

35 I just want to deal with a separate issue now. And that is that Ms Kelly in her evidence a couple of weeks ago referred to some concerns that she had with BAC.

40

MS MUIR: Commissioner, these questions need to be in closed court.

45

COMMISSIONER WILSON: Ms Rosengren.

MS ROSENGREN: I'm just thinking about whether I can phrase it in another way. I think probably it might be best if they are in closed court and I can deal with them shortly.

5 COMMISSIONER WILSON: Alright. Do you have other questions in open - - -

MS ROSENGREN: I do have some other questions.

COMMISSIONER WILSON: Alright.

10

MS ROSENGREN: Do you – Dr Sadler, do you recall being asked some questions yesterday as to whether you promote the BAC as an appropriate model of care. And your response was that you promoted elements of it but you were aware that there were things that weren't so good?---Yes.

15

Do you recall giving that evidence yesterday?---Yes.

What are the elements of the BAC model that you do promote?---I thought that the treatment and rehabilitation component was really quite important. And the – that
20 central component that happened during the day for most adolescents but sometimes that would continue at night for – into the evening for certain groups of patients.

And are there any other elements that you considered to be good?---Well, that's fairly broad, because the – there were multi-modal interventions within the treatment.
25 There were – there were things about adolescents living within the community who had been totally isolated from other adolescents interacting together. I thought that was - - -

Slow down a bit?---Sorry. Interacting with other adolescents, which was important.
30 The rehabilitation component offered adolescents who had been quite disengaged with their community, with school, with peers, to be – an opportunity to slowly engage with those, because they had confronted such difficulties in the community. So the intensive nature, the fact that we could promote treatments both integrate treatment and rehabilitation interventions, that we could do that on a daily basis and
35 reinforce and generalise across various settings, so – so from a group to various other activities in which they were involved.

And what sort of activities are you referring to there?---Well, so, for instance, a person with social anxiety might go on an outing or – and this is the first time they
40 had linked with the community for more than 12 months or so, this desensitised them to the community. Then when they went on leave we would encourage them to continue going out to a local shopping centre, for instance. But we would take them to various outings on the weekday and the weekend. So that's one activity of exposure which is very important in treating social anxiety. There's other things
45 like, for instance, the dialectical behaviour therapy group had many components and – including distress tolerance and interpersonal relationships. So that group went on a Wednesday morning and, from there, staff were able to encourage adolescents to

use those techniques outside of the group in their day-to-day situations, or when they were distressed, or when they were confronting new issues.

What were some of the BAC – the elements of that model that you thought weren't
5 as good?---I thought that the inpatient care was – should be reserved primarily for those who required full nursing staff for inpatient care. The – I thought that the lack of accommodation or Step Down facilities was a major thing which kept them, some of them there – when I say the inpatient care, my thought was that there were some adolescents who required lesser levels of – well, they could live in accommodation
10 that was, well, offsite but that would be – provide them with skills. They could access that treatment and rehabilitation program which occurred during the day. But the difficulties experienced of living on a ward environment where there could be distressing things or some adolescents were experiencing quite acute distress was – were things that I thought they didn't need to be part of that. But – so that
15 accommodation thing was part of it. Certainly the family therapy I would've – I made recommendations to – or tried to get better input for family therapy. And the length of stay I had concerns about, as I've said. Certainly nursing staff's ability was a key issue and I believe that in the last five years at least the nursing staff's ability was a major issue which impeded the – our capacity to deliver interventions in a
20 timely fashion.

In that - - -

COMMISSIONER WILSON: Can I ask a question there?---Yes.

25

Could you explain to me how, if at all, the day programs that you offered fitted in with what you say you would've liked to have happened?---So the day programs that we offered were part of that treatment and rehabilitation program. So adolescents who attended on – as a day program, tend to do the same programs that other
30 inpatients did. So it was the – those core activities that proceeded predominantly between 9 o'clock and 6 o'clock during the day, that's when a lot of the rehabilitation component occurred and that's when a lot of the treatment component occurred for many of the adolescents. For some adolescents the treatment component continued on into the evening.

35

Well, the day patients you had - - -?---Yes.

- - - what accommodation facilities were there for them?---So they could access the Centre as a – from their own homes.

40

I see?---So they came from their own homes. And that's one of the issues with day programs that you can – they have to be accessible from the adolescent's home.

So when you talked about what you would have liked to have happened, namely, that
45 some of the cohort would have lived offsite, would you have envisaged them attending as day patients undertaking the same treatment and rehabilitation as the existing day patients undertook? Or would you have envisaged them undertaking

some different form of treatment and rehabilitation?---No, the existing – the same treatment and rehabilitation program that the existing patients took, Commissioner. So it would just mean – say for a person from a country area who didn't have access to a day program, they'd have accommodation, they could access a day program or – and the same treatment and rehabilitation programs. So it would be one program that people would access from – either from their own homes, from the residential accommodation offsite, or if they needed an inpatient stay, as an inpatient.

I think I understand. Tha
MS ROSENGREN: And is one of the issues that you've raised there that there was no residential accommodation facility for those adolescents who were unable to reside at home in those circumstances?---No, there wasn't.

You were asked some questions by Ms McMillan yesterday regarding the Redlands Project and the view expressed by colleagues that up to six months was ideal as a length of stay at the time this project was being considered and that you considered that such a period was not adequate as a cut off point, if I can call it that, six months. Why was that?---Because in spite of intensive interventions, there was a – there were adolescents who didn't engage until four or five months and then their treatment started to begin after that period. So we found that people were staying longer than six months and that the – certainly the ECRG initially suggested a six month period and then changed that to, you know, a longer period, preferably 12 months because it considered the evidence. I don't know if I can clarify the reasoning behind that decision to – for a six month period. That was based on a comment from an academic who suggested his view was that six months was the optimum length of time. I and he produced some literature. His experience was based in an alcohol – drug and alcohol rehabilitation program in the United States that was with a different subpopulation. The literature that he supplied was not literature that was relevant to BAC. It was related to children in residential settings in the United States. And the – even the outcome of that literature didn't suggest that six months was necessarily an ideal time. There was also the consideration that Rivendell, for those people that it saw, aimed for a six month program.

Okay. I want to ask you this. If this was to be addressed moving forward, do you consider that up to six months would be an ideal length of stay provided there are the supporting wraparound services, Step Down facilities, those sorts of - - -?---I believe the minimum length of stay is the ideal. And there are some adolescents I know in acute inpatient units who would possibly spend less than six months but benefit from the treatment and rehabilitation program. I believe that an intensive service with stable staffing, all of the problems intact, a Step Down facility and then supported accommodation to which adolescents could go would see the lengths of stays reduced considerably. And I would be aiming for six months. I think the idea of a review, a clinical review after six months was good. But we continued to review with the referring service the length of stay and the – what people – what was happening for them so that they could comment.

Now, Doctor, onto a different issue now, Professor Kotzé gave evidence yesterday that there seemed to be a number of adolescents with eating disorders at BAC, and in her view a long-stay inpatient treatment is not a contemporary model of care for those adolescents. Do you agree with that?---It's complex because I have looked at the – or considered the eating disorder literature, and it doesn't address the issues of people with severe and persisting eating disorders. I attended a conference in London and a conference in Sydney that looked at this group in particular. One of the conclusions that they were coming to was that a rehabilitation program was quite important. So the literature doesn't address those particular group of people with a severe and persisting eating disorder, what is the best treatment for them. Certainly, we included a strong rehabilitation component because we felt that everything was becoming focused on the eating disorder for these young people and they needed to get on with the other developmental tasks. So I believe that that was important. I also visited Professor Simon Gower's unit in Chester in the UK, and although he wrote an article advocating for community treatment of – specialist community treatment of eating disorders, with which I agree is the predominant form, there were nevertheless adolescents who spent a long time in his unit in Chester, up to 12 months or so, with an eating disorder.

Now, Professor Kotzé also gave evidence that long-stay inpatient treatment is not a contemporary model of care for adolescents with personality disorders. Do you agree with this?---I agree that it's not a contemporary model of care for adolescents with borderline personality disorder, which is the predominant disorder to which people refer. For those with avoidant personality disorder, which is an extreme form of a social anxiety and anxiety disorders that pervades the whole of the young person's functioning, I believe that there can be improvements made in their level of functioning through contact with peers and through the intensive treatment and rehabilitation program.

What do you say to the suggestion that the model of care at Barrett prolonged the inpatient care for the adolescents being treated there?---I think the issue for the model of care was – is not so much an issue as the other factors which I've identified in my submission. The lack of a step down unit, supported accommodation, lack of stable nursing staff and the difficulties in providing family interventions. So - - -

Were there also issues with allied health staff as well in terms of adequacy and stability?---Certainly in allied health staff, we – I believe that we were understaffed. We often had masters and doctoral level psychology students with us for six to 12 months, and we ad to rely on them to provide some of the interventions for young people with – psychological interventions, yes.

Now - - -

COMMISSIONER WILSON: Excuse me, I didn't catch something Dr Sadler said a moment ago.

Dr Sadler, you summarised four points. You said the lack of step-down facilities, the lack of supported accommodation, the lack of stable nursing staff, and then there was a fourth one I didn't catch?---The difficulties in providing adequate family interventions.

5

Thank you. Sorry. Go on?---Sorry, Commissioner.

MS ROSENGREN: Thank you. Now, I just want to ask you a few very brief questions, and only two of them are issues briefly about the 2009 review. You spoke

10 in evidence yesterday about the fact that after the 2009 review came out, that you broke to Dr Stedman about it and you indicated to him that you would provide a response to the recommendations made?---I did.

And you then provided a response to him?---I did.

15

And do we understand from your evidence yesterday that you then met with him to discuss those responses?---Yes, I did.

And do we also understand from your evidence yesterday that he did not raise with

20 you any concerns regarding the adequacy of the responses you provided to that review?---No, he didn't.

And you then said that following this there was a process of implementation, I think were your words, in which the district set up a process to look at the various issues

25 that needed to be addressed?---Yes.

So would it be fair to describe the response to the review to have been a joint response, if I can call it that, at both the BAC level and also the district level?---It was - - -

30

MS McMILLAN: Commissioner, I object. The evidence was very clear last week that this witness absolutely rejected the recommendations made in 2009. He was unequivocal. Now, he said now he's provided a response, and this whole colouring that, in fact, he in some way embraced recommendations is completely at odds with

35 his evidence last week.

COMMISSIONER WILSON: Ms McMillan, I'm going to allow the question. He was taken through a number of the recommendations yesterday - - -

40 MS McMILLAN: Yes.

COMMISSIONER WILSON: - - - and he made comments one way or the other with respect to those recommendations. I can't see that the questioning doesn't follow from that.

45

MS McMILLAN: Very well.

MS ROSENGREN: Can you recall yesterday, Dr Sadler, being asked about one of the concerns identified in the review regarding the fact that there appeared to be negligible evaluation of treatments at BAC?---Yes.

5 If I could ask Dr Sadler to be shown his first statement, please. The Delium reference number is DTZ.900.001.0001. And, in particular, if we could go to page 0035 of that statement. Doctor, can you see the heading there – this is the first statement that you provided, about halfway down. If we can scroll down, please. Evaluation of BAC Interventions?---Yes.

10

And you've addressed in detail over the next three or so pages the evaluations of treatment that were undertaken at BAC?---Yes.

And had many of these various measures of evaluation, if I can call it that, detailed 15 under that heading been implemented prior to the 2009 review?---They were continuing processes that had occurred prior to the 2009 review.

And I think just before Ms McMillan made her objection, I just – I think the question I was asking you – whether it would be fair to describe the response to the review to 20 have been a joint response, if I can call it that, between the BAC and the district?---Yes, it was.

In relation to the 2003 review – and I'm not going to spend a lot of time on this – you were taken to a draft partially completed table of actions or steps that had been taken 25 in relation to the various recommendations?---Yes.

Was that provided in response to you to see if you could locate any documents that you had relevant to the 2003 recommendations?---That's – it was, yes.

30 And that was the only document that you were able to locate in your possession?---Yes.

Are you aware whether that review – whether that documentation was subsequently progressed and updated?---That was then finalised and signed off by the executive 35 director of the mental health services for The Park.

Okay. But you don't – you didn't - - -?---I didn't have a copy.

- - - personally have a copy of that?---No.

40

And I know – once again, was Dr Stedman your supervisor - - -?---Yes.

- - - your direct supervisor at that time?---Yes, he was.

45 Did he raise any concerns with you about the responses that you provided, insofar as you could in relation to the 2003 review?---No, he did not.

And would it be fair to describe that review to have also been a joint – well, the response to that review to be a joint response by BAC and also the district?---Yes, absolutely.

5 Commissioner, I have no further questions in open hearing for Dr Sadler. Actually, there is just one very brief issue, if I could just address that, and it relates to the issue of the CIMHA records?---Yes.

Nurse Clayworth gave some evidence a couple of days ago – about two days ago
10 now – that when she became, I think, the acting nurse unit manager in September, I think it was, or August 2013, that she fully activated the integration of the BAC records into the CIMHA system. And she indicated that there had been some reservations expressed by yourself and also Nurse Daniels about what records should be placed on CIMHA, if I can say that?---Yes. Yes.

15

Are you – were some reservations expressed by yourself?---So my reservation was in using the CIMHA template for case conference, because it prints out as an eight page document, and I felt that communications are not clear and staff do not refer to an extensive document that's eight pages in their day-to-day thing. So for the weekly
20 case conference, we had a template that was provided by The Park and was used elsewhere in The Park because it was a one-page document that staff could clearly refer to. It was coloured yellow so that there was a ready reference that staff should be addressing when they looked at the notes when they – when they looked at the case conference notes. Certainly, the – the care planning notes and the care planning
25 preparation notes were uploaded onto CIMHA.

And if a patient came in – or a young person came in with a particular diagnosis, is that the diagnosis that was recorded on CIMHA?---It would be recorded on CIMHA initially, but that diagnosis may change.

30

Okay. Now, they are all the questions I have for Dr Sadler in open hearing, Commissioner.

COMMISSIONER WILSON: Does anyone else have anything in open hearing?
35 There is one question that I would appreciate an answer to. And that's with respect to the recording of diagnoses on CIMHA. You said earlier this morning that you couldn't record outcomes without recording diagnoses. Was that correct?---That was correct, Commissioner.

40 If a patient had a number of co-morbidities, were all of those co-morbidities recorded in the diagnosis section of CIMHA?---No, they weren't, Commissioner. At that stage, my recollection is that we could only record up to three diagnoses so that there would be one diagnosis and then there would be room for another two. Subsequently, there seems to be the capacity to record all that needs to be recorded
45 about a particular young person.

Do you know when that change occurred?---No, I don't, Commissioner.

Does anyone have anything arising out of that? Well, the hearing should be closed so that you can ask some questions. Is that what you want?

MS ROSENGREN: Thank you, Commissioner.

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COMMISSIONER WILSON: The live streaming should go off, please, and people should leave the courtroom. When you're ready, Ms Rosengren.

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Closed Hearing

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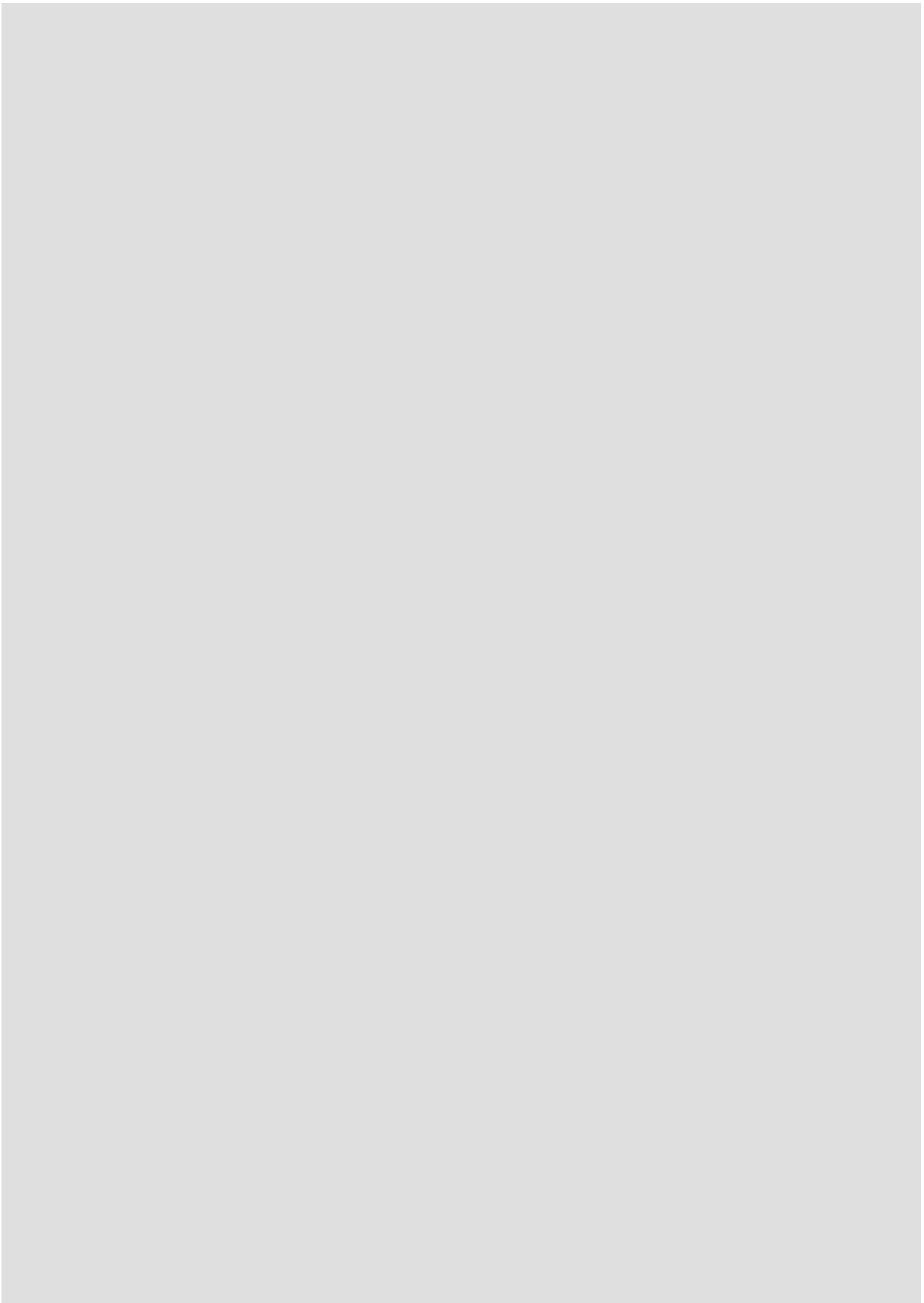

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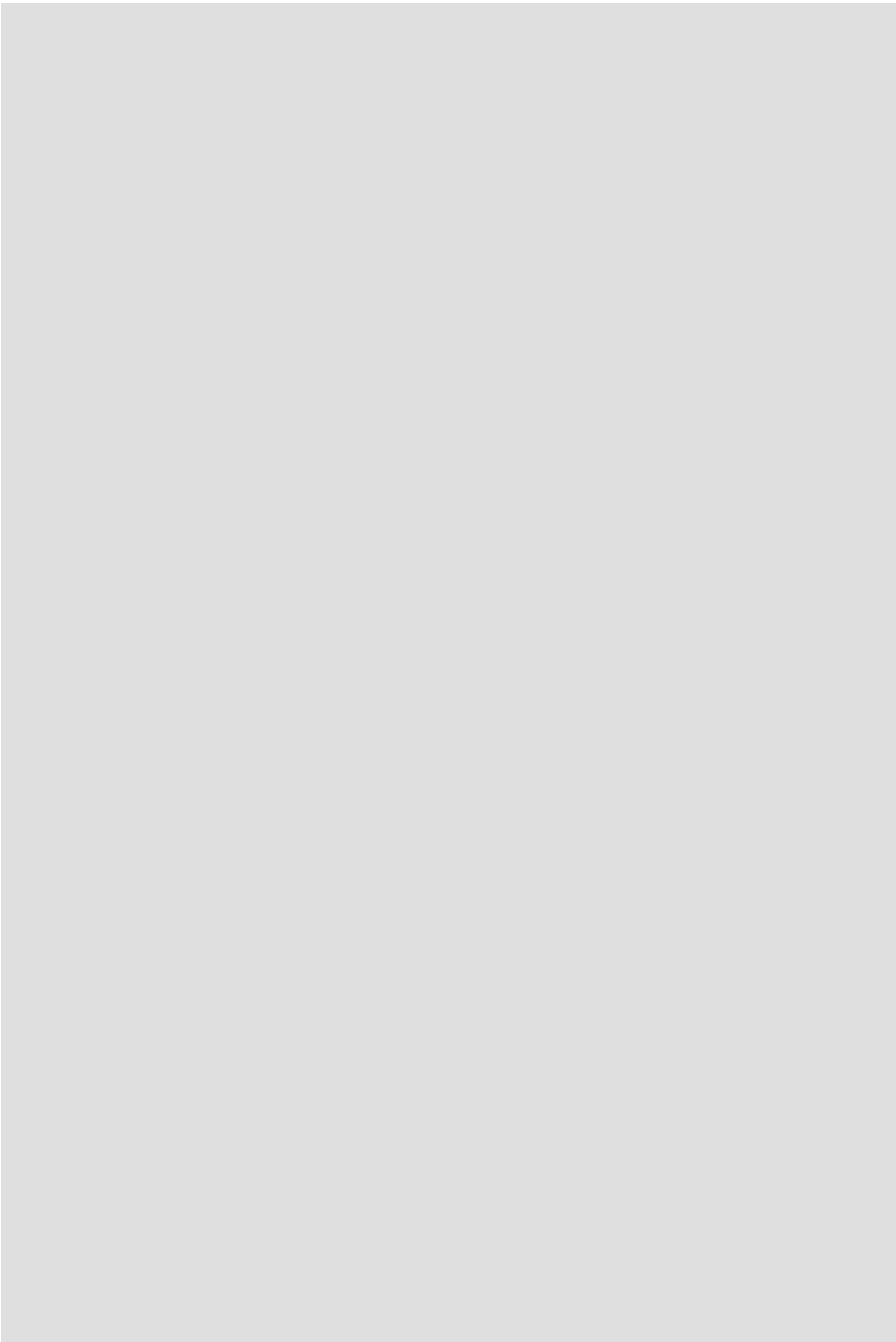

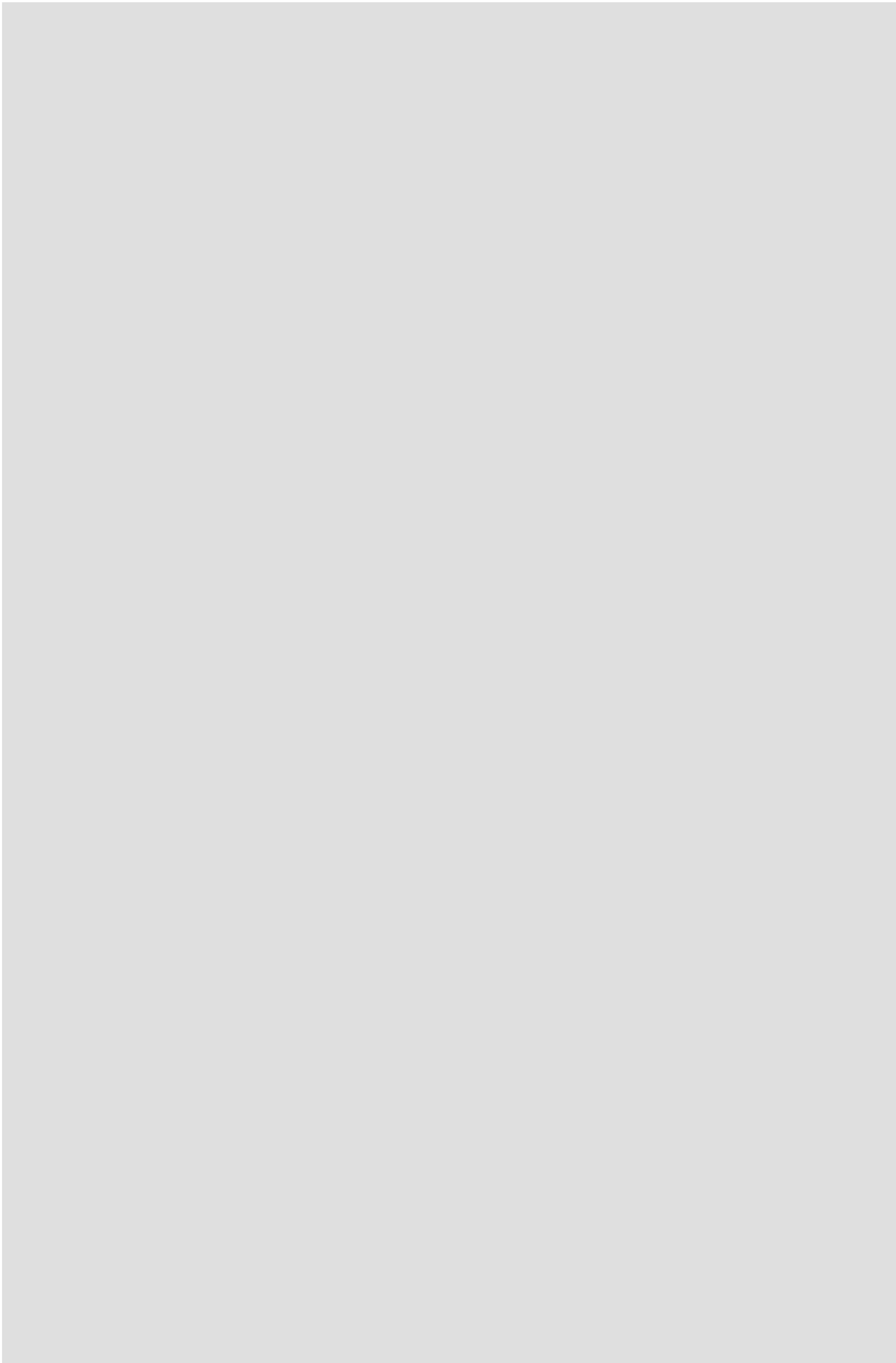

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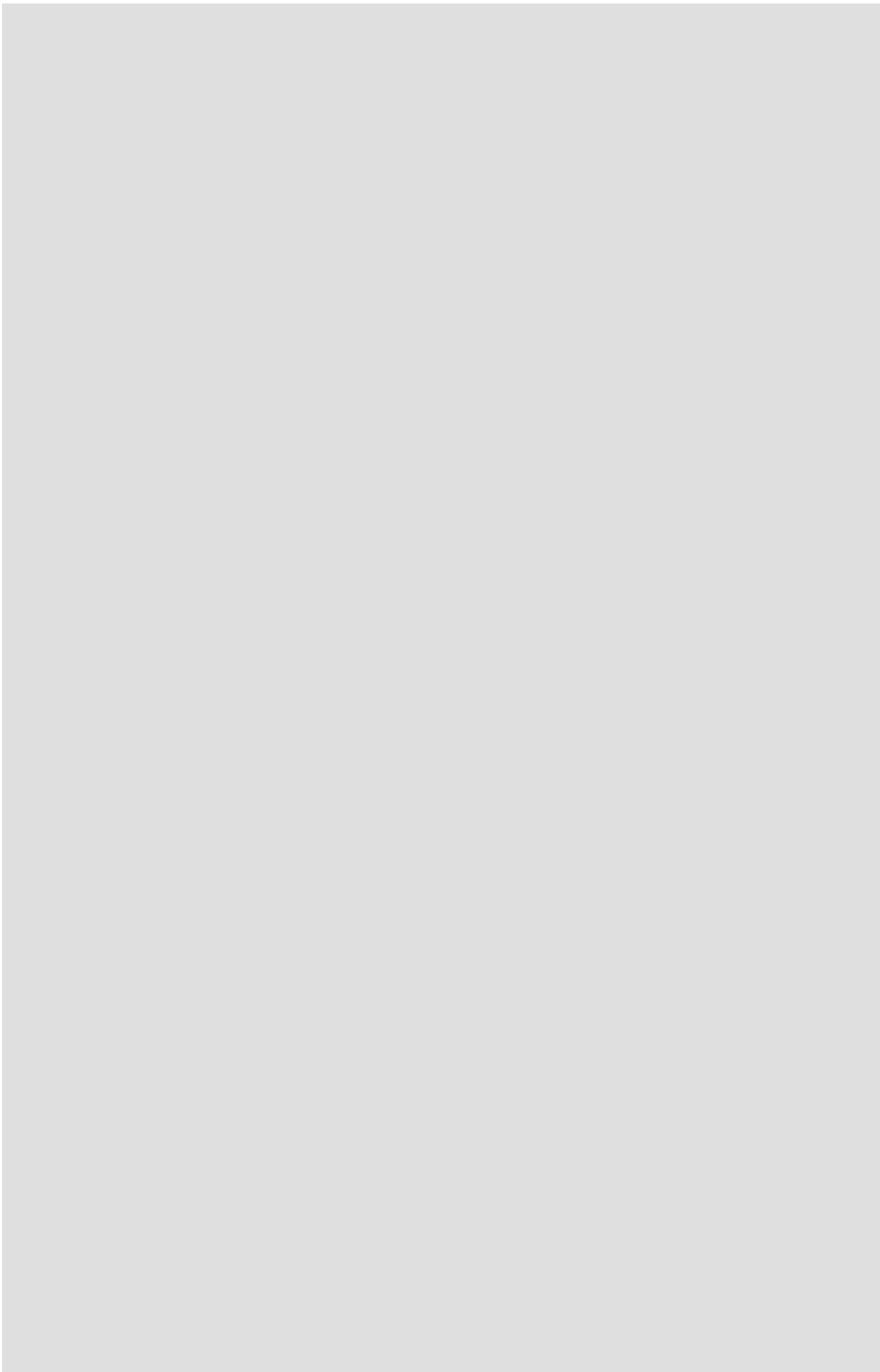

