

**AFFIDAVIT****BARRETT ADOLESCENT CENTRE COMMISSION OF INQUIRY**

I, Abigail King, of [REDACTED], solemnly and sincerely affirm and declare as follows:-

**Background and experience**

1. My full name is Abigail Lezah King. I am a fully registered occupational therapist with the Australian Health Practitioner Regulation Agency (AHPRA). My qualifications include a Bachelor of Occupational Therapy (1980) from the University of Queensland. My Curriculum Vitae is attached to this affidavit (Attachment A)

2. [REDACTED] is staffed by a specialised multidisciplinary team which provides a tertiary, community based mental health service to families of/and children and young people aged 4 – 18 years, who may be experiencing moderate to severe mental illness or be at risk of developing mental illness.

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Sheet 1

[REDACTED]  
Deponent

[REDACTED]  
A Justice of the Peace/Commissioner for declarations

Affidavit

Abigail King, [REDACTED]

Filed on behalf of the Applicant/Respondent

Form 25 – Version 1, March 2000

2 (a) I have been employed as Team Leader at [REDACTED] Child and Youth Mental Health Service since 2005.

(b) Reporting structure: [REDACTED] CYMHS is one of 7 community based clinics which are part of the Child and Youth Mental Health Service (CYMHS) provided by the Childrens Health Queensland Hospital and Health Service (CHQHHS).

As a CYMHS Team Leader, I report directly to the CYMHS Programme Manager, Community Services (Mr Tim Davidson). The CYMHS service is managed by the Divisional Director, Ms Judi Krause.

Prior to November 2014, when I was involved with Patient [REDACTED] [REDACTED] clinic was part of the Mater Childrens Hospital and Health Service. My role within that organisation reported directly to Mr Tim Davidson (Operational Manager, Communities) and the Director, Ms Erica Lee.

Key responsibilities:

(i) Provide clinical and operational leadership, strategic direction and management to a multidisciplinary team of child and youth mental health professionals.

(ii) Actively participate in divisional strategic planning processes consistent with State and National Mental Health Policies and Plans and CYMHS priorities, ensuring appropriate consultation occurs with key community stakeholders.

(iii) Lead ethical decision making in the achievement of organisational goals including leading the unit toward the achievement of best practice standards in the child and youth mental health field incorporating the introduction of new and innovative evidence based initiatives.

(iv) Lead, manage and integrate safety and risk management strategies within

the work unit to ensure effective and efficient child and youth mental health service delivery through developing and co-ordinating quality improvement and research activities at the team and program level.

(v) Lead and manage workforce planning and development within the team and contribute to service planning within CYMHS and direct and/or contribute to service capability strategies.

(vi) Ensure legislation and standards, information systems and databases that support the development, delivery and evaluation of child and youth mental health services are appropriately and effectively utilised by staff and provide analysis and advice in relation to policy development and legislation as it applies to clinical service provision.

(vii) Undertake resource and cost centre management to ensure the efficient and effective delivery of the health service within a defined budget.

(viii) Provision of leadership and clinical expertise in the management of:

- Direct provision of clinical services to a complex clinical case load utilising discipline expertise and specialist modalities supported by a broad range of ongoing professional development
- Complex clinical problem solving with staff to ensure high quality standards of clinical practice
- Provide clinical direction and/or mentoring to multidisciplinary staff in collaboration with the consultant psychiatrist.

(ix) Work collaboratively with a broad range of senior staff including management and discipline directors to identify and develop appropriate expert

clinical knowledge and skills within a multidisciplinary team environment.

(x) Establish an interagency approach to service development and implementation through consulting and liaising with non-government and other government organisations and developing, formalising and maintaining strategic partnerships utilising highly developed interpersonal communication, negotiation and conflict resolution skills

(xi) **Staffing and Budgetary Responsibilities**

- Service line management responsibility as per the organisational structure; delegations in accordance with the CHQ Delegations Manual for financial and human resources; manage staff in accordance with Queensland Health human resource management practice and principles, equal employment opportunity and anti-discrimination requirements.

2. c) Caseload:

- i) Children at risk of or experiencing moderate to severe mental illness
- ii) Children and young people aged 4 to 18 years and their families

3. I have worked as a clinician with children and their families for the past 35 years, mostly within multidisciplinary teams. I have worked clinically in paediatric hospital settings with developmental and psychosocial caseloads including child abuse, chronic illness, burns, oncology and developmental disorders for 17 years and more recently with CYMHS populations (0 – 18 years) in both hospital and community settings for the past 18 years. I have special interest in the impact of trauma on development and mental health and have undergone further training in psychotherapy and mental health assessment and

intervention. I regularly provide clinical supervision for colleagues and have provided training in areas addressing the impact/treatment of trauma, play therapy, infant mental health, psychosocial assessment, chronic illness, use of sensory psychotherapy interventions.

4. The nature of clinical work at a tertiary CYMHS community clinic involves ongoing attention to acuity and managing high risk behaviours, within the community setting. Clients are frequently referred to our service in relation to experience of extreme and/or chronic distress manifested in self-harm behaviours, suicidality, psychosis and extreme behavioural and relationship difficulties.

5. Involvement with the Barrett Adolescent Centre

In the course of my work within CYMHS services, I have had brief contact with the BAC in relation to [REDACTED] who were referred by colleagues within the [REDACTED] CYMHS service to the BAC service during my employment. I was involved in telephone and email communication with that service in relation to case planning for these clients, within my role as Team Leader.

6. Transition arrangements:

(a) Patient [REDACTED] was initially referred to this clinic on [REDACTED] by the Clinical Director of the [REDACTED] at that time, [REDACTED] This referral occurred following Patient [REDACTED] discharge from the Barrett Adolescent Centre when the service closed in December.

[REDACTED]

[REDACTED]

(c) Patient [REDACTED] was seen individually, as requested by the patient's [REDACTED], by Ms Charlotte Hambly, Psychologist. The patient had requested individual sessions to assist in managing anxiety symptoms and the patient's [REDACTED] had requested cognitive behavioural therapy as specific intervention.

Patient [REDACTED] was seen individually for parenting support by myself. Patient [REDACTED] attended two sessions.

Contact ranged from twice weekly to weekly then fortnightly. Patient [REDACTED] also phoned to discuss issues outside of planned appointment times.

Liaison occurred with Patient [REDACTED] school to support vocational planning and emotional support in that setting.

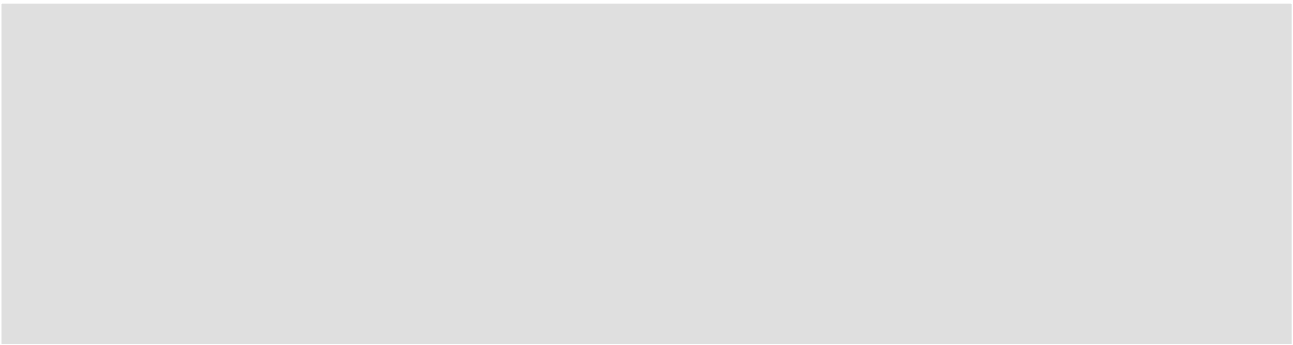
7. Process of transition of client:

(i) Prior to discharge from BAC, Patient [REDACTED] was engaged with a private Child and Adolescent Psychiatrist, [REDACTED] in November 2013. This plan provided for ongoing care past Patient [REDACTED] when CYMHS intervention typically ceases and referral to adult services occurs.

(ii) Around the time of discharge from BAC, the patient's [REDACTED] contacted a private psychologist who advised that he could only provide 3 to 4 weekly appointments, which the patient's [REDACTED] agreed was insufficient for the patient's needs at the time.

(iii) [REDACTED]

[REDACTED]



(iv) Following acceptance of the referral, Dr Anne Brennan subsequently phoned me, as Team Leader on 13/2/14 to discuss Patient [REDACTED] needs in detail.

8. Transition plans

Yes, the transition plans were clearly stated at the time of referral, both by Dr Brennan (phonecall and Discharge report) and by Patient [REDACTED] (phonecall and at first session). See attached (i) Copy of BAC Discharge report dated 29/1/14; (ii) Care Review Summary dated 20/1/14 (Attachment B (i) (ii))

9. Transition plans:

(a) Due to Patient [REDACTED] attending [REDACTED] close to [REDACTED] was offered intervention here ([REDACTED]) in order to support optimal access to a therapeutic service. The plan included a request for individual therapy to address Patient [REDACTED] anxiety. Parenting support was offered to Patient [REDACTED] which [REDACTED] accepted. Psychiatric treatment was being provided by [REDACTED] with view to continuing into adulthood.

(b) Unable to comment. Patient [REDACTED] was aware of [REDACTED] needs and was a strong advocate for meeting same.

(c) Unable to comment. In respect to Patient [REDACTED] progress within treatment, the

patient's case was reviewed regularly (twice weekly, then weekly, then fortnightly) in sessions with the patient and the patient's [REDACTED]. As part of routine clinical governance, Case Review occurred on a 3 monthly basis with the clinic's multidisciplinary team and Child and Adolescent psychiatrist, [REDACTED].

10. At the time of referral, BAC had closed. I spoke directly with Dr Anne Brennan, who contacted me by phone on 13/2/14 to discuss Patient [REDACTED] care during the time spent at BAC and details of [REDACTED] transition plan.

11. Patient [REDACTED] was seen regularly (initially weekly and at times twice weekly) with safety concerns monitored as they arose through discussion with the patient and patient's [REDACTED] directly.

Patient [REDACTED] and the BAC school initiated contact with the clinic to advise of highly distressing issues when [REDACTED]

12. There was clear and direct communication from the Acting Director of BAC, Dr Brennan, regarding Patient [REDACTED] referral to our service and the patient's detailed notes were readily available on the cimha database. An articulated risk management plan was not indicated in Patient [REDACTED] case as the patient had not engaged in significant high risk behaviours and was living with a supportive and protective [REDACTED], with support from the patient's [REDACTED].

13. I had no concerns about Patient [REDACTED] transition to our service. Communication was timely and clear and patient focussed.

14. I was not aware of any concerns about Patient [REDACTED] treatment at [REDACTED]. The patient and the patient's [REDACTED] were cooperative with the intervention provided and



attended regularly.

**The transition of BAC client to [REDACTED]**

15. Patient [REDACTED] attended individual sessions with CBT focus with an individual clinician (Ms Charlotte Hambly) and the patient's [REDACTED] attended weekly individual supportive sessions with myself.

16. As described previously, Patient [REDACTED] saw [REDACTED] Child and Adolescent Psychiatrist in a private capacity. The patient also saw their longstanding previous psychologist, [REDACTED] on one occasion during our intervention. Patient [REDACTED] continued to engage with the BAC school who supported the patient's vocational planning needs at the time. Charlotte Hambly liaised with the school around this aspect of the patient's care. Towards the end of our involvement with the patient and [REDACTED], the patient's [REDACTED] independently located a private psychologist who specialised in working with clients with special interest in [REDACTED] and was able to work into adulthood with Patient [REDACTED]. Patient [REDACTED] and [REDACTED] chose to finish with our service to engage with this clinician.

18. School liaison occurred on a few instances. No other specific case related communication was indicated during our involvement with Patient [REDACTED].

(a) Communication with Patient [REDACTED] occurred regularly both directly and by phone.

(b) Patient [REDACTED] attended regular supportive sessions alongside [REDACTED] child's therapy.

19. My involvement with Patient [REDACTED] occurred in response to BAC's having developed and facilitated the patient's transition to this service. BAC seems to have communicated the this plan in a very clear manner, as the patient's [REDACTED] was very clear about all aspects of [REDACTED] child's plan. My contact with Patient [REDACTED] occurred in relation to the provision of therapy and parenting support.

Patient [REDACTED] and [REDACTED] engaged positively and attended regularly with this service over a four month period and used services that were offered in an ongoing and well communicated way.

20. Yes, individual assessment was conducted by myself and Ms Charlotte Hambly and occurred through direct observation, interview and history taking with Patient [REDACTED] and [REDACTED], as well as reference to existing clinical notes from BAC.

(c) See Assessment report (ATTACHMENT C)

21. Patient [REDACTED] made steady and positive progress during involvement at this clinic. Patient [REDACTED] continued to engage in schooling and began to demonstrate behaviours indicative of an emerging desire for autonomy. Patient [REDACTED] attended the BAC school regularly, catching public transport independently and eventually demonstrating improved motivation to engage in activities towards young adulthood eg vocational interests, friendships.

Understandably, the patient experienced times of significant distress on learning of the [REDACTED] from BAC. At that time, the patient stated thoughts of [REDACTED], which the patient was able to articulate with the clinician and which the patient's [REDACTED] was aware of. Patient [REDACTED] did not engage in [REDACTED] behaviour. Patient [REDACTED] was able to use individual therapy well in this respect, to reflect on and contain [REDACTED] distress.

22. Patient [REDACTED] was discharged from our service on 25/8/14 after commencing on 3/3/14.

a) Discharge occurred at Patient [REDACTED] and [REDACTED] request, after the patient had commenced seeing a private psychologist, [REDACTED] who the patient's [REDACTED] had located and who had special interest in the area of [REDACTED]. Patient [REDACTED] had [REDACTED] and this clinician was able to see the patient through adulthood, as well as provide access to an intern who could support vocational skill development, which they were interested in addressing as a priority. Patient [REDACTED] therapist offered to liaise with the new clinician as indicated.

b) Ongoing parenting support was offered at this clinic. Patient [REDACTED] declined and advised [REDACTED] would access Patient [REDACTED] previous long term therapist for this support as indicated.

c) Patient [REDACTED] also organised for the patient to commence psychiatric support with [REDACTED] after deciding to cease seeing [REDACTED]. Patient [REDACTED] advised that [REDACTED] offered [REDACTED], which [REDACTED] hoped might offer a creative way of facilitating emotional development for Patient [REDACTED].

d) The patient's [REDACTED] identified that [REDACTED] had found it difficult when Patient [REDACTED]'s individual support at this clinic was reduced from weekly to fortnightly, although was aware [REDACTED] could contact as needed in relation to dealing with the patient's distress. This was particularly distressing for [REDACTED] in the context of the recent [REDACTED] previous [REDACTED] classmate. Patient [REDACTED] was satisfied with the fortnightly appointments at this time and expressed a sense of personal safety in this regard.

23. N/A

24. See attached copy of clinical record. (ATTACHMENT D)

.....Content of report.....

ALL the facts and circumstances herein deposed to are within my own knowledge and belief save such as are deposed to from information only and my means of knowledge and source of information appear on the face of this my affidavit.