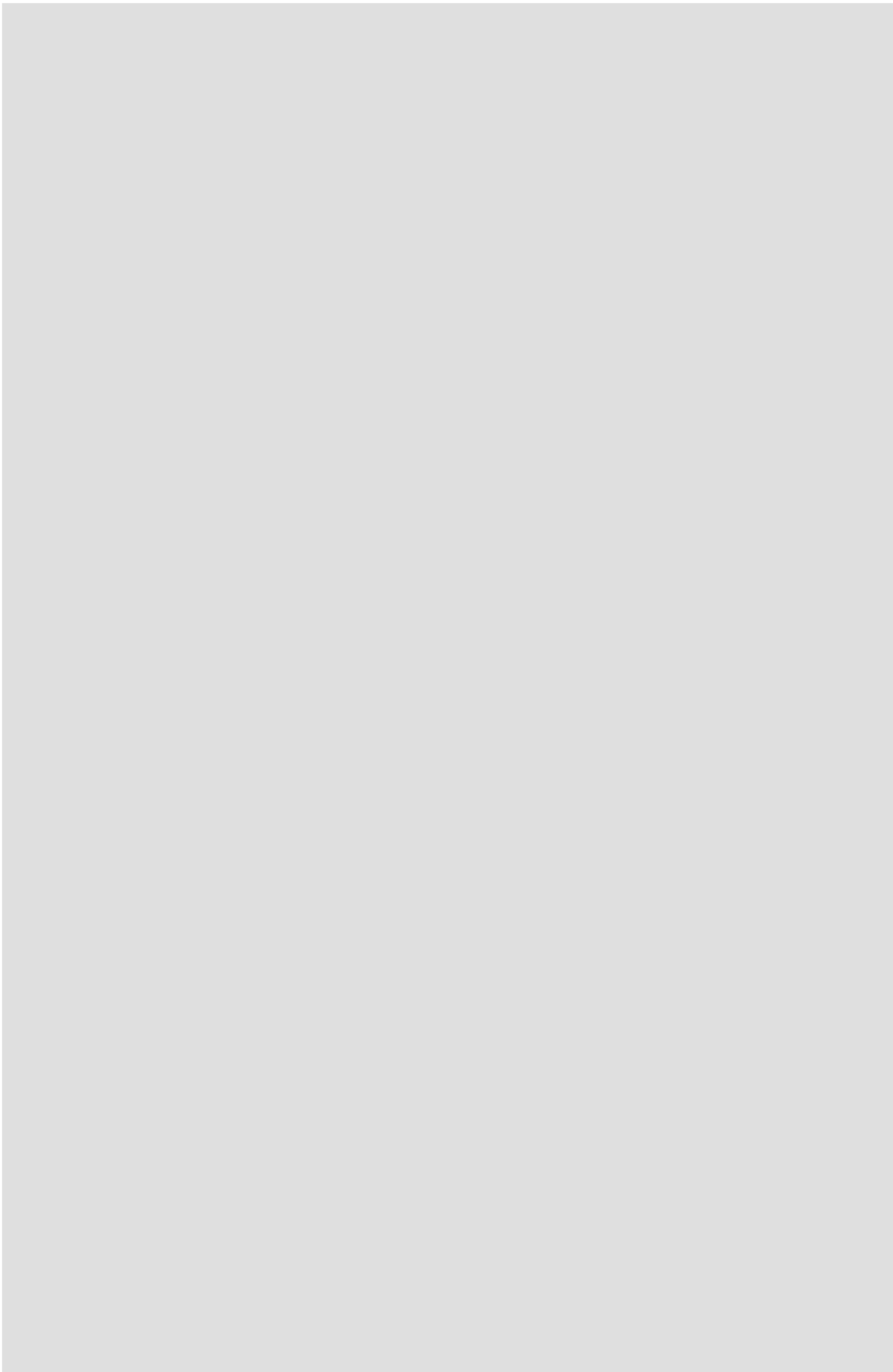

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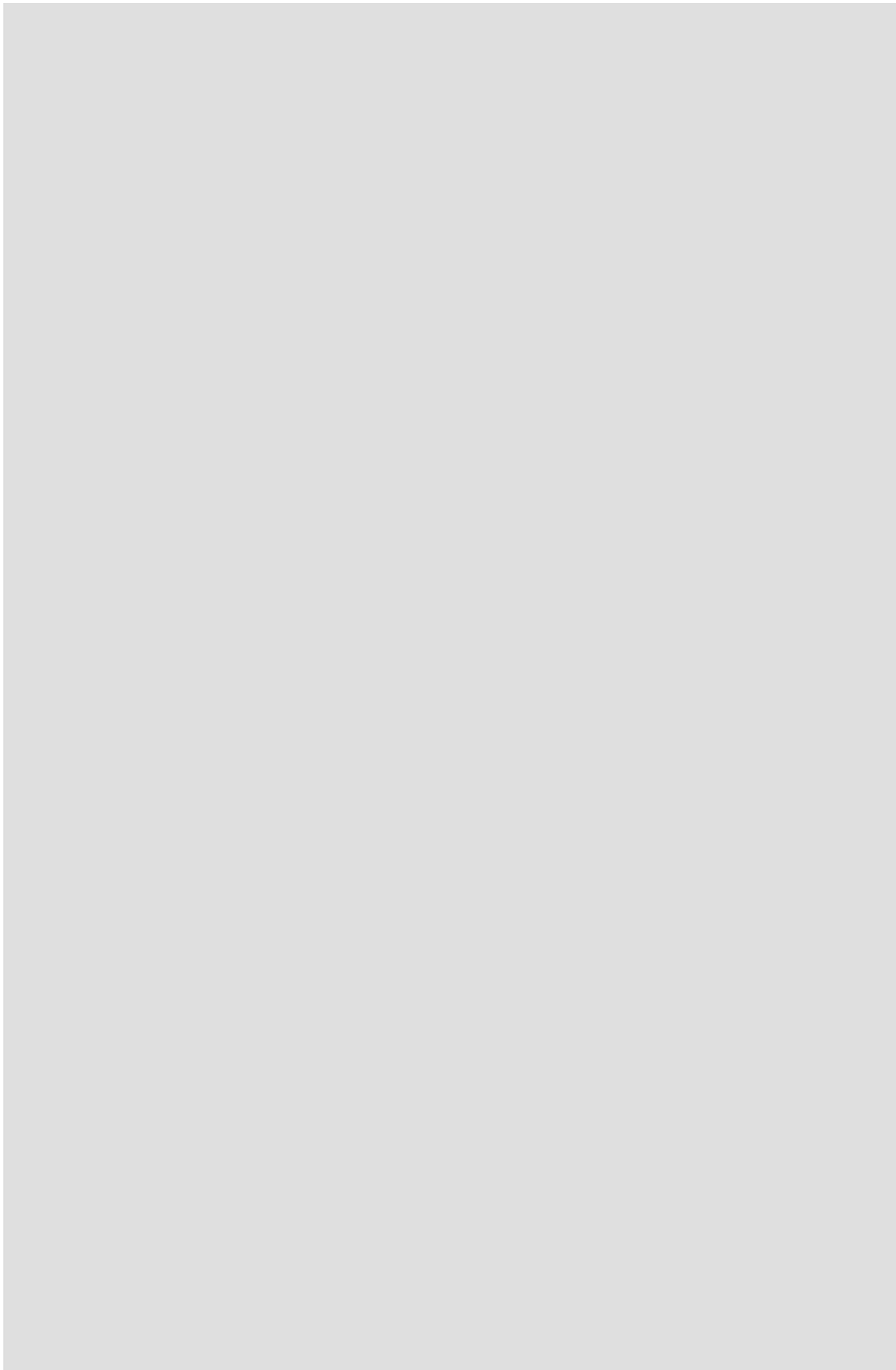

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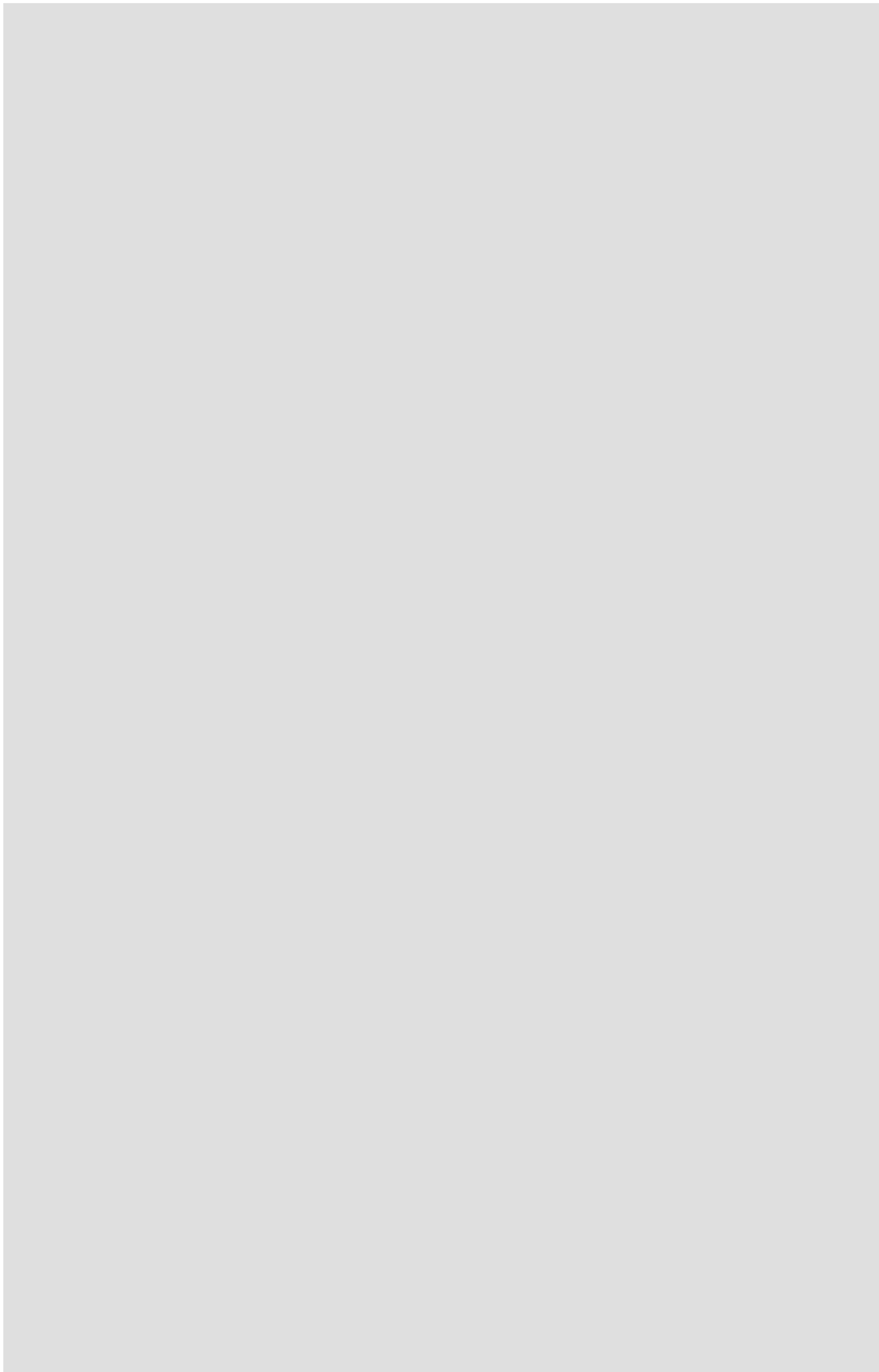

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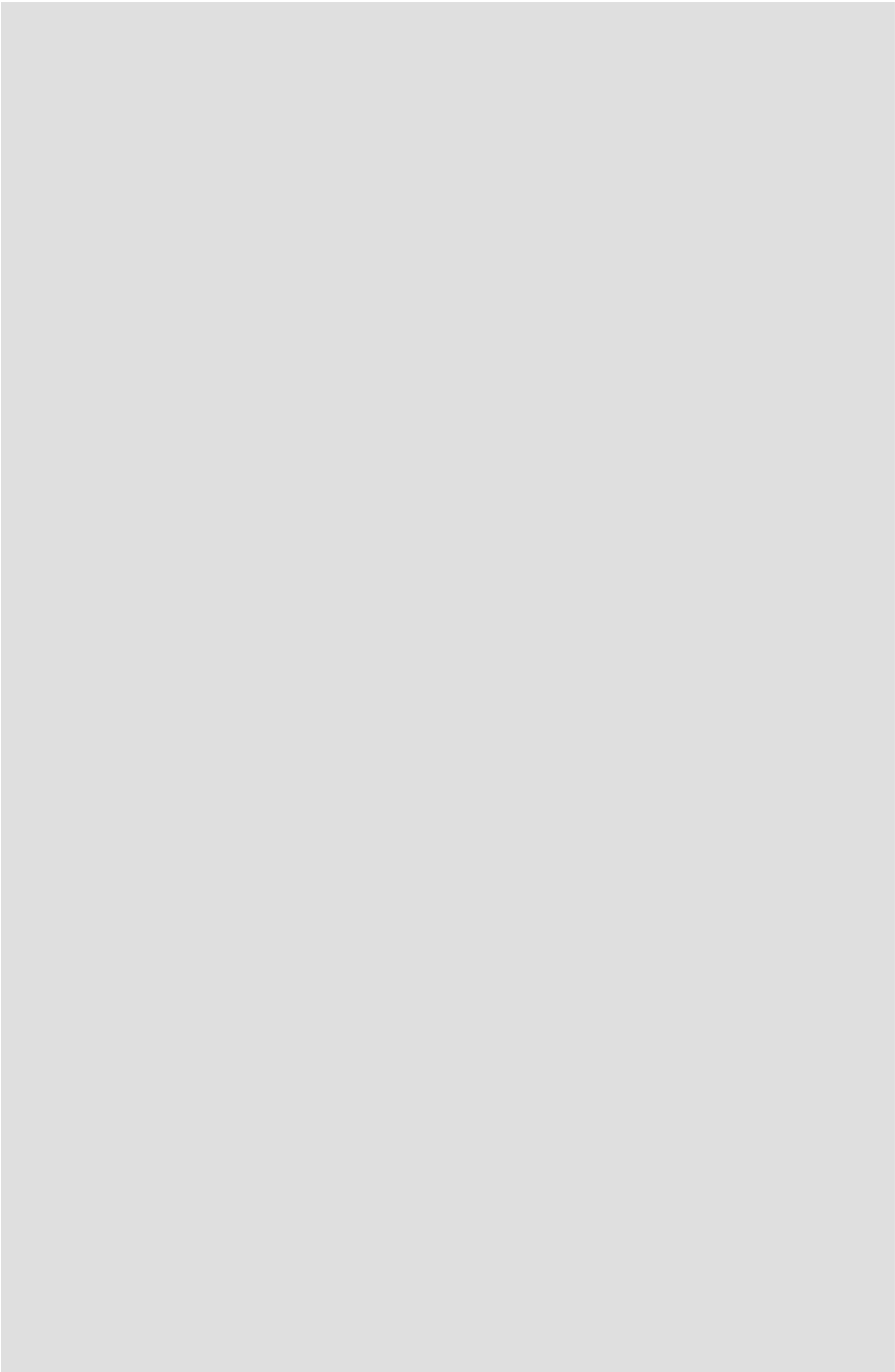

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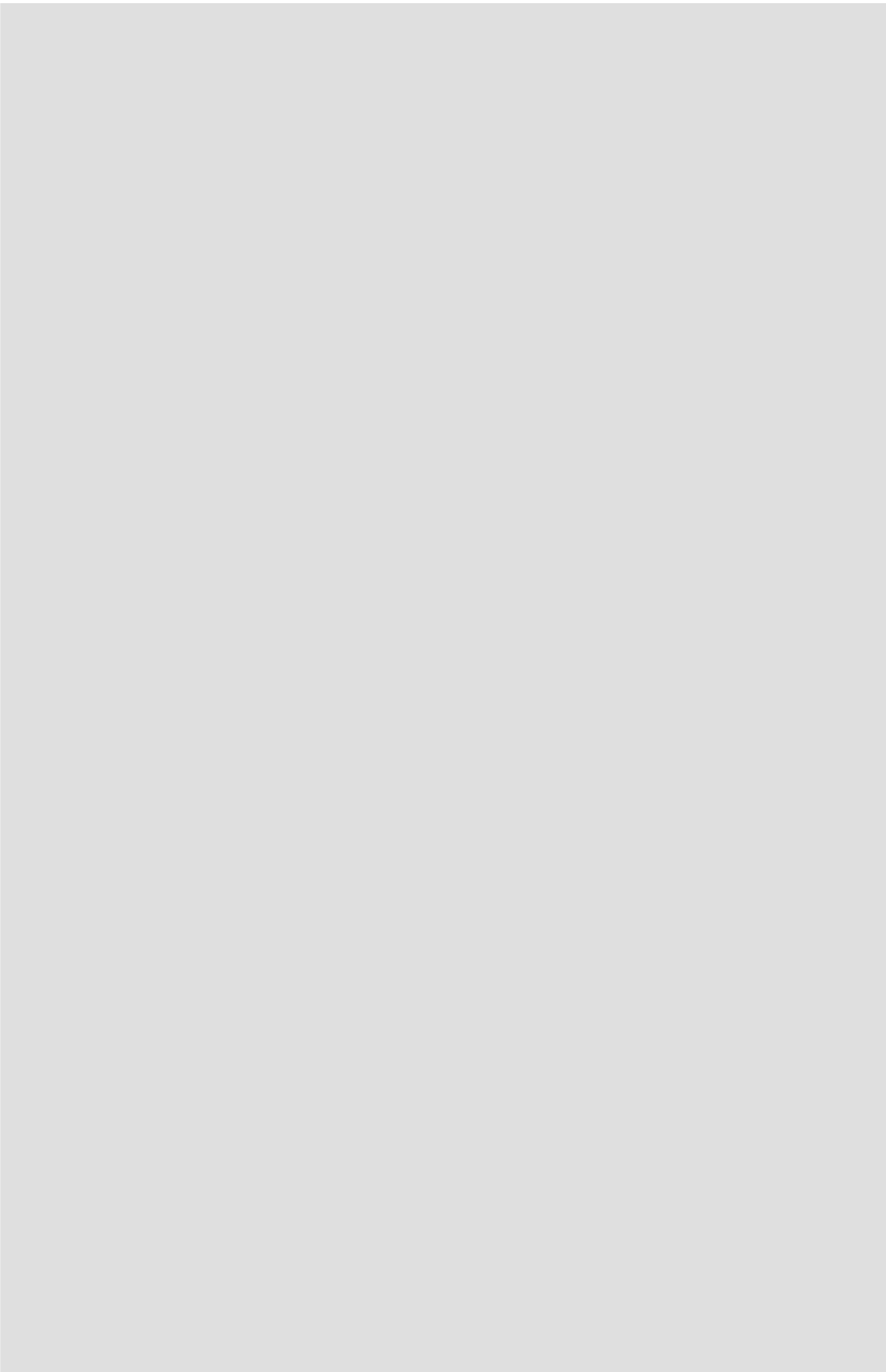

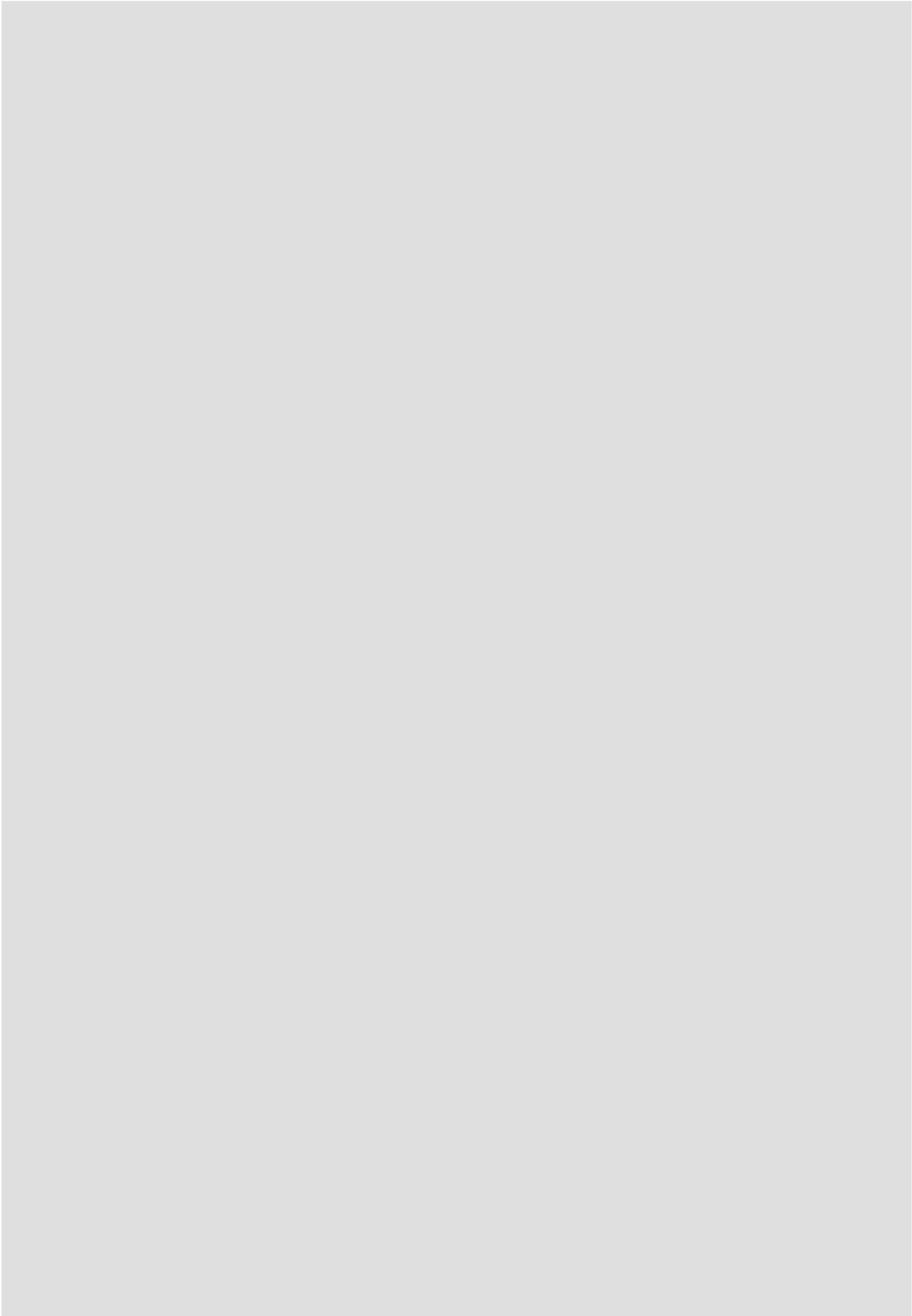

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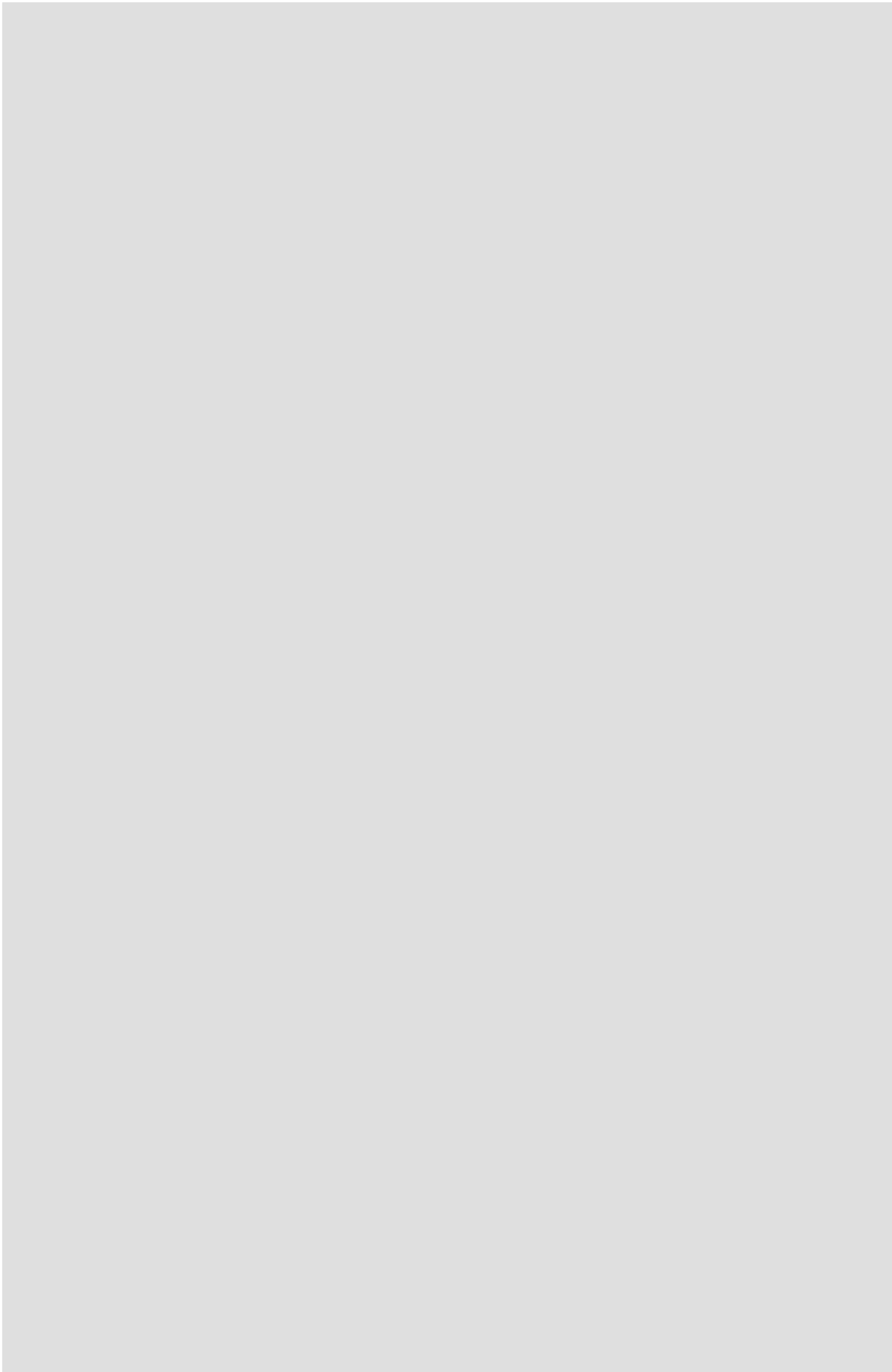

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MR FREEBURN: Thank you, Commissioner. I call Dr Stephen Stathis.

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**STEPHEN STATHIS, AFFIRMED** **[10.10 am]**

**EXAMINATION BY MR FREEBURN**

COMMISSIONER WILSON: Mr Freeburn, the court should be opened.

5

MR FREEBURN: Yes.

COMMISSIONER WILSON: The live streaming can come on, please. Yes, Mr Freeburn. When you're ready.

10

MR FREEBURN: Dr Stathis, you're currently the medical director with CYMHS at Children's Health. Is that right?---That's correct.

And you previously held the role of clinical director of CYMHS at Children's
15 Health?---That's correct.

What's the difference between those two positions?---It was just a progression. When the two hospitals amalgamated last year there was a difference – that's the Royal Children's Hospital and the Mater Hospital. When we amalgamated, there
20 was just a difference in the governance structure, and so given that difference, I applied for the position of medical director of Child and Youth Mental Health Services at Children's Health Queensland. That was the position.

Is there a difference in the nature of the role of a medical director versus a clinical
25 director?---Well, it depends. I guess in this context, I was the clinical director of Children's Health Queensland, so that took into account the services covered by Children's Health Queensland at the time, but not the Mater Health Services. So in this context, then, I took over also as the medical director of Child and Youth Mental Health Services across the whole spectrum.

30

Okay. Looking at your curriculum vitae, you're the author or co-author of 28 separate publications, and looking at them, those journal articles cover a wide variety of topics?---Correct.

35 Do you agree with that? About half of them, 14 of the 28, are adolescent forensic articles. Three are on paediatrics, which might've been early on in your career?---Yes.

And then there's something called liaison services?---Consultation liaison services.
40 Correct.

And rural or telepsychiatry?---Yes.

Which I gather means psychiatry at distance?---Correct.

45

And there are some others like autism– so does that fairly reflect your areas of professional interest?---It reflects my areas of professional interest and also, over time, the areas where I worked clinically.

5 Yes. Now, I want to take you to the memorandum where you announce your appointment as clinical director of CYMHS. It's at page 52 of your statement?---Yes.

It's on the screen. Look, the way in which you express it is to say your
10 responsibilities are as clinical director of all statewide and local child and youth mental health services covered by Children's Health Queensland Hospital and Health Service. And then you say the majority of your consultation liaison responsibilities will conclude by 7 January. Then you say you will continue to do four things. I'm trying to summarise and go quickly. The four things that you will
15 continue to do – have I got this right – were provide advice for children with gender dysphoria and disorders of sexual development?---Correct.

You remained a consultant psychiatrist on a child and youth forensic outreach service?---Yes.
20
You continued to run something called an option A private practice clinic through Royal Children's Hospital. What's that? What's the option A?---It's a small clinic where I see a variety of young people with mental health problems. It's run within the hospital. It's now termed the right of private practice. It's not a private practice
25 in the traditional sense. I have just referrals in from GPs and I provide advice and consultation in relation to those referrals. I don't retain any of the funds.

Right. And the fourth thing that you were going to retain was your e-CYMHS responsibilities. What were they?---Those were the telepsychiatry responsibilities.
30
I see. So that's distance - - -?---Plus we also would frequently fly out to regional areas to provide face-to-face consultation.

I see. So I take it from all of that that you've got fairly broad child and adolescent
35 psychiatric experience. Correct?---Correct.

But you don't have a particular focus on non-forensic adolescents requiring extended treatment and rehabilitation?---I don't have a particular focus on that. No.

40 Can I deal now with a document– for the operators I'll give the number, it's QHD.012.002.2527?---Yes.

Now, if we start at the bottom we can see that Professor Martin starts the discussion. And I gather there's an internet group of psychiatrists?---Yes.
45
Child and adolescent psychiatrists?---Mmm.

And this is part of a – well, it certainly starts as part of a discussion amongst that group. Can you see that?---Yes.

And I wanted to focus on a particular line. You'll see – if we can get it up on the screen, it's down the second of three pages. That's it, if we scroll down a bit further. So you see the paragraph that's on the screen that starts "the rhetoric is that no front line" - - -?---Yep, the rhetoric. Yep.

Rhetoric. Now, Professor Martin is saying:

> *Our own service has been asked (behind closed doors) to reduce our budget by five per cent across the board.*

Now, what was his own service? What was Professor Martin's own service?---At the time, Professor Graham Martin also had some clinical responsibilities. And at the time, the Professor – he was the Professor of Child and Adolescent Psychiatry at Children's Health Queensland. One of his responsibilities was that he was historically the clinical director. Unfortunately, Graham suffered a severe medical illness and he was off for a prolonged period of time. Over that time, I then started to take over the clinical directorate responsibilities. Graham, though, was kept in the loop, as much as possible given his medical illness, about clinical issues as they came up. Graham had then just returned to work, I believe, at that time. And we were keeping him informed.

But what was his service when he said - - -?---He was, at that time, the Professor of Child and Adolescent Psychiatry.

Right. So he's saying that five per cent cuts across the board were going to apply to Child and Adolescent Psychiatry?---The context to that statement was that Peter Steer had talked confidentially with Judi about possible cuts. And this was at the time where there were efficiency dividends that had been floated across a range of the Queensland Health services by the then government. Judi then spoke to Graham and I in confidence about those cuts. But the Board were also backing Children's Health Queensland to negotiate with the Government to reduce those cuts. These were confidential discussions that, as you can see in the email, I was concerned that Graham had then broadcasted across the general group.

So was it the case that there'd been a direction to cut by five per cent but there were attempts to negotiate that? Or was it the – was it put in some sort of preliminary way that there were to be five per cent cuts?---No direction had been given. It had just been floated that a five per cent cut might be required.

So do you know where the directive came that – or the floated idea of five per cent came from?---I wasn't part of the original conversations. It was just what Judi had told me. No.

And if we scroll back to the first page we see your response:

> *Thanks, Graham –*

at the bottom. And you say:

5 > *The issue of the five per cent cuts mentioned in Graham's email is not to –*

it should be "not to be disclosed outside our consultant group." And then you say:

> *My most recent information indicates that the cuts may not be as deep as*
10 > *initially thought.*

What was your recent information?---I can't recall.

You see at the end of that same paragraph you say:

15

> *The board has been actively engaging with the Minister and the final decision will be announced in about a month.*

Were you part of those discussions?---No.

20

Was it the Children's Health Queensland board that was being referred to here?---Yes.

Do you remember what the final decision was?---I don't.

25

Do you remember whether the five per cent cuts applied?---I can't recall.

COMMISSIONER WILSON: Were there any cuts?---Commissioner, I can't recall whether there were cuts at that time. There may have been small cuts or we may
30 have had to redesign some positions.

MR FREEBURN: Dr Stathis, can I take you to paragraph 29 of your statement, please. This is your initial statement. There's two of them, isn't there?---Yes.

35 Perhaps I can just read it:

> *I do not specifically recall –*

this is on page 8 of the document:

40

> *I do not specifically recall exactly how or when I was informed of the closure date for the Barrett Adolescent Centre. The information was public knowledge. The decision about the closure date was made by West Moreton Hospital and Health Service.*

45

Do I take it from that that you only learnt of the closure of the Barrett Adolescent Centre when it became public?---From memory, yes.

Can I take you to this document – QHD.012.002.2433. You'll see it's an email from you to Dr Kingswell?---Yes.

And I just wanted to ask you about – if we scroll down to near to the end. You see
5 item number 2?---Mmm.

Continuing:

*Anything new re Barrett. I've kept your confidence and have not discussed. Is*
10 *Peter Steer aware of the plan.*

Did you know at this point that the Barrett Adolescent Centre was closing?---I didn't know the date. No. I didn't know the date.

15 Does that mean you did know but you didn't know the date?---Well, there was a lot of discussions about the Centre being closed – closed right back from 2012. That's what Trevor actually put on his email.

Yes?---At that time, he said the Centre was going to close in December 2012. But I
20 didn't know the date.

Well, this is July 2013. And by this time, you participated as a member of the planning group. Did you know at this pointIs that what you're talking about when you say:
25

*I've kept your confidence and have not discussed.*

Is there - - -?---No. The confidence about not discuss was in relation to developing an extended treatment and rehabilitation services. It had nothing to do with the exact
30 date of the closure of the Barrett.

Well, did it have something to do with the actual closure of Barrett?---No.

So what precisely was the plan that you're talking about in that paragraph?---The
35 plan – can you just scroll up about the date of that email, please. The plan was – that email was written on 22 July.

Yes?---And the plan was that we were going to have a meeting, from memory, that week. And then we were going to actually have a meeting which took place on 2
40 August 2013 to discuss the commencement of the implementation plan.

The implementation plan meaning Barrett was to close and there was to be replacement services?---The implementation of the replacements services. Yes.

45 Can I just take you to another email about a week or two weeks later. It's QHD.012.002.4812.

MS WILSON: For the doctor, it's number 7 in your bundle.

WITNESS: Yes.

5 MR FREEBURN: So, now, I'm interested in the final paragraph of that email. And you say:

*I understand that the tier 3 model recommended by the ECRG is at odds with the National Mental Health Services Planning Framework –*

10

Etcetera. Do you see that paragraph?---Yes. The last one.

Yes. And do you understand that that first sentence in that paragraph up to "funding" – is that something you understand because Dr Kingswell has told you
15 that?---I can't recall whether he had told me that or not. I do recall that in the discussions we had previously it was clear that the tier 3 model was at odds. But I can't remember exactly who told me that it wasn't at odds.

You see, at the end of that paragraph, you ask Dr Kingswell the question:

20

*How can we write up a model of services for our draft document that you don't have access to?*

So that suggests that you certainly hadn't seen the national framework
25 documents?---No. Up until that time, I hadn't seen the National Mental Health Service Planning Framework document.

And, in fact, if we look at your two witness statements, you haven't attached them. There's two pages from one edition of them that's dated after October 2013. So do I
30 take it even now you haven't actually seen the framework documents?---I haven't seen the full framework documents. Let me amend that. We were given permission to go to the branch to have a look at the National Mental Health Service Planning Framework. It's a big document. And from that, we photocopied the relevant parts of the document which would allow us to develop these new services in alignment
35 with the planning framework.

I think we can see those in your statement. They're Step Up Step Down type facilities?---Well, a number of them. Yes.

40 And you'll see the other comment there that the tier 3 model will struggle to attract attention in the ABF model of funding. ABF means activity-based funding?---Yes.

Am I right in thinking that ABF funding would be a Commonwealth assistance to funding based on a particular activity?---Correct.

45

But not every health service will be comprehended by ABF, will they?---Well, it depends on the level of services they were offering.

Yes. What you're saying is it depends on what the Commonwealth Government give?---Partly, yes.

Alright. It's likely, isn't it, that some health services will always sit outside an ABF model?---Well, it wouldn't be ideal that they sat outside the ABF model, because then they wouldn't attract that funding.

That's right?---It would be in their best interests to sit within the model.

Well, it's in the state's best interests for it to sit in the model so it gets funding from the Commonwealth?---It's in the health service's best interests too, then.

Yes. Now, I want to deal with – and I'm going to use the abbreviation SWAETRI?---Yes. Okay.

Which we know subsequently became AMHETI?---Yes.

Now, can I take you to exhibit I of your initial statement, which for the operators is at page 103. The first page of that document, just for the record, is 097. But you can see that this process starts with a project plan?---Yes.

Correct?---Can we just go down. Is that the October 2013 plan that I've attached? No. That's the September.

September?--- There's a October 2013 plan, which is version 1.1 which is more accurate, but I'm happy to go to that one.

Alright. I think we're dealing, I suppose, with the one that's attached to your - - -?---Okay.

But we can check whether there's any material differences. Now, if we go to that page 103 and we scroll down a little to the purpose/objective. Now, the third of the purposes or objectives of this plan was to ensure continuity of care, etcetera. Do you just want to read that to yourself?---Yes. I'm aware of that dot point.

And you see the fifth dot point:

> *Oversee the redistribution of BAC operational funds and other identified funding to adolescent mental health service models to support the identified target group.*

So is it correct that under this plan Children's Health Queensland was undertaking the task of ensuring continuity of care for adolescents currently admitted to the BAC and overseeing the redistribution of the BAC operational funds?---That's incorrect.

Right. And are both of those parts incorrect?---Correct. Both are incorrect.

And why is that an incorrect reading of those purposes and objectives?---Well, the first point is that's a draft plan, and it wasn't the plan that was endorsed by the CE and Department of Health Oversight Committee. That's the first point. The second point is – and I don't have the page on that plan, but on the plan that was endorsed, if you went to page 18 of that plan – so you may have to scroll down – it very clearly states that West Moreton, who is the project partner, was responsible for the clinical care of current BAC and waitlist consumers and was also responsible for the transition of BAC operational funds. It was not Queensland Health's – Children's Health Queensland's responsibility.

COMMISSIONER WILSON: Mr Freeburn, it may save time if you can take the witness to the October version of this document.

MR FREEBURN: Yes.

COMMISSIONER WILSON: And if you need time to have it brought over to court, we could take the morning tea break now.

MR FREEBURN: I'm happy to. That would be good. Yes, please, Commissioner.

COMMISSIONER WILSON: In case that takes a short time, we'll come back at 11 o'clock.

**WITNESS STOOD DOWN**

**ADJOURNED [10.37 am]**

**RESUMED [11.03 am]**

**STEPHEN STATHIS, CONTINUING**

**EXAMINATION BY MR FREEBURN**

COMMISSIONER WILSON: Yes, Mr Freeburn.

MR FREEBURN: Thank you, Commissioner. I think we've found the document that Dr Stathis was talking about.

COMMISSIONER WILSON: Good.

MR FREEBURN: Can we please call up – the front page of the document is CHS.001.001.0741?---That's not the document.

Well, if we go to the project plan which - - -?---The project plan.

5

There's a project plan which is included in it. If we go to page CHS – well, go to page 0750 of the same document?---That's the document.

Thank you. And if we now just go to the equivalent page that I took you to before.
10 It's page 7 of that document. The document ends 0756. And if we scroll down a little bit further we can see the third dot point?---Correct.

And the fifth dot point. So those third and fifth dot points are the objectives of this project plan?---Yes.

15

And then I'll take you to the page that you were keen to go to in a minute. But before if we get to page 0762 you'll see at the top of the page there's a division of the budget. And am I right in thinking that's divided partly between Children's Health Queensland and West Moreton?---That was the budget for the project officers. Yes.

20

Yes. And then we can see here the project officers if we go to the next page, 0763?---Yes.

And am I right in thinking that Ingrid Adamson is from Children's Health
25 Queensland and Laura Johnson is from West Moreton?---Yes.

And you're there, at least part of your salary is attributed to the project?---Yes.

On the basis of supervision by you?---And also on the basis of the amount of work
30 this project took up.

And I gather the budget – no money changes hands, it's just an allocation between the two services. Is that right?---Yes.

35 And then if we go to page 0765, see Project Governance and Control. See, if we scroll down a little bit we can see there's an oversight committee?---Yep.

And there's a steering committee and project manager. And the project manager is Ingrid Adamson. Is that right?---Yes.

40

So you were particularly keen to take us to page 18. So that's page 0767. See the – under the heading Communication Management. And if we scroll down a little bit further we can see in the fourth of those boxes, CHQHHS, the board and the project sponsor. So CHQ is the project sponsor and it's responsible for the governance of
45 the project. Correct?---Correct.

And if we scroll down, the project partner is West Moreton. Is that right?---Yes.

And is it correct to view this as, effectively, a partnership between CHQ and West Moreton?---It was a partnership which – with each objective being divulged down to one or both of the HHSs.

5 Well, where do we see that, each objective being divulged to one or either?---Right on that page. The objective is the responsibility for the clinical care for current BAC and waitlist consumers.

I see?---One of the objectives was the continuity of care for adolescents currently
10 admitted to the BAC or on the waiting list to a supported discharge and transition plan. That was one of the objectives. That's the partner.

Right. But it's not so easily split, is it, because there's – Children's Health Queensland is the project sponsor responsible for the governance of the
15 project?---No, I disagree. It's very easily split.

Well, is the proposition right though that CHQ was responsible for the governance of the project?---Correct.

20 And the fourth dot point:

*Achievement of the project objectives.*

?---Yes. But if you scroll over to the next page, page 19, you'll see that West
25 Moreton also had achievement of the objectives.

Right. Alright. Thank you. So - - -

COMMISSIONER WILSON: Where was that? I see. It's up the top of the page.
30 Is that what you're referring to - - -

MR FREEBURN: Yes.

COMMISSIONER WILSON: - - - Dr Stathis?---Yes, Commissioner.

35

Thank you.

MR FREEBURN: Now, I just want to take you to –in your statement you talk about the working groups established under this plan?---Yes.

40

I first of all want to talk about working group 1. So you've described it, I think, in paragraph 16 of your affidavit – we probably don't need to go there – but you've listed the different working groups. And working group 1 is the service options implementation working group?---Yes.

45

And you were a member of this working group?---That's correct.

And the purpose of this working group was to:

> *…build on the ECRG recommendations and develop preferred service options for adolescent mental health extended treatment and rehabilitation services.*

5

Is that correct?---Correct.

And what does – in that context, what does build on – what are you building on what ECRG said?---Well, the ECRG's recommendations were for 2A, 2B and three – tier
10 2A, tier 2B, tier 3 services. And our objective was to build on those recommendations to develop a suite of statewide services.

Okay. Do you accept, Dr Stathis, that the ECRG had said in fairly plain terms that inpatient extended treatment and rehabilitation care – that is, tier 3 – is an essential
15 service component?---I accept they said that.

Was there anything in that that there was to build on? That is, were you building on that recommendation?---Well, then in terms of then the planning group, we accepted that recommendation with a caveat for the tier 3 services that we had to further
20 explore other service options, and that's been tendered.

Right. So the building on it meant looking at other alternatives?---Looking at a broad range of other service options, yes.

25 Thank you. Now, how many meetings did working group 1 have?---I can't recall.

They had a working forum on 1 October. Are you able to recall any others?---We had that, and then we had a follow up of that meeting. I wasn't at the 1 October meeting. I was on leave.

30

Yes, I understand. Was that forum provided with a copy of the ECRG report, do you know?---I'm not sure.

Now, I realise that you weren't at this forum, but there was an agenda paper prepared
35 beforehand, and it's – I think the agenda paper's in your material, so I'd assume that you would've got the agenda paper at some time?---I would've seen the agenda paper after I returned from leave.

It's DSS.001 – sorry, it's attached to the initial statement, and it's at page 365 of the
40 Delium document. Just for the operator's benefit, that may not necessarily be the same number as the PDF version. So it's 365 of the document, which I think is 349 of the PDF. So that's the agenda we're talking about, and I think – pretty sure you're noted as an apology. Yes. See down the bottom. So if we go to the next page, could you just read those top two paragraphs, please?---

45

> *The purpose of this workshop is to explore - - -*

Sorry, you can just read it to yourself?---Okay. Yes.

There's the expression the target group in the following paragraph, and there's a description of the target group. That's young people who might otherwise be at
5 Barrett?---No, it's broader than that. It would possibly include that - - -

I see?--- - - - but it's broader than that.

Okay. Now, can I just ask you about the first paragraph again? Is the purpose of this
10 workshop similar to the purpose of the ECRG?---The purpose of the workshop, as I said, was to build on the recommendations of the ECRG so that we weren't starting from scratch. We had a body of work that had already been done, and we were building on that body of work.

15 I know you say that, Dr Stathis, but what intrigues me about that is that you say that you're building on the ECRG, but the ECRG is not mentioned in this document?---We had the document itself, and so what we were asking this group of people to do is ask them what they as consumers, carers and clinical experts across the state – what they believed they needed. By the way, I don't think that ever
20 occurred under the ECRG, so we were building on the recommendations of the ECRG. We decided to engage with consumers and carers and clinical experts across the state to ask them, what do you think you need.

What I'm trying to work out is what's the difference between this exercise and the
25 exercise that the ECRG was involved in, appreciating that you've got a wide variety of people here, not just from your department and from other departments and other clinicians, and it's the same with the ECRG. Is it the case that you're either duplicating or partially duplicating what the ECRG was doing?---No, I don't agree we were duplicating what the ECRG was doing. We were building on what the
30 ECRG was doing – what the ECRG had done. In particular, asking consumers, carers and clinicians what they actually wanted. Now, I can't – I can't comment on what was said during that time, but I'm assuming that the ECRG recommendations were discussed.

35 Alright. You see, the two odd features of this document are that it doesn't mention the ECRG or the ECRG report, and it doesn't mention the Barrett Adolescent Centre or that cohort?---We were asked to provide services for those young people between 13 and 17. Almost all the Barrett adolescent cohort were almost 18 or beyond. That wasn't part of the remit for this group. And the second thing is I can't comment on
40 what was said during that meeting, but – and that may be a matter for Ingrid Adamson to discuss, but I'm sure that the ECRG recommendations were discussed in that meeting at some point.

Dr Stathis, you started that answer with "We were asked". Who asked you? "We
45 were asked" - - -?---Well, we were asked as part of this project plan. I mean, this is

the – this is the implementation group, so as part of the project plan, we, in terms of this group, was asked to look at alternative services.

Right. You see– I'm going to summarise. It looks as if this working group is
5 looking at the 13 to 17 mental health patient cohort in a broad, general sense?---No, they were looking in terms of extended rehab, the treatment and rehabilitation. That was what the focus of the project was.

So is it right to say that this working group was not looking at that third dot point
10 objective, which was ensuring continuity of care for adolescents currently admitted to the BAC?---That wasn't under the remit of this working group. It was under the remit of the other working group.

And what about the funds? The redistribution of the funds from the Barrett
15 Adolescent Centre. Was that under the remit of this group or the other group?---It wasn't under the remit of this group. We were just looking at further services.

Alright. So you were looking at further services, but not specifically the Barrett Adolescent Centre cohort?---That wasn't the remit for this group.
20

Well, can we deal with the other group? That's working group 2, and it was called the BAC Consumer Transition Working Group. Is that right?---Yep.

And Dr Brennan was the chair of that group? Are you happy that she was a member
25 of it but you're not sure whether she was the chair of it?---The clinical care transitional panel are you talking about?

No, I'm talking about – in your affidavit you refer to three working groups, this being the second of them - - -?---Yes.
30

- - - and this second one is called the Barrett Adolescent Centre Consumer Transition Working Group?---Yes. Dr Brennan wasn't a part of that group. She wasn't part of the steering committee. I'm sorry, of the group?

35 Yes, the group. Let's go back to your affidavit?---Okay.

Paragraph 16 or 17, I think. Sixteen on page 4 of your affidavit?---So forgive me if I've got this wrong, but it seems as if there is a steering committee?---Mmm.

40 The steering committee establishes some committees that work under it. And the first one was the one we were talking about a moment ago, which is the Service Options Implementation Working Group, working group 1; correct?---Yes.

And the second one was the Barrett Adolescent Centre Consumer Transition
45 Working Group?---Yes.

And was Dr Brennan a part of that group?---I can't recall. You'll just have to take me to the minutes of those meetings.

Alright. But do you have any involvement in either choosing the members of that group or in what that working group did, that second one?---The transitional working group looked at the transition of the Barrett patients back into the community and were working as part of the plans of that. I do know that there was a weekly Barrett update meeting every week, and Dr Brennan was a part of that meeting as well as Leanne Geppert and Elisabeth Hoehn. Both Leanne and Elisabeth reported up to the steering committee in relation to transitional planning for the young people.

So working group 1 was working away on service options for 13 to 17 year olds?---Yes.

And working group 2 was involved in specific transitioning of these patients?---That's correct.

Were there members in common between the two groups?---I don't believe so. But – but then they all reported up to the steering committee, and so in relation to the BAC update meetings, which looked at the transitional planning of the young people as part of their standing agenda items, Elisabeth – Leanne Geppert would report at every fortnight steering committee meeting about the transitional plans. There was close, robust discussion between West Moreton and CHQ about the transitional planning of these young people at that higher level. The communication between West Moreton and CHQ was of a very high standard.

Can I just ask you was there a system for working group 2 communicating with working group 1, saying, "We need these types of services"?---Absolutely. It was through the steering committee.

So first of all they had to go to the steering committee and then back down to the other working group. Is that right?---Yes, given the fact, though, that people on the steering committee were parts of each working group, and in addition to that there were very frequent phone calls between people within each of those groups. The communication between both groups was of a very high nature. We were not acting in silos.

Can I take you to exhibit M of your initial statement, please. Now, this is DSS.0001.0001.0001 at 353. Actually, it should be 335. Okay. Now, if we can keep going to – I'll just get you the specific page reference. Three-five-three, as I originally said. So this is a bundle of meeting minutes, Dr Stathis, and we're just going to go to one in January – well, it's – you see, it's actually dated 22 January 2014, but I'm going to suggest to you that it's one of those January dates that should actually be 2014?---Yes, I can accept that.

Now, again, I don't think you were at this meeting. I think you're the second of those apologies. Is that right?---Yes.

Now, I just want to take you to 5.2 on page 354, the next page. Now, you'll see the
5 point about five points down:

*BK and LD –*

so that's Bill Kingswell and Leanne - - -?---Lesley Dwyer, I believe.
10
- - - Lesley Dwyer –

*confirmed that there is \$2 million from Redlands and \$3.9 million from BAC in recurrent operational funding.*
15
So am I right in thinking that that total of \$5.9 million was available for the options?---That's correct.

That the working group 1 was considering?---Yes.
20
I noticed when we were at the agenda for that working group 1 there was no mention of that budget. Is that because that budget became available, or is it because – sorry. Is that right? Is it right that the working group 1 did not have an identified budget?---There was no identified budget at the time. Judi and I were aware that the
25 budget was going to fall somewhere in the 5.9 million, but at the time of the working group back in October – 1 October 2013 – there was no real understanding about what the final budget would be.

Right.
30
COMMISSIONER WILSON: Sorry, budget for what?---For the whole suite of services, Commissioner.

Thank you.
35
MR FREEBURN: For the development of these options that working group 1 was considering?---Correct.

COMMISSIONER WILSON: I'm sorry, that's confusing me more, Mr Freeburn.
40
For the development of the options. Was that what was going to be spent in developing them or what was going to be spent in running them?---No, Commissioner. That would've been the budget for the operational running of the options.
45
Thank you.

MR FREEBURN: Now, can I take you to exhibit J of your initial statement, which are the minutes of the SWAETRI meetings. It's your initial statement at page 179 and then 181. So you'll see this is back in November 2013?---Yes.

5 And this is a meeting you are at. So if we go to 181 at the top of the page. See SS advised that the projected funding requirements $17 million exceed current funds available and therefore propose services cannot be implement immediately but rather will be rolled out over a period of time. Do you want to just get the context of this?---I can give you the context.

10

Okay?---Back in October 2013, we submitted our project plan to the board – CHQ board. They then asked us to develop a broad costings for the five tiers which we then subsequently submitted to the board in November 2013. These and the project plan was thereby endorsed by the board. It was during this time that we were then –

15 and this was – this meeting was 18 November, I think. So it was during that period of time that we were developing the costings. And on our initial estimates, they were going to cost projected $17 million.

So that's effectively what you were advising this committee that the projected

20 costings – and I appreciate they're not hard figures - - -?---Correct.

- - - are $17 million. And it's clear, isn't it, that because there was not the funding at that point for $17 million, there may have been, we can see from a later document, $5.9 million available. Correct?---Yes.

25

So the excess – the eleven-odd million dollars – was that going to be supplied over the following years or was somebody going to go to the government and say, "We need that extra money"?---That would be a matter for government – a matter for Treasury.

30

Right. We see in the subsequent point that JK – that's Judi Krause; is that right? She noted a point of interest?---The question?

Do you recall that being a topic at the meeting?---I don't recall that specific topic.

35

Thank you. And in your statement, I see your supplementary statement this time. You say – and I probably don't need to take you to it, but you would continue to liaise with the government and request funds to stand up all planned further services. Is that right?---Yes. I'm a strong advocate for adolescent mental health services,

40 including extended treatment and rehabilitation. We had costed by that time our fee services and I'll advocate for more services from government.

Alright. So it was a strategy, then, to continue to advocate for more funding for adolescent mental health rather than accepting the limited budget that you might

45 have had?---That's always my strategy, Mr Freeburn.

Thank you. Can I take you to paragraph 62 of your supplementary statement? Now, the supplementary statement, for the operator's benefit, is DSS.001.002.001. And in particular, I would like to take the witness to page 20. Now, paragraph 62 on that page. Can you just explain the transition services plan? What was that?---Yes. So
5 what happened was – and I've been given that in the bundle of documents – that in November 2013, West Moreton was looking at transitioning the young people within the Barrett and had developed or had planned to develop a suite of services, yes. By - - -

10 Sorry. This is West Moreton had planned to develop a suite of services?---Yes. As part of their transitional planning – looking at how they were going to support the Barrett young people.

Right?---And these were a bundle of services. It wasn't a patient journey. It was a
15 bundle of services. But this is something that was evolving over time, Mr Freeburn. By December 2013 when, indeed, we presented that plan on 11 December to the parents at the Barrett at a meeting that we'd organised, CHQ was starting to take ownership of the implementation of further services because the young people in Barrett were slowly being successfully transitioned into existing services within the
20 community.

So - - -

COMMISSIONER WILSON: Could you explain for me what plan it was that was
25 presented to parents on 11 December?--- That, Commissioner, was a plan – was a series of – was a PowerPoint presentation that was done between myself and Leanne Geppert. And as part of that PowerPoint presentation, the suite of services was presented, including part of this plan.

30 Thank you.

MR FREEBURN: So those parents weren't told about the working group one overall plans, or was that part of the discussion, as well?---I can't recall, and that's a matter for West Moreton.

35

Whether they told them that or not?---About the transition one plans?

Yeah. Can I see if I can clarify this. Working group one - - -

40 COMMISSIONER WILSON: Someone seems to have a phone that rings quite frequently. Would they please put it on to silent.

MR FREEBURN: Working group one was – I think as we've discussed, your evidence is that it wasn't looking specifically at the Barrett cohort. It was looking
45 more generally at service options for young people with mental illness?---Yes.

And at this meeting, there was discussion by West Moreton and a presentation to the parents of specific plans for specific children or for service options more generally?---Service options more generally, not about specific young people.

5 I must be at cross-purposes. So why would West Moreton be presenting the options more generally when it was Children's Health Queensland who were preparing that?---Well, that's precisely what happened. You see, West Moreton were so committed at developing transitional plans for their young people that they initially decided to look at the possibility of using a range of services – day programs, resi
10 services within West Moreton HHS. Then they – and don't forget this was evolving over time very rapidly. And then by November/December 2013, West Moreton recognised that: first, CHQ was taking responsibility of the implementation of a range of new services. Second, they were – West Moreton were able to transfer a number of young people from Barrett very rapidly out. And, thirdly, the few young
15 people that remained, they were able to develop their own individual transitional plans.

When do you say that there was a change of responsibility? When did Children's Health Queensland take on that responsibility of developing – I think you mentioned
20 a moment ago that in about December, Children's Health Queensland took on the role of transition plans?---No, we didn't take on the role of any transitional plans. We always took on the role of broad implementation of services.

Okay. So who was reporting to you about the transitional plans?---Leanne Geppert
25 reported to the steering committee every fortnight about the transitional plans of these young people.

Alright. Okay. So can I take you to paragraph – so we've got that paragraph on the – can you just read 62 and 63, please. Now, 63, are you saying that Children's
30 Health Queensland only provided financial support for wraparound services as requested by West Moreton and/or other health services?---Yes. Particularly after Barrett closed, we then held the funding and were able to provide additional services if requested.

35 And as you've explained your evidence, Children's Health Queensland didn't have responsibility for either the transition plans themselves or for placing or assisting to place any of the specific patients?---Correct, except for the occasional patient that might've been within CHQ's catchment area. And then we would then accept the patient into our Hospital and Health Service, into our range of services.
40

COMMISSIONER WILSON: What do you mean by CHQ's catchment area? Are you talking of a geographic area?---Yes, Commissioner, in our geographical area. So I believe I mentioned further in my affidavit about one young person from - - -

45 MS WILSON: Commissioner, maybe this can be done in closed court.

COMMISSIONER WILSON: Yes. If you're going to refer to a particular patient, we need to go into closed court?---I understand. I apologise.

But I just want to know what the geographic catchment area of CHQ was?---So it's hard to define but, essentially, it's part of Metro North in Brisbane and Metro South of Brisbane. So, Commissioner, CHQ has a geographical area where patients drain into our hospital and health services. And we also have a statewide remit. But in terms of the geographical catchment area of CHQ, it corresponds roughly with the greater Brisbane area.

Thank you. Perhaps in due course there will be some questioning to explain the difference between the geographical catchment and the statewide remit.

MR FREEBURN: I was going to go to that. Why is it that there's two borders? There's the geographical borders, which are Brisbane, and then there's the statewide borders which is, presumably, Queensland. Can you explain how those two things fit?---Yes. Sure. So the geographical borders for CHQ is a historical thing and really corresponds to the geographical borders of the former Royal Children's Hospital catchment and Mater Health Services catchment. It's complicated. It overlies Metro North Hospital and Health Service catchment and Metro South Hospital and Health Service catchment. That's the local geographic spread.

But I think we all understand where you're drawing the lines on the map. What we're trying to work out is where you're drawing the lines in terms of responsibility?---Well, then in terms of clinical responsibility it's the responsibility for other hospital and – Hospital and Health Services. But CHQ also has statewide remit to oversee Children's Health Services or paediatric services across Queensland.

It's not just paediatric services. Barrett Adolescent Centre is a statewide facility, wasn't it?---Yes.

Doesn't that mean it falls within Children's Health Queensland?---No. That statewide facility fell within West Moreton.

Right. To develop the options for the Barrett Adolescent Centre cohort, wasn't that a statewide matter?---It was precisely why because of Children's Health Queensland's statewide remit Judi Krause, as a divisional director of the Child and Youth Mental Health Services, and myself as a medical director of Child and Youth Mental Health Services were asked to drive this.

Wasn't there a point at which governance for the extended treatment of adolescents transferred to Children's Health?---After the Barrett closed in late January 2014, the funding came to CHQ which would allow us to support other Hospital and Health Services who required additional wraparound funding for ex-Barrett patients. But the

governance or the clinical governance of young people would always be under the Hospital and Health Service with whom they were transferred to.

COMMISSIONER WILSON: So can I ask a hypothetical question there; if an adolescent were transferred to somewhere within the greater Brisbane area, it would be Children's Health Queensland which would have clinical governance over the care of that adolescent. But if the adolescent were transferred to Townsville, it would be the Townsville Hospital and Health Service – or whatever it was called – that would have clinical governance over that patient?---That's correct, Commissioner.