\*Sworn / Affirmed by Abigail King on 15/1/2016 at Brisbane in the presence of:

ELIZABETH CAREY

(signed by deponent)

Deponent

(signed by Justice of the Peace)

Justice of the Peace/Commissioner for declaration



## ATTACHMENT A

### CURRICULUM VITAE: Abigail King

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**EDUCATION:** Bachelor of Occupational Therapy, University of Queensland, St Lucia (1980)

### SUMMARY OF CLINICAL AND PROFESSIONAL EXPERIENCE

#### Permanent Positions:

- Team Leader, Yeronga Child and Youth Mental Health Service, 51 Park Rd., Yeronga 4104  
(Feb 2005 – current)
- Assistant Director, Occupational Therapy Dept., Royal Childrens Hospital, Herston 4029  
(Feb 2001-May 2003)
- Acting Director, Occupational Therapy Dept., Royal Childrens Hospital, Herston 4029  
(Jan – July 2002)
- Senior Occupational Therapist (1996/7), Occupational Therapist (PO3), Mater Childrens Hospital, South Brisbane 4101  
(1987 – 1997)
- Director, Occupational Therapy Dept, Matheny Hospital and Special School, Peapack, New Jersey. USA  
(1994 – 1995)
- Arts Administration Officer, Prime of Life Arts Programme, Queensland Performing Arts Trust, South Brisbane  
(1987 to 1990)
- Occupational Therapist, "Warilda" Residential Institution, Department of Childrens Services, Woolloowin Q. 4030  
(1982 to 1986)
- Occupational Therapist, Services for the Developmentally Delayed, Community Health Centre, Port Macquarie N.S.W.  
(1980 to 1982)

#### Relevant Locum Positions:

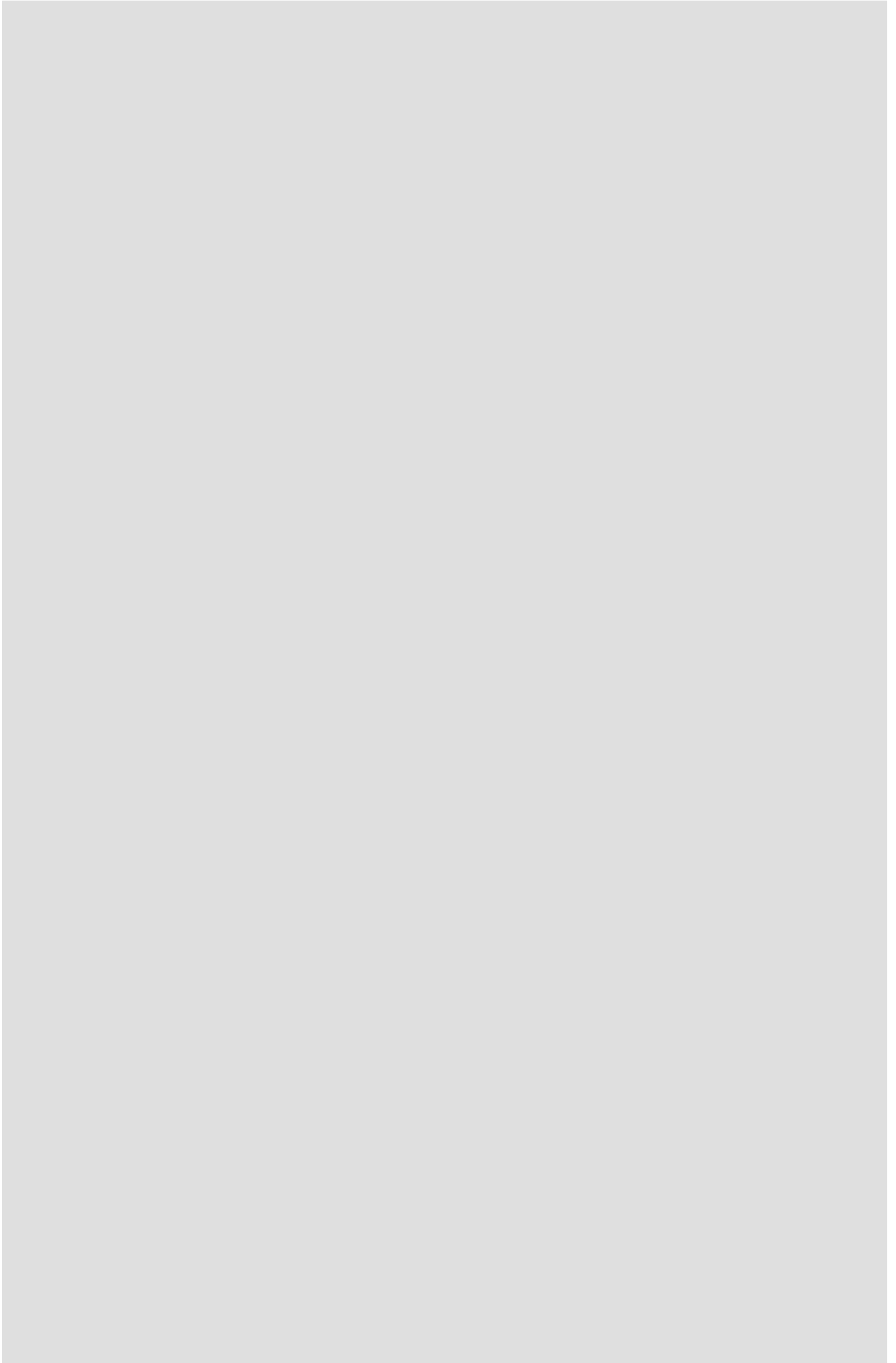
- Occupational Therapist, Mater Child and Youth Mental Health Services, Greenslopes CYMHS  
(May 2003 – Feb 2005)
- Occupational Therapist (PO3), Royal Children's Hospital, Occupational Therapy Dept., Herston QLD  
(Feb 1999 to Feb 2000)
- Acting Assistant Director Occupational Therapy Dept., Royal Childrens Hospital, Herston 4104.  
(Feb 2000 to Feb 2001)
- Child Therapist, Mater Child and Youth Mental Health Service, Greenslopes CYMHS, Greenslopes Q 4120  
(Nov 1998-Feb 1999)
- Occupational Therapist (PO3), Royal Brisbane Hospital, Adolescent Mental Health Inpatient Unit, Herston Q  
(Dec 1997-Oct 1998)

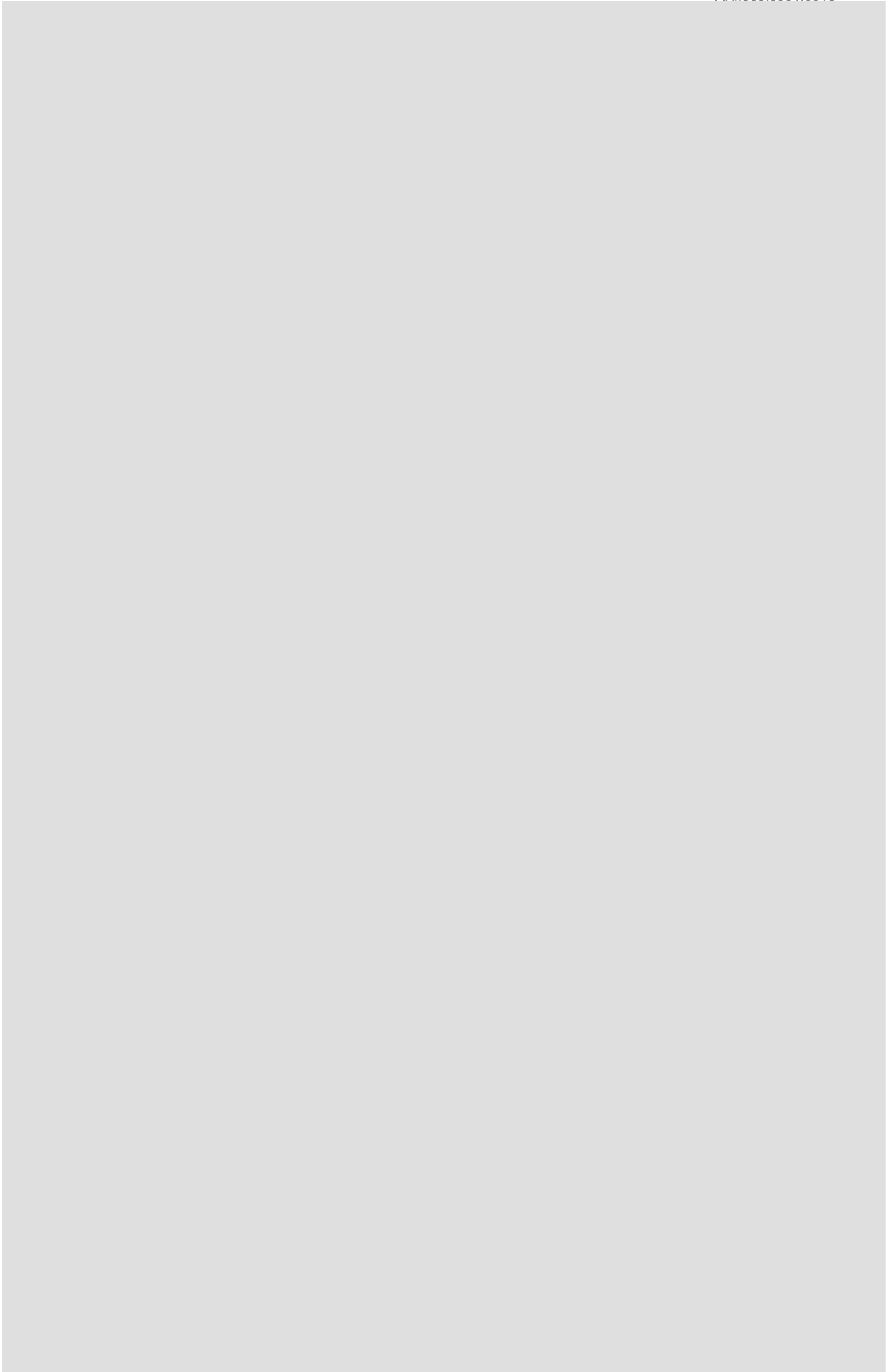
### PROFESSIONAL ASSOCIATIONS/ MEMBERSHIPS

- Registration Board of Occupational Therapists of Queensland
- Australian Association for Infant Mental Health (1996 - current)
  - Committee member 2003 – 2009;
  - President, Qld AAIMH committee (2006-8)
- Network for Occupational Therapists Working in Infant, Child and Adolescent Mental Health.(1999 – current)
- Working Group - Professional Development Strategy, Child and Youth Mental Health (1998)
- Inter-agency Working Party on Interviewing Sexually Abused Children Under 6 Years (1996/7)
- Working Group - Core Competencies in Child and Youth Mental Health: Occupational Therapy (1996/7)
- Professional Advisory Board of the Abused Child Trust (1987 - 1993)
- Network for Effecting Creativity through the Arts: Queensland (1982-1987)

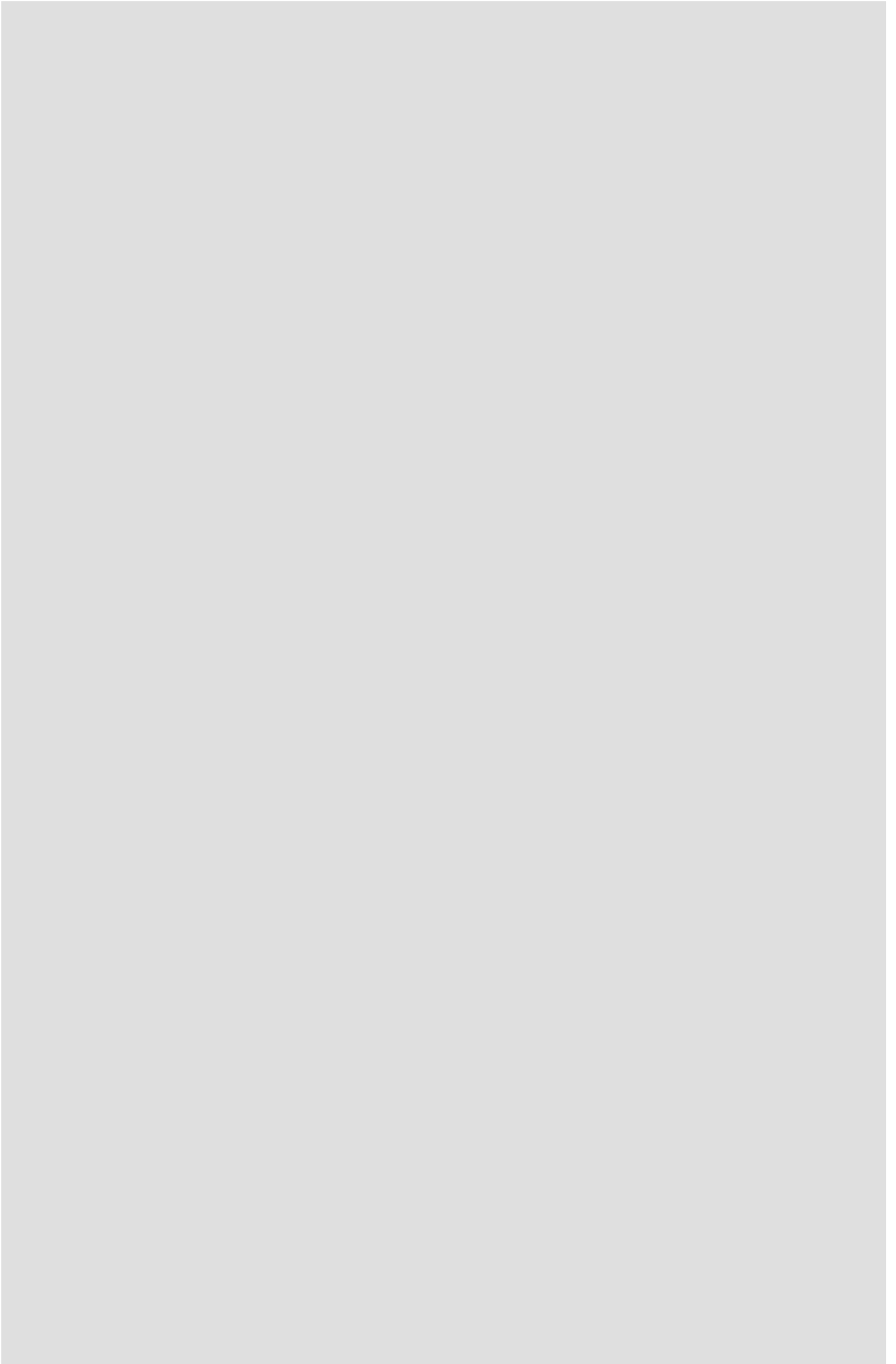


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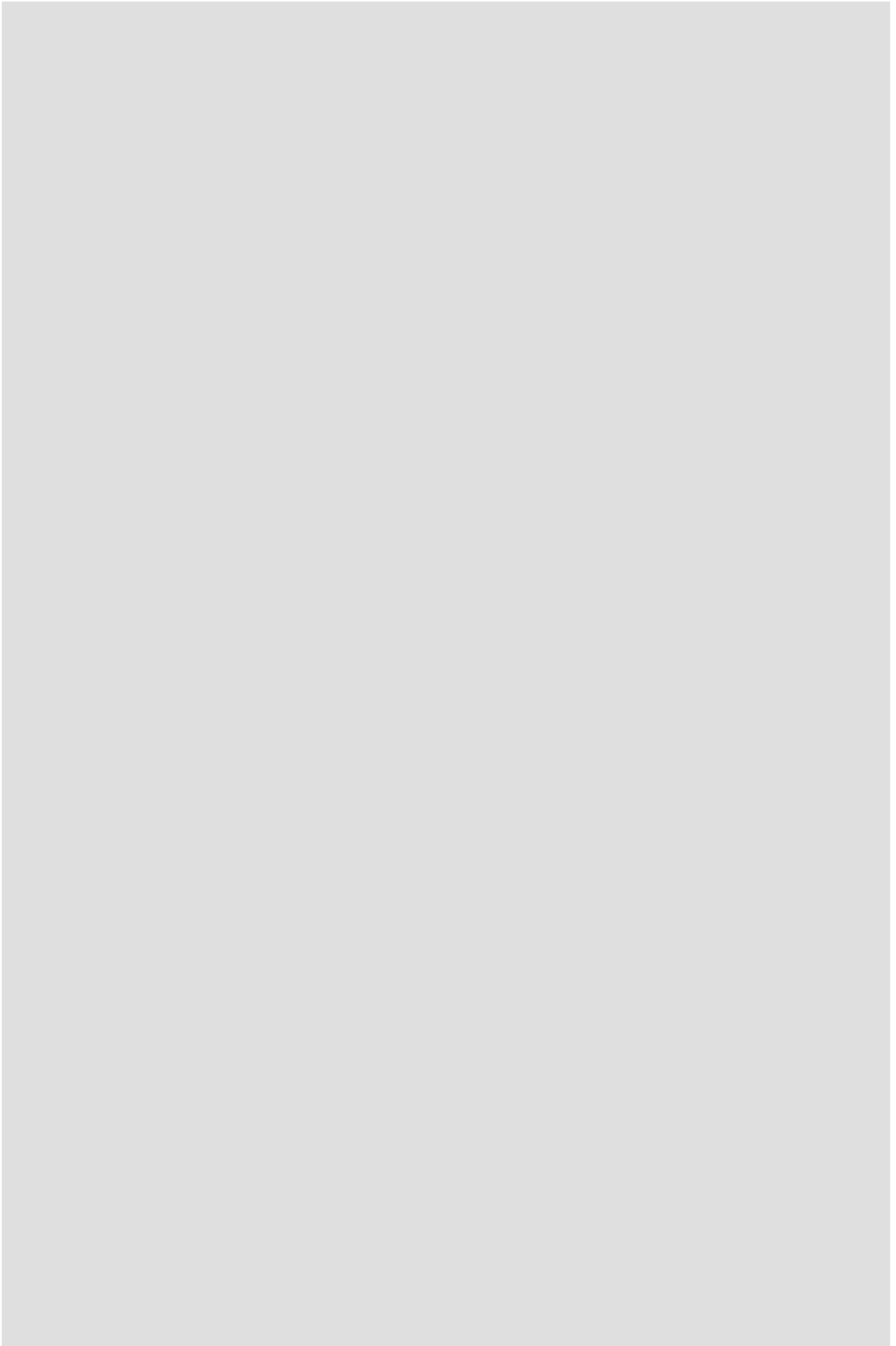