Thank you.

MR FREEBURN: Can I take you to a document. It's DSS – so it's actually at page 418 of your statement. It's exhibit X to your statement.

COMMISSIONER WILSON: This is the first statement, is it, Mr Freeburn?

MR FREEBURN: Yes. It's the first statement.

So this is a business case. Now, it's the April 2014 version. Dr Stathis, I want to deal with that version because of the timing of it?---Okay.

Now, if we go to page 423. You see point 3 at the top of the page has similar words to what we were looking at before? So you might just have to explain to us the business case was a business case for what?---The business case was a business case for the extended rehab and – for the suite of services that we were rolling out.

Right. And does this mean that by this time Children's Health Queensland had assumed that responsibility identified in that paragraph?---The business case sits under the project plan, which had been endorsed. So no, Children's Health Queensland is not going to accept the clinical responsibility of ex-Barrett clients or patients that have been transferred out of their catchment area. That's not how the system works. But we did hold funding and we could assist other hospital and health services in terms of further support for young people, and, indeed, we did. We provided funding for young people in a range of other hospital and health services who required it.

It wasn't to ensure the continuity of care. Aren't these concepts related? The continuity of care for adolescents is related to the suite of services that you're talking about, isn't it?---And the continuity of care of adolescents is also related to the ability to fund those services.

Yes?---So we were there to provide the funding to allow those adolescents to continue to be managed in the community. It's not a question of clinical governance; it's a question at that time of funding.

You see, the two major documents I've taken you to – the business case and the project plan – they don't make that distinction that you've just made and limit Children's Health Queensland to funding responsibilities, do they?---I disagree. I believe that the – if you read through the suite of documents, it's very clear that Queensland Health held funding to support adolescents in the community, but we never were looking to provide clinical governance and care of those adolescents. That's not how the system works.

But you understand the point, don't you, that the continuity of care for particular patients is related to the services that are available for them?---And if there's no services available for them, they can't continue. So we provided funding to allow those young people to continue within the community. Without funding, there's no services, Mr Freeburn, and that's what we did.

Now - - -

COMMISSIONER WILSON: So the clinical governance for that adolescent, you say, was with the – I'll call it - the local hospital and health service?---Yes.

And you provided funding or were to provide funding to the local hospital and health service to enable it to run a particular service?---We provided funding at that time to individual ex-Barrett patients to provide wraparound services for that young person, Commissioner. So we're talking here about ex-Barrett patients and wraparound services specifically designed for that young person.

I see. So we're not at this stage talking about the future and the future role of Children's Health Queensland vis-à-vis the future role of hospital and health services?---That's covered in the first point there, develop service options within a state-wide mental health model of care.

No doubt we'll come to that.

MR FREEBURN: So if we look on the screen, we see that specifically the initiative will – and there's a series of things – ensure continuity of care for adolescents currently admitted to BAC and on the waitlist. So you read that to be - - -?---Can we scroll up to the next page, please. These are the objectives of the project plan. And we're talking about the objectives of the project plan, which we've already covered.

It's actually the business case, but I understand?---Yeah, but the objectives of the project plan were embedded within the business case. We've already covered this.

You recall, don't you, that the Minister had announced that there was going to be a range of options available to the Barrett Adolescent inpatients and waitlist patients. And he talked about the options being available in early 2014 and the transition starting in early 2014 as we build up services in other areas around the state. Do you know who was doing that?---Can't comment on individual services. Many different

people in different services were being – many different HHSs were trying to wraparound services for these young people.

But as I understood it, you're saying that Children's Health Queensland weren't doing it because you were actually providing the funding. Was West Moreton doing it?---What's the question again?

Well, the Minister was talking about a range of options which were going to be available in early 2014. I'm asking who was doing it if it wasn't - - -?---A range of options for whom?

For the Barrett Adolescent patients?---The service implementation group never focused specifically on the Barrett patients. In fact, our remit was to provide services for young people between 13 and 17 years of age, and that was the extended rehabilitation services and the suite of services we developed. It was never specifically for ex-Barrett patients, most of whom were over 18. the transition plans for the ex-Barrett patients and the ongoing follow-up was a matter for West Moreton.

COMMISSIONER WILSON: You talk about your remit. Remit from whom?---Is that the state-wide remit, Commissioner?

Well, you just said what your remit was, and I'm asking you who set your remit?---Well, that was part of the project plan which was endorsed by the oversight committee, and on page, I believe, 5 of that project plan, it states that it was for young people from 13 to 17. That was the plan, to develop services for those young people. So the service implementation group were focused on young people aged from 13 to 17.

Alright. I think you've answered my question, Doctor, thank you.

MR FREEBURN: Were you aware that Fast Facts or documents were being produced to the parents and families of the Barrett Adolescent patients?---I was aware.

Are you aware of the expression being used of "there will be no gap in services"?---Yes.

And the responsibility for there being no gap, was that a matter for West Moreton?---Correct.

Can I deal with a topic, AMYOS. Can I take the witness, please, to QHD.012.001.2479. Now, Dr Stathis, I expect you've read this in the preparation for - - -?---Mmm.

- - - this hearing. If you read through this email, it looks like Dr Steer has asked your team to – reassuring that you are moving rapidly to recruit mobile outreach teams, and he says they need to be in place by the end of February?---Mmm.

From these emails it looks as if you and your team may not have been anticipating this. Is that right?---Rolling out new services with new position descriptions takes some time. We hadn't anticipated February, no.

5 When had you anticipated that it would happen, the AMYOS teams would be online?---We were anticipating sometime in the first few months of 2014, but we hadn't landed on a definite date. So if I just give you the context of that, the project plan wasn't endorsed – or wasn't given in-principle endorsement by the board of CHQ until November 2013. It would've been reckless to go ahead with un-trialled
10 new services with an unknown workforce until endorsement of that plan was provided by the board. It would've put the board and CHQ at significant clinical and reputational risk. Immediately that we had received endorsement, we proceeded to procurement for residential – for resi services and to start the quite long process of developing the framework to employ permanent employees across CHQ and the
15 other hospital and health services. We were working under the processes of Queensland Health, and despite our best intentions, those processes to employ new workers take time. We have to develop role descriptions, establish the role, then we have to advertise, we have to recruit, we have to then – and then the – the successful applicants have to come on board. For example, the AMYOS teams have two allied
20 health or nursing positions and appoint two psychiatrists. A psychiatrist has to give a minimum of three months' notice before moving to a new hospital and health service. So these things take time. We worked as hard and as quickly as we could within the constraints of Queensland Health and the HR system that we work under.

25 Dr Stathis, wasn't the projected date for the AMYOS teams July 2014?---We finally fell on July 2014, which was as fast as we could do it, bearing in mind - - -

No, no - - -?---I haven't finished. Bearing in mind that this was also the time where the two hospitals were amalgamating, and there was a whole complex workforce
30 review of positions within the hospital and health service.

I want to ask you about the projected dates. So in late 2013, what was the projected date for the AMYOS teams coming online?---I can't recall the projected date at that time.

35

See, I wanted to ask you about paragraph 69 of your supplementary statement, which has projected commencements for the various AMYOS teams, and the majority of the first lot seem to be July 2014?---That must – could you bring me – could you bring that up, please.

40

Yes. It's DSS.001.002.001 at 21. Scroll down. Keep going. Now, we don't know when it's projected, but - - -?---Yes. July 014.

And the youth resi unit – I think this is the Greenslopes one?---Correct.

45

That was established for a type 4 procurement. That's an urgent procurement?---Yes. We worked very hard to procure that service.

Is there a reason why that procurement didn't start in August or September 2013?---I've just given you the answer before. We couldn't proceed. It would've been reckless to proceed with an un-trialled service in Queensland with an unknown workforce with a high visibility services, with high risk patients, without
5 endorsement of the board. The board endorsed it in late November 2013, and within two weeks we had then proceeded to procurement.

Now, I want to deal with the subacute beds. You see that same – if you scroll down to the next page – this – it will be supplementary – do you see "Subacute beds:
10 Mater/LCCH"?---Yes.

So subacute beds were projected for February 2014?---Correct. As soon as Barrett closed.

15 That's sort of right, isn't it, Dr Stathis, in the sense that patients were being transitioned from September to January?---Yes, and none of those patients required a subacute bed.

What makes you say that? What information do you have that enables you to say
20 that none of the patients at Barrett Adolescent Centre required a subacute bed?---So let us go back.

MS WILSON: Commissioner, this may be best done in closed court too.

25 MR FREEBURN: Are you going to – is your answer going to refer to specific patients or - - -?---Yes.

Alright. We'll come back to that. Is the idea behind this subacute beds item that either patients in the Barrett cohort or other patients who require extended treatment
30 can be treated in beds in an acute ward, but designated as subacute beds? Is that right?---Yes, and I'll give you that context and I won't mention individual patients, obviously. From November 2013 I had informal discussions with Dr Brett McDermott, the clinical director of the adolescent – of the Mater inpatient unit. Dr – Brett and I have a very close collegial relationship. We were struggling as to where
35 we were going to put the subacute beds. Initially we had landed on eight to 10 beds. That was subsequently reduced. From November 2013 Brett had very kindly said that he would accept these patients into the Mater unit, if required. So there was a very open conversation. On 22 October 2010 a memo was sent out from Sharon Kelly to all CEs and clinical directors of services across Queensland, stating that –
40 and these are clinical directors of a mental health services – stating that if anyone required a subacute bed, they should contact me. No inquiries were received. However, the plan was that if I had received an inquiry, I would then discuss this with Brett, who said that he would be very happy to accept these beds. There was no money for capital funding. Given there was no money for capital funding, we had to
45 put subacute beds within an adolescent inpatient unit to fulfil the requirements of the ECRG which was hospital based beds with access to onsite schooling. And the best place we felt to do that was the Mater Hospital.

Did you discuss with any expert, any child and adolescent expert who knew about this cohort, the idea of putting subacute beds in an acute ward?---We had no other option. And it was suboptimal. But I did. On 26 November 2013 I presented the whole suite of services to the quarterly meeting of the faculty of child and adolescent psychiatrists, the most senior child and adolescent psychiatrists within the State. And I outlined the suite of services that were available, including beds within the Mater. Now, I knew that Brett was not going to be able to make that meeting. I can't recall why. But what I do recall very clearly is having a conversation with Brett before that meeting asking him whether he would mind if I mentioned the Mater. And he said he didn't mind at all. So I discussed this with some of the most senior child and adolescent psychiatrists in the State.

You're aware, aren't you, that the ECRG report addresses this question of treating subacute patients in an acute ward?---I'm aware of that. I'm also aware that it was accepted with a caveat that we'd have to look at other models of service for tier 3 and that there was no other place to put these young people.

Alright?---We had no capital funds. And, in addition, we had only a few months before the Barrett closed to find possible beds. We also didn't know what the appetite for these beds were so we had to monitor that. And it was curious that although this memo from Sharon Kelly was sent out right across the State from 22 October, I received no requests for subacute beds.

Dr Stathis, do you conclude from the fact that you received no requests for these subacute beds in acute wards, you conclude from that that there was no demand for it?---I'm not concluding anything. I'm just simply saying I didn't receive any requests.

Have you spoken to Dr Peter Parry about this concept of having subacute beds in an acute ward?---Peter Parry works under me as the medical director campus. Absolutely.

And has he given you the benefit of his views about subacute beds in an acute ward?---All our view is that subacute beds in acute wards are not ideal. But if there's no capital funding to build another unit and if there is no demand for another – for subacute beds, then I guess we have to make decisions about how to manage these young people.

Excuse me. During the transition process, which is that period from September 2013 to January 2014, are you aware whether anybody told Dr Brennan that these subacute beds were available?---Dr Brennan was at the faculty meeting on 26 November.

So - - -?---Where the subacute beds were raised.

And, you see, it's pretty vital information for Dr Brennan to know, isn't it, that there were subacute beds available to patients that she was at that point

transitioning?---The beds were available at the Mater Hospital. I need – I think we need to discuss that in a closed court, Commissioner.

When did - - -

5

COMMISSIONER WILSON: It can be closed in due course.

MR FREEBURN: When did the Mater beds become available?---As I said, I had informal discussions with Brett McDermott from November that year, 2013.

10

So are you saying that they became available and the profession was notified in November 2013?---Every – the clinical directors of all services were notified on 22 October in the memo to contact me if they needed anyone. And I – I discussed with Brett from November 2013 about whether he could make beds available for subacute

15 patients. And the faculty were alerted formally to that fact during that meeting on 26 November.

Now, I'm going to try and speed through this, Dr Stathis, because I'll outstay my welcome. But there's reference in some of the documents in April 2014 to a concept

20 of statewide subacute beds. That refers, doesn't it, to these two – I think there's two Mater beds and then, subsequently, in November 2014 it became four Lady Cilento beds?---That's correct. So there were two interim beds in the Mater. When the Lady Cilento Children's Hospital opened in late November, 29 November 2014, we expanded the beds to four subacute beds, despite the fact that we had almost no

25 referrals.

COMMISSIONER WILSON: Just to be clear, you say you expanded it to four beds. If there were no referrals, those beds were used for acute patients if needed, were they?---Yes, Commissioner. We have an 11 bed acute adolescent inpatient

30 unit. Words have been used as swing beds, for instance. And so those beds can be, and indeed usually are, full. As of yesterday, our whole unit was full with acute inpatients. So the beds are virtual beds in terms of if we needed to make a bed available for a young person, we would.

35 Thank you.

MR FREEBURN: I'm going to ask you about a few different topics and if I jump about a bit I'm sorry about that. In July 2013 Dr Kingswell was talking about Y-PARC. Do you remember the email of the – and he – I think he talked about having

40 confidence that Y-PARCs would be up and running by January 2014?---That was – I didn't say that.

No, I know?---Dr Kingswell said that.

45 Yes. Now, ultimately, what in fact happened was a youth resi was established and had its first client in about March 2014?---Can I correct you there? The youth resi

was actually established in February 2014. And the first patient was transitioned across that month. And that's very normal within the sector.

Alright. And some other youth resis have been established in Cairns and
5 Townsville?---Correct.

Since that date?---Since that date.

And a Step Up Step Down unit based on the Y-PARC model is being planned for
10 Cairns and is to open next year sometime?---I believe so.

Now, can I just deal – again, get up in the helicopter for a moment. Within this continuum or the suite of services, as you've called it, three of the five services are for 13 to 17 year olds. That's day programs, AMYOS, state-wide acute beds;
15 correct?---Yes.

Two of the service elements are for older adolescents and young people, and that would be youth resis and step up step downs. They're for 16 to 20s or something like – 21s?---You're partly correct. So the Y-PARCs or the step up step down units
20 we recommended for 13 to 17 year olds, as was part of the project plan. With the first Y-PARC being established in Cairns – and we've always said local HHSs can adapt the model for local sensitivities and requirements. They've made a decision for 16 to 21, I believe. I may be – I think it's 16 to 21, with some flexibility on the lower age range. The resis were always going to be 16 to 21, with a focus on the 16
25 and 17 year olds. The reason is simple. We were given legal advice that to place 15 year olds in youth resi services under our framework would be subjected to a lot of consent issues, so we focused on the 16 to 17 year olds. However, our view was that was too narrow an age group, and also a lot of these young people who are 17, moving on 18, have a lot of developmental vulnerabilities. You don't suddenly
30 become an adult when you're 18, and the whole point of the resi services is to allow these young people to transition within the community. So we pushed up the age range to 21. In Brisbane here, the Greenslopes resi, given our large population, the majority of the resis – the young people in the resis are 16 to 17, pushing on 18. In Cairns you have a slightly older age range because they have a smaller population. It
35 remains to be seen what happens in relation to the age range in Townsville.

What I'm just wondering is if there is a gap for the 13 to 15 year olds, meaning that if they need a bed-based option, their only option at the moment is either an acute unit or subacute beds in an acute unit; correct?---Well, based on the Barrett data, I
40 understand there were very, very few 13 to 14 year olds accepted, and, indeed, I don't believe Barrett generally accepted young people under 15 anyway. Second – but I agree. That is why we fell on the age of 13 to 17 for the Y-PARCs. Under our Y-PARC model, young people can be in there for up to three months.

45 Well, both Barrett and the Walker Units accept 13 to 15 year olds, don't they? Or Barrett did?---Well, my understanding was that Barrett accepted from 15 on, but I may be incorrect there.

Now, I want to deal – there's a discussion paper that your group or a group of which you are a member has produced recently. Now – excuse me. Commissioner, because we don't have the facility to put two screens up, I wanted to put a document which has got two different documents on it, so I produced a hard copy.

COMMISSIONER WILSON: Well, just make sure that everyone knows what you're talking about, what document.

MR FREEBURN: Yes, I will just hand it - - -

MR O'SULLIVAN: No, we don't. I don't.

COMMISSIONER WILSON: Well, I don't either at the moment, Mr O'Sullivan.

MR O'SULLIVAN: It might be the document referred to in paragraph 7 of the second statement, which is – we've been wondering whether such a document exists.

MR FREEBURN: No, it's not. I'll just hand it around, then I'll explain it. Can I get a copy to the witness and a copy to your Honour.

MS WILSON: Commissioner, could I just note that the witness has been in the witness box for an hour and a-half now, and if you - - -

COMMISSIONER WILSON: You'll have to speak up, Ms Wilson.

MS WILSON: Could I just note that the witness has been in the witness box for getting on to an hour and a-half now, and just wondering how much further to go, whether this might be a convenient time for a break.

COMMISSIONER WILSON: Would you like a break at this stage, Dr Stathis?---Thank you, Ms Wilson, but I'm happy to go on for the sake of time.

Now, does every counsel and solicitor who wants a copy of this document have it? Right.

MR FREEBURN: Now, I can hopefully explain to you, Commissioner, and the counsel as well as the witness what it is. You'll see that there was a meeting that established the idea of doing the discussion paper, and that's on the left of the document?---Yes.

And there is the end product, the discussion paper recommendations?---Yes.

And it's really a short point. It looks as if the first dot point on the left is similar to the third point on the right?---Well, that would be because it was supported by the evidence found in the discussion paper.

Yes?---That's a good thing.

MS McMILLAN: Commissioner, could I just clarify I think my learned friend has got them the wrong way round in the document. It seems the discussion paper recommendations – the reference should be CHS500 at page 8. That's where those recommendations appear. So for those of us trying to follow it in the report, it's the
5 wrong way round.

MR FREEBURN: I'm indebted to my learned friend. I'll get that changed in the document.

10 COMMISSIONER WILSON: In fact, it will be important for the record - - -

MR FREEBURN: Yes.

COMMISSIONER WILSON: - - - either that this document goes in as an exhibit or
15 somehow it's identified what it is you're talking about.

MR FREEBURN: Yes. I'll get that corrected and we'll have the corrected version produced.

20 So, Dr Stathis, I think what you're saying is – and you're probably agreeing with me – that you started with the proposition that we needed a discussion paper to address these things, and ultimately that's where – the discussion paper went where you thought it was going to go?---I'll take you back a step. Michael Daubney, who is the medical director of our specialist services – I tasked him with the case of developing
25 a model of service for subacute beds. He came back to me and said I can't find any evidence for this. There is no evidence – international evidence – best practice guidelines for subacute beds. I can't produce a model of service. I said, okay. Then let's actually look at what the documentation is. Let's pull together a discussion paper so that we know what we're dealing with. And that was the start of the
30 concept of the discussion paper.

Okay?---The discussion paper then ultimately was commissioned by the Youth Elections Committee.

35 COMMISSIONER WILSON: The Youth Elections Committee? What's that?---Sorry, I've got the wording wrong. The Young People's Commitments Committee. Youth Mental – sorry, the Youth Mental Health Commitments Committee.

40 MR FREEBURN: Can I just – I just want to deal with one more topic. Sorry, two more. This discussion paper talks about a visit to the Walker Unit; correct?---Well, the visit to the Walker Unit occurred in October 2013 - - -

Correct?---Yes.

45

23 October 2013. That's correct?---Yes.

And you were on that excursion, so did you interview Professor Hazell on that occasion?---I talked to Professor Hazell before that, when he was at the Rivendell Unit, yes.

5 At - - -?---At Rivendell, which is close by the Walker Unit.

Yes. But not a formal discussion or a discussion about how Professor Hazell goes about the Walker Centre?---He doesn't work at the Walker; he works at Rivendell.

10 Right. Alright. At Rivendell, did you talk to him about how the Walker Centre operates in any detail?---I can't recall the specifics. When we went to the Walker, I did talk with the nurse unit manager, and I also had an informal conversation with one of the psychiatrists who works there who happened to be visiting at the time.

15 Now, can we go to the actual discussion paper? And I just want to turn to one specific topic in the recommendations. The discussion paper should be CHS.500.0001.0001. And can I take you to page 85, please. So the author of this document is Sophie Morson; is that right?---Correct.

20 And Sophie Morson is a psychologist; is that right?---Yes.

Okay. The third paragraph. You'll see in the fourth line, there's a sentence that commences:

25 *A small sub-group of young people.*

?---Yeah.

I just wanted to ask you to read the rest of that paragraph, please?---Mmm.

30

So that suggests that there are three groups that may benefit from an extended inpatient admission: those with severe psychosis, those with a life-threatening eating disorder and those who've not responded sufficiently to treatment in a less restrictive setting?---The point is may benefit because there's very limited evidence. And after
35 – and we actually said there was limited compelling evidence for a subacute unit except possibly in these three groups, which is, as you've read, severe psychosis – and it's a life-threatening eating disorder with coexisting medical complications. Not trivialising in any way or minimising the distress a young person might have and their families might have who have an eating disorder, this is an eating disorder with
40 comorbid medical complications. And by medical, I also include mental health. So these are complicating – complicated young people.

Now, if we turn to page 88, you'll see:

45 *An extensive review of the literature*

- - -?---Found limited compelling evidence. Correct.

Yes. And then if we scroll down to the bottom of the page:

5 *Having reviewed the available evidence base, it's proposed that most adolescents requiring extended inpatient care be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care.*

What I want to deal with is the not most. Do you know what I mean by
10 that?---Mmm.

When we talk about the people that don't fit that most. What is it that this paper is recommending for those not most people?---Well, first of all, it would depend on what is available in the local community, because it says prior to discharge to less
15 restrictive care. And that's the whole point of our initiative. The greater the suite of services, the less restrictive the care and the more likelihood a young person can remain within or close to where they live. But if you don't forget there are – there was this third group of young people that we said were those who weren't responding. There's always going to be a small subset of young people, and it's very
20 hard to get an evidence base around this subset.

Quite right?---So it's – so for those small subset, maybe a longer stay is required. Whether they need a longer stay in an acute unit or a subacute unit is hard to determine because there's no evidence base out there. But the more extensive the
25 continuum of care as close to home as possible would mean that they're more – less likely, I should say – less likely to remain in hospital.

Dr Stathis, is there in this paper a discussion about the evidence for the effectiveness of treating a young person who needs a more extended admission – so a subacute
30 patient in an acute inpatient unit?---None of these units exist – or very – I should change that statement to these units really don't exist or don't exist in any consistent form. And, indeed, they're being closed down – these subacute units in the UK – or these long extended stay units. There's different words to describe them. So it's hard to get an evidence base.
35

So doesn't that make it more important to deal in a careful way with the Walker model?---It makes it more important to have an extended suite of community-based services. The Walker model is very different to the Barrett model.

40 COMMISSIONER WILSON: Can I ask this. Just for present purposes, if you put the Barrett model aside and considered some modified Barrett model with a general limit on the length of stay which is perhaps attached to a hospital, would your answer differ?---Yes, Commissioner. Indeed, when we developed the overarching model of service – not the specific model of service I wanted from Dr Michael Daubney but
45 the overarching model of service – we proposed a maximum admission time of about six months with a review after three months which incorporated an intensive family assessment.

MR FREEBURN: Commissioner, that's all I have.

COMMISSIONER WILSON: I think we'll break for lunch at this stage before any cross-examination commences. And I know we have another witness at - - -

5

MR FREEBURN: Dr Fryer. I think she was allocated 2.30 or 3 o'clock.

COMMISSIONER WILSON: And Dr Steer.

10 MS WILSON: There's Michelle Bond, as well, Commissioner. Michelle Bond is from the Department of Education. Ms Muir was going to spend about 20 minutes with her.

COMMISSIONER WILSON: And there's a witness by video link at 5 o'clock.

15

MS WILSON: There is. There's one at 5 o'clock – Dr Steer.

COMMISSIONER WILSON: Well, we'll come back at 2 o'clock after lunch, I think, and do our best.

20

**WITNESS STOOD DOWN**

25 **ADJOURNED** **[12.42 pm]**

**RESUMED** **[2.03 pm]**

30

**STEPHEN STATHIS, CONTINUING**

COMMISSIONER WILSON: Yes, Mr Freeburn.

35

MR FREEBURN: Commissioner, can I provide 20 copies of a corrected version of that document that I handed up.

COMMISSIONER WILSON: Yes.

40

MR FREEBURN: Sorry. I can supply two to the Commission and copies to the parties.

COMMISSIONER WILSON: So are you wanting to tender this as an exhibit?

45

MR FREEBURN: Yes, please.

COMMISSIONER WILSON: So this is the statewide subacute beds discussion paper recommendations with extracts from two documents to which Mr Freeburn referred earlier. That will be the next exhibit. Do you have any further questions?

5 MR FREEBURN: No, I don't, Commissioner.

COMMISSIONER WILSON: Any questions in closed session?

MR FREEBURN: No, I don't, Commissioner.

10

COMMISSIONER WILSON: Alright. Who wishes to cross-examine?

MS McMILLAN: I do.

15 COMMISSIONER WILSON: Yes, Ms McMillan.

MS McMILLAN: Thank you.

20 **EXAMINATION BY MS McMILLAN [2.04 pm]**

MS McMILLAN: Dr Stathis, I appear for the West Moreton Hospital Service and Board. I want to ask you some questions, please. Dr Stathis, do you remember
25 earlier in your evidence to my learned friend Mr Freeburn he asked you in relation to papers that you listed in your CV that you prepared that there was not a particular – there was a focus not on non-forensic extended treatment. And he asked if that – this is my paraphrasing – a fair assessment of your papers and other works you've provided. Do you remember those questions?---Yes, I do.

30

What do you say about particular focus you have on – other than forensic youth and adolescent mental health issues and, secondly, how that works into extended treatment for them?---Well, I've had extensive experience in consultation liaison and other services, particularly in community child and youth mental health services.
35 I've asked to cover – I've asked to cover when people are on leave a range of other mental health services. And from time to time, I was asked to give second opinions of patients who were in the Barrett Centre.

So – just so I understand, you previously worked – you were sited at Royal
40 Children's, weren't you, prior to the amalgamation into what is now known as Lady Cilento. And as I understand it, you undertook clinical work there, didn't you?---For most of my year – most of my career, I've undertaken clinical work, yes.

And did that combine both children and young people who were inpatient and also
45 outpatient?---That's correct. And still does.

Still does. So you still have a clinical role, do you?---I do.

Right. Now, in relation to extended treatment, have you treated or supervised young people who have had what might be termed as extended inpatient treatment?---I've been asked in the past to provide second opinions to patients in the Barrett. And I've also been asked to provide second opinions for young people who've had extensive
5 inpatient – inpatient admissions. And also I've been asked on numerous occasions to provide advice about complex young people in the community who require a range of services.

So, for instance, what that might be a combination of government services in the
10 community and non-government sector, as well?---Most government, but also non-government, too.

Alright. So what do you understand by the term wraparound services? Because we've heard varying, perhaps, definitions of that. What would you understand that
15 means?---Well, it's a broad definition, but essentially it looks at what are the community services, educational services, mental health services, vocational services, housing, etcetera, maybe wrapped around or pulled around young people to provide them with a platform of support, particularly in the community, because most of these young people – they require a transdisciplinary approach, which I've
20 written about, which means that they don't just require mental health services. The complexity of their issues require a whole range of government and non-government organisations to collaborate together to provide an adequate treatment plan.

Alright. Thank you. Now, you were also asked some questions about working
25 groups in relation to a business plan and objectives. Is my understanding correct that the branch, that is, the mental health branch were responsible for the provision of funding for these packages?---Yes, they were and – up to when the Barrett closed. And then the money ultimately transferred over to CHQ.

30 Right?---Sorry. From time to time, we did ask the branch for additional funding for particularly complex young people, and the branch were very forthcoming and helpful.

Alright. And did that include – when you say certain young people, that included
35 part of what you understand to be the Barrett cohort?---That's what I'm referring to.

That's what you were referring to?---Yes.

Alright. Thank you. Now, you were asked some questions about governance and
40 responsibility between Children's Health and the individual health services. Do you remember those questions?---Yes.

Again, I may have misunderstood this, but post-July 2012 – so when the health services became operational – is it correct that the individual health services have
45 responsibility and oversight for patients within their health service?---That's correct.

Right. So what role, for instance, does Children's Health have if you're looking at, say, a child or adolescent with mental health issues?---Maybe I could give you an example.

5 Yes. Thanks?---If there was a child who was going to, say, Pine Rivers Community Child and Youth Mental Health Service or Inala or Nundah – we have six or seven across our Hospital and Health Service. Then the clinical responsibility for those patients in the community is Children's Health Queensland. If a child is attending the Gold Coast CYMHS service or Bundaberg CYMHS or anywhere else outside the
10 state, it's the local Hospital and Health Service that takes over the clinical care and governance of that child or young person.

And that's, I suppose, if for no other reason to make it absolutely clear who has responsibility for that child or young person?---Yes.

15

Right. Now, a different topic. You were asked some questions about a PowerPoint presentation. Do you remember that?---Yes.

And about it being made to parents. Could the witness please see
20 WMS.9000.0004.00001 at 00129. This is an attachment to Dr Geppert's statement. So this was a presentation I think you referred to in December 2013, was it, Dr Stathis?---It was, I think – I believe, 11 December.

And this was the one that involved Dr Radovini; is that right?---That's correct.

25

Alright. Okay. And parents of the Barrett cohort were invited to it?---Yes.

Do you remember how many attended?---Three, I believe.

30 Three. Thank you. I'll just wait for that to come up.

COMMISSIONER WILSON: So was there a wider audience than parents?---At that point, the invitees were parents specifically, Commissioner. From memory, there may have been extended family, also. But it was a focus on parents of young
35 people who had – parents of young people from the Barrett.

So you had an audience of, what, three or five?---It was – it was a small audience.

Thank you.