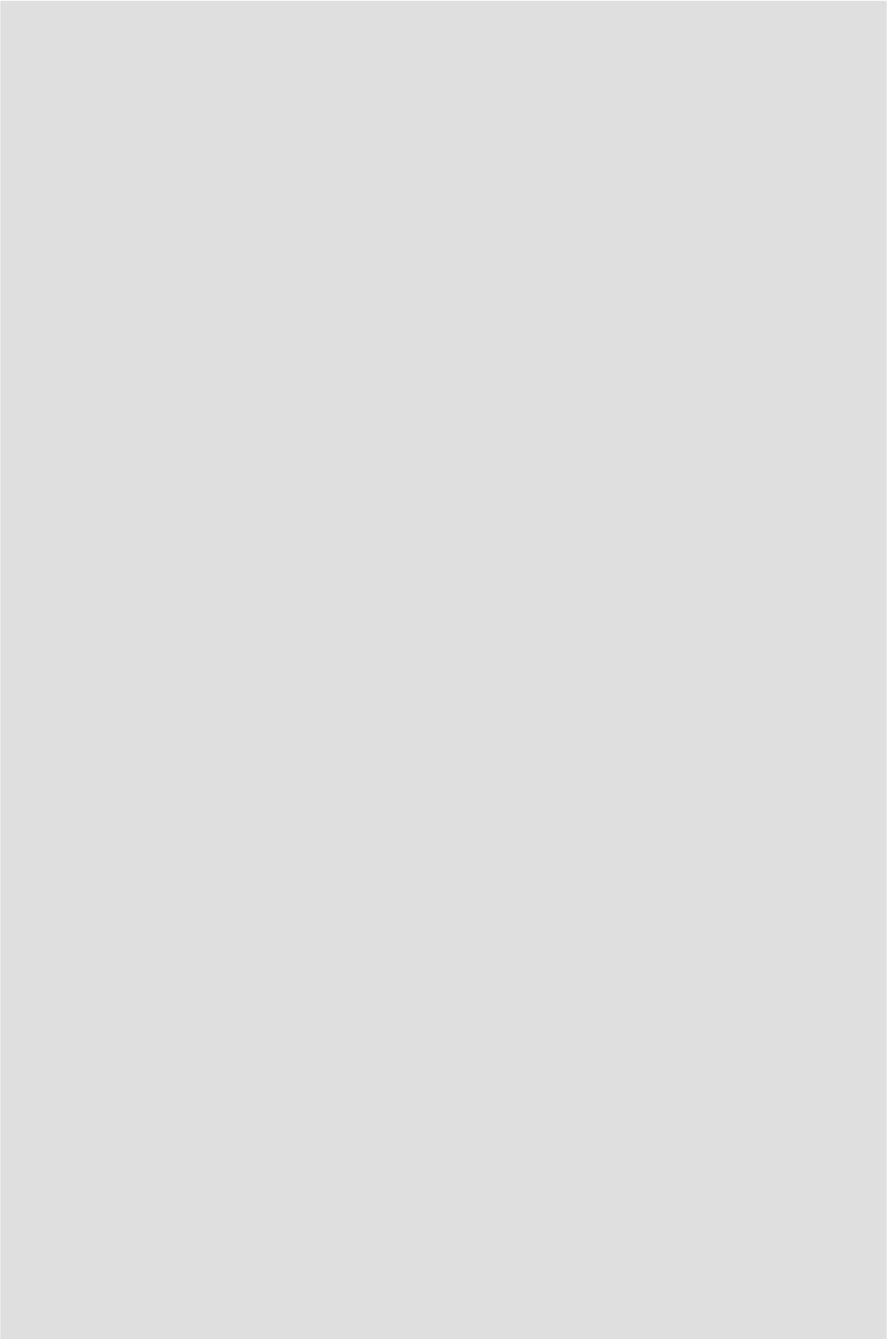


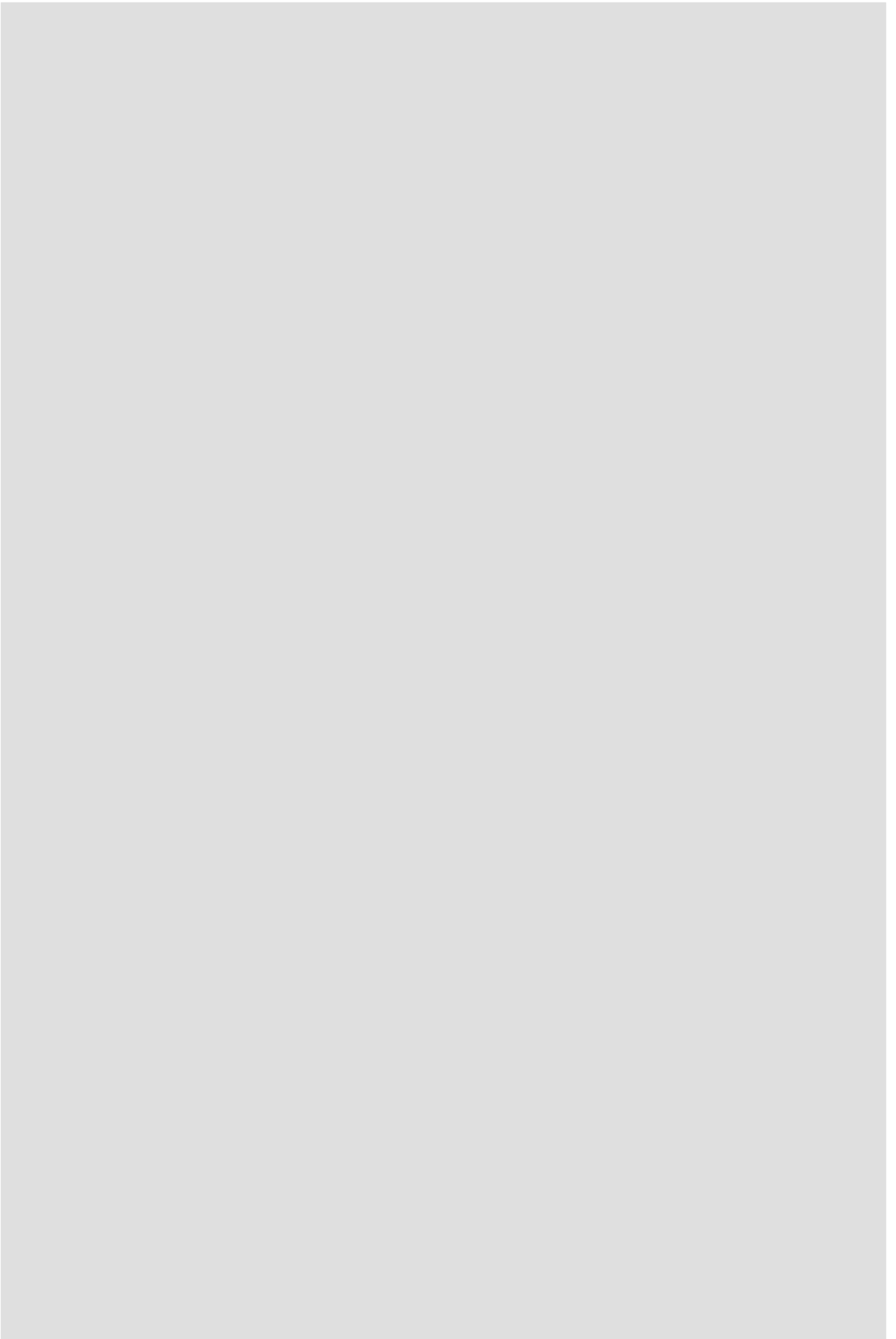


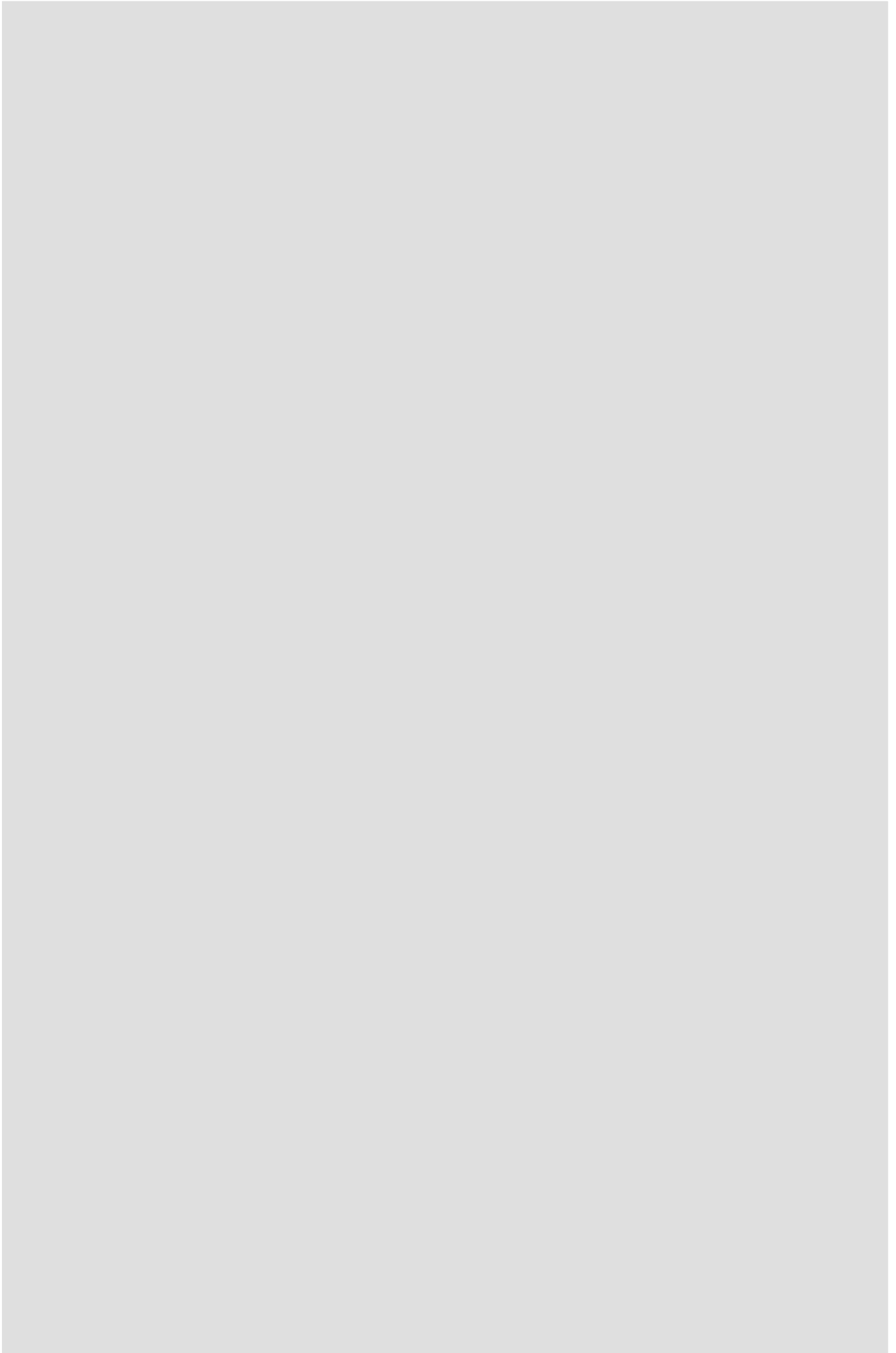


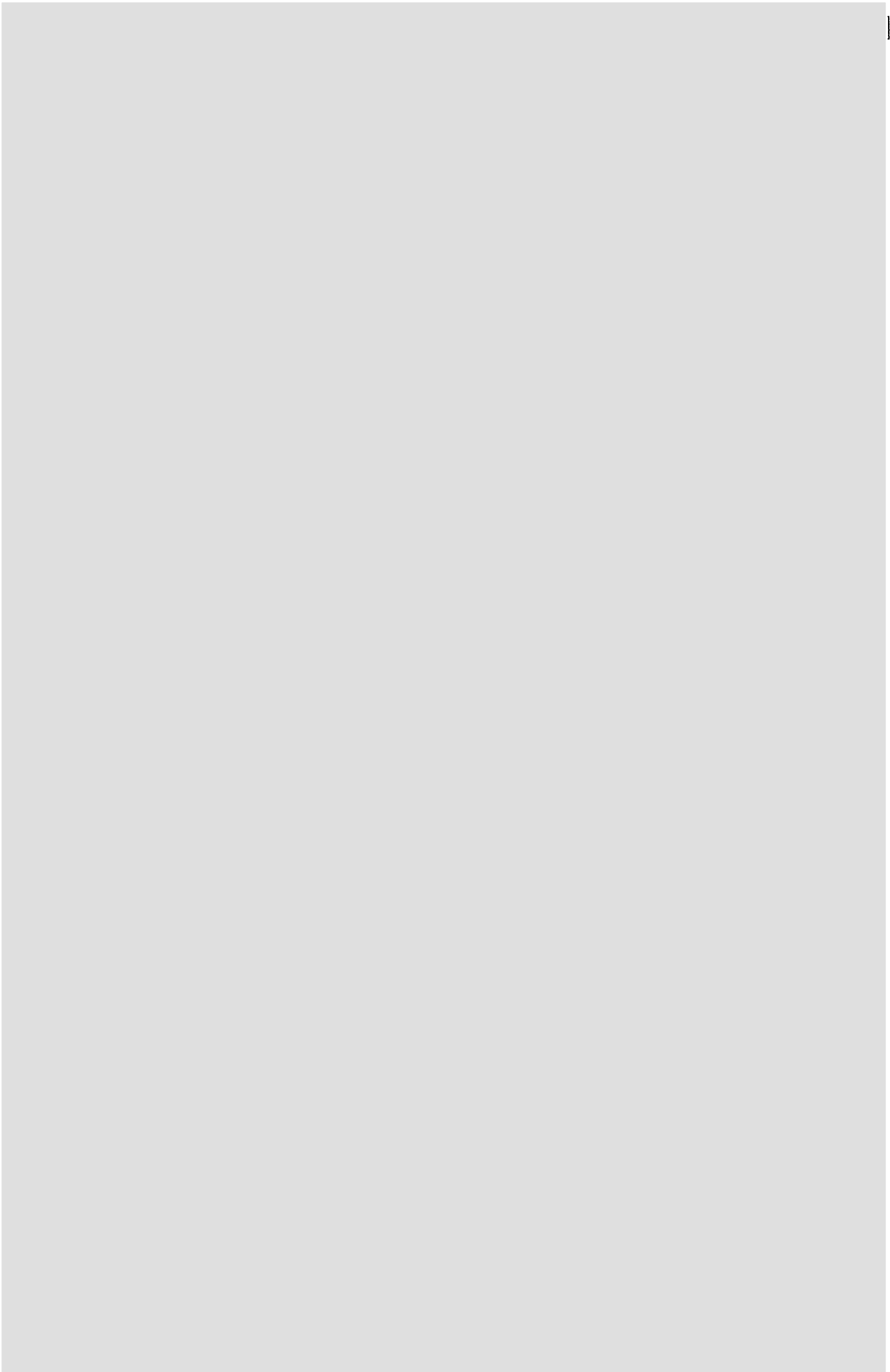
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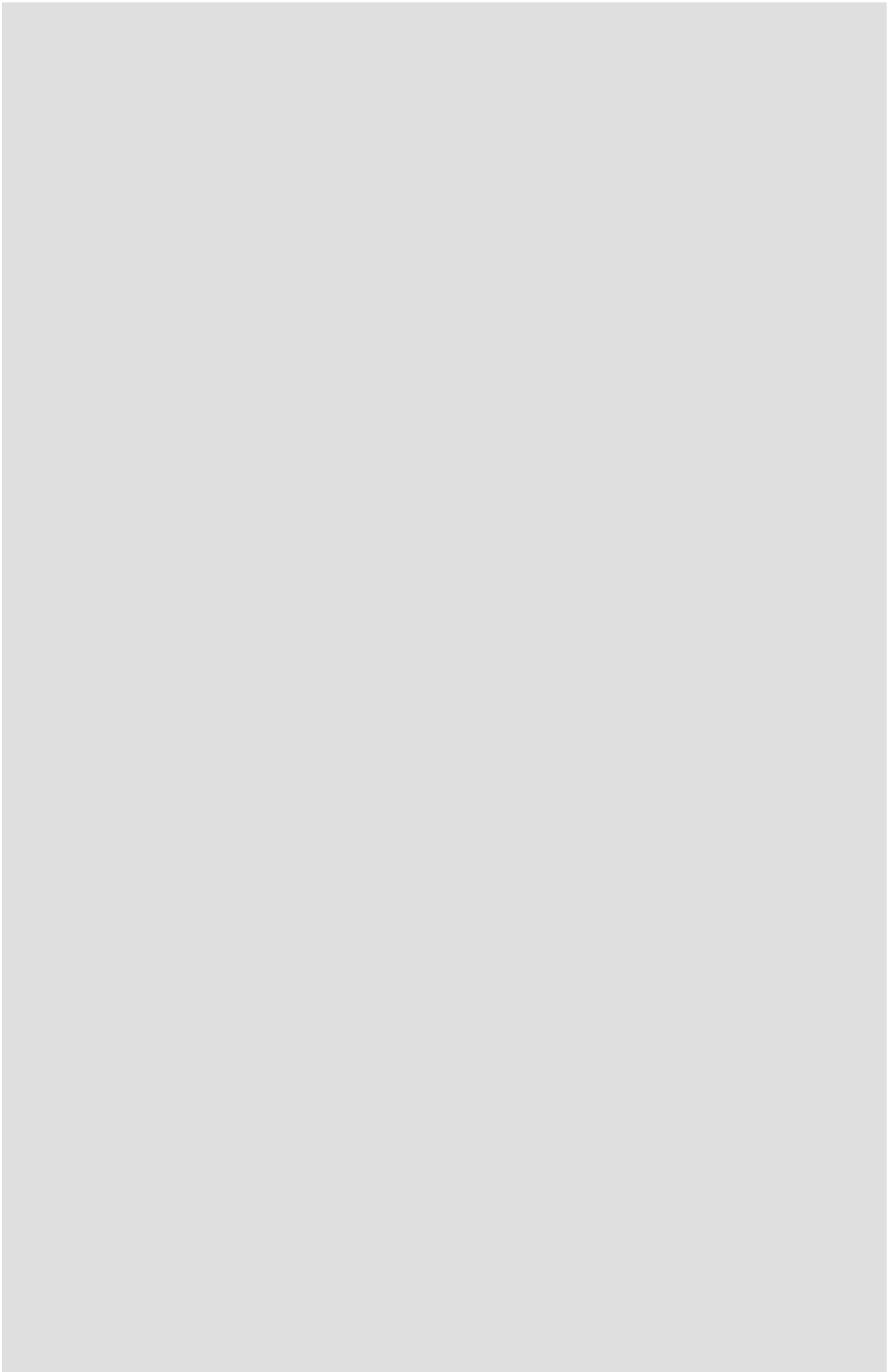