40

MS McMILLAN: I'll come back to that when that document is found. I can move on to something else, Commissioner. You were also asked in relation to, as I understand it, that Y-PARC model that you said could be modified throughout Queensland in various locations?---Yes.

45

And I take it – would that be to accommodate for not only the size of the population but also the mix so – particularly if you had other ethnic groups, Indigenous

population – there would be perhaps some tailoring that might need to occur?---Absolutely, which is, indeed, what they're looking at doing up in Cairns.

Because I take it there would be a higher Indigenous population, for instance, in
5 Cairns?---Yes.

Than – in the Cairns area than, say, here?---Correct.

Right. Thank you. Alright. If we just – Doctor, have you seen this before?---That's
10 my presentation.

Right. And is that the presentation you were referring to earlier in your evidence?---It depends. Leanne also provided a presentation.

15 Perhaps if we just scroll down to see whether this is yours, Doctor?---This is my presentation.

Right. So that's your presentation?---Yes.

20 Okay. Thank you. You were also asked about suites of services, and you were pointed particularly to AMYOS and other endeavours. CYFOS wasn't mentioned. Now, that's obviously a service as well available, isn't it?---Absolutely. The Child and Youth Forensic Outreach Service. But that was outside our Terms of Reference.

25 And this was the terms of reference for which particular group?---The initiative.

The initiative?---Yes.

Right. That you were referring to earlier?---Yes.

30

Right. And Evolve – that's a service, isn't it, for children and young people who are in care?---It is, and this was also outside our Terms of Reference.

Alright. So in your answers to questions you weren't there identifying the full range
35 of services available to that age group?---No, all the answers to my questions was always to look at what our project plan was, which was treatments extended – adolescent extended treatment and rehabilitation services.

Alright. Thank you, Doctor. I want to ask you about in relation to – you gave some
40 evidence about the Walker Unit - - -?---Yes.

- - - and you said that there were – again, I'm probably paraphrasing your answer. Walker was very different to Barrett Centre. Do you remember that?---Yes.

45 Can you indicate to us what you understand the differences to have been?---The vast majority of young people in the Walker Unit suffered from severe psychotic illnesses with other comorbid complications. Only – and also talking to the psychiatrist there,

she mentioned that the length of stay was approximately three months. They had some that would stay longer, so it was a much shorter length stay, and the focus of their treatment was primarily, but not entirely on young people with severe psychotic illnesses, such as schizophrenia.

5

And how does that, in your view, contrast with what you understood of Barrett?---Well, from reading the documents, I understand that the Barrett cohort didn't have predominantly psychotic illnesses as a diagnostic treatment.

10 And the length of stays?---I've seen documentation to indicate the average length of stay in the Barrett upon closure was approximately 17 months compared to about three months at the Walker Unit, so it was a much shorter length of stay.

In fact, paragraph 9, Commissioner, of this witness's first statement, you talk about 15 the average length of stay at Barrett being 17 months, with some young people having up to three year stays?---That was my understanding, yes.

Alright. Now, the discussion paper you've been taken to that was authored by – this is Ms Morson, is it?---Yes.

20

Now, you say that effectively – and correct me if I've got this wrong, but you'd asked Dr Daubney to come up with a model of service delivery, hadn't you, for a subacute extended stay?---Yes.

25 And, in effect, he'd said to you there isn't evidence base to support that. Is that correct?---He found the evidence base difficult to find.

Right. And so was it yours or yours and others' initiative to have this discussion paper put together?---So Judi and I discussed about what to - - -

30

This is Ms Krause?---Sorry, Judi Krause and I - - -

Yes?--- - - - discussed what to do, and the decision was made for Sophie Morson, who's a very experienced project officer working for us, to pull together a discussion 35 paper looking at treatment options for this cohort.

Right. And you've clearly read the paper?---Yes.

And one sees in it that she surveyed literature within Australia and overseas; 40 correct?---Yes.

And also looked at other perhaps not necessarily comparable, but other services available to this cohort; correct?---Yes.

45 She's also looked at evidence-based treatments for these – for young people; correct?---Correct.

And topics such as engaging and supporting families; correct?---Yes.

And is there anything in the report that you disagree with in terms of the content?---No, I think it's a very comprehensive report.

5

And is it consistent with both your experience and your understanding of the relevant literature?---It's consistent.

Alright. Thank you. Now, I want to go to page 88 of that document, which should
10 be CHS.500.0001.0088. So, Doctor, for your reference it's page 88, yes, the conclusions and recommendations?---Yes.

The second paragraph – if you read that to yourself?---Yes.

15 Now – and then the next two paragraphs?---Yes.

Now, as I understand it, you said that there may well be a need for some subacute inpatient care for those with, as I understand, psychotic symptoms; correct?---Yes.

20 Secondly, there was this, I think, eating disorders, but I want to ask you a bit more about that. I understood, perhaps, from your answer what you envisage was not strictly speaking an eating disorder simpliciter. It was issued that might be productive of someone who had eating disordered behaviour?---That's correct.

25 Is that right? And can you explain the difference?---Well, it's a young person who has eating disordered behaviour, complicated by a whole range of other mental health and potentially other health issues. As I said, I don't want to in any way minimise the distress of a young person who might have a primary eating disorder, but this is different. These are young people who have complex diagnoses, one of
30 which is an eating disorder. So I would like to say, as such, that they're eating disordered.

Rather than an eating disorder?---Yes. There may be a diagnosis of an eating disorder – say, anorexia – within the comorbidities, but it's much more complex than
35 that.

Right. And then you say, thirdly, there might be what might be perhaps termed a more amorphous group, where they're treatment resistant and – is that a fair way of putting it?---That's correct. There's always going to be other young people who
40 don't fit any definite mould, but they are very complex for whatever reason, and we have to have some latitude to consider those young people.

I just want to ask you generally, with eating disorders, there's in the literature for this inquiry mentioned the Maudsley model. Just explain what the Maudsley model
45 is?---So it's basically an outpatient model focused on family therapy, and the trend now, in terms of best practice treatment for young people who have an eating

disorder, is to get them out of hospital as quickly as possible and manage them in the community.

And Dr Sadler gave some evidence yesterday – and I'm paraphrasing what he said – but, in effect, that you may have a young person with psychosis who's acutely unwell, but you might have someone who, for instance, has an anxiety disorder and is acutely unwell. Is the issue in terms of, perhaps, differentiation in treatment, that one is in more need of containment and, perhaps, restriction than the other?---I mean, I guess it depends. We always need to look at mental health problems and consider the functional impairment and emotional distress inflicted on that young person by the mental health issue. So in considering treatment, you need to consider both those issues. You might have a young person with a psychotic illness which is causing relatively little functional impairment. You may have a young person with an anxiety disorder, and the disorder's causing significant functional impairment and emotional distress. And, of course, in terms of the patient's journey, that can vary from month to month. So it's quite complex.

Alright. And I gave an incorrect page reference, Commissioner, before. It should be page 85 of that discussion paper, paragraph 3. I don't need to take the witness back to it, but I took you to the wrong reference, I'm sorry. Now, I just had a few more questions, but they should be in closed session, Commissioner.

COMMISSIONER WILSON: There are sufficient of them to close the session at this stage, are there?

MS McMILLAN: Yes. It won't be just one.

COMMISSIONER WILSON: Alright. The live streaming should go off, please. And the hearing will be closed, so people will have to leave the courtroom. Wherever possible, I'd like to restrict the number of times we open and close the courtroom. It's, I think, distressing for some of the families who are in the courtroom to be up and down.

Closed Hearing

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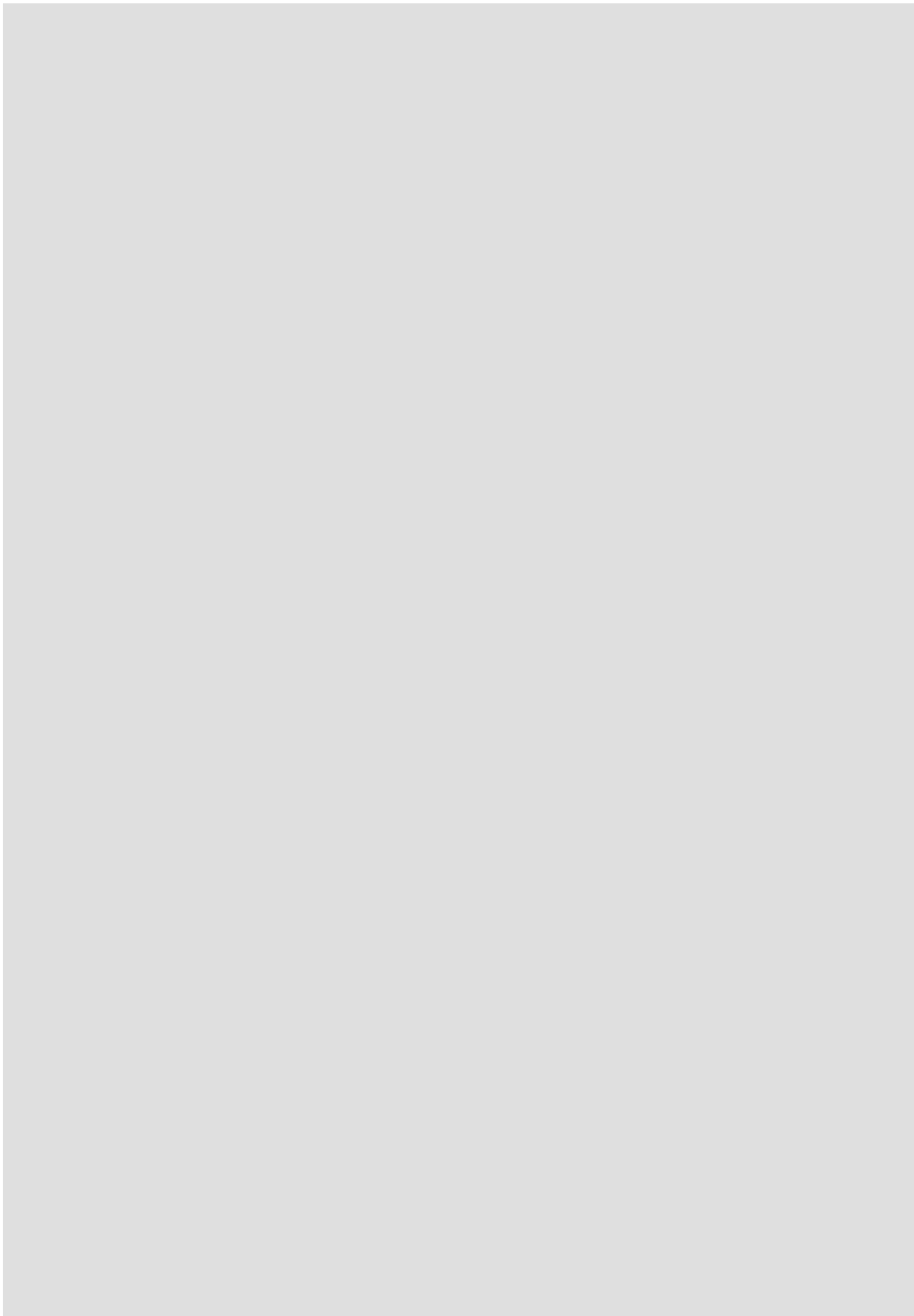

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45 COMMISSIONER WILSON: Very well. So I can open the hearing again now? Yes. The live streaming can come on, and people can come back into the hearing room.

MR DIEHM: I'm sure it would be more convenient if Mr O'Sullivan completed his questions before I commence mine, Commissioner.

COMMISSIONER WILSON: Yes. Mr O'Sullivan, you can complete your
5 questions now.

MR O'SULLIVAN: As your Honour pleases.

Professor Stathis, you are a fellow of the Royal Australasian College of
10 Physicians?---Correct.

You're also a fellow of the Royal Australian and New Zealand College of Psychiatrists?---Correct.

15 And you have a certificate in child and adolescent psychiatry?---Yes.

You're an Associate Professor at the University of Queensland?---I'm an – yes. I'm an Associate Professor, not a Professor.

20 No. Quite?---Thank you.

Perhaps you'd prefer Doctor rather than Professor?---Doctor is fine.

And, indeed, in 2011, you became a foundational member of the Faculty of Forensic
25 Psychiatry?---Correct.

And I understand from the questions that you gave in answer – the answers you gave in questions to Ms McMillan that you continue to practise?---Yes.

30 Now, I'm going to ask you a series of questions which are connected with the January 2016 policy document – discussion paper document that you were asked some questions about. Do you follow?---Yes.

Now, I showed you an email earlier from March 2015 before this Commission of
35 Inquiry was instituted. I'm going to take you to a document from September 2015 just before the Commission of Inquiry. Could Dr Stathis see QHD.004.006.3961. It's a two-page document. It's an email chain, the second page of which is at 3962. Could you read the email to yourself:

40 *Dear –*

how do you pronounce that name?---Sorry. Hi - - -

Fiona?---Fiona. Yes.

45

Fiona. And Bill. Just read that email to yourself, please. Now, is it your understanding in September 2015 that the discussion paper that you were shown earlier is the same discussion paper referred to in this email?---Yes.

5 And that discussion paper was developed to explore the evidence supporting the subacute bed model proposed by the government in their pre-election commitment rebuilding intensive mental health care?---Yes.

And it was hoped by you as well as the sender of this email that the discussion paper
10 will help inform the planning towards that election commitment?---Yes. It was ultimately commissioned by the Youth Mental Health Commitments Committee.

And the Commitments Committee means the election commitments committee?---that's correct.

15

Yes. It wasn't – it wasn't – it wasn't Dr Michael Daubney who took charge of it?---No. I asked Michael to look, as I've given evidence - - -

Absolutely?---Yes, I asked Michael. He found it very difficult to develop a model of
20 service, so then I thought we needed a discussion paper to help inform us.

I understand. Now, if you turn back to the first page, 3961, just read that email to yourself, please, the email of 10 September?---Yes.

25 Now, is the first paragraph of the email true, to the best of your knowledge?---Yes.

The substance of that first paragraph is that there's been very low utilisation of beds, since the closure of the Barrett Centre: And those beds mean subacute beds –
30 subacute beds in an inpatient setting?---Yes.

35

MS McMILLAN: I think – sorry, I just think this might need to be closed, Commissioner.

MR O'SULLIVAN: I'm sorry. It's my fault. I'll jump over it. I'm sorry,
40 Commissioner.

COMMISSIONER WILSON: Well, that shouldn't be on the screen, in the circumstances.

45 MR O'SULLIVAN: Yes. Could that be - - -

COMMISSIONER WILSON: Take it down, please.

MR O'SULLIVAN: It was redacted on the screen, I'm told, Commissioner.

COMMISSIONER WILSON: Well, names were redacted, but there was still considerable information there from which - - -

5

MR O'SULLIVAN: Thank you, Commissioner.

COMMISSIONER WILSON: - - - people may have joined the dots.

10 MR O'SULLIVAN: Now, in terms of the second paragraph of that email, I'll read that out, Commissioner, because it has no patient-oriented information. It states that:

> *When we turned our attention to this body of work we struggled with finding evidence to support a specific model of care for subacute. None of our*
> 15 *psychiatrists felt comfortable establishing a model of care that we could not base on contemporary evidence.*

Just pausing there, were you one of the psychiatrists – I withdraw that. Judi Krause is speaking of "our psychiatrists". That would've included you and others within the
20 mental health branch?---And Michael – well, not within the branch.

Yes?---Across the sector.

Yes?---So I also had informal discussions with a number of child and adolescent
25 psychiatrists – colleagues - - -

Yes?--- - - - and to the best of my recollection, everyone was struggling with trying – with determining whether the subacute beds were necessary and/or what type of model of care we would be able to provide.

30

Yes. The email goes on in the second paragraph to say:

> *Essentially, most of the evidence points to assertive community-based care and does not support long-term institutional care.*

35

?---Yes.

Does that remain your understanding of the evidence?---Yes, particularly the current – the current evidence base would suggest that.

40

Yes. I'll come in a moment to the difference between community and inpatient. You go on to say that the discussion is to be balanced in its approach, and you consider that it is?---Yes, I do believe it's balanced.

45 Yes. Now, I'll tender that email. It can be tendered in its unredacted – in its redacted form, if that's convenient, Commissioner. The - - -

COMMISSIONER WILSON: Well, just a moment. In the closed session you relied on an email. I assume you're tendering that. It may be something that won't go on the web, but it can still be an exhibit.

5 MR O'SULLIVAN: I did say I tendered that.

COMMISSIONER WILSON: Very well.

MR O'SULLIVAN: I probably should've been clearer, Commissioner.

10

COMMISSIONER WILSON: The two of them will be marked as exhibits.

MR O'SULLIVAN: Thank you, Commissioner.

15 QHD.027.001.3355. I'm going to show you the minutes of the Youth Mental Health Commitments Committee?---Yes.

If you just take a moment to orientate yourself, you will see that these are dated 22 September, so soon after the governing council appointed this commission of
20 inquiry. Do you follow?---Mmm.

And do you see that one of those attending is yourself?---Yes.

Now, you turn the page, Delium number 3356, if it please the Commission,
25 paragraph 1. Can you read not the first bullet point about confidentiality, but rather the second bullet point, please?---Yes.

Now, YMHCC is the Youth Mental Health Commitments Committee, and that means election commitments committee?---Yes.

30

And the concept that was discussed in this meeting is that the committee would develop a final position paper which will incorporate recommendations from the Commission of Inquiry to be released in January?---Yes.

35 And – I'm so sorry. Was the thinking in September that the Commission would have reported by January and you would have a discussion paper incorporating both input from the discussion paper and also the Commission's findings?---Well, no. What that means is the assumption back in September was that the - - -

40 No, I understand that?--- - - - Commission of Inquiry would've – yes.

No, quite?---Yes, so we would've used that to inform the final position paper - - -

Exactly?--- - - - of which the discussion paper we were to provide would also inform
45 the final position paper.

Yes. I understand. Now, if you turn the page and look at item 2, please, the first bullet point, the Youth Mental Health Commitment Committee is formed with a time limit and specific role to progress work relating to the government's election commitment. That's a true proposition?---That's correct.

5

Yes. Now, you'll see that the second bullet point under item 2 is that the committee was asked to consider the discussion paper provided to guide the work of the committee, and there is a reference to a discussion paper there?---Yes.

10 Is that an earlier draft of the discussion paper dated January?---From memory, that is an earlier draft that we then have refined over the last – over the subsequent two months.

Yes, leading to the document that the - - -?---Yes.

15

- - - Commission has seen today. Yes. If you turn the page, please, to page 4, Delium number 3358, you'll see there's an item SS summarised. That would be a record of you, your summary?---That's correct.

20 I put that badly. Things you said in the meeting?---That's correct.

Yes. Can you read, please, the whole of the document on this page 3358 and focus on the last two bullet points, please?---Yes.

25 The last bullet point says that:

> *Children's Health Queensland is preparing a literature review on the use and effectiveness of subacute beds.*

30 Was that after Dr Michael Daubney reported back to you that he couldn't find anything in international literature?---Yes.

And it states thereafter:

35

> *Internationally, it appears that subacute beds are not the preferred service option for extended treatment for adolescents, and where alternative community options are available, existing subacute beds are being closed.*

The information that you provided to the group encapsulated in that statement, was
40 that the information that Dr Daubney provided to you?---Both Dr Daubney and also in the draft discussion paper, it also was pointing to that evidence too.

And does it remain your view today that that is a fair summary of the evidence internationally?---Yes.

45

The next statement that you – recorded as being made is that the evidence supports that where it is deemed clinically required, extending the length of stay inpatient care

appears to be the preferred options compared with dedicated long-stay subacute facilities?---Yes.

And that means extending the length of stay inpatient care – does that mean in an
5 acute inpatient care setting?---Yes.

And does it remain your view that the evidence today supports the conclusion that the appropriate therapeutic approach is extending the length of stay in an inpatient unit rather than a dedicated long stay subacute facility?---I guess my views there
10 have changed somewhat over the last four months with the final discussion paper.

Yes?---That there may be a very small cohort which we mentioned in the discussion paper that might require subacute beds.

15 Yes?---The difficulty is, it's a very small cohort. And it would be difficult to stand up a unit – an independent unit just for those young people.

Yes?---Based on the referrals we've currently received, we've only had a few, two.

20 Yes?---So it is – and that's, I guess, what everyone is grappling with. There may be this very small cohort but in terms of economies of scale and setting up a unit, for such a small cohort it would be difficult to staff and it would be difficult to manage.

Yes.

25

COMMISSIONER WILSON: What I'm grappling with, Doctor, is this: you say you've had such a limited uptake for the subacute beds in an acute unit which seems to me to be different from the concept, for example, that was being worked up for Redlands, which was different from the Barrett Adolescent Centre in terms of the
30 length of stay. There seems to me lots of criticism of the length of stay at the Barrett Adolescent Centre. Dr Sadler has given some explanations for it. I'm not entering into that at the moment. But a reduced length of stay and the other changes that Redlands would have made from how the Barrett was managed seems to me to be a different concept from subacute beds at an acute unit. I just don't know that we're
35 comparing apples with apples in the way you're speaking. That's all?---That's – that's an interesting proposition, Commissioner. I would have to agree. You could argue – it would be reasonable to argue that the limited referrals are because we have had to, because there is no capital build, put together these swing beds. We don't know. What we do know is that there are very few dedicated subacute units
40 anywhere in the world. And from the discussions I've had, these are closing. They're not opening any new ones.

Well, the Walker Unit is not closing as far as we know. There seems to be some discussion of a re-scoping of the Bentley Unit in Western Australia?---That's correct.
45 So it may well be that if there was a subacute unit with a new contemporary model of service, we may well find that the patients there look very different in terms of diagnostic profiles to the patients that had been admitted into the Barrett. So even

then we may be comparing apples with oranges because when the Barrett was built, as I'm sure you've had evidence back in 1983/84 - - -

It wasn't even built then. It was opened then?---Opened then. Yes. There was none
5 of the suite of services we have and we are wanting to develop across the State. So it's difficult to know and we don't have any real evidence base to determine what is required.

Well, one of the other things that's been troubling me as you've been giving
10 evidence is this. If I accept for present purposes that it was West Moreton's responsibility to make arrangements for the existing patients of the BAC and those on the waiting list, put those aside for the moment. We're now two years down the track from the closure of the BAC. The suite of services is still being developed and rolled out?---Yes.
15

We still don't have a Step Up Step Down service, for example. And things are coming online rather slowly, it seems. What's happened to young people other than the existing Barrett patients and waitlist patients in the meantime?---For those up to 18?
20

Well, even 16 to 21 in some cases but - - -?---Yes. Well, I can't comment on those over 18. Though everyone within the sector says there's clear gaps for young people 18 and above because they don't suddenly turn into adults, functioning adults at 18. For those up to 18, it's only anecdotal and new evidence. But inpatient admissions,
25 generally speaking, across the State into adolescent – acute adolescent inpatient units have fallen over the last year or so by about 10 to 15 per cent. We don't know the reasons for that but we have asked the branch to start crunching the data. One of the reasons may well be that these young people who were frequent users of the inpatient services are now being managed by AMYOS services or other community services
30 leading to a reduction in inpatient admissions. That would be good news.

Well, that's speculation, though, at the moment?---It's all speculation. It's early days.

35 The other thing that is concerning me, and you may be able to help me with it, is this: we do seem to be considering a very small number of patients or mentally ill young people. Let me put it that way. I appreciate immediately that the pie is only so big and that very difficult decisions have to be made as to how it's cut up. That's a job, I would've thought, for the policymakers, a very difficult job. But let's take a patient
40 who theoretically would be best cared for in a Y-PARC facility?---Yes.

One in Cairns. What about the patient who comes from South East Queensland or from Mount Isa? Queensland is a very big State geographically. Its population is very dispersed. It's not only in the provincial towns down the seaboard but then west
45 of the Great Divide. Is this suite of services going to overcome that problem? Or is there a need for something – and I'm not sure what – but is there a need for something that is one service that's statewide so that young people, unfortunately,

have to come from their hometowns? Now, I say unfortunately because it would be unfortunate if they were in stable family situations. And some of them, no doubt, will be. But I suspect there will be some who are not from such families. And there may even be cases where the conflict or the unhappiness is such that their condition
5 would be better catered for away from the family?---That's - - -

Is that a fair comment?---That's a fair comment. To answer that, first of all, that's precisely why we wanted to put AMYOS services right across the State. The difficulty we have, of course, is not just having the funds to develop the services but
10 finding the clinicians to run them. So in one of the AMYOS services that was established in a large – in South East Queensland, it took almost two years to find clinicians to – that had the experience to run the services. So it's all well and good to have the funding – and I appreciate the funding – to roll out the services but we also have to have the experienced clinicians. And they're very hard to find in regional
15 areas.

Well, is that - - -?---And that's the rub that we have.

Yes. Is that not also a pointer to perhaps the need for one – in addition to these other
20 services which, really, will be sprinkled across the State, a long way away from many people geographically and with, well, services that are no doubt consuming the available expertise?---Yes.

What happens to the rest of the patients?---Economies of scale are important, and I
25 guess that is also one of the reasons we were looking at Step Up Step Down units – Y-PARCs in the northern cluster and in the central and southern clusters. And notwithstanding the real difficulties people in regional areas have, about 70, 75 per cent of the population is clustered in the south-east corner as defined from roughly the Sunshine Coast down to the border. So that's also what we're grappling with – is
30 providing services across such a decentralised state but also trying to focus on the 70, 75 per cent in the south-east corner.

It's a very difficult issue, isn't it?---It's incredibly difficult.

35 And I appreciate what you said about finding the right clinicians. And this would be not just psychiatrists, I would think, but the other disciplines who are involved?---Definitely. I'm not just talking about psychiatrists. I'm talking about experienced psychologists, social workers, nurses – to try to assist in establishing these services. The – if I may say, the other pleasing change is that the level of
40 experience within the NGO sector has, in my view, improved over the last few years. And that was demonstrated by the tender process we had for the youth resi services that was – and the procurement process last year. And that demonstrated an appetite for these services, that large national NGOs were interested and could draw on their resources nationally. That's a pleasing change. It still doesn't cover all those issues
45 about the tyranny of distance and decentralisation.

I see. Thank you. Mr O'Sullivan.

MR O'SULLIVAN: May it please your Honour.

The tyranny of distance is – it's right that it's particularly important, because the evidence at the moment, as you understand it, suggests that caring for young,
5 vulnerable people close to their home has a therapeutic benefit?---It has a therapeutic benefit and it also was clearly what the – what the consumers and carers and parents and young people all want. And that's across the board. That is in consultation with the Barrett families and on our broader consultation. That message was said again and again and again.
10

And when one has a very large state, if one's aim is to meet that request for caring for someone close to their home because that's what the patients and families want and because – and we'll come to it – the evidence supports that being therapeutically appropriate, is it not the case that a logical difficulty with a single state-wide
15 building, if we can put it that way, is that one has inevitable dislocation when one's patients come from around a large state?---That's what we're grappling with, and that's why we decided to have these multiple different suites of services – a continuum of care, I should say.

20 Yes. And - - -?---To try to manage that as best we could.

And in terms of the Commissioner's question about – there are limited resources that taxpayers only have so much money, the government has only so much money to spend. There are difficult policy choices to be made in terms of how does one spend
25 a scarce resource, namely, cash, to get the best outcome for young people in Queensland?---It's something we all grapple with.

Yes. And it's the case, isn't it, that the costs of acute units are far higher than community-based care options, typically?---Yes, yes.
30

About two and a-half thousand dollars per bed per day?---I don't have the numbers off the top of my head, but I believe it's around that.

About 2400. Yes. Now, 3358 was the document that you were giving evidence
35 about. It's the 22 September Youth Mental Health Committee – Commitments Committee minutes. The last bullet point on page 4, we just finished reading. May I take you to the next page, Dr Stathis. This is item 5 SE and AD are discussing something. So that's not you?---That's not me.

40 No. Now, if you go to – you can pass over the allocation of funding to support election commitments and go to the fifth bullet point down. You'll see that the document records that SE – who was SE?---I'd have to look - - -

Sandra Eyre?---Yes.
45

And AD must be Ingrid – AD must be Anna Davis?---Must be.

It states here:

> *An evidence base for the inclusion of subacute beds into the extended treatment model is limited/non-existent.*

5

Does that remain – I withdraw that. Is that your understanding of the evidence base today?---Well, based – that was based in September.

Yes?---The wording we've used is there's no compelling evidence. That's the
10 wording I'd prefer to use.

Thank you. The next bullet point down – can you read that to yourself. It says that the current evidence suggests that complex needs consumers requiring high levels of support have better outcomes when cared for in the community and that hospital
15 admission increases the risk of adverse outcomes for this highly vulnerable group of consumers?---Yes.

Does that remain your understanding of the evidence today?---That is my understanding. Inpatient units should be there to stabilise young people and enhance
20 their immediate functioning. Yeah.

Yes. And that's true of inpatient units whether it be called acute or subacute – whatever the nomenclature?---The focus is – there is on acute inpatient units. Yes.

25 Now, it says outcomes are improved when care is delivered close to family support networks. That's – that reflects your understanding of the evidence?---Absolutely.

Absolutely. Now, we'll come in a moment to the risks of adverse outcomes by an inpatient admission because they're dealt with in the discussion paper. But may I
30 take you to the discussion paper next?---Yes.

May I tender that document, Commissioner.

COMMISSIONER WILSON: Yes. That document will be marked as an exhibit.

35

MR O'SULLIVAN: The discussion paper that emerged from a process that you've been giving evidence about is CHS.500.0001.0001. This is a document developed by the Youth Mental Health Commitments Committee. Now, if you turn, please, to – just before you do, paragraph 7 of your second statement – I'll just read it out to
40 you, Dr Stathis. You state at paragraph 7 that in your opinion there is limited compelling evidence to support subacute inpatient extended treatment and rehabilitation for young people suffering mental health problems. And you then say – if you'd like me to show it to you, I can. You then say:

45
> *There is, however, evidence to support extended treatment and rehabilitation for young people with mental disorders in their community.*

And you then say:

*The evidence to which I refer is contained in the discussion paper developed by Sophie Morson, currently in draft.*

5

Is that the document – the document by Sophie Morson is the document I'm taking you to now?---Yes.

And is it – does it remain your view that what you've said at paragraph 7 that I've
10 just read out remains a fair summary of - - -?---Can you show me that?

I should. I should. Could Dr Stathis be shown DSS.001.002.001 at two. Paragraph 7, Dr Stathis. Just take your time?---Yes. Sorry. When you read it out, I thought you said that I said there is, however, no evidence to support extended treatment and
15 rehab for young people with mental health disorders in their community. That's why I got confused.