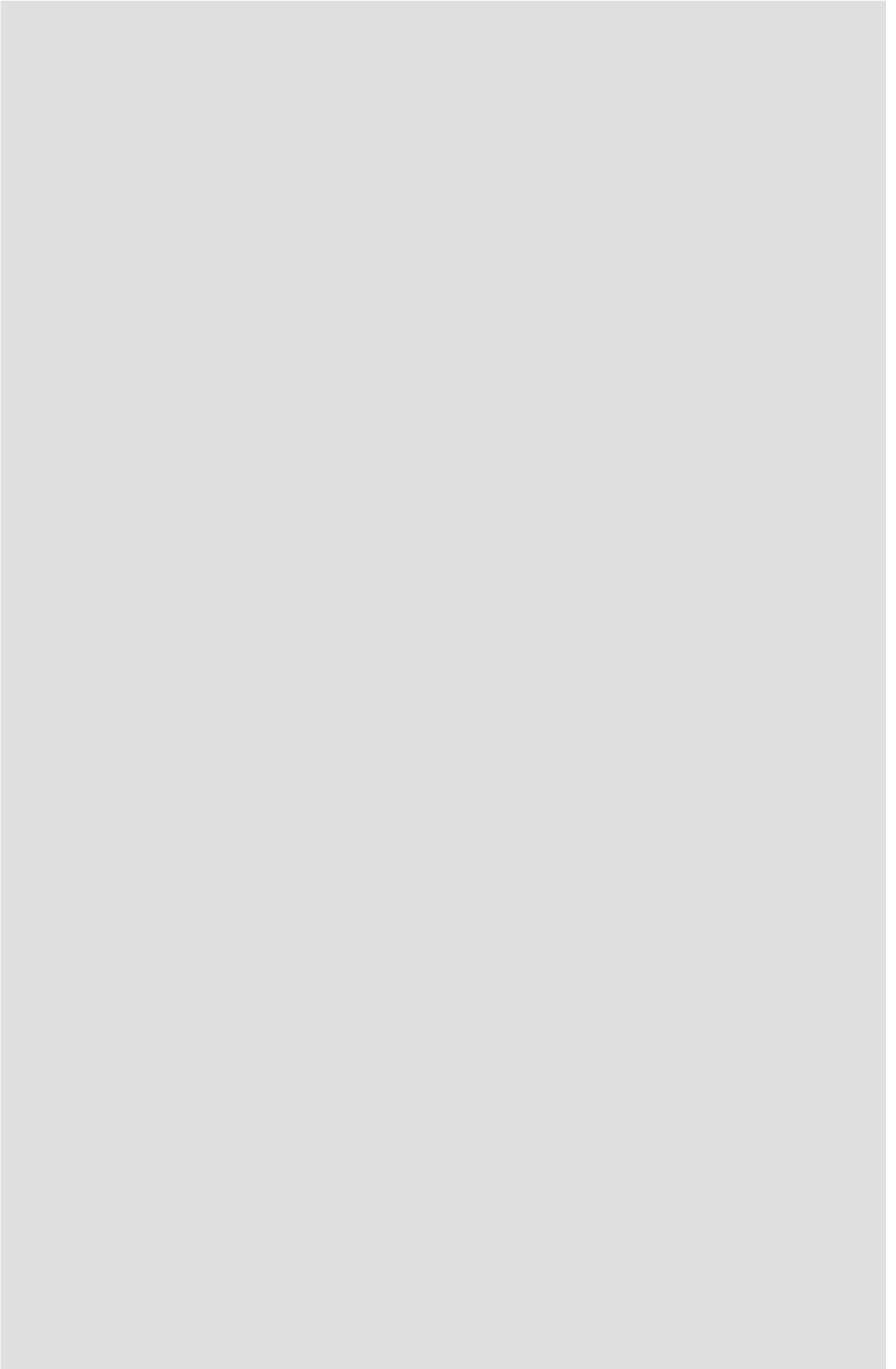


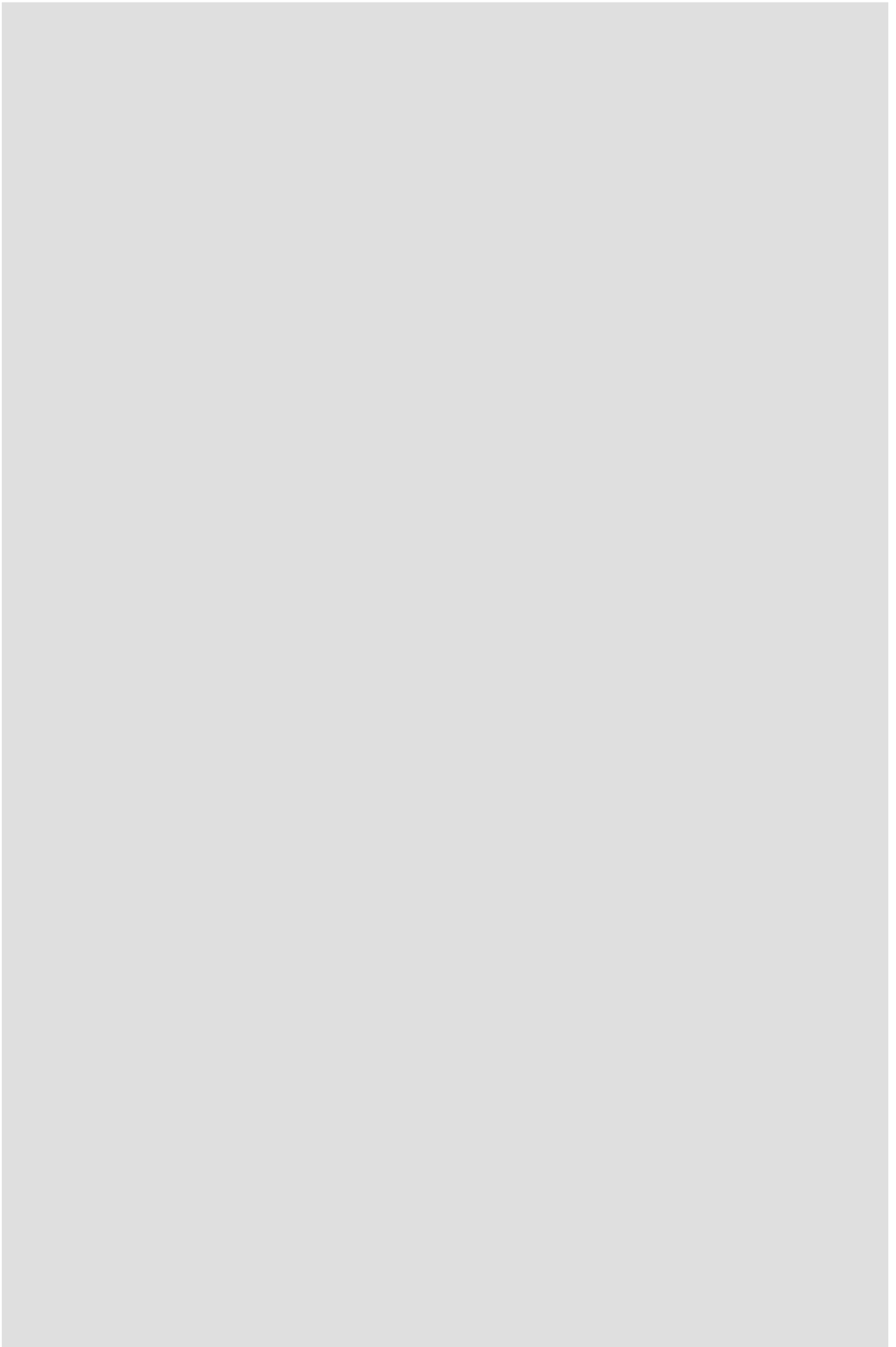


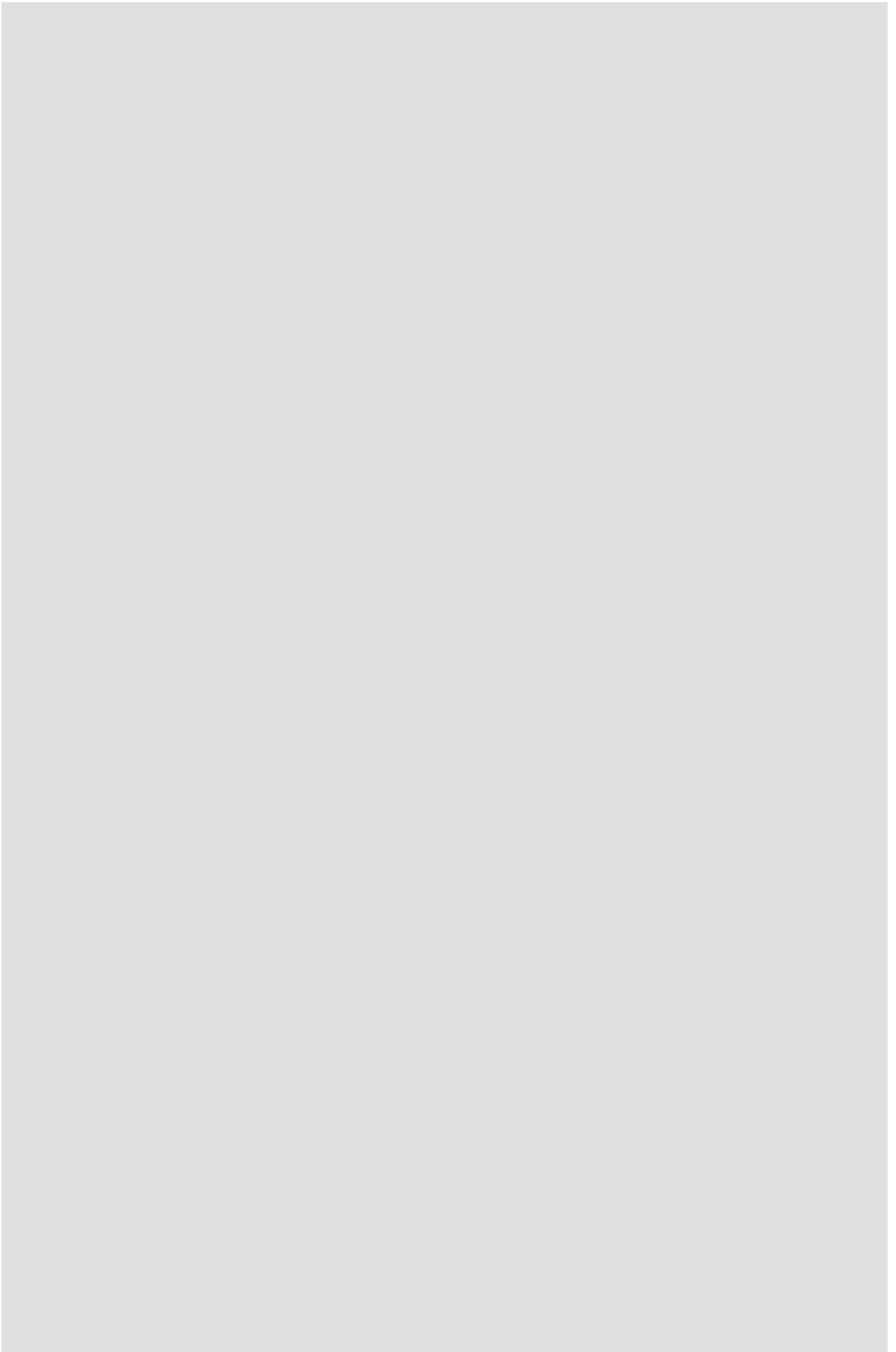
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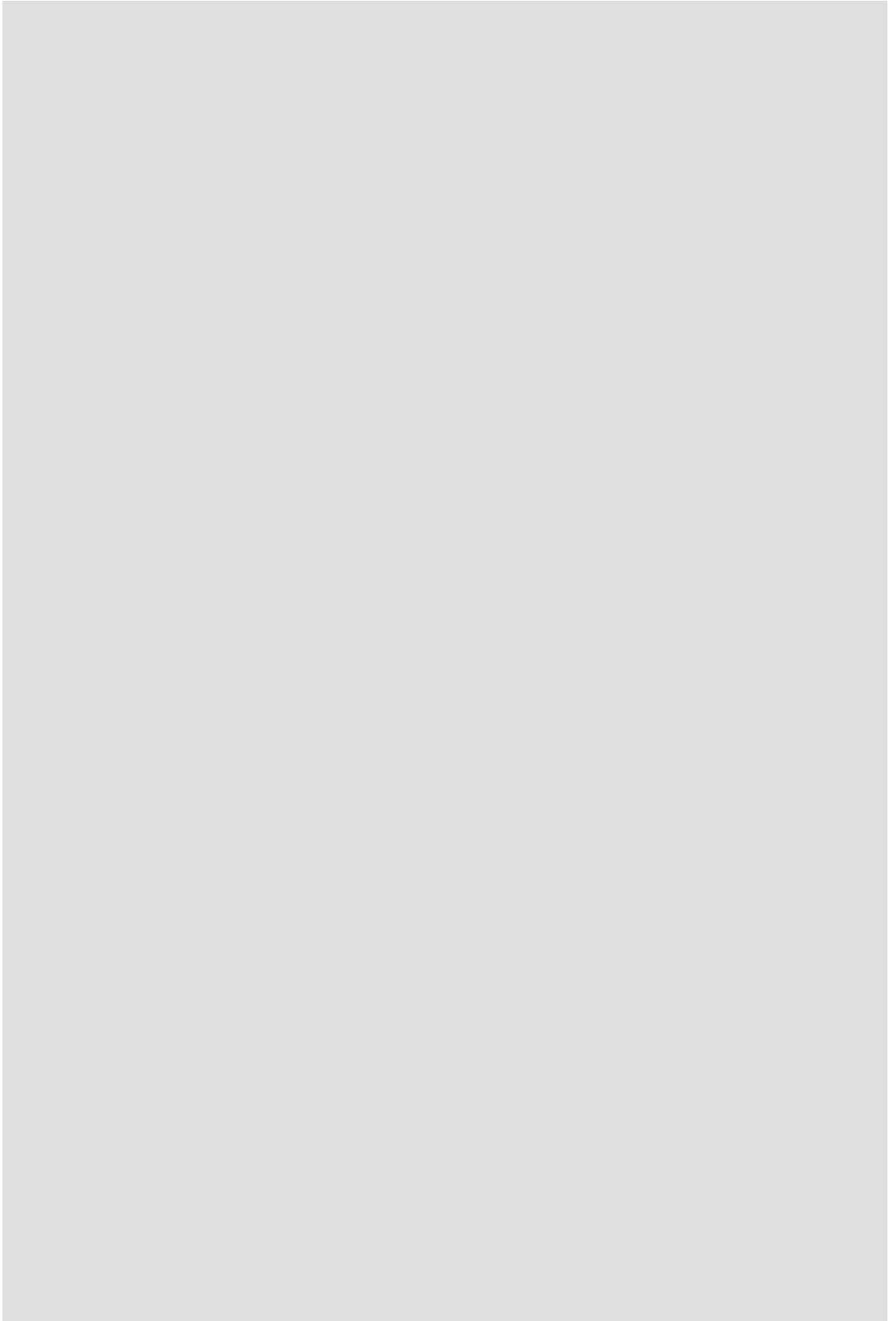


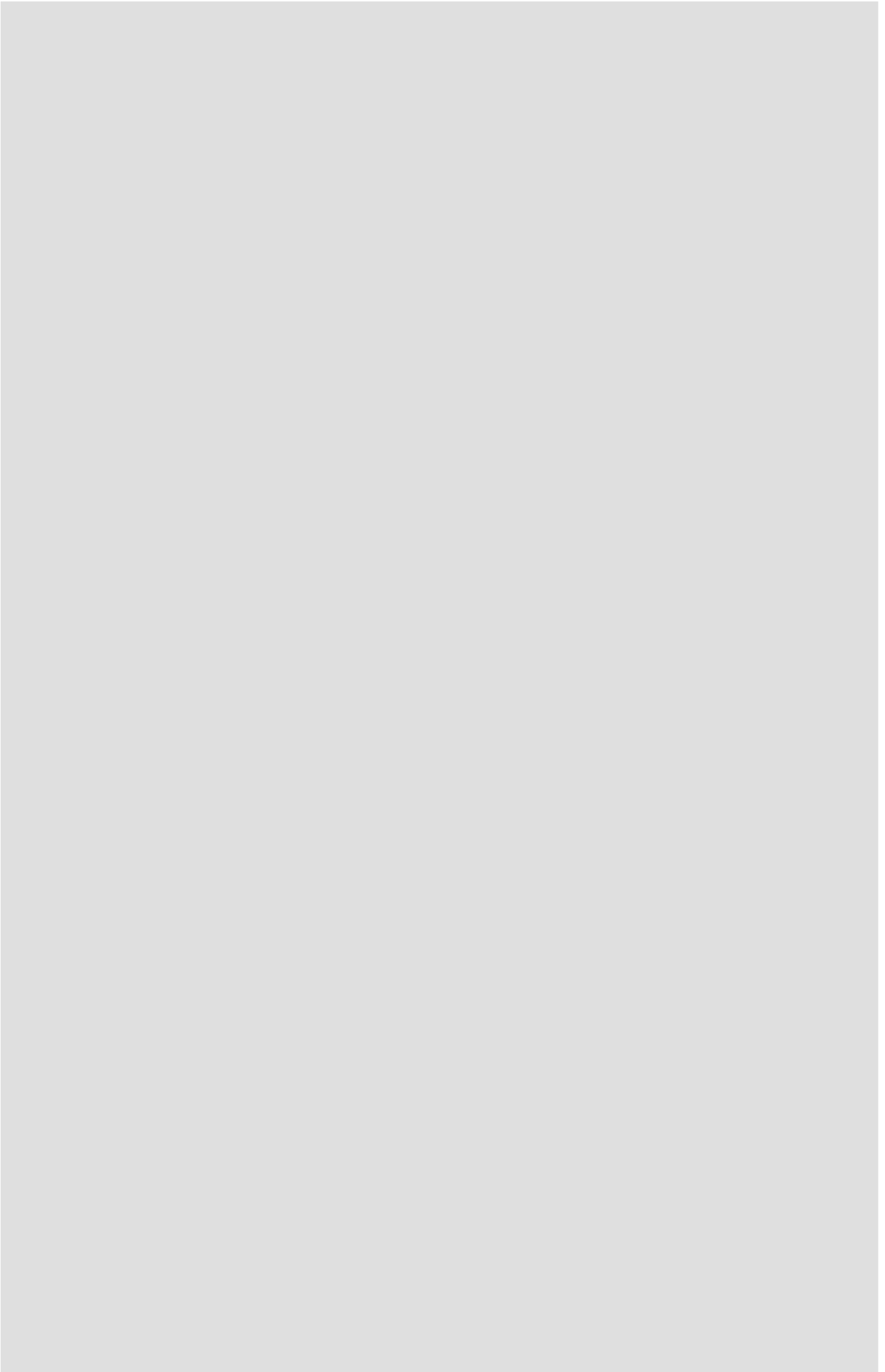


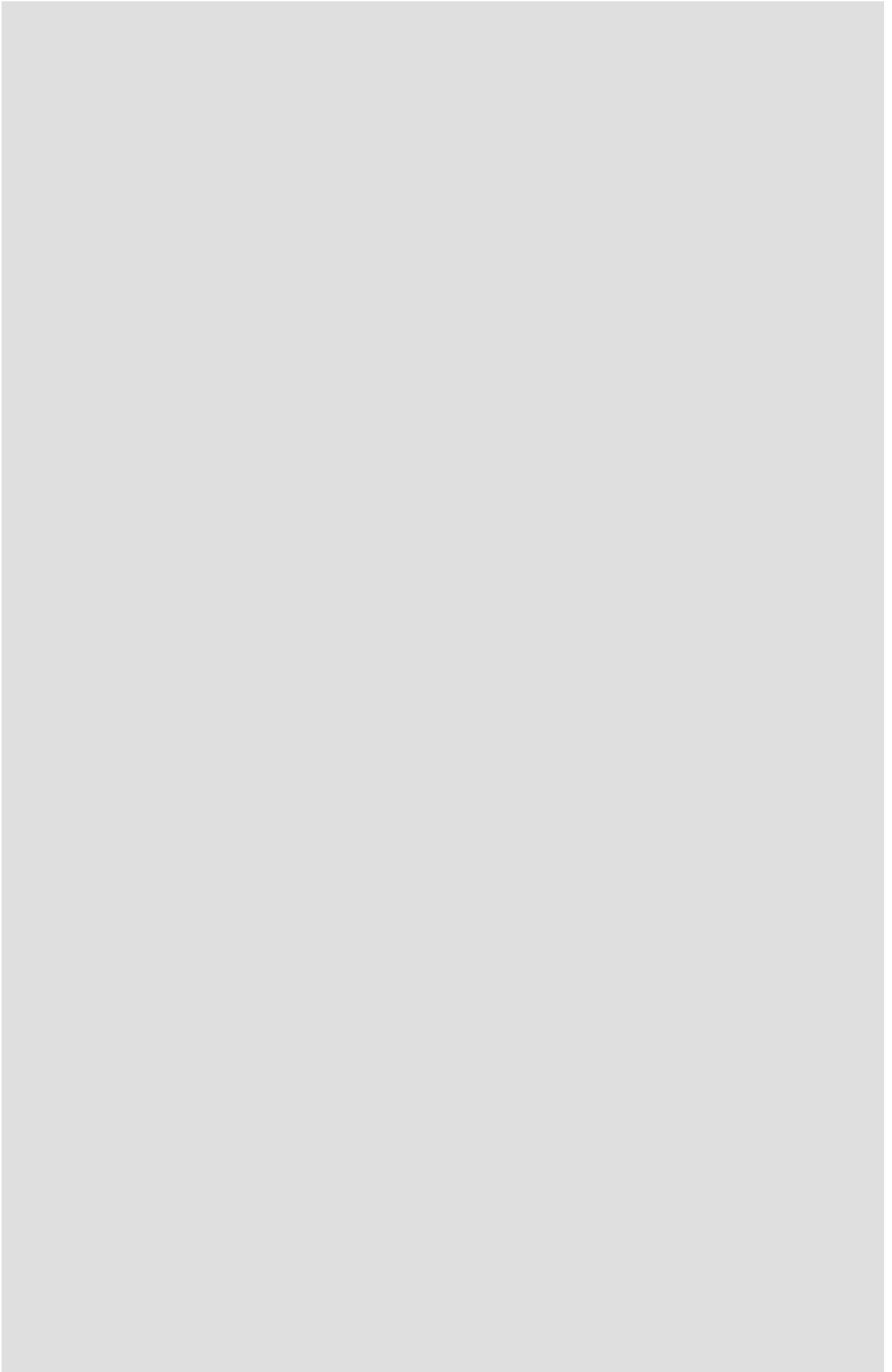


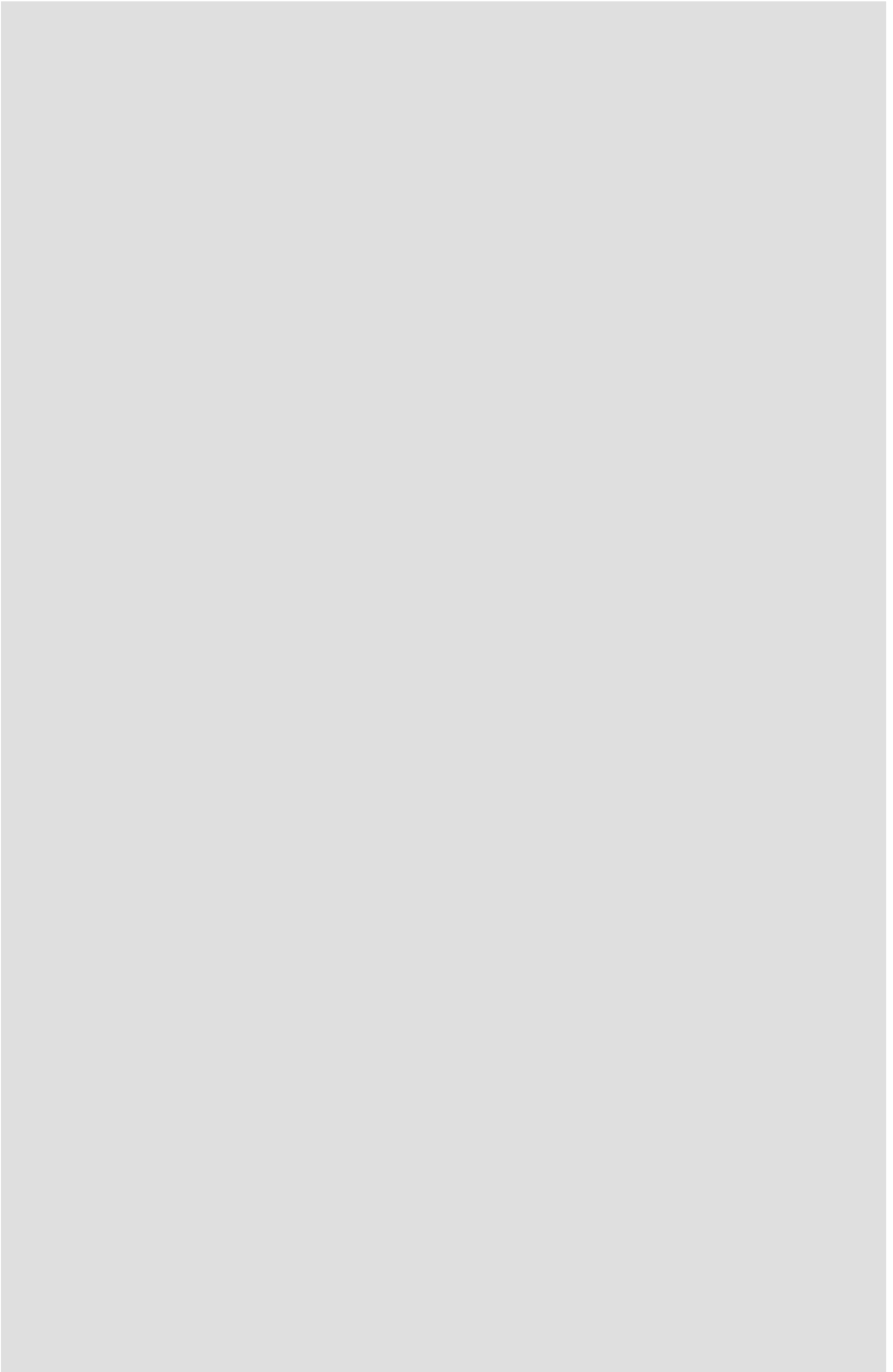




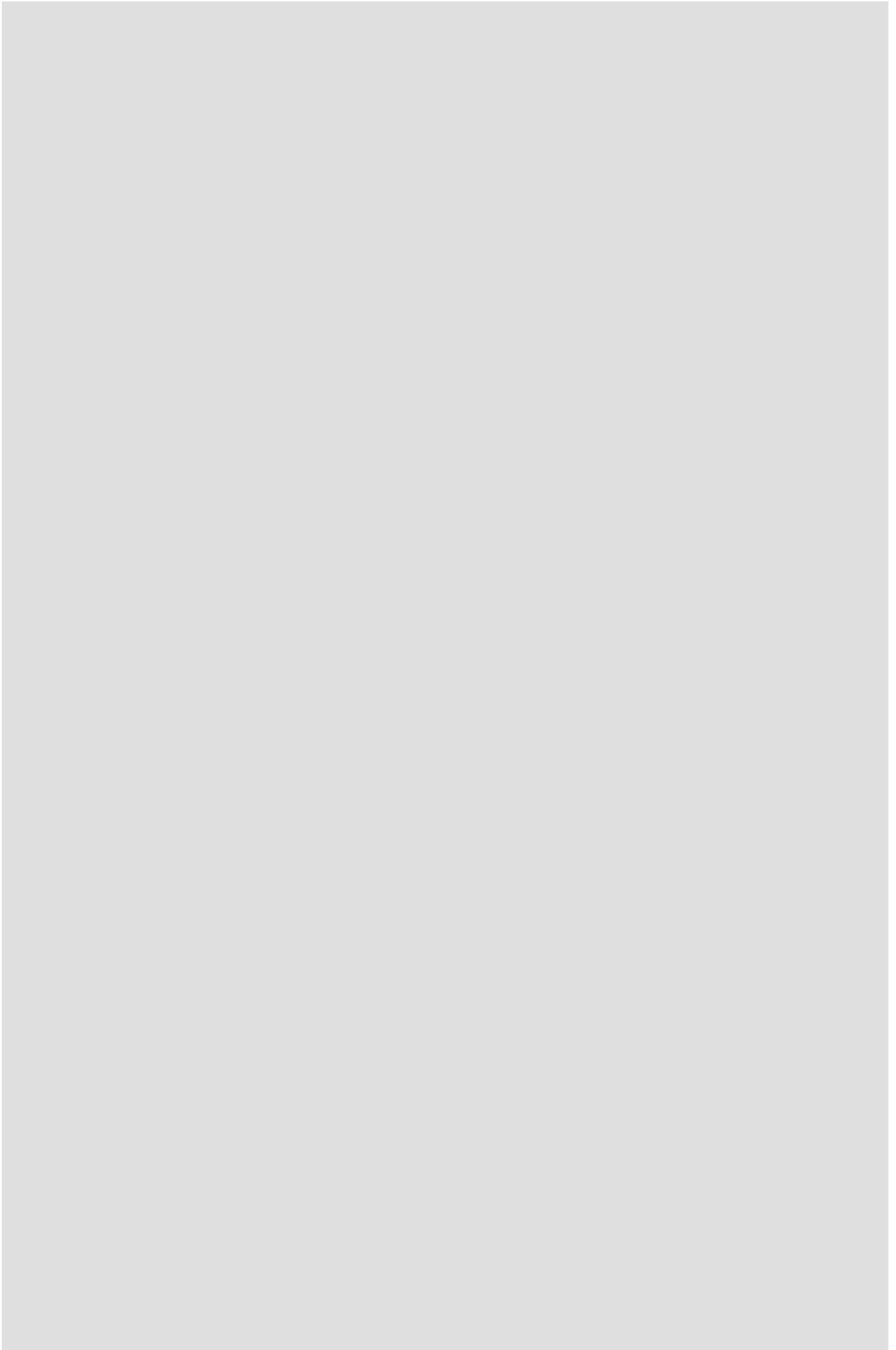


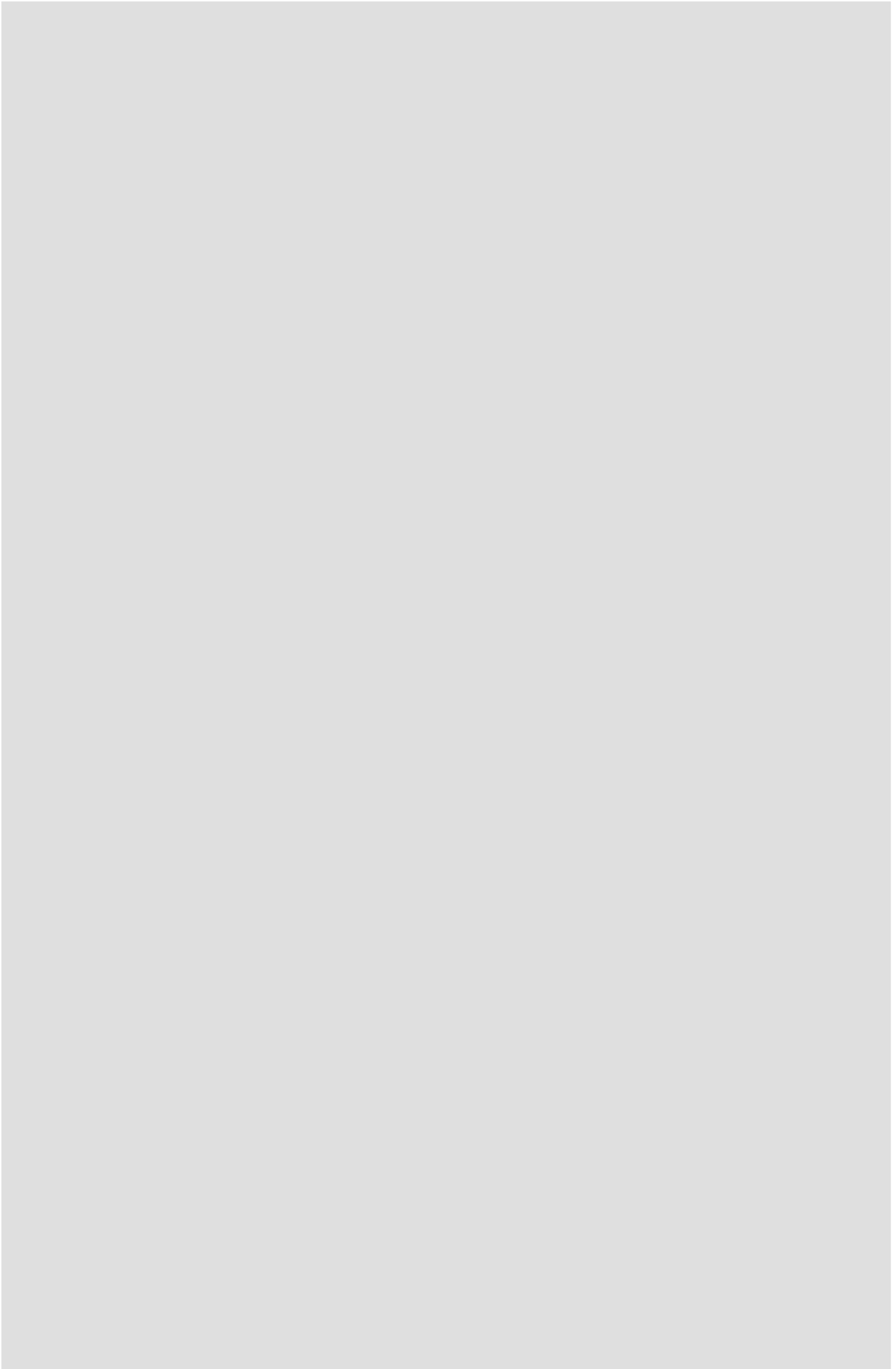


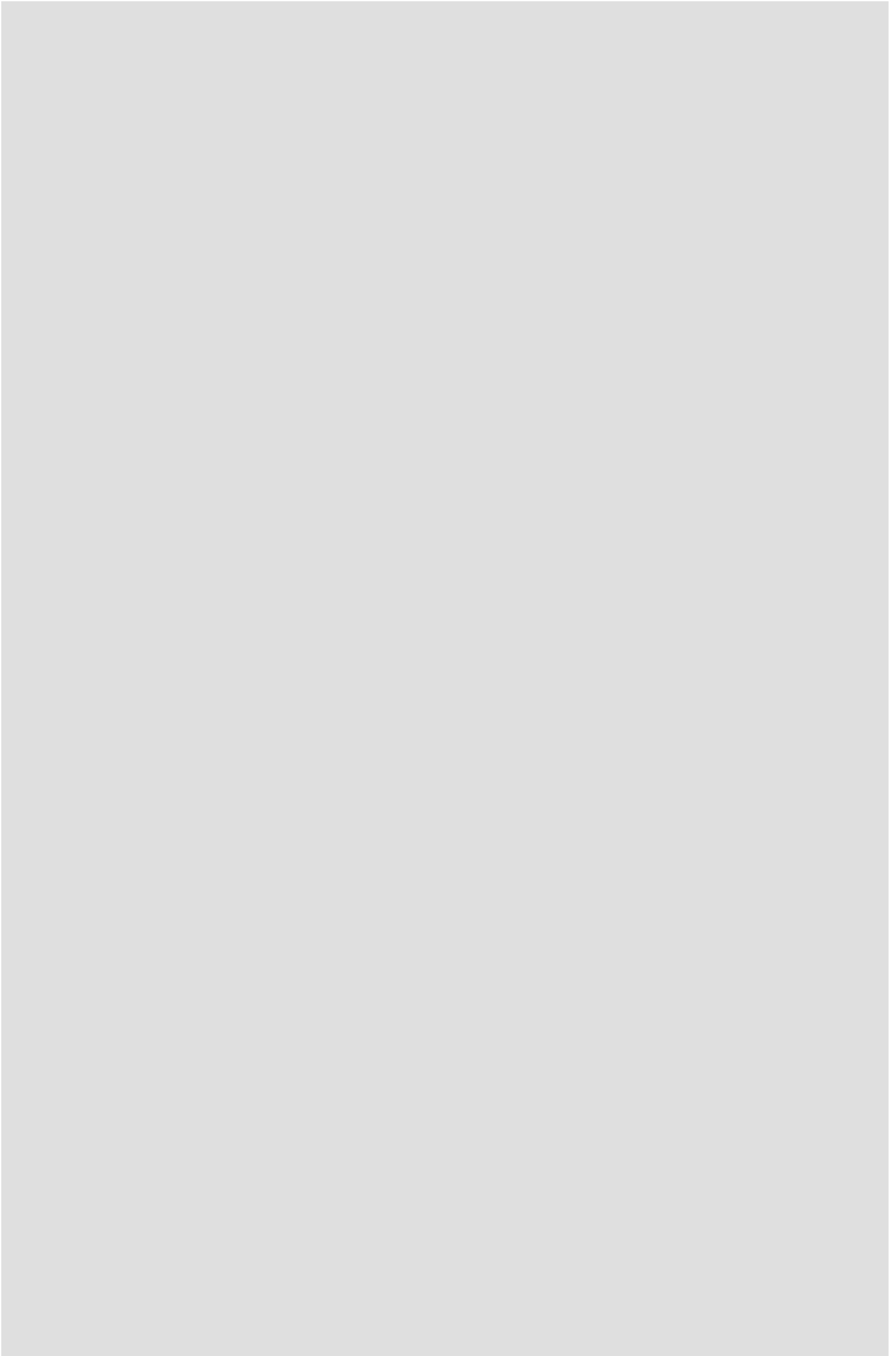


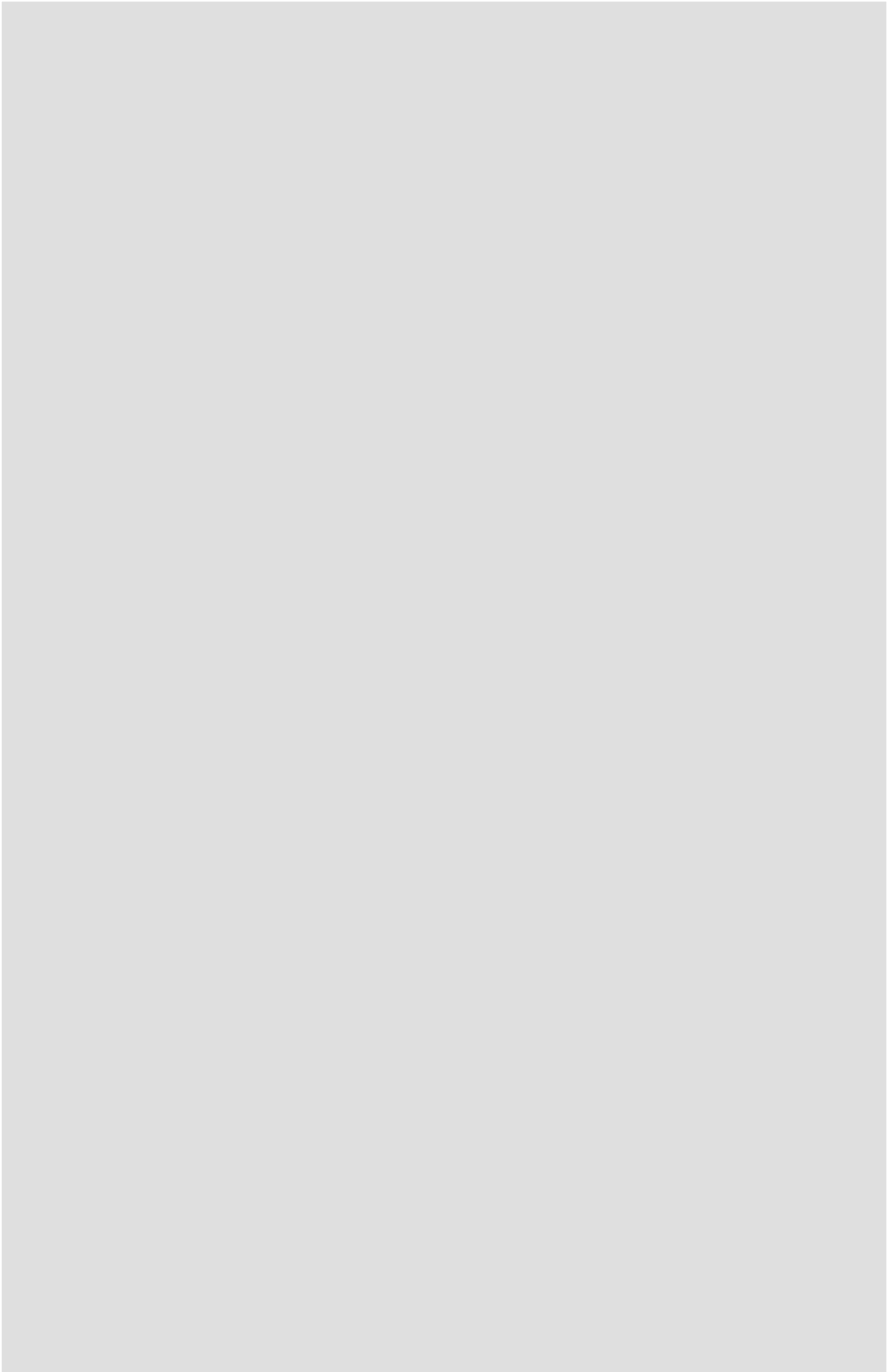












**Abigail King**

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**From:** Brett McDermott [REDACTED]  
**Sent:** Wednesday, 12 February 2014 3:42 PM  
**To:** Abigail King; Abigail King; [REDACTED]  
**Cc:** Erica Lee; Tim Davidson  
**Subject:** RE: Appointments for [REDACTED]

Thanks Abby,  
If you d/w [REDACTED] I'll follow up with Stephen about contact details.  
cheers

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**From:** Abigail King [REDACTED]  
**Sent:** Wednesday, 12 February 2014 12:07 PM  
**To:** McDermott, Brett; King, Abigail; [REDACTED]  
**Cc:** Lee, Erica; Davidson, Tim  
**Subject:** RE: Appointments for [REDACTED]

I am happy for this plan. We will need to clarify psychiatrist's role etc so [REDACTED] and I will discuss. Do we have a time frame for contacting [REDACTED] ?  
Regards,  
Abby

---

**From:** Brett McDermott [REDACTED]  
**Sent:** Wednesday, 12 February 2014 11:54 AM  
**To:** Abigail King; Abigail King; [REDACTED]  
**Cc:** Erica Lee; Tim Davidson  
**Subject:** Appointments for [REDACTED]  
**Importance:** High

Hi Abbi and [REDACTED]  
See below – essentially a request from the [REDACTED] team for this [REDACTED] patient and lives on the [REDACTED], to attend [REDACTED] clinic. Happy to talk about this but in brief

- I have d/w DR Anne Brennan who feels this anxious [REDACTED] will not be an issue at clinic