No, no. If I said that, it was my mistake. Limited compelling evidence?---Yes.

20 And that's the language you referred to earlier?---Yes.

Yes. Now, my question is does paragraph 7 reflect your general – I withdraw that. Does it reflect your summary assessment of the evidence which is recorded and analysed in the discussion paper?---Yes, it does.

25

Yes. And in the first two sentences you contradistinguish, on the one hand, subacute inpatient extended treatment and rehabilitation for young people, on the one hand; on the other hand, in the second sentence, you say there is evidence to support extended treatment and rehabilitation for young people with mental health disorders
30 in the community. Do you see that?---That's correct.

Now, when you say "in the community", what precisely do you mean?---Outside of the hospital.

35 Yes?---And this is also – drawing on what the Commissioner said, the difficulty here is that much of the data is from the UK, Europe, even parts of North America, where they're not grappling with the decentralised state that we live in here in Queensland, but certainly I stand by that comment.

40 Yes. In terms of the best way to treat these very vulnerable people, your view is that in the community is a mode of treatment that has support in the evidence?---Yes, that's a good way to put it. There is good evidence in the community. There's limited compelling evidence for subacute beds in hospital, except for the three caveats that we've already discussed.

45

Yes, and we'll come in a moment to – in terms of the caveats – the three species – I withdraw that. The three types of disorder that might warrant this kind of therapy?---Perhaps.

5 Perhaps. Perhaps. But there are risks which are different between an inpatient setting and a community setting, aren't there?---Absolutely.

And we'll come onto those in a moment?---And I if could say - - -

10 Please?--- - - - there's technically differences of risk, as the Commissioner pointed out, having subacute beds in an acute unit versus a dedicated unit.

Yes. Going back to – if Dr Stathis could be shown the discussion paper CHS.500.0001.0001. Now, 00025, which is page 25 – I'm taking you 25 pages in,
15 Dr Stathis?---Yes.

There's a heading, 1.2: State-Wide Subacute Beds Demand and Future Directions. If you could read that to yourself, please, and let me know when you're finished?---Yes.
20

Now, passing over the two patients who required subacute admission – put those to one side. Can I ask you to direct your attention to the sentence underneath that. It says:

25 *Development of an SSB model –*

that's a state-wide subacute bed model?---Yes.

Continuing:
30

> *...was delayed by the work arising from the amalgamation of the CHQ CYMHS with Mater CYMHS.*

Just pausing there, that was the creating of Lady Cilento Hospital?---Yes, who were
35 tremendously busy in the first few months of that year, trying to pull together that amalgamation and working through any small issues as they arose.

Yes, and that was early 2014?---2015. We amalgamated on the 29th of November 2014.
40

Thank you. Early 2015. That was the period of – I withdraw that. Now, it says:

> *Development of a draft model commenced in April 2015.*

45 Is that a reference to the discussion paper?---No, no. that was when I asked Dr Michael Daubney - - -

I understand?--- - - - to commence the model of service.

Yes, and he reported back that he'd done an international search and he couldn't find any evidence?---He had done some searches and he couldn't find any evidence,
5 which is why then we asked for the discussion paper - - -

Quite?--- - - - to be written.

Underlying the methodology that you're explaining to the Commission – the
10 underlying methodology is one is looking for evidence before one commits to a model of service and recommendation to government to commit funds to it?---I think it would be foolish to do – not to do so.

It would be irresponsible?---It would be irresponsible.

15

The next sentence is:

> *In June 2015 confirmation was received that there will be no recurrent funding to resource the subacute beds, which promoted senior Children Health*
> 20 *Queensland staff to reflect on continuation of service provision.*

Now, does that remain the position today?---Yes. There is no funding for the subacute beds. We decided to direct the funding into other areas of the model, given that there was no uptake. Having said that, we are still committed to supporting
25 these young people within these swing beds, and so if a young person was referred – and we have a state-wide committee to look at any referrals, and on the committee are a number of very senior child and adolescent psychiatrists. I'm not on the committee, because I wanted an arm's length approach.

30 Yes?---We will accept them into those beds.

And to be clear, Commissioner, the committee to which you're referring is a committee which would assess patients for potential admission to the subacute beds at Lady Cilento?---We wanted an open, transparent assessment process.

35

Yes?---Correct.

And - - -

40 COMMISSIONER WILSON: You said this morning, I think, that there are 11 beds in that unit - - -?---Yes.

- - - and as at today, all of those beds are taken up with acute patients. Did I misunderstand you?---As of yesterday they are. I'm not sure about today,
45 Commissioner.

Well, as of yesterday?---Yes. In other words, the flow-through can be quite rapid, so you may have two or three discharged from the unit. The other issue is that all the inpatient units across the state communicate with each other, so we know twice a day at any given time whether there are spare beds across the state.
5
I see. Thank you.

MR O'SULLIVAN: Thank you, Commissioner. The next sentence states that they propose this discussion paper to review the evidence, benefits and risks of such a
10 service, with a focus on lived experience to help inform the level of need and scope for an ongoing SSB model of care. And that's what's been done in this discussion paper?---Well, the discussion paper will then inform a model of care, a model of service.

15 Yes. Now, if we turn next, please, to page 85 – Delium number 85, there's a heading here, Discussion, Dr Stathis. Just read the first sentence to yourself?---Yes.

That's consistent with your explanation to the Commissioner earlier, that there are – it's a highly complex problem, particularly when one is dealing with limited
20 resources and variable evidence base, if I can put it that way?---That's correct.

Paragraph 3, please. Could you read that to yourself?---Yes, that was the paragraph referred to this morning.

25 Yes, quite. Now:

> *There are numerous evidence-based treatments available to be delivered in community settings, with expert guidelines for a range of disorders advocating that inpatient care be minimised as much as possible.*

30
The reason for minimising inpatient care is – is that – are those reasons set out on page 86, first and second paragraphs?---Yes.

Does it reflect your opinion that inpatient care does carry with it potentially the risks
35 that are set out in paragraphs 1 and 2 at page 86?---Child and adolescent psychiatry is a specialty of risks. We manage risk all the time, and the last thing we want to do is admit a patient into an inpatient facility if at all possible.

Yes?---It comes with a whole set of its own risks. We'd rather manage them in the
40 community.

And those risks are, to be clear, potential emotional cost to the young emerging adult?---Yes, absolutely.

45 And aggressive incidents in inpatient units being common, and the challenges of exposure to other young people with disturbing behaviours, as well as those six themes of dislocation?---Yes.

And of those six themes of dislocation, removal from family and removal from friends are, in your opinion, real and serious issues?---Yes. Adolescence is a time of identity and individuation. And the last thing you want to do is take a young person from their community if at all you can help it.

5

And that, I suggest, is the reason why your evidence earlier is that, if it can be done, treatment in the community is by far and away the preferred model both because there's an evidence base and, secondly, because it doesn't carry with it the risks that are identified in this paragraph?---It's my preferred model. It's the sector's preferred

10 model. It's certainly the preferred model of consumers and carers.

If you turn to the third-last paragraph on page 86, you'll see there, Dr Stathis, it says:

*There appears to be strong and converging evidence regarding the*

15 *acceptability and effectiveness of community-based care in supporting these young people with severe mental illness.*

Just pausing there, when it says severe mental illness, just to be clear, you're referring here to those young persons who might have had a mental illness of the

20 kind which saw them admitted to the Barrett Centre when it was open?---Yes, you could – yes. That would be correct.

And you refer to growing advocacy for its greater availability and resourcing in order to better meet individual human rights through the service principles of proximity

25 and least restrictive care. Are those important matters?---Absolutely.

Community-based care is also commensurate with the spirit of the recovery model in supporting people to apply treatment strategies in their own community. Is that a serious statement?---Is that a - - -

30

Serious statement?---It absolutely is.

The next paragraph states:

35 *An examination of community-based models operated by CYMHS throughout Queensland demonstrated their effectiveness for young people with severe and/or complex mental illness.*

Has that examination been done?---I believe so, but I can't recall off-hand the

40 reference to that.

Yes. Can I take you, please, to paragraph – I withdraw that – page 87, the second paragraph commencing with:

45 *It is worth noting.*

Can you read that to yourself, please. Just focusing on – I'm so sorry?---Yes.

Focusing on the first sentence. The fifth – there's a reference to the Fifth National Mental Health Plan in 2016. Has that been released yet?---No.

Is it intended by Children's Health Queensland that you will have regard to that?---Absolutely.

Why is that?---Well, because it informs the development of services across Australia. It's critical that we adhere to any of the recommendations and that – of the Fifth National Mental Health Plan.

Do you know when it will be released?---I'm uncertain.

Now, the next paragraph – can you read the last sentence to yourself, please:

> *It is suggested that –*

sorry. The last two sentences?---Yes.

It would be right to say that the recent data you have that inpatient admissions in Queensland have dropped by 10 to 15 per cent may or then again may not be causally related to the broader continuum of care that has been rolled out in the last two years?---We're uncertain. It needs to be further investigated.

Can you turn, please, to page 88, Dr Stathis. Just read that to yourself?---Yes.

The first sentence of the second paragraph is a theme that you have, I suggest, adopted in your evidence that an extensive review of the literature found limited compelling evidence regarding the benefits of extended inpatient care. That remains your view?---Yes.

Yes. The fourth paragraph refers to the considerable risks associated with inpatient admissions and the way they may prove a significant challenge to the young person's achievement of developmental milestones and forging a meaningful and contributing life. Those risks are the risks that I took you to earlier?---We always look to treat a young person within the least restrictive setting. Yes.

Yes. You say that – I withdraw that. The document says:

> *These risks may be even more pronounced if the unit is far from home and the admission is of an extended duration and/or incongruent with the young person's cultural background. And treatment gains may therefore be undermined by the inpatient setting if not carefully managed.*

That's your professional opinion?---That's my view. You're fracturing them from their community.

Now, the next paragraph:

*Regardless of the length of stay, the young person will at some point need to be discharged to a less restrictive treatment. The evidence suggests a young person experiencing an extended admission may have more difficulty successfully transitioning into the community.*

5

It would be right to say that that was one of the concerns you had with the length of stay that was seen in the Barrett Centre?---Yes.

The second-last sentence in that paragraph says:

10

*Sufficient access to community-based options appears to be associated with both a reduced need for inpatient care and a reduced rate and length of admission. Research is increasingly demonstrating that comparable or better outcomes associated with inpatient care may be achieved in less restrictive*
15 *settings.*

In practical terms, what does that mean?---In practical terms, it means if you can treat people in the community you might get better outcomes because it's a least – a less restrictive setting.

20

Now, the - - -

COMMISSIONER WILSON: You said might. Did you mean to say might?---It's hard to always say always, but you're more likely to get a better outcome.

25

MR O'SULLIVAN: The word in the last sentence is "may", Commissioner – may be achieved.

WITNESS: May be achieved.

30

MR O'SULLIVAN: So the document doesn't say will be achieved. Taking you down to the last three lines, it says it is proposed that – I withdraw that. The last paragraph:

35 *It is proposed that (1) most adolescents requiring extended inpatient care be stabilised in their nearest existing acute adolescent unit prior to discharge to less restrictive care as per the state-wide model of service.*

?---Yes.

40

That means an adolescent requiring extended inpatient care would be admitted to an acute unit, stabilised and then, once stabilised, discharged to a less restrictive non-inpatient environment?---Yes.

45 The second recommendation is that any proposed service for CYMHS, C-Y-M-H-S, be based on a clearly articulated model of service with explicit attention to addressing the risks outlined above?---Yes.

Those risks are the ones I took you to in the fourth paragraph of this page?---Those risks are included in that. Yes.

Yes. And developed earlier, explained in more detail in the other pages I took you to?---Yes.

Yes. So any service model – the recommendation is must give explicit attention to those risks. The third recommendation – I withdraw that. The third proposal is that additional resources – that means money and time and effort - - -?---And personnel.

And personnel – be directed towards establishing a comprehensive continuum of community-based adolescent mental health services across Queensland?---Yes. And that goes to what the Commissioner mentioned before. We've got a large, decentralised state. You can only discharge – going back to number 1, you can only discharge patients to a least – a less restrictive care in their community if there are services in the community to discharge them to.

Yes. It's right to say that the recommendations of this document do not include establishing a new standalone facility, do they?---As I've said, there's limited compelling evidence.

Now, the other evidence you've given is in relation to referrals to the subacute beds, and there's been a discussion of apples and oranges and so on. You recall that discussion. The evidence you gave in answering questions from my learned friend Mr Freeburn is we had almost no referrals. You remember giving that evidence?---Yes.

Can I take you to your second statement to paragraph 44. I tender that discussion paper if it hasn't been tendered, Commissioner.

COMMISSIONER WILSON: I suspect it is already in evidence, but if it's not it will be marked as an exhibit.

MR O'SULLIVAN: Thank you, Commissioner.

Your statement, paragraph 4, Delium number DSS.001.002.001 at page 14. If you just read paragraph 44 for yourself?---Yep.

Does that remain the position today?---Yes, that remains the position today.

And to give a complete picture to the Commissioner, one would be cautious in drawing conclusions from that for the reasons given by the Commissioner that we're dealing here with beds in the Lady Cilento unit?---Yes.

Yes. Now, paragraph 45 – you say that in your opinion there may be limited need for adolescent subacute beds if the whole of the continuum is endorsed and funded. Does that remain your opinion?---Yes, and then I quoted from the discussion paper.

I mean, the whole point of the discussion paper was only to look at the evidence, not to make a recommendation whether there should be subacute beds or not.

Yes. One reason for that is that you weren't asked to make a recommendation, and
5 that involves policy questions, and it involves those who are elected to make the decision, as it were?---Correct.

Would that be fair?---That's fair.

10 Paragraph 48 – I withdraw that. Could you read 44 to 48, page 15?---Forty-four to 48?

Sorry, 46 to 48, I'm sorry?---Yes.

15 Now, the last sentence of paragraph 48 says the treatment – we're dealing here with the unit Lady Cilento:

> *Treatment is tailored to the needs of the patient regardless of their acute/subacute status.*

20

?---Yes.

Now, is that statement – do you understand that to be understood by those practising in adolescent psychiatry within Queensland?---Yes. There's a model of service
25 around acute care – acute inpatients. There's no model of service, as I've said, around subacute beds. So what we would do is we would tailor-make a service plan around any individual that came in for – into a subacute bed. Regardless of that, we always tailor treatment to the individual.

30 Yes. Yes. And so insofar as one is attempting to draw any conclusions about demand or need, if it's right that those who are referring young people to Lady Cilento understand that care will be tailored to their needs irrespective of whether you call them acute or subacute, would it be right to say that one would infer that at the moment there isn't regarded to be, for those who are referring to the unit, a great
35 demand for subacute inpatient beds?---There's been very little demand.

Now, do you remember being asked some questions about – you were asked a question about a statement that the Minister made?---Yes.

40 Would it be right to say that sitting here now, you don't have any recollection of the details of what the Minister might or might not have said?---No. I should've asked for that statement to be brought up - - -

No?--- - - - because I can't recall what he did or didn't say.

45

Yes?---And in reflection over lunch, he may not have even mentioned the Barrett cohort in that statement. I would need to actually see it.

Just finally, if Dr Stathis could be taken to – this is your second statement, Dr Stathis, paragraphs 77 and 78 at page 26, Delium number 26. If you just read those paragraphs 77 and 78 to yourself, please. Does that remain your opinion today, the opinion you've set out in 77 and 78?---It does remain my opinion. The context at the
5 time – can we just go up to 77, please. It's just – that context, paragraph 77, was made on the – in relation to a meeting I had with the DG, Ian Maynard, on 26 November 2014. And the pain of those parents – and I won't say anything more – was palpable - - -

10 Yes?--- - - - and I wanted to understand the level of pain and the complexities of the issues that they were going through, and the question of a therapeutic community mainly for the parents was brought up, and the advantages that the parents reported in relation to their interconnectedness.

15 Yes?---But I guess that paragraph, I was then reflecting back on whilst the parents found it tremendously supportive, I was trying to work out how such a community would be supportive for young people in relation to the whole point of an admission, which is to then transition them back into - - -

20 That's right?--- - - - their local community.

And that's why, in the last sentence of 77, you say that it was a concern of yours, and that's why you gently questioned the parents about it?---Yes, because these parents had the lived experience, which we value greatly.

25

Yes?---But I was also reflecting that it was their lived experience, and I was trying to understand the lived experience for the young people in the Barrett, but how that might help or hinder them in integrating and individuating back into the community.

30 Yes, and the concern that you had at the time is really expressed in the third sentence of paragraph 77, isn't it?---Yes.

No further questions, Commissioner.

35 MR MULLINS: Commissioner, just before Mr Diehm starts, I think he has got some closed questions - - -

COMMISSIONER WILSON: Just a moment, if you would, Mr Mullins. Just a moment, if you would. Yes. Mr O'Sullivan, I'm sorry.

40

MR O'SULLIVAN: No, I just - - -

COMMISSIONER WILSON: I don't - - -

45 MR O'SULLIVAN: I have no further questions, Commissioner.

COMMISSIONER WILSON: - - - have anything to ask you. I was just wanting to complete my note, that was all.

MR O'SULLIVAN: Thank you, Commissioner.

5

COMMISSIONER WILSON: Now, Mr Mullins, you were on your feet, and I think Mr Diehm was about to get on his feet. What's the position?

MR MULLINS: Mr Diehm was going to close the court at the end of his questions,
10 so I thought since mine are all open, I will ask mine now, Commissioner, if that suits.

COMMISSIONER WILSON: Does that suit everyone?

MR DIEHM: Yes, Commissioner.

15

COMMISSIONER WILSON: Yes, go ahead, Mr Mullins.

**EXAMINATION BY MR MULLINS [3.33 pm]**

20

MR MULLINS: Thank you, Commissioner. Can the witness please see DSS.001.001.399. And while that's being brought up, Dr Stathis, my name is Mullins. I appear on behalf of Ms Pryde and Ms Olliver and Ms Wilkinson, who are
25 the parents of three of the patients.

COMMISSIONER WILSON: Mr Mullins, can you move the microphone so that you're speaking into it.

30 MR MULLINS: I apologise, your Honour. Is that 399? You were asked about the slideshow that you presented on 11 December 2013 to the parents?---Yes.

And you were taken to this document in a different exhibit. But this is annexed to your document?---Yes.

35

Very quickly running through, this is the presentation you gave to the parents?---Yes.

And also did you say Leanne Geppert gave a presentation, as well?---Yes.

40 And if we run through – if you scroll down, please, we see the background on 6 August 2013. The Minister made an announcement that adolescents requiring extended mental health treatment and rehabilitation would receive services through a new range of contemporary service options from early 2014. Continuing on through – scroll down, please. And that's your consultation process?---Yes.

45

And then your ECRG recommendations – you spoke about that?---Yes.

Keep scrolling down, please. We see the new proposed model of care. And then we can see in the next slide proposed assertive community treatment service – tier 2A?---Mmm.

5 Continue on, please. Proposed day program – tier 2A. At the bottom there, proposed Step Up Step Down unit – tier 2B. And next, please. This is a proposed residential rehabilitation unit – tier 2B. And we can see that this was for adolescents not just between the age of 13 and 17 but prospectively for adolescents 16 to 21 years?---Yes.

10

And then continue on. Proposed subacute bed based unit – tier 3. And just continue on, please. And then it had timeframes. The model of care nearing completion – that's nearing completion of the design of the model, isn't it?---Yes.

15 Yeah. Not nearing completion that the model is ready to go?---No.

With work being undertaken to finalise the details of all options. And then the last slide refers to:

20 *For more information.*

Now, it's the case, isn't it, that this was really information that was provided to the parents solely as information. That's right?---To allow – yes. To allow them to understand the breadth of services that we were going to provide.

25

Correct. Because none of the Barrett patients were going to be transitioned to this model?---None of the Barrett patients – no. That's correct. None of the Barrett patients would have been transitioned to this model. At the time I wrote that I didn't know that but that's correct. None were. Some – some have been transitioned

30 subsequently.

To this particular model?---Absolutely.

And is it the case that as early as 11 December 2013 you knew that this model would

35 not be in place by early 2014 in its entirety?---In its entirety? Yes.

And it was always the case, from 6 August 2013, that you knew that a new model of this type couldn't be in place by early 2014 in its entirety?---To put a model like this in place within five months would be impossible.

40

Correct. Thank you, Commissioner.

COMMISSIONER WILSON: Mr Duffy, do you want to ask a question in open hearing?

45

MR DUFFY: I do. Thank you, Commissioner.

**EXAMINATION BY MR DUFFY [3.66 pm]**

MR DUFFY: Dr Stathis, my name is Duffy. I appear for Dr Kingswell. Do you
5 recall being asked some questions by Counsel Assisting in relation to the work of the steering committee?---Yes.

And you referred to at least some of the work of the steering committee as building on the work of the ECRG and you were asked some questions about that including to
10 the effect why would you be building on the work of the ECRG when you already had the ECRG recommendations. Do you recall that?---Yes.

Could the witness be – or could we pull up, please, the ECRG report, I'll call it. It's WMS6006000233021, please. Thank you. Dr Stathis, you will see that that
15 document there is, in fact, titled Proposed Service Model Elements. I've called it for shorthand the report of the ECRG. It's a document you've seen before. If we can go over to the second page, please, 33022. Could I direct your attention to the first paragraph starting at the end of the third line:

20 *This elements document is not a model of service –*

And so on?---Yeah.

And the final sentence:
25

*As a service model elements document it will not define how the key components will function at a service delivery level and does not incorporate funding and implementation and planning processes.*

30 ?---Yes.

Can I go over then, please, to the next page, 33023, and there we find the first green box – I'll call this recommendation number 1 – broader consultation and so on. You can read that?---Yes.
35

And then if you go down, the first dot point, the second sentence of it says:

*Formal consultation and planning processes have not been completed.*

40 Then the recommendations:

*Further work will be required –*

And so on?---Yes.

45

And finally, formal planning. Now, is this the work or is this included in the work that the steering committee was doing?---That was then going to be incorporated into the work of the steering committee.

5 Alright. And is that the work that you describe in answer to questions about building on the work of the ECRG?---Yes.

Yes. Thank you for that. There's nothing further.

10 COMMISSIONER WILSON: While that document is on the screen could you scroll back, please, to 33022. And could you scroll down that page for me, please. Dr Stathis, about a little beyond halfway down the paragraph beginning the ECRG comprised of?---Yes.

15 There's this:

> *It is understood that BAC cannot continue in its current form at The Park Centre for Mental Health, however, it is the view of the ECRG that like the community care units within the adult mental health service stream a design*
> 20 *specific and clinically-staffed bed-based service is essential for adolescents who require medium-term extended care and rehabilitation. This type of care of rehabilitation program is considered life-saving for young people and is available currently in both Queensland and New South Wales, for example, the Walker unit.*

25

Do I take it that you disagree with the sentiment expressed there?---Not entirely. What they are obviously referring to is the Barrett Centre and the Walker. If I may, Commissioner, if we could – if I could take you to recommendation 2 of this document.

30

Certainly. Scroll down, please?---That's that inpatient extended treatment and rehabilitation care tier 3 is an essential service component.

Yes?---That's essentially what they were referring to. If you could just scroll down
35 again. The recommendation was that we should be – we should be prioritised to provide further extended treatment. We accepted that. And then – forgive me, Commissioner – this was the recommendations of the ECRG. It's then very important to go to the – the – the committee that was overlooking this.

40 The planning group I think you're referring to?---The planning group. And so that – because the planning group was then going to bring it up and – and the planning group accepted these recommendations with a caveat and the caveat was that further review of a tier 3 model was required. So do I accept their recommendations in entirety? No. Because I was part of that planning group. The caveat was, yes,
45 they've made this recommendation but further assessment of models of service for a tier 3 level of service was required and I've tendered those documents.

Thank you. I understand your position.

MR DUFFY: Yes. I have nothing further.

5 COMMISSIONER WILSON: There's one other question arising from that. You were taken a moment ago to the PowerPoint presentation. Could that be put up on the screen again, please. Could you scroll up, please. Keep going, keep going. Could you stop there. Could you explain the different levels in that pyramid? I'm particularly interested in the top one which is rather blurry and what you understood
10 it meant?---Yes. So this was how we tried to conceptualise the continuum of care. Underneath, we have primary carers. They may be GPs, private – private psychiatrists, psychologists, headspace services, etcetera. Then we have our CYMHS and assertive outreach services – that's the AMYOS group. Building up on the pyramid you have the day programs and then you've got the acute inpatient units
15 and then, finally, at the very tip is the bed – the subacute beds. That's what it is, right at the top, Commissioner.

So what does that say at the top? I can't read it. I can read bed?---It – it says bed-based unit but I explained that as subacute beds. Yes.

20

I see?---So – and then over that you have the residential rehab. And so the plan was if we had this full continuum of care in Queensland operating, you could see how young people would seamlessly transition from one to another as they – and what isn't in there is the Step Up Step Down units. But as they become more distressed,
25 say, in an assertive outreach service they may step up to a Step Up Step Down and then move back down into a CYMHS service. As, in fact, that's what they do in Victoria. Or as they get more unwell they move into an acute inpatient unit. Let's just say the parents are unwilling or unable to have the young person back home, they then move into a resi rehab. So you have this wonderful situation where young
30 people, instead of just as was current they had the Barrett, inpatient units and community CYMHS services and that's it with a couple of day units across the State, you have this continuum of care right across the State allowing young people to move through as their clinical situation dictated.

35 Thank you.

MR DUFFY: Commissioner, there's just one follow up question to that.

So, Doctor, the elements that you understood were included within the tier 3 that was
40 recommended by the ECRG, would they be included within that pyramid?---Yes. We tried to incorporate the ECRG's tier 2A and tier 2B within this. So the ECRG recommended us tier 2A day programs which we already had. And in addition to the day programs, we actually incorporate – we put the AMYOS services in as tier 2A. Tier 2B they recommended residential programs with clinical in-reach. We then
45 added into that tier 2B. We changed it somewhat and looked at resi services and Step Up Step Down units and the tier 3 was the subacute beds. Bearing in mind that

the taxonomy was not what was used by the National Mental Health Service Planning Framework which we were told to use in developing these services.

Quite. But all of the relevant components are included there somewhere?---Yes.

5

Yes. Thank you, Commissioner.

COMMISSIONER WILSON: Alright. Now, who else wants to ask questions? Mr Diehm.

10

**EXAMINATION BY MR DIEHM [3.47 pm]**

15 MR DIEHM: Commissioner, me. Thank you.

Dr Stathis, my name is Diehm and I act on behalf of Dr Brennan. Dr Stathis, you've provided two statements to the Commission, haven't you?---Yes.

20 The first of those statements was signed by you on 5 November 2015?---Yes.

And it was prepared on your instructions by the Crown Solicitor?---Yes.

The Crown Solicitor was acting on your behalf at that time?---Yes.

25

And has continued to act on your behalf since?---Yes.

You have been following the course of the proceedings of this Commission since it commenced, I assume?---When my time allows me to. Yes.

30

I appreciate that you've got a day job, Dr Stathis. You're aware, are you not, that Dr Brennan provided a further statement, a third statement, to the Commission about three weeks ago that included details of her knowledge as she described it of the subacute beds at the Mater Hospital?---Yes.

35

And you read what Dr Brennan had to say then?---I did.

You'll recall that Dr Brennan referred in what was paragraph 11 of that statement to a circumstance that she said that she had never been informed prior to the closure of
40 the BAC that there were two subacute beds available at the Mater Hospital?---Yes.

And she said that after she had become aware of the existence of those beds that she had made contact with you in about mid-2015 to ask you when they had become available?---Yes, I read that.

45

And she described that an answer that you gave in response to her query involving there having been verbal cost estimates given by Mater Children's Hospital on 19

February 2014 that the beds were funded in July 2014 and that they became available between August and September of 2014?---Yeah. I can't - - -

Doctor, please, can I be clear. At the moment I'm just asking you about your recollection that that's what Dr Brennan said in her statement?---That's my recollection.

Thank you. Now, do you accept that Dr Brennan did contact you in about mid-2015 to inquire of this topic?---If that's in her statement, I accept that.

Do you have no recollection of it having occurred?---I don't recall.

Alright. If you – given what Dr Brennan says that you told her, would you accept that that was the true position?---I can't recall what I said.

Alright. I appreciate you can't recall what you said. But had she of asked you, is that likely to have been the sort of information you would have provided her?---No. That's not what I would've provided her.

Alright. Because that is not anything close to the true position, you say?---No. Mainly because of the timing of when the funding stopped or started. The funding – we had funding for subacute beds until June that year, June 2015.

So this is – I'm sorry, you had funding until June of 2015?---For the subacute beds.

Yes. Dr Brennan's statement records that you told her that the beds were funded in July 2014?---Well, the beds had been funded even before July 2014. They were funded from the amalgamation of the hospital. And, indeed, if there were to be patients admitted into the Mater over that time they would've been funded.

When was the funding arrangement for the Mater established, for the beds in the Mater?---So as I've said, we discussed it informally with Brett McDermott. Then a decision was – we had a conversation. When I say we, that was Brett McDermott, Peter Steer and I and perhaps Ingrid Adamson, had a conversation in late January 2014 to finalise the position. We then asked the Mater to provide us with costs and to sign off on – to sign off on the costs. From memory, and I have this written somewhere but I can't recall the exact dates, the Mater then provided us with the costs in April. We – Commissioner, I'll need to refer to an email I have to try to work out the exact timing.

Dr Stathis - - -?---But can I assure you that the beds were always going to be funded if the patient was to be admitted into a subacute bed.

Dr Stathis, we'll come to your need to look at the email in due course. And if before I get to the end of my questions, or by the time I get to the end of my questions you need to do so then we'll see if we can accommodate that for you. You have given evidence here today that you communicated the existence of and the availability of

subacute beds, if I understand your evidence correctly, subacute beds at the Mater Adolescent Unit to a meeting of your adolescent – child and adolescent psychiatrist colleagues on 26 November 2013? Is that so?---Correct.

5 And you've said that Dr Brennan was present at that meeting?---She was.

You have supplied your solicitors with an extract of the minutes of that meeting. Is that so?---I have.

10 And you've done so because that extract contains the reference in it to you having conveyed this information to your colleagues. Is that so?---Correct.

Can I ask you to look at this document, please. There's a copy for the Commissioner and other copies that might be distributed amongst counsel. Ms Wilson provided this 15 document to me as a courtesy, Commissioner.

MS WILSON: I have got copies, Commissioner. We can easily disperse it.

COMMISSIONER WILSON: Does the witness have a copy yet? Give that to Dr 20 Stathis, and I'll - - -

MR DIEHM: So, Dr Stathis, you've got that - - -

COMMISSIONER WILSON: Excuse me, Mr Diehm. I'm not - - -

25

MR DIEHM: - - - document in front of you now?---Can I have a copy? I'm trying to find one in my notes, but - - -

COMMISSIONER WILSON: He hasn't been given one yet.

30

MR DIEHM: I'm sorry, I thought you'd been given one?---Thank you.

That's the document that you provided to your solicitors?---That's correct.

35 And can you identify for the Commissioner which part of the extract of the minutes reflects what you told your colleagues that afternoon?---Yes. So the context was prior to this I recall having a conversation with - - -

Dr Stathis, can I just ask you to concentrate on my question. Can you identify which 40 part of the minutes reflects what you said that you told your colleagues during the course of that meeting?---Three-point-four.

Three-point-four. And is it the first item under 3.4?---It's all of 3.4.

45 All of 3.4?---Yes.

Alright. Can you identify for the Commissioner which part of all of 3.4 refers to you telling your colleagues that there were two subacute beds available at the Mater Children's and Adolescent Unit as at November 2014 – sorry, 2013?---It's contained within the first point, and that's what I wanted to make a point of, is that prior to the meeting I discussed with Brett McDermott whether I could talk about the beds being available at the Mater, because we'd had informal discussions beforehand. He said yes, by all means. I did that as a courtesy because I knew he wasn't going to be at that meeting. And then you have to understand this is just a brief synopsis of what I discussed at the meeting, and it says – and I'll read it:

> *Stephen allocated responsibility for this along with a project officer. Five tiers identified: assertive community treatment (AMYOS), day units, step up step down units, Y-PARCs, bed-based subacute unit and youth residential service.*

Now, that's just a synopsis. I then discussed with them all of the services available at that time.

You see, Dr Stathis, the commencement at the foot of page 1 of that item – the introductory part of the very sentence from which you just read says "plans for extended treatment and rehabilitation services from West Moreton funding", doesn't it?---Where's that?

The first sentence of that first dot point under 3.4 – sorry, second sentence, I should say?---Yeah, plans. That's the plans.

Plans. So it's not speaking of something that exists; it's talking about what is being planned for?---Yes, but at the time the beds did exist, and that's why I talked about them with Brett McDermott, so I would've included them in the subacute units.

Dr Stathis, it says that the funding for these plans is to come from the West Moreton funding, doesn't it? The top of the second page?---

> *Plans for extended treatment and rehab service from West Moreton funding.*

Well, that was the funding from the Barrett, and we were always going to be able to roll out these services from the Barrett funding.

Yes, once the Barrett closed you were going to be able to do that, weren't you?---Yes.

Not before, but once the Barrett had closed?---Yes, but I contend to you that I spoke about the subacute beds, which included at the time two interim beds, at the Mater. We would be able to use part of that funding to support the beds.

One of the – in fact, the service immediately preceding your reference, as far as the minutes record it, to bed-based subacute unit is a reference to step up step down units, isn't it?---Yes.

Which, for the most part, haven't yet been established; that's so?---No, they haven't, but that's the whole point. I was telling them about the whole suite of services that we were going to offer and what would or would not be available.

5 Yes?---And at the time – I think you're splitting hairs. At the time I told them that what was available was the bed-based subacute unit, and I know I did that because I talked to Brett McDermott beforehand and asked him out of a courtesy whether I could mention that those beds were available. Whether they were - - -

10 Well, that's about three times - - -?---I'm not finished. Whether they were funded or not funded or when they were going to be funded or how long they were going to be funded is not an issue. These are clinicians. They weren't interested in the funding; they were interested in what was available, and I told them what was available at that time.

15

Dr Stathis, nowhere, I suggest to you in these minutes, is it recorded that you told those present at the meeting that there was already available two subacute beds at the Mater Children's and Adolescent Unit, is there?---It's not recorded in the minutes, but I told them. And can we just look down - - -

20

No, Dr Stathis - - -?---I'm not finished.

Well, you are, because you have to respond to my questions?---Commissioner - - -

25 MS WILSON: Commissioner, he's got to let him answer – Mr Diehm should just let the doctor answer the question.

WITNESS: Please. If you're wanting me to refer to the minutes, we also looked at the point – where are we? The point where it says:

30

*SW raised concerns about how the Barrett kids will be covered.*

Myself and Anne explained the plans at this time to ensure that these children have appropriate and suitable placements. And as part of that, a potential was that they
35 may have been able to be admitted into the Mater unit. Now, I'm not prepared in an open court to talk about the outcomes of that, but the subacute beds were always going to be located at the Mater, and that was an issue.

MR DIEHM: Dr Stathis, did you – even if not present in court, but by webcast, at
40 least – watch Dr Brennan give evidence on Friday?---I saw about 10 minutes right at the start, and none of this was covered in that evidence.

Right. Can I suggest to you that, in fact – or put it to you that none of this – that is, this conversation at the meeting on 26 November – was canvassed with Dr Brennan
45 at all.

MS WILSON: Commissioner, why is this a matter for this witness? I mean, you know, if it's going to be a *Browne v Dunn* issue, this is not litigation where *Browne v Dunn* issues should be made at this time to the witness. I mean, even in criminal trials, the highest proof of evidence required, the High Court has made remarks about *Browne v Dunn*. This is not the forum, in my submission.

COMMISSIONER WILSON: Mr Diehm.

MR DIEHM: It's not a *Browne v Dunn* point; it's a credit point, Commissioner.

MS WILSON: Well, Commissioner, this is a point that if the legal representatives didn't do it and we've got it now – I mean, there are a lot of matters that have been ongoing, as you can imagine. There's a lot of matters that every party has to deal with.

COMMISSIONER WILSON: Well, it is a fact that this conversation was not put to Dr Brennan.

MS WILSON: Absolutely. It was not put. When we conferred with the doctor this week we got this document, and I immediately, when I got this document, walked over to court and gave it to Mr Diehm.

COMMISSIONER WILSON: Thanks, Ms Wilson. Yes, Mr Diehm. I think you'd better move on from this question.

MR DIEHM: Very well. Thank you, Commissioner.

Dr Stathis – can I ask if the witness, please, could be taken to page 194 of his first statement.

COMMISSIONER WILSON: What do you want to do with these minutes? Anything?

MR DIEHM: Yes, they should be tendered, Commissioner, I'm sorry.

COMMISSIONER WILSON: They'll be marked as an exhibit.

MR DIEHM: Now, for the doctor's reference, if this can go back to page 193, firstly, just so the witness can see what it is.

Dr Stathis, you'll see that these are minutes for the SWAETRI committee for 2 December 2013?---Yes.

If we can go, then, to 194, please, and what is about halfway down the page, you'll see a – if we can just scroll up a little more, thank you. The reference there:

*SS noted the interim subacute inpatient unit being discussed with the Mater. It is hoped that it will be in place until the Mater closes in November 2014.*

?---Yes.

5

Alright. So there had been some discussion going on with the Mater Hospital as at the beginning of December 2013?---Yes.

Thank you. If the witness could then be taken, please, to page 354. Now, Dr Stathis,
10 again, perhaps if we can go back to 353 to orientate the witness?---This is the same minutes of that meeting in December?

No, a different – different – same committee. I'm sorry, I withdraw that?---This is the oversight committee.

15

The oversight committee, and these are minutes for 22 January 2013. I think Mr Freeburn took you to these minutes earlier, and you were an apology for that particular meeting. But if we can go to page 354. Again, it's an item that Mr Freeburn took you to, but I'm taking you to for a different purpose. If we can just
20 scroll down a bit further, please. It says:

*Peter Steer to meet with the Mater to discuss and seek agreement re the interim bed-based option.*

25 See that?---Yes.

So that's as at 22 January, the chief executive of children's health is proposing to have a meeting with the Mater to discuss an agreement regarding the same?---And that occurred about a week later.

30

Thank you. We'll go to that. If we can take the witness, then, please, to page 218. Now, this is a steering committee paper for January – or the date of generally January 2014. And we'll come to another document shortly that will help us – I withdraw that. Perhaps – perhaps if we go, then, through to the page 220 just to,
35 again, orientate the witness.

You'll see that it declares that you are one of the people who has been involved in the preparation of the paper?---Yes.

40 So back to 218, please. And if we can scroll down to the first unnumbered paragraph, it says by February 2014 – refers to the Greenslopes unit and an interim subacute bed-based unit at the Mater will be in place?---Yes.

So what that's reflecting is that as at January 2014 there was not an interim subacute
45 bed-based unit in place at the Mater. Do you agree?---Yes, on that, but I had already, as I've repeatedly said, had discussions with Brett McDermott, who stated that he would accept other patients into subacute beds. To remind you, on 22 October 2013

a memo was sent out right across Queensland by Sharon Kelly, asking that if anyone – any clinical director of any service required an extended treatment bed, that they should contact me. And the aim was that if they contacted me, I would then let Brett know. The beds were available.

5

Well, Dr Stathis, as far as Dr Brennan was concerned, there were already established lines of communication through to you concerning the transition of patients?---Absolutely. Could you please go back to the first document you showed me, the steering committee document of December.

10

2 December?---Please.

That's page 194. And did you want the entry that I took you to?---And yes, go to where you – the beds were mentioned.

15

Yes. About the middle of the page. "SS", it begins. Just there?---Yes. So I noted that the interim subacute bed unit being discussed with the Mater were already in discussion. It is hoped that it will be in place until the Mater closes in November 2014. This was all – don't forget this is the steering committee. On the steering
20 committee was Leanne Geppert and Elisabeth Hoehn. Leanne and Elisabeth met weekly with Dr Brennan at the weekly Barrett transitional planning group in the Barrett to inform her of developments. That was why they were in the committee, so that there was clear communication between CHQ and West Moreton. We aimed to have clear, consistent communication between the different services for what was a
25 very complex set of circumstances. Could you please go up to the top of that, to the start of the minutes, and let's see who was there.

Yes?---Leanne was there - - -

30 And Elisabeth Hoehn?--- - - - and Elisabeth Hoehn was there.

Yes?---Both of them sat weekly with Anne to discuss patient transition. That was the way that we were communicating across the services.

35 Alright. While we're on that page, Dr Stathis, you'll see that the bottom entry after the number 5 matters for discussion is headed Draft Model of Care, and if we go over the page you'll see - - -?---Sorry, which – I'm – you're just going too quickly. Where is that?

40 I'm sorry. If we go back to page 193 - - -?---The draft model of care, yes.

Heading of Draft Model of Care. You see that?---Mmm.

And then we have one dot point there, and then we go over the page and we continue
45 down to the item that I had taken you to about noting the interim subacute inpatient unit being discussed?---Yep.

So that was a discussion in the context of talking about a draft model of care, wasn't it?---Yes, but I also noted that the interim subacute inpatient unit had been discussed with the Mater.

5 Yes, but you don't say – or at least the minutes don't record you as having said, Dr Stathis, that those beds were available as subacute beds, do you?---Yes, but it's noted that they were being discussed with the Mater, and Leanne and Elisabeth were well aware of that and could've cascaded that down to Anne as part of the whole process. That was why we had these plans in place.

10

Can we take the witness, please, to page – sorry, just bear with me. I'll make sure I don't leave out anything I want to touch upon. The witness could be taken, please, to IAD.900.0001.0759?---That's actually the document I was trying to find.

15 I suspected it might've been, Dr Stathis?---Yes.

So, please, do read it just to yourself?---Yep.

Now, you'll note that the date of this email from Ms Adamson to you is 22 July
20 2015?---Correct.

And you'll note, I suggest, when you read the contents of the email that it is substantially in conformity with the information that Dr Brennan says that you conveyed to her in a telephone conversation in about the middle of 2015?---Are you
25 saying it doesn't conform?

It does, I'm saying. It's not identical but it's very close to it?---Well, no, in that – could you please bring up Dr Brennan's affidavit so I can see what was written, please?

30

I'm not sure whether the operator is going to be able to do that, Commissioner, but perhaps I can show the witness – I have a single copy of the extract of Dr Brennan's statement. Alright. Well, I can read out the number. It's DAB.005.0001.0006.

35 COMMISSIONER WILSON: It'll take a moment but it can come up.

MR DIEHM: Thank you, Commissioner. So I'll read it again, DAB005.0001.0006. I'm sorry. Ms Muir is correcting me.

40 COMMISSIONER WILSON: Is that it?

MR DIEHM: Yes. Yes, it is. Thank you.

So you will see the paragraph 11 there on the screen, Dr Stathis?---Thank you. Yes.

45

And you will see in particular (a) verbal cost estimates given by Mater Children's Hospital on 19 February 2014?---Mmm.

That was something – I'm sorry, I withdraw that. It refers to the beds being funded in July of 2014 – I'm sorry, I'll go back to the 19 February. Ms Adamson's email said to you in the second dot point:

5 *Mater submitted a budget. Preparation commenced on 19 February and a final version received by CHQ in early April 2014.*

?---Yes.

10 So you will see that that corresponds fairly closely with what Dr Brennan has put in her affidavit?---But it's not about the funding. It's completely different. The Mater said that should young people be referred into the unit, bearing in mind that none had been, that this would be the costs that they would request. But the funding had always been available. It's – they're two completely different points. The funds
15 were available from – from February 2014 for young people who required admission into the Mater for subacute beds.

Yes. Dr Stathis - - -?---The Mater delayed their – if you can go back to the document – the previous one - - -
20
Dr Stathis, I'm going to ask you to respond to my questions, please?---I'm trying to respond to your question.

Well, at the moment you're not, with respect?---Well, with respect, I think I am.
25
And I'll ask the Commissioner to direct you - - -

COMMISSIONER WILSON: Excuse me, both you, please. Please.

30 MR DIEHM: Dr Stathis - - -

COMMISSIONER WILSON: Excuse me, Mr Diehm.

MR DIEHM: Yes. I'm sorry, Commissioner.
35
MS WILSON: Commissioner - - -

COMMISSIONER WILSON: And excuse me, Ms Wilson.

40 MS WILSON: I'm sorry.

COMMISSIONER WILSON: It's been a long day. Everyone is tired. But we must understand that it's counsel's role to ask questions. They can be probing questions. They can be irritating questions for the witness. It's the witness's role to answer the
45 questions that are asked and that's it?---Yes.

Alright. Yes, Mr Diehm.

MR DIEHM: Thank you, Commissioner.

Dr Stathis, another matter that Ms Adamson refers to in her email to you on 22 July 2015 is the Children's Health Queensland centre service agreement for the Mater's
5 signing on 15 April 2014 and that the Mater eventually signed that on 16 September 2014 despite monthly follow-ups for the agreement?---Can you bring that up, please.

Yes. If that email can be brought back on – the IAD900?---Yes.

10 So you can see there that there's some correspondence. I'm not suggesting to you that it exactly matches but some correspondence and the references to the dates?---Yes.

So perhaps some degree of Chinese whispers but what I'm suggesting to you
15 ultimately is that the reason why Ms Adamson was sending you this email was that you had requested from her information of that kind so as that you could answer Dr Brennan's query?---That email was written on 22 July 2015.

Yes. And Dr Brennan says - - -?---And I'm – and I'm entitled to look at the range of
20 emails that Ingrid and I sent according to that email the email outlines when we were able to get a signed budget from the Mater for children who may have been admitted into the unit, of which none were. But we still had held the funding and the funding had been held from February 2014.

25 Dr Stathis, you may not be able to recall but I will still put it to you in any case that when Dr Brennan – that Dr Brennan, having contacted you in about mid-2015 to inquire about when the subacute beds at the Mater became available, was not told by you that they were available at any time before the BAC closed?---I can't recall what I said in that conversation.
30
Thank you.

COMMISSIONER WILSON: Mr Diehm, I don't want to cut you short. How long do you think you'll be?
35
MR DIEHM: Probably about another 10 minutes I will try and keep it to, Commissioner. I appreciate the time that it's taken.

COMMISSIONER WILSON: Well, the court does have to adjourn at 4.45 because
40 there's a video conference with a witness from London, I think it is - - -

MR DIEHM: Yes.

COMMISSIONER WILSON: - - - at 5 o'clock. So if this is not finished today
45 we'll have to continue tomorrow. But bear in mind we must adjourn at 4.45.

MR DIEHM: I appreciate that. Thank you, Commissioner. If the witness could be taken to page 233, please, of his statement. And if we could scroll down to item 6.4, please. Now, Dr Stathis, if you need to go back a couple of pages you can, but I could otherwise tell you that these are meetings of the adolescent mental health – minutes, I should say, of the meetings of the Adolescent Mental Health Extended Treatment Initiative Steering Committee of 10 March 2014?---Can I just go back and see who was there, please?

Yes, please. That's page 230?---So Leanne was there. Yes.

And you were present?---I was present, yes.

Alright. If we can go back then to page 233 and scroll to item 6.4, please. Now, you'll see that in the third dot point of 6.4 the members of the committee were informed that the Mater subacute inpatient beds – or it's said that they were briefly discussed and it was confirmed that the Mater was setting up two swing beds. That conveys, does it not, Dr Stathis, that as at 10 March 2014 the beds were still being established?---No. The beds were always there, and they were setting up them for swing beds that could be used or didn't need to be used as necessary.

The next item, Dr Stathis – the next dot point has you describing four actions needed to formalise those beds, terms of reference, referral pathway, communication to other HHSes, and the service agreement with the Mater?---Absolutely - - -

Sure?--- - - - because, as we said, these were informal conversations. Did we want to proceed with a formal service agreement with the Mater? Should a young person be admitted into the beds?

Right?---Which never happened.

Now, the reason for communication to other HHSes being required is because, to that date, I suggest, the Health and Hospital Services hadn't been informed of the existence or availability of those beds; is that right?---I'm uncertain. I'd have to look through the documentation. But the point is that anyone who needed a bed could contact me and I would arrange it. They didn't need to know per se that the beds were available. What they did need to have is a clear line of communication to contact someone who might need a bed, and I was that person.

Dr Stathis, is the position this, really, that if there was a patient who needed to be admitted in circumstances where the Barrett Adolescent Centre was closing or closed, they could be admitted to the acute ward?---Correct.

They were not going into, at that point in time, I suggest, subacute beds, but just, rather, were being admitted to the acute ward?---Well, it was swing beds. They would have been admitted into the acute ward as a subacute patient in a swing bed, just like, today, they would be admitted into the adolescent unit at the Lady Cilento Hospital in an acute unit with – in a subacute bed. The position hasn't changed.

Can the witness please be taken to page 244. Perhaps again to orientate you, Dr Stathis, if the witness could be shown page 243; again, minutes of the same committee, this time on 2 June 2014?---Yes.

5 If we go over to page 244, and you'll see the – if we scroll down to the bottom of the page, the last three dot points, beginning with "subacute beds". And just so that you've seen the whole entry, if we can go over to page 245?---Yes.

What I want to ask you about is on page 244, Dr Stathis, if we can go back to there.
10 Now, we're told there in the first dot point that the service agreement is still being finalised; part of the delay that Ms Adamson, no doubt - - -?---Yes.

- - - was referring to in her email. But the next dot point tells us that a person with the initial AT – do you know who that is?---Just scroll to the top. It's probably
15 Amanda Tilse.

That's the operational manager, alcohol and other drugs campus?---Yes. She was - - -

20 Thank you?--- - - - working at the Mater at the time. Yes.

She is recorded as having confirmed the beds were available at the Mater?---They're available, yes.

25 As at June 2014?---Yes.

That was news to this committee, wasn't it?---No. She was just informing us.

Informing, you say, the committee of something that had been the case for, by then,
30 seven months; is that so?---It says she confirmed that the beds are available at the Mater.

Yes?---There's nothing new here. We all knew that.

35 Well, that's why I'm querying, Dr Stathis. Why would a member of the committee be advising the committee something of which it already knew and had known for seven months?---It was part of the conversation. We all knew that.

It's because, I suggest to you, that the beds had, some time between March and June
40 of 2014, in fact, become available as subacute beds?---No. They were always available, and the committee was well aware of that.

Right?---It was in the business plan. They were always available.

45 Commissioner, I won't take the matters any further than that, including by going into closed session.

COMMISSIONER WILSON: So that's the end of your cross-examination, is it?

MR DIEHM: Thank you, Commissioner. Yes.

5 COMMISSIONER WILSON: Ms Wilson, you wanted to ask questions.

MS WILSON: Yes, I do, Commissioner.

COMMISSIONER WILSON: Is there anyone else before Ms Wilson does? No? In
10 open hearing?

MS WILSON: Yes, Commissioner.

COMMISSIONER WILSON: Yes.

15

**EXAMINATION BY MS WILSON [4.26 pm]**

20 MS WILSON: Thank you, Commissioner. Doctor, if I can just cover a number of matters, first of all, can I ask you some questions about the governance of Children's Health Queensland. You were asked some questions by Counsel Assisting about the remit of the state-wide remit and the geographic remit?---Yes.

25 And then my learned friend, Ms McMillan, took you and asked you some questions about your geographic remit, and that's just the area just around Lady Cilento?---Metro Brisbane, yes.

Metro Brisbane. And, for example, if there is – and if there were CYMHS in Pine
30 Rivers, Northwest, down to Inala and Mount Gravatt, that is under Lady Cilento; is that the case?---We have seven community CYMHS services scattered across Brisbane.

Okay. So in terms of mental health, it is nothing – you've got no remit in terms of
35 adult services. It is only youth and adolescent services?---Child and adolescent services.

Child and adolescent services. And you said that you've got a number of CYMHS around Brisbane?---We have seven community CYMHS, we have two Evolve
40 services, we have a zero to four service, early year service, and a range of other services. Yes.

So if a child or adolescent has mental health issues, for example, and they reside in Nundah, how would that be dealt with in terms of the services that are
45 available?---The governance would be under Children's Health Queensland, and they would be seen at Nundah CYMHS. And if they required any additional support

across the community, the case manager would liaise with – say, with school or family or child safety or whoever else would be involved in the case.

We take that same child and we place that child or adolescent in Townsville, how would that be dealt with?---Similarly. The – the clinical governance is under Townsville Hospital and Health Service, and so the case manager in Townsville would be liaising with community services and would be treating that young person within their own CYMHS.

But how does Children's Health Queensland have any relationship with a child or adolescent seeking services, say, in Townsville?---We don't have any direct relationship with a child who is established in services in Townsville, but we do have an electronic database which allows us to see children right around the state. And, for instance, if the child in Nundah was going to be transferred to Townsville, then there's a process to organise that seamless transfer.

Is it the case that for Children's Health Queensland they – you have a state-wide tertiary paediatric role?---Yes.

Okay. And that is, basically, care coordination?---It includes care coordination, not just of mental health, but of paediatrics.

Paediatrics, mental health?---Yes.

But because we're in a Inquiry focussing on mental health I will ask you some questions about mental health. So in terms of – it has a care coordination in relation to mental health issues and other issues but mental health issues?---It has a statewide remit for a number of services across the state, yes.

So going back to that child or adolescent in Townsville, if the mental health of that child or adolescent gotten to become very complex?---Yes.

Would that then come to the attention of Children's Health Queensland?---Not necessarily. What would happen would be that – it's complex because you use Townsville as the example - - -

Okay?--- - - - what would – but because this is where it gets even more complex. Queensland is then divided into three different clusters so Townsville is in the northern cluster. That child psychiatrist might ask for a teleconference involving experts around the state. Indeed, I've been involved in that. They would look at what is needed for that child in Townsville and they would look at local services for that child or an admission into Townsville inpatient unit.

Okay. So it's fair to say, just in summary in terms of the statewide remit of Children's Health Queensland in terms of tertiary paediatrics involving all paediatric issues, the statewide remit is in terms of a very high level – high level issues dealing with care coordination, education and development?---Yes. And – and – and

coordinating other tertiary services across the – across the state which would – may potentially feed in to the Lady Cilento Children's Hospital. That's mainly for paediatrics, not so much in mental health.

5 Okay. You asked some questions in terms of funding and we're dealing with the BAC – the Barrett Adolescent Centre patients and their transition plans and you were asked from time to time to try to access some funding. Do you recall those questions?---Yes, I do.

10 Do you recall being asked for funding to help assist some of the transition plans for the patients of the Barrett?---Yes. And I won't mention the areas but five hospital and health services asked us for funding and we provided the funding for them.

Did you ever decline?---Not that I'm aware of.

15

Thank you. Can I now take you to a document that Counsel Assisting took you which is QHS.001.001.0750. The document I'm taking you to, Doctor, is the project plan of statewide adolescent extended treatment and rehabilitation implementation strategy October 2013 version 1.1. Okay. QHS.0001.001.0750. Perhaps if we can

20 scroll – there we go. Thank you?---That's the project plan, yes.

Thank you very much. You're obviously aware of this document?---Very much so.

Okay. Can we go to 0756 and can we look at that third dot point. That was the dot

25 point that Counsel Assisting took you to - - -?---Yes.

- - - which was regarding the continuity of care - - -?---Yeah.

- - - of adolescents?---Yeah.

30

You recall that. And you were asked some questions about that. If we can go over the page to 0757 and we've got there the assumptions?---Yes.

And the first dot point, we can read that. I won't read it out to you?---Yes.

35

Okay. Have you read that?---Yes.

Where it refers to the lead governing body for the project will be CHQHHS in partnership with West Moreton and the Department of Health?---Yes.

40

And is that the case the partnership involved – each had separate responsibilities and roles in relation to this project plan?---That's correct.

If I can then take you to .0762 and if we can – 61, I apologise. Okay. Exactly.

45 That's where I'd like to be. And there, we refer to the key deliverables, and it sets out the milestones, products and activities to be delivered by the project. We see

there are three columns, one with the key milestones and products tasked and activity, one the responsible officer - - -?---Yes.

- - - and finally, a completion date?---Yes.

5

And this is as of October 2013. We can go through a number – can we go through these. Project initiation: that's Ingrid Adamson?---Yes.

That's Children's Health Queensland; is that the case?---Yes.

10

And project plan and communication strategy: Ingrid Adamson, Children's Health Queensland. Then we go down to the BAC consumer and staff: that's done by – responsible – the officer is Leanne Geppert from West Moreton? The SWAETRI service model: that's you. You're the responsible officer?---Yes.

15

And is the SWAETRI service model looking at the future services that you're looking at?---Correct.

Okay. And then we get the governance model, including financial and workforce
20 requirements for the SWAETRI service model, which is for future services?---Yes.

That is for Ingrid Adamson. The interim consumer clinical care plans for current BAC and waitlist consumers: the responsible officer is Anne Brennan - - -?---Yes.

25 - - - the clinical director of BAC. And do you know any – do you know why the term interim consumer clinical plans are used?---Yes. Interim because the Barrett was going to close, and at that date we just assumed it was 31 December, because this was written back in October, before we knew a date. And so interim in terms of it was going to be time-limited.

30

And is it the case, was it, because the SWAETRI plans could be up and running?---Correct.

Okay. The implementations for the SWAETRI service model: Ingrid Adamson
35 - - -?---Yes.

- - - back to Children's Health. And then the mobilisation of phase 2, the service options implementation: you and Ingrid?---Yes.

40 And that's, again, future-looking?---Yes.

Okay. Then we go to 0764 – sorry – 0763. This refers to risk management, and we – there's – looks at – the risks to the project are listed below. If we can then go to the page of – the next page, which is 0764, where – the risk event and impact, it's
45 divided up on this page, at least, into two categories, current health service delivery – when it talks about current health service delivery, is that – comes at the time of – I suppose of 2013?---Yes.

Okay. We go down there, we get – we can all read what the table says, but there seems to be an owner. What do you – what does it refer to when there's – when you refer to owner in such a table like this?---That was a person responsible or the – the entity responsible.

5

Okay. The first one is talking about loss of specialist BAC staff. West Moreton: it appears to be the owner of the first two dot points?---Yes.

And is it that Children's Health was the owner of the third dot point, which was
10 developing a recruitment strategy for future service options?---A future – yes, correct.

Then we go down to – the next point is about employees. That's BAC employees, is it?---Yes.

15

Yes, not sure?---Sorry, I've just lost you. Where is that?

The second part of this table?---The union action?

20 Yes, in relation to - - -?---Yes, I'm assuming that's BAC employees.

Anyway, that's – the owner of that - - -?---Is West Moreton.

- - - is West Moreton. The – any BAC incident resulting from collocation; you see
25 that?---Is West Moreton, yes.

West Moreton. And the critical incident with an adolescent during transition from BAC facility: the treatment for that is appropriate, detailed, consumer clinical care transition plans, and that's West Moreton, working with the local Hospital and
30 Health Service?---And that's the point: it's the local HHS that then takes up responsibility.

Okay. And then the next part of that table looks at the future health service delivery, and it seems that Children's Health, in terms of the future health service delivery,
35 owns it all?---Yes, for the future - - -

Except for the – a critical incident with an adolescent prior to the availability of newer or enhanced service options, appropriate consumer clinical care plans is for the local HHS?---For reasons that we've discussed.

40

And that is because they're on the ground, developing the appropriate consumer clinical care plans?---Individual consumer care plan, yes.

Thank you very much.

45

COMMISSIONER WILSON: Keep an eye on the time, Ms Wilson. Just keep an eye on the time.

MS WILSON: Certainly. Then can I take you to – Commissioner, I know that is a strict 4.45. I'm not too sure whether I will be able to finish, but I will – I'll be – I won't be too far over the other side of 4.45.

5 COMMISSIONER WILSON: Well, I'll stop you at 4.45. So if you want to stop now and come back in the morning, say so.

MS WILSON: Can I do this one other document, Commissioner?

10 COMMISSIONER WILSON: Very well.

MS WILSON: Can I take you to a document that Counsel Assisting took you to, which is DSS.001.001.365.

15 COMMISSIONER WILSON: What page do you want of that?

MS WILSON: First of all, the first page. This is the meeting agenda that Counsel Assisting took you to of a meeting that you weren't there, which is on the Tuesday, 1 October?---It's the Options Implementation Working Group.

20

That's right?---Yes.

And it's about working group 1?---Mmm.

25 Now, working group 1 reported to the oversight committee?---Yes.

Okay. That – and is it correct to say that the working group remit was directed by the project plan?---Yes.

30 Okay. If we can then go to 366, at the top of the page, if we could. Okay. You were taken to those two paragraphs by Counsel Assisting?---Yes.