- [REDACTED]
- [REDACTED] is highly anxious and is demanding [REDACTED] also is seen by a [REDACTED] team
- And the request is to [REDACTED]

The [REDACTED]

In the spirit of helping the [REDACTED] I feel the request is reasonable. It's over to you. Please get back to me about this issue  
Cheers,  
Brett.

---

**From:** Stephen Stathis [REDACTED]  
**Sent:** Friday, 31 January 2014 4:54 PM  
**To:** McDermott, Brett; Judi Krause  
**Subject:** FW: Appointments for [REDACTED]

Dear Judi and Brett

I've just managed to have a phone call with Leanne. Brett, not sure if you have been briefed on this young

13/02/2014

person. [REDACTED] patient. [REDACTED] has been very vocal. Diagnosis of [REDACTED]. Dynamics at home - I can fill in the details at another time.

We need to get some clarification whether [REDACTED] plans to attend the school five days a week (Leanne didn't know) If so, [REDACTED] does make a good point for [REDACTED] accessing [REDACTED] (I would suggest that appointments be made during the day, where there is an expectation that [REDACTED] would make [REDACTED] way over to [REDACTED] without [REDACTED] being present)

If [REDACTED] was to attend the [REDACTED] school, would you be prepared to accept [REDACTED] at [REDACTED]? If so, do you have a policy for YP attending [REDACTED] when they have a private psychiatrist?

I don't believe we need to make a decision urgently ([REDACTED] is engaged with [REDACTED] after all). However, WM will be wanting a decision soon in order to reply to [REDACTED].

The other options would be for [REDACTED] to find separate private AH therapists and/or attend [REDACTED].

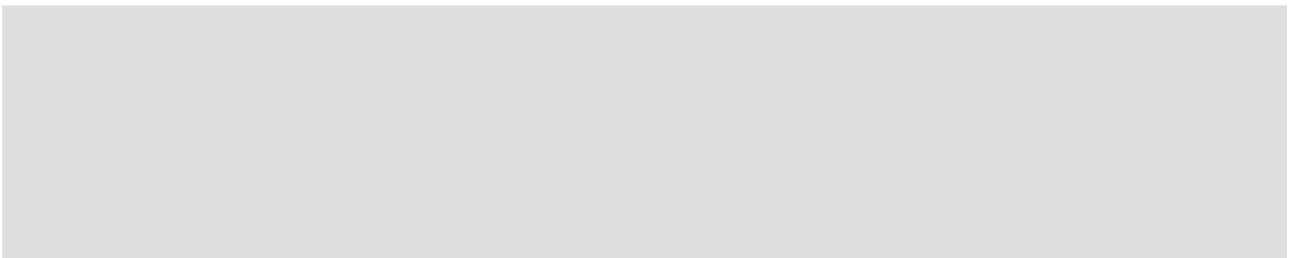
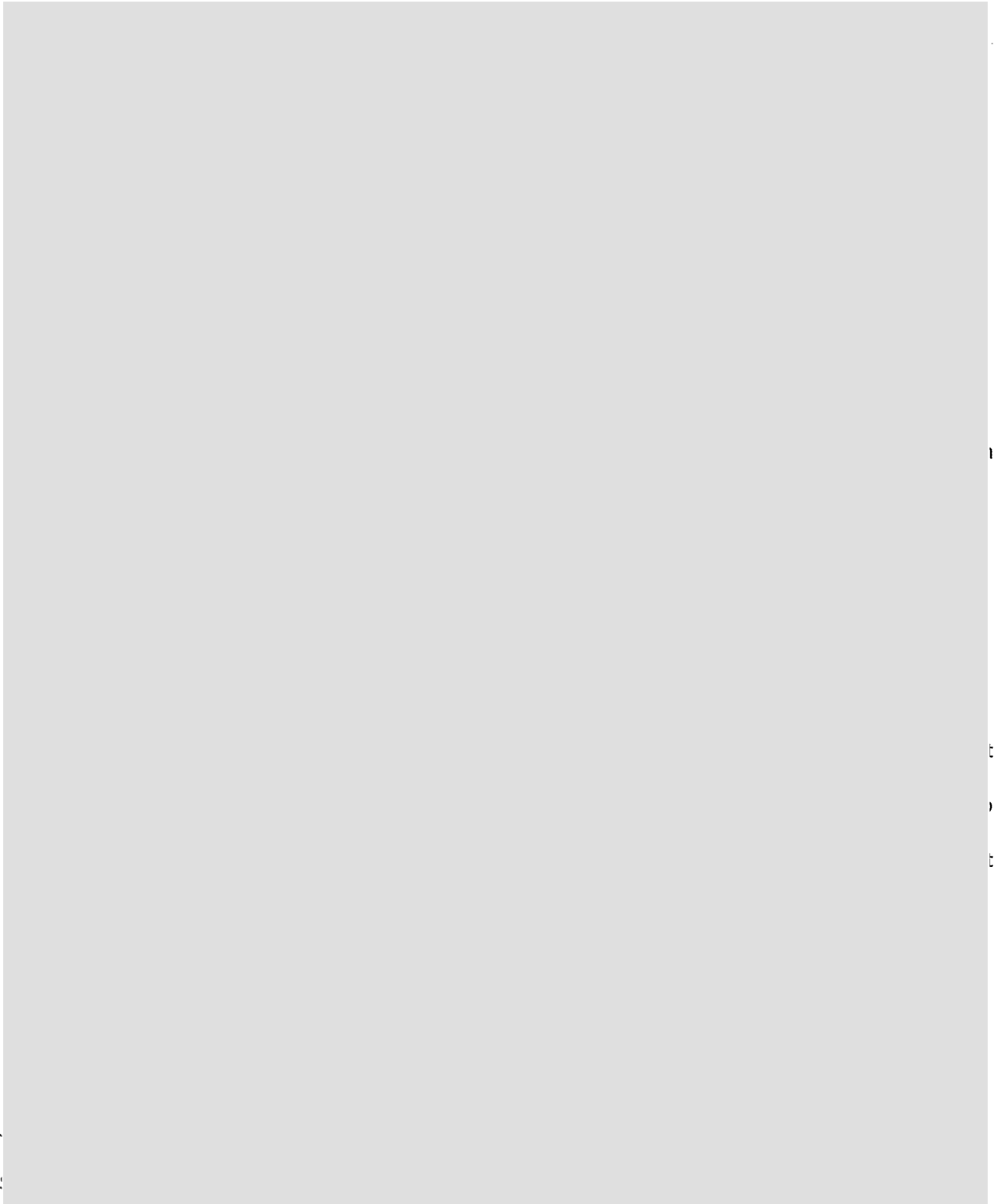
Cheers

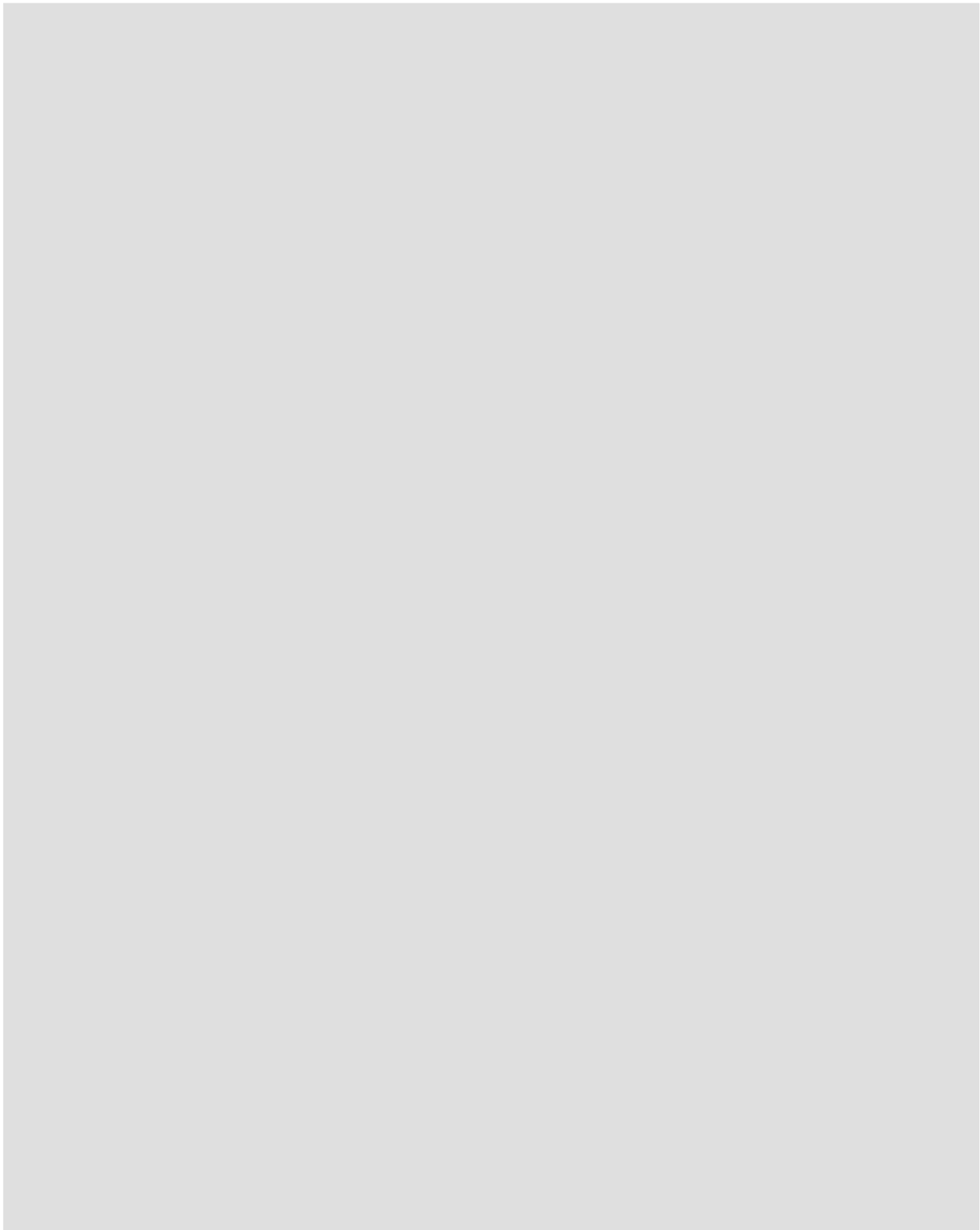
Stephen

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[REDACTED]

[REDACTED]





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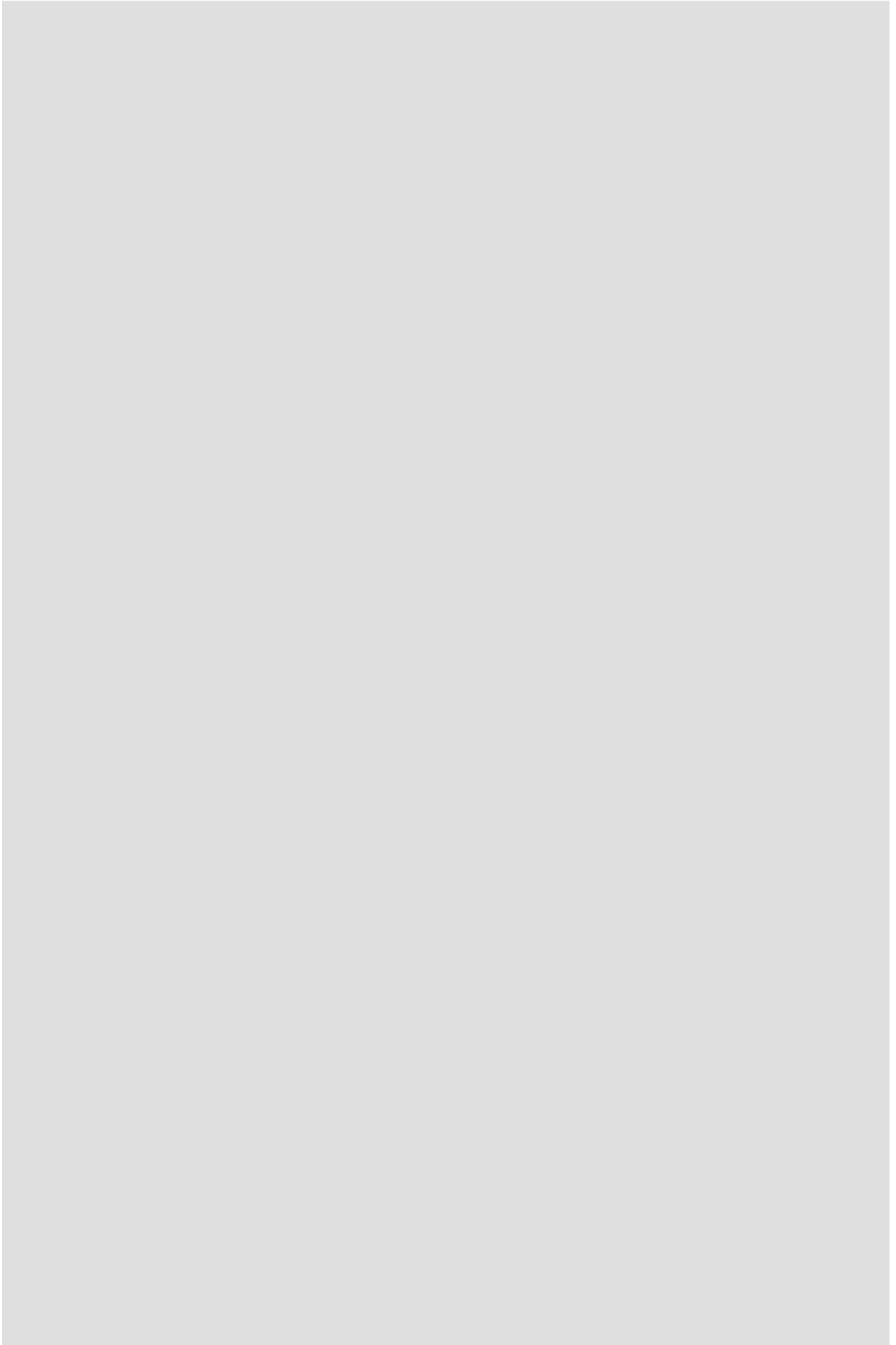
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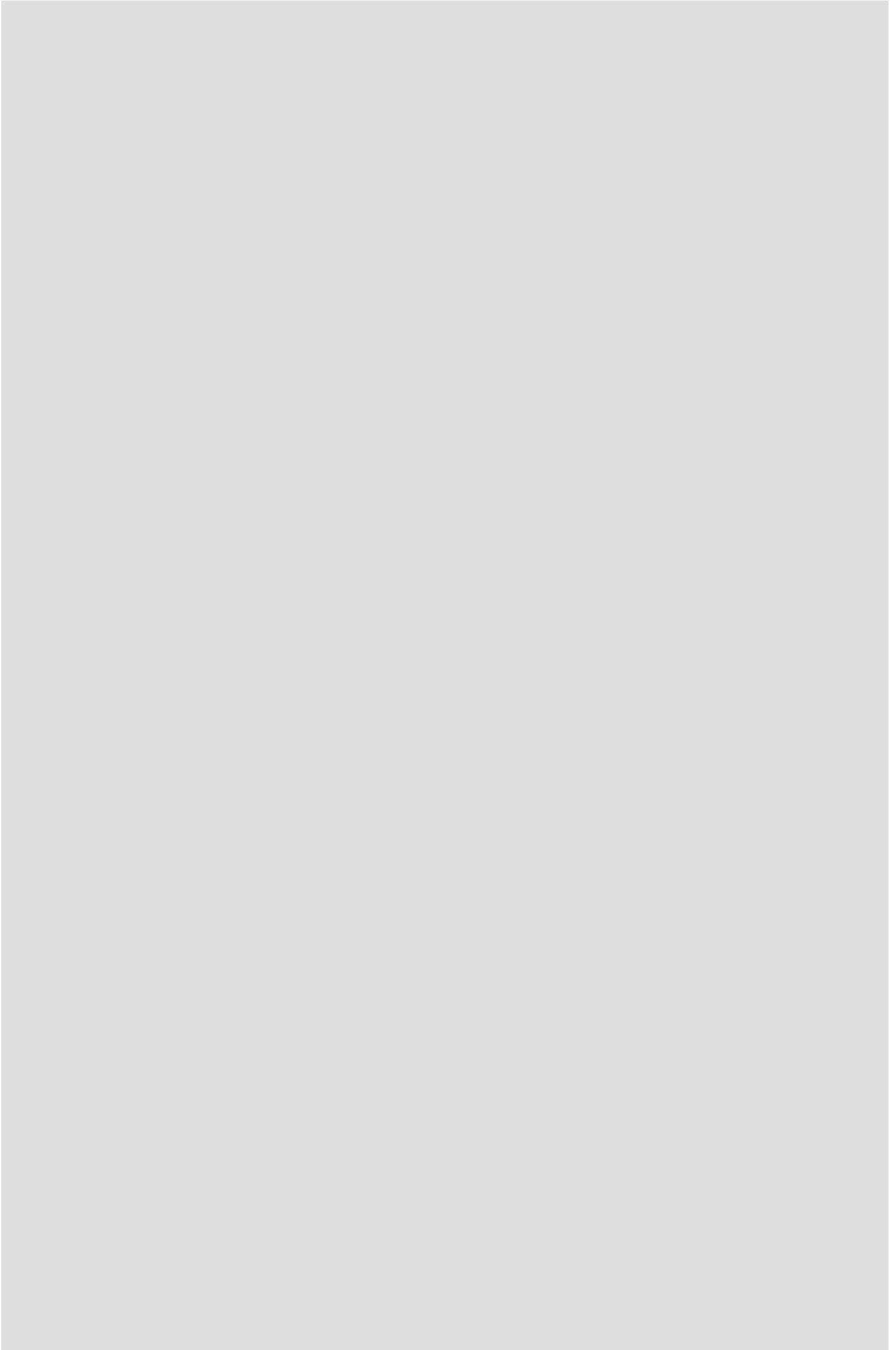
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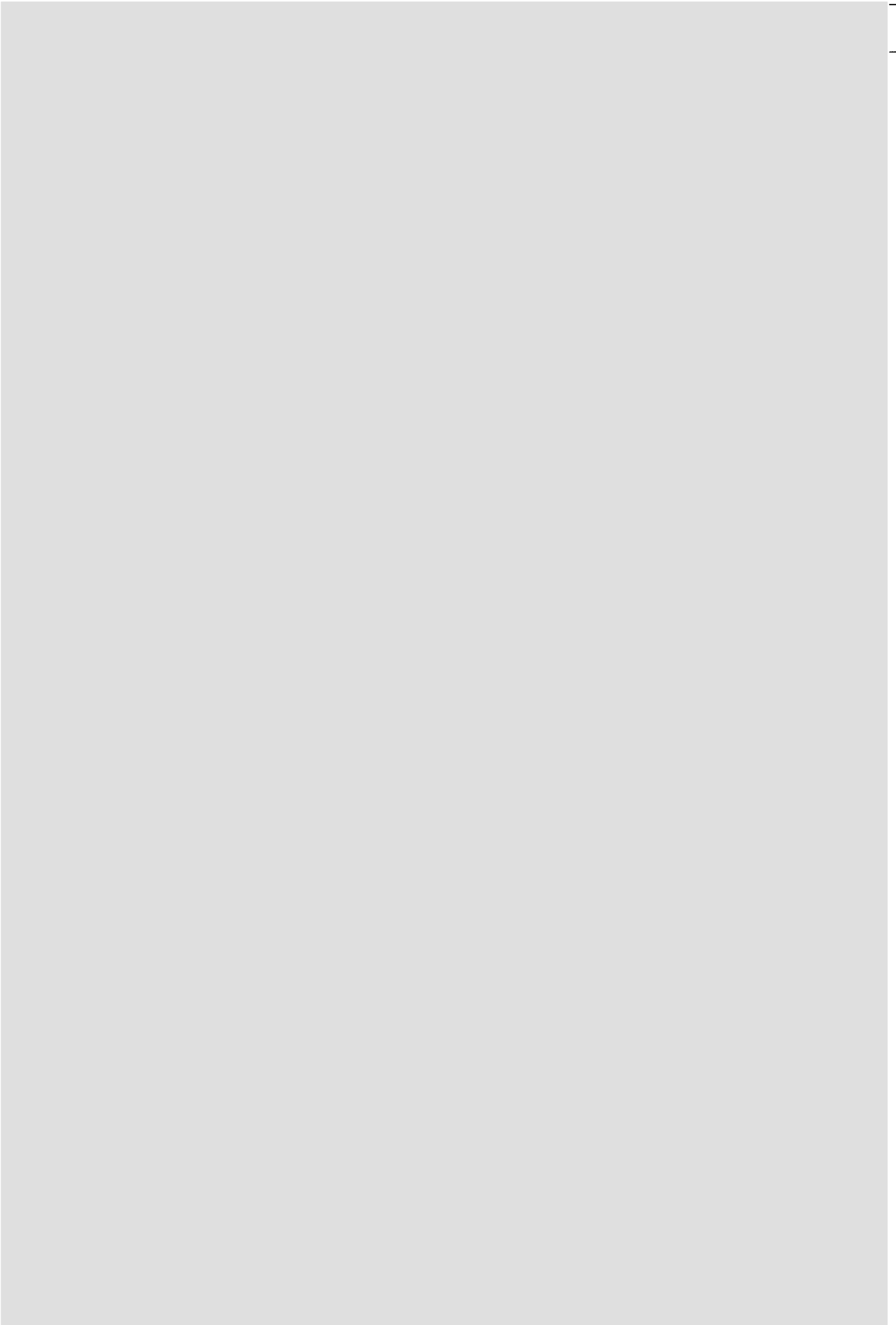