I'm not going to read the two paragraphs out. Is this the case, that to understand the task of this working group, to put it in proper context, should this be read in
35 conjunction with the project plan and the responsibilities and roles set out in that project plan?---The working group took place on 1 October, so there wasn't the project plan completely developed at that time. There was a plan developed from September, but yes, you need to understand this working group should be seen in conjunction with the broader plan. Absolutely.

40

And how it worked was within the roles and responsibilities that are set out in that project plan?---Yes. Absolutely.

Thank you, Commissioner. Shall I – I know that I've got three more minutes, but
45 should I - - -

COMMISSIONER WILSON: Two.

MS WILSON: I've got two. I am going to another topic that would be more than two minutes.

COMMISSIONER WILSON: I think you'd better leave it then, Ms Wilson.

5

MS WILSON: Thank you.

COMMISSIONER WILSON: Another early start tomorrow. What time were we scheduled to start tomorrow anyway, Mr Freeburn?

10

MS WILSON: 10.45, I think, your Honour – Commissioner.

COMMISSIONER WILSON: So it's like a sleep-in almost, 10.45. I think we better start at 9 to make sure we cover everything, and if we have a break that would

15 be good. Alright. So I'm sorry, Dr Stathis, but you'll have to come back tomorrow morning at 9 o'clock?---Thank you.

Thank you.

20

**WITNESS STOOD DOWN** **[4.43 pm]**

**ADJOURNED** **[4.43 pm]**

25

**RESUMED** **[5.10 pm]**

30 COMMISSIONER WILSON: Mr Freeburn.

MR FREEBURN: Commissioner, I call Dr Peter Steer. He appears via video link. Dr Steer, can you - - -

35 COMMISSIONER WILSON: Just - - -

MR FREEBURN: Can you hear me?

DR STEER: I can, Mr Freeburn. Yes.

40

MR FREEBURN: Okay. The Commissioner will administer the oath.

**CONDUCTED VIA VIDEO LINK**

45

**PETER STEER, AFFIRMED** **[5.11 pm]**

**EXAMINATION BY MR FREEBURN**

COMMISSIONER WILSON: Thank you. Yes, Mr Freeburn.

5

MR FREEBURN: Dr Steer, just a few preliminary questions. Your area of clinical expertise is in paediatrics. Is that right?---I – I trained in paediatrics and then a sub-specialty of neonatology within paediatrics. That's right.

10 Right. And I take it from your witness statement – paragraph 18 – that you relied heavily on the expertise of Dr Stephen Stathis?---That's – that's right. Dr Stephen Stathis was the lead of our clinical child and youth mental health service and an expert in this area.

15 Right. And his lead was in shaping the plan for the subsequent services that would be offered after the closure of the Barrett Adolescent Centre?---That's right.

Now, your words in that paragraph were that you were permissive and supportive of his work. Correct?---That's right.

20

Okay. Now, I'm going to take you to a document if I can. If the technology fails I've got a plan B. The document is QHD.012.002.2513. There we go?---Is this the email from Graham Martin?

25 That's right. That's correct. It's an email – sorry, do you have that?---Yes, I do.

Right. Now, I'm not sure if you've read that in preparation for this hearing but there's talk in that email about five per cent cuts. Do you recall reading about that?---Well, I have read this email in preparation for this hearing. I had obviously
30 not been copied in or seen it prior to a few days ago. In terms of the five per cent cuts, again, this email is missing the precipitant email that resulted in Graham Martin's reaction and I have no understanding of the context of that five per cent cut. If the concern is that any engagement we had with respect to planning replacement services for the cohort of adolescents cared for by the Barrett, there was no
35 suggestion of budget cuts related to that activity, as our planning and in fact our project plan and budgeting process, there's clear evidence of that.

Well, this email was sent on 8 November, which we know was a date when it became public that there may be an intention to close the Barrett Adolescent
40 Centre?---That's wrong.

So are you able to say whether you recall there being some sort of direction or suggestion that there may be five per cent cuts?---On the contrary. In fact, the working understanding, and in fact our whole budgeting process for the immediate
45 services through 2014 was on an agreement with the leadership of West Moreton, that in fact the current – that is, the active budget of that financial year, would be

transferred to Children's Health Queensland to support those new services. There was none – never any conversation around a cut to that current budget at the time.

I just want to make sure we're talking about the same time zone. This email is 8
5 November 2012, so this is prior to - - -?---Right.

It may be a year or so prior to when you're thinking?---Well, my apologies. I – I – in the context of that timing I genuinely have nothing to add to that. My engagement with this, as you are quite rightly pointing out, was significantly after that time
10 period. I can only speak to the time period I was involved, and certainly there was no talk of budget cuts. So unfortunately I can't add any further wisdom to this.

Thank you. Now, throughout your statement you talk about replacement services?---Yes.

15

Can I confirm that by "replacement services" you're really talking about services meant to replace those particular services that were previously delivered by the Barrett Adolescent Centre?---I mean, it's a good question, and in fact thank you for that. And it's probably an interesting issue to spend a moment on. I think it's
20 contextually – I think my and Children's Health Queensland engagement was in fact to look at a new contemporary – a comprehensive contemporary model to care for the cohort of children who had been up to that time managed through the Barrett Centre. So I guess the word "replacement" is probably actually a genuinely inadequate statement. I think we were genuinely looking for – and having looked at
25 evidence and obviously other parts of Australia, in examples we were looking for a much more contemporary that was more sensitive to the time and also perhaps more sensitive to access issues across a very, very geographically dispersed state.

Okay. Now, I just want to deal with this concept a little bit more. In paragraph 49 of
30 your witness statement – do you have that there?---Yes, I'll just turn to that.

It's on page 11 of your witness statement?---Thank you. Right. My apologies. I'm – sorry. Yes, I'm on page 11. Yes.

35 So would you mind just quickly reading paragraph 45 and in particular I want to focus on the fifth line, the sentence commencing "The priority"?---That's right. Yes.

So was that the process, that the Barrett Centre – you see the previous paragraph – previous sentence:

40

> *There was a recognition that the Barrett Adolescent Centre would not close until the transition plans for every adolescent had been finalised.*

And then you say:

45

*The priority and commitment was to ensure that transition plans were in place for all patients prior to the closure.*

?---That's right.

5

Who had responsibility for that?---Well, just to be clear, that paragraph 45, if I recall, was addressing in response to me understanding whether or not the Barrett was being closed at a particular time. So that's the context of that answer.

10 Yes?---As you know, West Moreton were the governors of that transition process, rather than Children's Health Queensland. And I think I've made it evident in my statement and other – other parts, that in fact we were necessarily engaged on a number of levels understanding the progress around those transition plans, (1) because we may have inherited some of those adolescents for ongoing care at
15 transition, but also we did actually have to interface our planning of new services to the timing of the closure of Barrett eventually.

Alright. Now, I want to take you to a specific document. It's the project plan, which is actually exhibit D to your statement. They're the operators, and for those in court,
20 it's CHS.900.002.0001 at 0070.

COMMISSIONER WILSON: What version is this, Mr Freeburn?

MR FREEBURN: This is actually the September one.

25

COMMISSIONER WILSON: Would it not be better to put to the witness the October one?

MR FREEBURN: Yes, it probably will. That document is
30 CHS.00.00.0750?---What exhibit was this in terms of my – my affidavit?

Well, your exhibit I think exhibits the September 2013 version of the project plan, but there's an October 2013, a later version, of it. Now, do you have access - - -?---Perhaps you - - -

35

Do you have access to the screen?---Yes, I do, yes.

Can you see on the screen - - -?---Right. Yes, I can. Yes.

40 So there is the October version. And if we go over a few pages to the page ending 5-6. So hopefully that should come up on your screen. Can you scroll down a bit. Dr Steer, have you got that on your screen, a paragraph that commences "1.3 Purpose, Objective"?---Right. Sorry. Yes, I do, I just can't see the page number. Yes, I can see that "1.3 Purpose, Objective", yes.

45

Okay. And you see the third dot point?---Yes.

You see the purpose:

*One of the purposes or objective of this plan was to ensure continuity of care for adolescents currently admitted to BAC and on the wait list.*

5

?---Yes.

Now, am I right in thinking that that was, as it states, a purpose and objective of this plan?---It certainly – it certainly was. Again, that's the interface period that was
10 managed by West Moreton, but as I understand it there was an enormous amount of energy led by Dr Anne Brennan around this particular aspect of care. And I think for the first time there was not only appropriate transition planning and comprehensive transition for the currently admitted patients, but I think Anne Brennan and her team actually started to work very actively on case managing those on a waiting list. And
15 I think the – that transition review by the external experts whose names escape me at this point in time, Kotzé at L, I think later reviewed this process and work by Anne Brennan and her team and were only complimentary about the extraordinary, care, compunction and detail with which they went to around the individual wraparound care for these adolescents.
20

Alright. Look, I just want to draw your attention to the fifth dot point and then I will ask you some more general questions about the plan. See the fifth dot point?---Yes.

Now, what I'm interested in is the division of responsibility between Children's
25 Health Queensland and West Moreton. Now, as this plan seems to read it's a partnership and both organisations are responsible for the implementation of the plan. Does that accord with your recollection?---I'm not sure I understand the question exactly. There was a very deliberate transfer at the time of closure of the Barrett Adolescent Centre of those operational funds to Children's Health
30 Queensland. Having said that, the caveat to that – and of course we hopefully are sensitive to the issues that these aren't black and white – there were operation funds committed to the ongoing wraparound services in support of the transition of those adolescents that were inpatients at Barrett. So there was an understanding collectively about how those funds would – would work but essentially the overall
35 transfer of those funds occurred at that time to CHQ.

Alright. If we put aside for the moment the question of the funding and look at who was actually taking responsibility, is it correct to say that what's envisaged by this plan and your understanding of it was a partnership between Children's Health
40 Queensland and West Moreton?---No. I think, to be clear, the governance was explicitly laying with Children's Health Queensland so in an operational sense sort of Dr Stephen Stathis, Judi Krause and supported by Ingrid Adamson, the project manager at the time, would have been accountable for those operational funds. Understand that some of those funds may have been allocated through the rest of that
45 2013/14 financial year to continue to support quite reasonably ex-patient Barrett inpatients that were, in fact, discharged in the latter part of 2013.

Can I ask again, if one puts aside the funding issue and who was doing the funding and I ask you about the responsibilities of the two organisations– is that similar to the funding, that is, there was governance in Children's Health Queensland?---Absolutely. Moving forward after the closure of Barrett there was a transfer of the operational governance and responsibilities for ongoing services to Children's Health Queensland. That's right.

Alright. I'll go back a step. I'll refer you to a document, DMZ.001.001.0305. Now, whilst that's being called up, Dr Steer, it's an email from Dr Kingswell to Dr Cleary on 12 November 2013. Now, I understand the email didn't involve you but it records some information I'd like to ask you about?---Yes.

Now, can you see that on your screen?---I can, yes. I've never see this before but, yes, I can see it on the screen.

Alright. Just have a read of it just so you can put yourself in the time zone. I think you probably only need to read the top of the document?---And the date of this again, Mr Freeburn – the date of this email?

It's 12 November 2013 so it's - - -?---Right. Yeah.

Now, do you recall whether you gave Ms Dwyer this advice that's spoken about in about four or five lines down – that he will not have a model in place to address the closure of BAC for 12 months?---Well, clearly that's an inaccurate representation of any communication that I've had with Lesley at that time and certainly is not evidenced by documentation around the project or in reports back to the Children's Health Queensland board.

So why do you say it's inaccurate?---Well, I think what we have – and I think if one looks to the August project statement that we've actually previously looked at rather the September, right from August we've made it very clear that the comprehensive nature – the five elements of the new service model would not be ready within the six months. That was made very clear both within in the project scope, business case and in fact in communication with parents as is evidenced in documentation of our meeting with the parents. There was always a – a plan that was delivered around sort of three elements of that service including the – the day programs, the single resi – as it was called – opened at Greenslopes and finally the subacute bed capacity that in the short term was negotiated at the Mater Children's Hospital. It may be that there's some reflection on – in this comment that the whole of the model will not be in place but, I mean, I – I can't explain why that would appear like that.

Does this reflect, perhaps, a misunderstanding in November between West Moreton on one hand and Children's Health Queensland on the other about what their responsibilities were?---I think the key issue here around the relevance of this email is what – whether Lesley Dwyer would consider that was a very accurate description of her understanding at the time. This is a third – this is just me trying to

interpret an understanding of a discussion between Lesley Dwyer, Bill Kingswell and subsequently Michael Cleary. It's getting very, very difficult to follow that trail, I'm sorry.

5 Well, at this time, wasn't Children's Health Queensland saying to West Moreton that some of the future service options won't be fully operational for possibly 12 months?---We were clear about that particular issue, as I've said to you, from documentation as early as August 2013 so that should not have been news to Lesley Dwyer and I'm sure it wasn't news to Lesley Dwyer or anybody as – as late as
10 November 2013.

Alright. Well - - -?---And – and just to add, I mean, I think the documentation around this project and its monitoring is – is I think, remarkably clear and transparent around the progress to the new model so I'm just – it certainly is dislocating to see
15 that email but I cannot explain it.

Well, at the same time – and I'll just – you won't have the document. But at the same time, a Fast Facts 10 document being produced by West Moreton was saying recent information received from Children's Health Queensland has indicated that
20 some of the future options will not be fully operational for possibly 12 months. I can put that up on the - - -?---I did actually – I was actually sent that particular document in the early hours of this morning in my time, and I understand that there's a consistency in that announcement with what you have here in this email. But if I could refer you back, perhaps, to the August project plan documentation – I think it
25 is the August project statement and the objectives – page 3 of that document, which, basically, clearly says page 3, performance indicators will be: item 2, commencement of service provisions through alternate service options that meet the needs of the adolescent target group starting early 2014 and support transition of services from BAC accordingly. Note while no alternate service options – sorry –
30 note while not all alternate service options will necessarily be available early 2014, there will be no gap in service delivery to the target group. So all I can say is this was clearly circulated to all relevant stakeholders, and I just cannot explain that particular dislocation that you are obviously providing examples of here.

35 Alright.

COMMISSIONER WILSON: Mr Freeburn, if you are able, could you read into the record the Delium reference for the document the witness has just referred to?

40 MR FREEBURN: Yes, please. The document is – it's Fast Facts 10. It's WMS.1002.0009.00834.

COMMISSIONER WILSON: I'm sorry. I think we're at cross purposes. That's Fast Facts 10, but, Dr Steer, you referred to an August document?---I'm reasonably
45 certain it's the August statement on the project plan for the state-wide adolescent extended treatment and rehabilitation implementation strategy. Unfortunately, I don't have a reference number on top of this particular document at this moment.

COMMISSIONER WILSON: Alright. Thank you. We'll track it down.

MR FREEBURN: Can you give us its title and its date, and that should enable us to find it at some future time?---It has a – unfortunately, there isn't a date. The last – the revision history: I could just say that the last revision history box date on the first is 16th of the 8th '13, version 3.

And the title of the document?---It's Project Plan: Statewide Adolescent Extended Treatment and Rehabilitation Implementation Strategy. I wonder if it is the earlier version of that September document you brought me to, I think.

I see?---I'll certainly be able to pass this back to counsel - - -

Alright. Thank you?--- - - - after the meeting.

Thank you. Now, is this a fair summary of what you're saying the division of responsibility was, that Children's Health Queensland were looking at models of care more generally for 13 to 17 year olds?---This particular project and focus was related to the cohort of adolescents who were particularly served by the old Barrett Centre model, yes. With that caveat, yes.

Right. But - - -?---That work also grew out though, I might quickly add, just to be fair – and these things are complex – but we had – historically had the West Moreton Hospital and Health Service District inherit what was a state-wide service, was the Barrett Centre, an unusual thing for a near city but a regional health service. In the process of deliberations as the board, I understand it, they did have that external clinical reference group reporting through to a planning group that, in fact, gave advice that fed into our planning process.

Can I just put this proposition to you, that Children's Health were looking at the models of care more generally, and West Moreton were developing solutions for the particular young people: is that the way you would split the responsibility?---Yes, under their care at that time. Yes.

And what was the system or the process for West Moreton, for example, saying we needed a particular type of service, do you see what I mean, for the silos to talk to each other?---Well, as I said, the process of planning began, quite appropriately, in advice to the West Moreton board, as I understand it, after the appointment of an external expert clinical reference group that provided the recommendations under Barrett Adolescent Strategy to the West Moreton Board. That fed into their decision and advice to government around the Barrett Centre future. That information was, in fact, passed through the planning process to the Children's Health Queensland as we evolved and planned the continuing or contemporary services.

Alright. Now, I want to take you to paragraph 58 of your witness statement, please. It's on page 14 of the document. Have you got that?---I – I do, yes.

So you list there some new or replacement mental health services that were established around the time of the closure of the Barrett Adolescent Centre. I suppose there's some vagueness about the words "around the time of the closure of the Barrett Adolescent Centre". Are you aware of the dates or approximate dates for
5 each of those services?---The – I must apologise and point out that I have mis-mapped the Y-PARC equivalent. The Y-PARC equivalent should, in fact, not be in point A, and my apologies for missing that on proofreading this document. This resi or residential rehabilitation service set up in Greenslopes, in Brisbane was opened in February. The day program in Townsville emerged as an opportunity out of the
10 West Moreton planning of ongoing services and transition for some of their patients, and the tier 3 subacute beds at the Mater Hospital were available from February 2014, to my memory.

I want to suggest to you that your day program in Townsville was not established
15 until December 2014?---I would have to reflect on that. My understanding is that there was engagement through 2013 with the day program that was in Townsville about accepting and expanding to look after this cohort. That is my memory.

Right. And I want to suggest to you that the tier 3 beds at the Mater Hospital were
20 established some time between March and June 2014?---There was a – certainly, a day in the formal signing an – an agreement around the – the beds. But, again, my understanding: if necessary, those beds were available from February 2014.

When you say your understanding, is that based on having a look at
25 contemporaneous minutes and notes?---I think in reflecting and reading and preparation for this, I would have to find the document, but I – I understand this was reported back to the Children's Health Queensland board within their – their broad papers.

30 Further on in your statement, paragraph 61, you talk about the AMYOS services. You say that they were negotiated through - - -?---Yes.

- - - the first half of 2014 with recruitment proceeding through the second half of 2014. Is that correct?---That's right. Again, the – while I would not be able to put
35 my fingers on this, but the regular updates the Queensland – Children's Health Queensland Hospital and Health Services Board detail the progress of the recruitment and action already those AMYOS teams. I've got a note here that – from those board papers that there was at least two AMYOS teams in Brisbane active by July and recruitment for the rest of the services – the still-in-plan services was
40 continuing at that time.

Okay. So can the witness – just one last document, Doctor. Can the witness please see document QHD.012.001.2444?---Email from Judi Krause?

45 Yes?---Yes. Yes.

You see, your email at the bottom of the page – bottom of that page, says:

*Can you please reassure me that we are moving rapidly to recruit against our mobile outreach teams. They need, as per plan, to be in place by end of February.*

5 Do you recall that?---Well, I certainly remember it when I've seen it again, yes.

Right. But it accords with your recollection that it ultimately didn't happen until the second half of 2014?---That's right. And I guess the – I mean, I can only sort of reflect back on the intent of my email at the time was to ensure – and it is not exactly
10 a surprise that some of the HR recruitment processes across Queensland Health and across our health services was not different to many others, were not necessarily as timely as they could be. So I can only infer from my – from reading this again that I was concerned that we were in fact doing everything we could in a timely fashion to not hold up the recruitment of these – these teams.
15

Thank you. Now, Dr Steer, that's the end of my questions. Some other of the lawyers here may have questions of you.

COMMISSIONER WILSON: Is there any cross-examination of Dr Steer? No? Do
20 you have any questions, Ms Wilson?

MS WILSON: Yes.

25 **EXAMINATION BY MS WILSON [5.48 pm]**

MS WILSON: Thank you, Commissioner.

30 Dr Steer, my name is Elizabeth Wilson. I think you've heard my voice before, but you perhaps have not seen me?---I haven't. Thank you.

You were asked some questions just before at paragraph 58 of your statement. Can we go to that, please. You refer there to – Counsel Assisting asked you a number of
35 questions. Have you got that, Doctor?---I might leave it on the screen. It's easier for then me finding it. Thank you. Yes.

And you've gone through a number of the times when you understood these services stood up – is that the right time to use? Opened. What's the term that you like to
40 use?---Well, certainly the resi service was – I would use the term "open", and I would use the day program – and by the way, there were at Townsville was available, as were the subacute beds at the Mater. So I think I'd use different words for the resi and the day program and the subacute beds. I think it's important to be a little expansive here. I think one of the – of the good things that occurred as a result
45 of the activity around this planning process was in fact the coming together of the – what had previously, I think, been quite disparate and disconnected child and youth

mental health services across the state. And certainly I do want to commend the leadership of Stephen Stathis and Judi Krause, not only their talent but I think their style that enabled people to come together to ensure that in fact the services, even if not ideal, were responsive to placing together what really were bespoke packages not just for the planning of the discharge and transition and – and transition of the current Barrett patients at the time but also, obviously, for that cohort of patients across the state through 2014. And I mean, I obviously may have not been in the loop but I think to be fair this collaboration across the state and the fact that Stephen Stathis and his team provided both a consultant, supportive and in fact an assessment process for admission to the resi and the subacute beds at the Mater I think was a huge step forward in making sure that there was a coordinated patient path for this particular clientele. I think the fact that the subacute beds at the Mater Hospital, as I understand it, were literally used by over that – I think the 10 month period. I'm not quite sure I have any recall after October would suggest to me – and again, I have no other evidence that kids or adolescents were falling through the cracks – that in fact we had a – a system in place and a very thoughtful process in place to look after this cohort.

Just in terms of the day program in Townsville, Counsel Assisting put a December date. Do you recall that? Being asked about a December date?---I – I do and I must say I'll just have to reflect on that, yes. As I said, I certainly do remember engaging with the Townsville in a – in a symposium or gathering of different services across the state through the second half of 2013 and talking about their day program's capacity in that setting.

Was it the case that the day program was actually pre-existing but in February 2012 there was a new inpatient service opened?---Well, certainly - - -

2014?---Certainly the - - -

2014, sorry?---Yeah.

Doctor, I - - -?---It was – sorry. Certainly the day program was existing. Their engagement with this particular cohort of adolescents was part of the dialogue through the second part of 2013 and that availability and flexibility to engage with this cohort and commitment through the end of 2014, I think, was very important given the fact that the government quite reasonably and, I think, sensibly were trying to ensure that geographic positioning of these – of these – of this cohort was not a disadvantage to access – to care. So that Townsville and Cairns became a very important part of the dialogue going forward.

Doctor, you might appreciate but I just got a note from Counsel Assisting:

> *Sorry, got that December 2014 date wrong.*

So I think we can put that to one side?---Thank you.

In term of the tier 3 beds at the Mater Hospital, you said that – and we can see that in paragraph 60 – that the tier 3 beds were available at the Mater from February 2014. And I think that the evidence was that you gave to Counsel Assisting was that the formal process took a bit longer or – I don't want to put words in your mouth –
5 something to that effect. Could you explain that, please?---Well – well, look, I have – through a long history and certainly in a parallel activity in the establishment of the LCCH hospital which was going at the time I had an enormous amount to do with the Mater and planning services. I can speak with confidence that the Mater Children's Hospital were committed to supporting from February 2013. What took
10 some further time to do, which is not unusual, was the formal agreement written and signed around that particular process. I think I can speak – and I know I can speak with confidence about the Mater's approach in attitude, that they were certainly available, and I – I know that Dr Stephen Stathis and the clinical leadership at the Mater had spoken about, and very deliberately about, the different model of care that
15 would be required for this subacute service at the Mater Children's, as opposed to their acute inpatient service. So this was, in fact, a very, very deliberate piece of work, to be available by February.

So when you say the tier 3 beds were available at the Mater from February 2014,
20 why didn't the formal process also finalise in February 2014? Can you explain that process?---I think the – for reasons which may not be understood, but – and I hate the word bureaucratic, but the time taken, even between individual hospital and health services to sign agreements around transfer of funds and performance relationships is extended and unusually long. I can't explain it. It's disappointing, but it takes time.
25 As evidence about that, it was a number of months before, as I remember it – I can't remember the exact timeline – where it took us considerable time to sign off with Metro South Hospital and Health Service around the transfer of funding and the running of the AMYOS teams out of Metro South. One tries to be respectful about governance arrangements with these, that they are embedded in the local services,
30 but one also has to make sure, getting back to the original questions, about budget integrity, and, in fact, there's a clear understanding that given this money is available for this particular cohort of patients that it stays it, agreements, formal agreements become important. They take some time to do. They take even longer, often, and, unfortunately, with the Mater Hospital. So it's actually just that process of detailing
35 how both the agreement, the funding, and, in fact, the performance indicators will be monitored going forward. As I've said, to be fair to the Mater, my relationship with them was incredibly positive, and I know for a fact that they were certainly available to look after this cohort if necessary from February 2014.

40 Okay. Now, Doctor, you referred to a doctor that you seem to have in front of you. Perhaps if we could just confirm that it is this document. Can we bring up QHD.012.002.3853. Is that the document that you've – you were referring to?---Yes. And if we can go to page 3 of that document - - -

45 Page 3 of that document?--- - - - I think – I think that – I think this – and just a little bit further down – I can – I think it's under the performance indicators for these objectives, and you'll note there two – item 2, note, at the bottom. As I said, this is a

– I think this has been a very clear understanding in the context of our planning from this date, and as I said, it's just – it's just a surprise to me earlier – earlier demonstration of those late emails in November, given these communications early on.

5

Okay. Can I now take you to the project plan which Counsel Assisting took you, which is CHS.001.001.0750. And if we can go to 0756. And we can go down to the third dot point under 1.3: Purpose and Objective. Now, Counsel Assisting took you to that dot point; you recall that?---Can I – I'm just – I thought I'd just wait for you,
10 sorry. The third dot point there?

The third dot point - - -?---Yes.

- - - under Purpose: do you recall about being taken to that?---That's right, yes.

15

Okay?---That's right, yes.

Can you just park that memory for one moment. Can I now take you to 0757, which is the next page, and the assumptions, if we can go down. And we can see that first
20 dot point, which I won't read out?---Right. Can you just bring down a little, please, on the screen - - -

Sure. Can it just - - -?--- - - - my apologies.

25 - - - down a bit?---Yes. Thank you. Yes.

You want it more in the middle of the screen?---No, that's fine. Thank you.

Okay. Okay. Now, that's saying that – without reading it out, it's the lead governing
30 for the project will be Children's Health, but there will be partnerships with West Moreton and Queensland Health - - -?---That's right.

- - - under the project plan. And it was the case that each of those entities, Children's Health, West Moreton and Queensland Health, had their own roles and
35 responsibilities under this project plan?---Well, absolutely. I guess what I was trying to do was to be – to be fair, that I think Children's Health Queensland and myself in the position are not trying to shirk the accountability for the new service model. But, certainly, in this day and age you cannot develop what would be a comprehensive, state-wide model without a recognition of what has come before and the
40 collaboration with the Department of Health. So that partnership is, I think, critical in any of these, very, very complex organisational change agendas.

Okay. Can I now then take you to 0761. And I appreciate, Doctor, you've just seen this document for the first time, so if you want more time to look at it – if we can go
45 down to the key deliverables, which is 2.2, see that, Doctor?---Yes.

Okay. And what it sets out, it's clear for everyone reading it, is milestones are one – in one column, the responsible officer another, and then a date. If we can go down to the sixth entry in that table, which talks about interim consumer clinical care plans - - -?---Yes.

5

- - - and then we see the responsible officer is Anne Brennan?---That's right.

Okay. And that's for the current BAC and waitlist consumers?---That's right.

10 Okay. And you were aware that Anne Brennan is the – was the clinical director out at BAC, BAC?---I am. I've known Anne for many years. She's an exceptional clinician and extraordinarily talented and committed one.

Okay. So here, it talks about the interim consumer clinical care plans for the current
15 BAC and waitlist consumers?---Yes.

And that is, Anne Brennan's responsibility?---That's right. She was the lead clinician at that time, yes.

20 Okay. Can we now go back to the parked dot point, which is at 0756 – if we can go down – you see that – the parked dot point, which is the ensure the continuity of care - - -?---Yes.

- - - for adolescents currently admitted to Barrett and on the waitlist through
25 supported discharge programs?---Yes.

Bringing those two bits of information together – and if it's not enough information, please tell me – does that reflect that the ensuring the continuity of care that is set out there was Anne Brennan's responsibility?---Yes, it was, and as I remember correctly
30 I think nine out of the 11 inpatients at the time of the commencement of this process were, in fact, moved into the adult care sector anyway. So yes, Anne had enormous challenge to – to provide that care and interface, not just across the health sector, but the education and training sector and social and welfare sectors as well. And as I've said before, from – from my perspective – and I'm not surprised – the independent
35 review commended her, and in fact suggested that her approach and her model as learning and material for state-wide standards going forward.

Okay. Thank you. Thank you, Doctor. That's all the questions I have.

40 COMMISSIONER WILSON: Do you have anything, Mr Freeburn?

MR FREEBURN: No. No, Commissioner. May the witness stand down?

COMMISSIONER WILSON: No one else wants to ask any questions before the
45 link is cancelled? Thank you very much, Dr Steer. You can stand down?---Thank you. Thank you, Commissioner.

**WITNESS STOOD DOWN** **[6.05 pm]**

COMMISSIONER WILSON: Alright. Tomorrow morning, we'll start at 9 to finish
5 Dr Stathis' evidence. What other witnesses are outstanding?

MR FREEBURN: We think there's Dr Fryer, Ms Adamson and Dr Martin. We think pretty well all of them should be relatively short.

10 COMMISSIONER WILSON: Well, Dr Martin has some health problems, so we must accommodate him and must start him at the time that he has been given, even if that means interposing him.

MR FREEBURN: Yes.

15

COMMISSIONER WILSON: Alright.

MR FREEBURN: And I should say: we think the – that between counsel we've arranged for it not to be necessary to call Michelle Bond, the education person. The
20 process will involve further – a supplement to her statement.

COMMISSIONER WILSON: Very well. So we should finish tomorrow?

MR FREEBURN: Yes.

25

COMMISSIONER WILSON: Let's hope so.

**MATTER ADJOURNED at 6.06 pm UNTIL FRIDAY, 11 MARCH 2016**