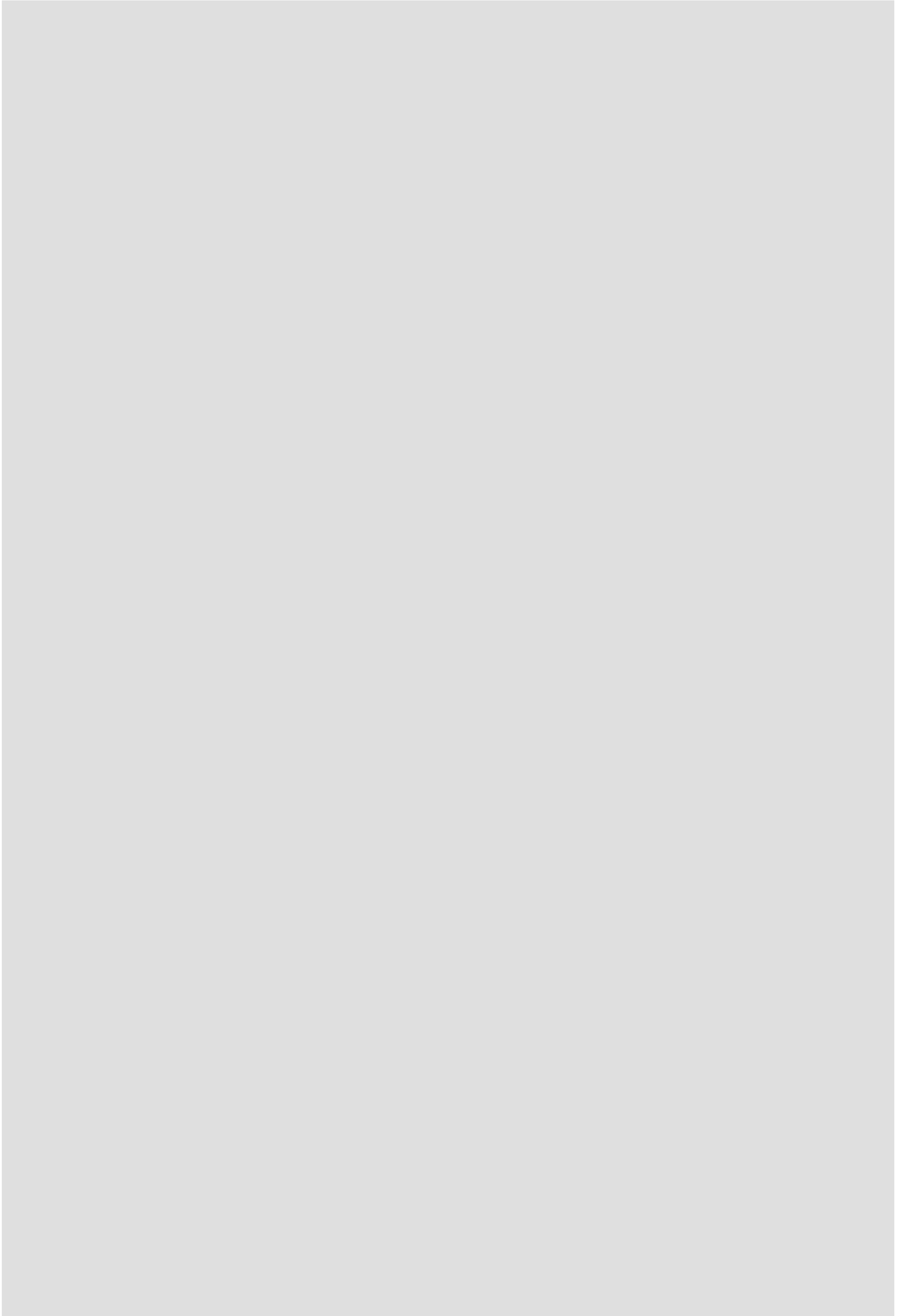
SW022

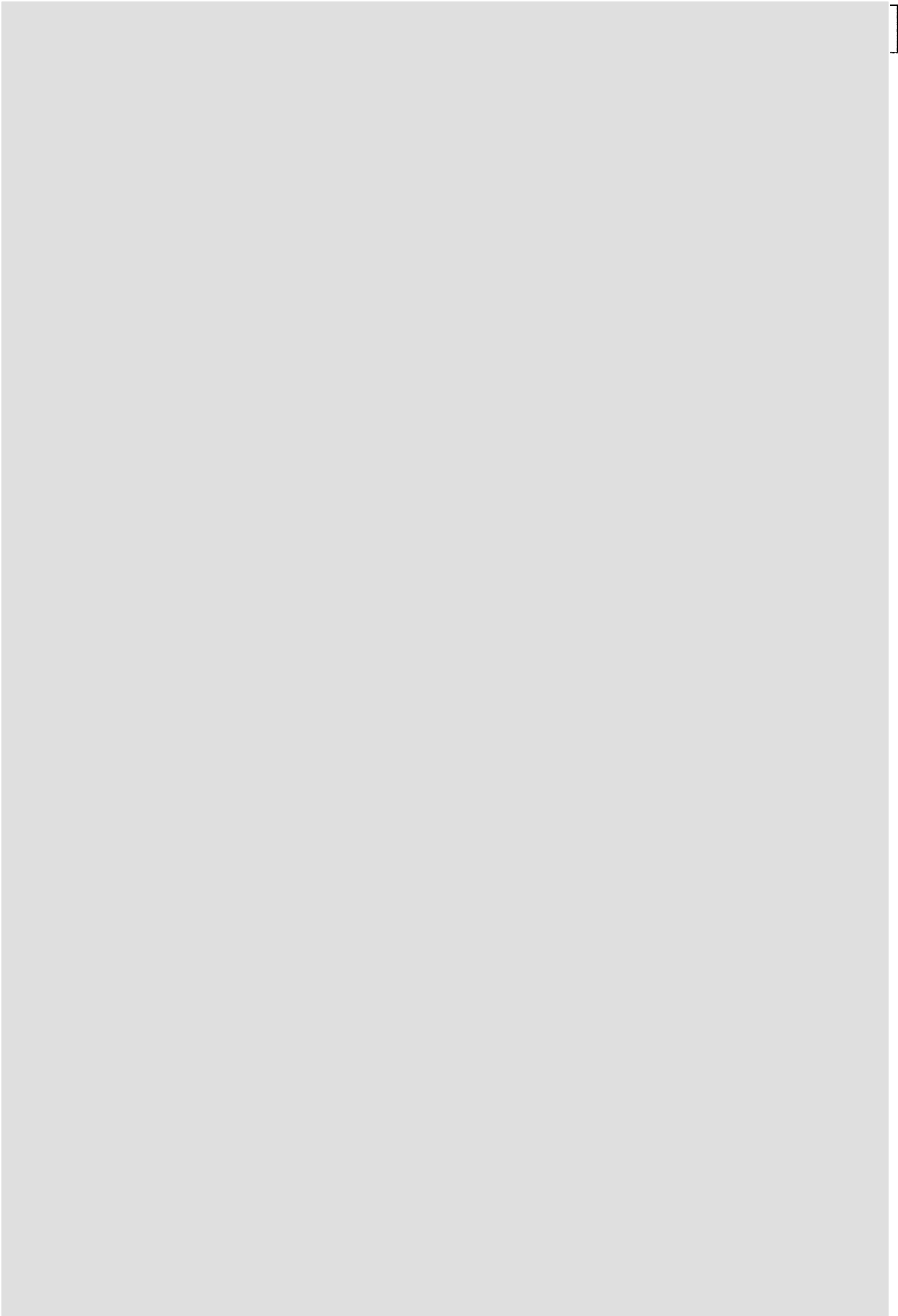




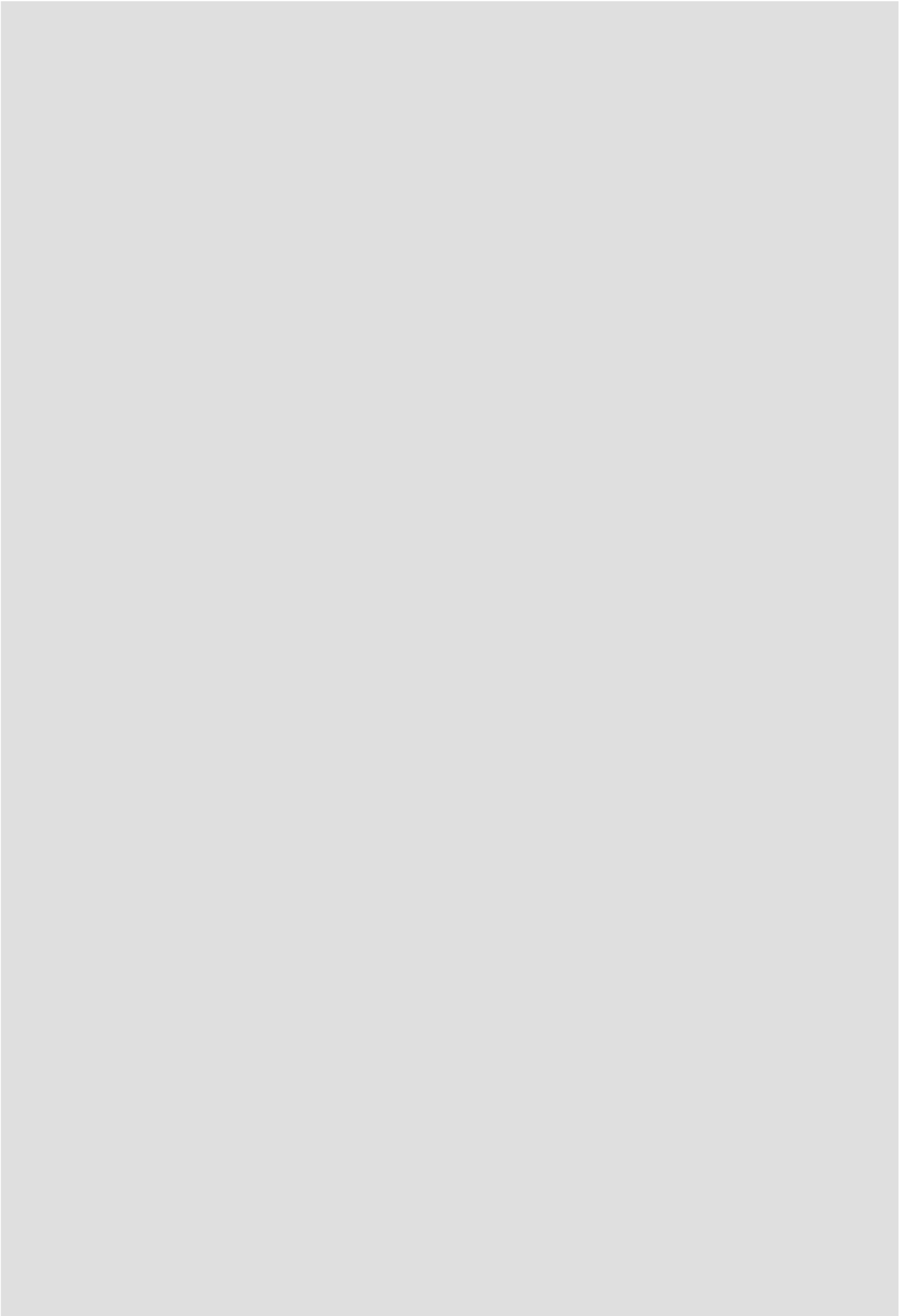
PROGRESS NOTE

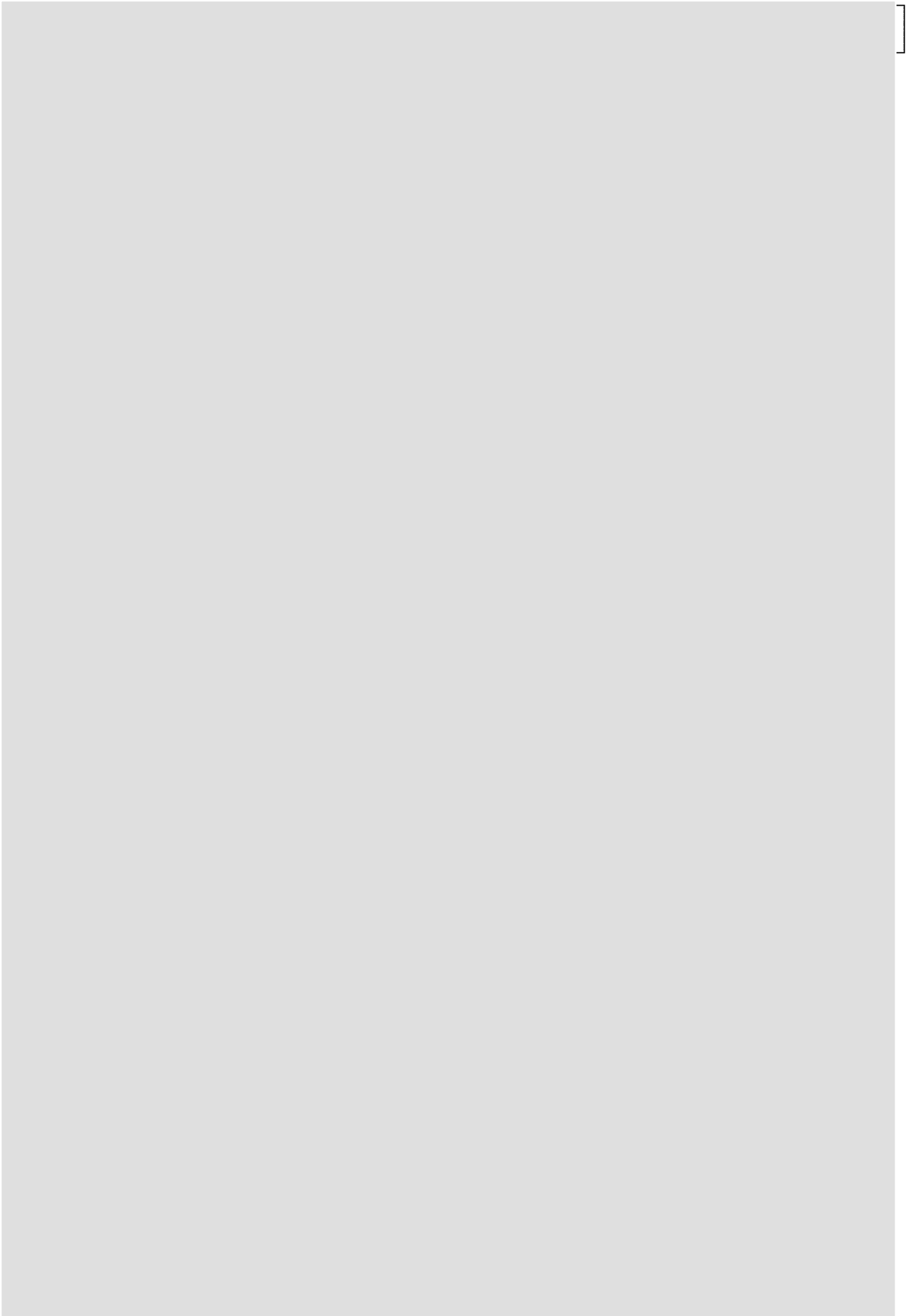


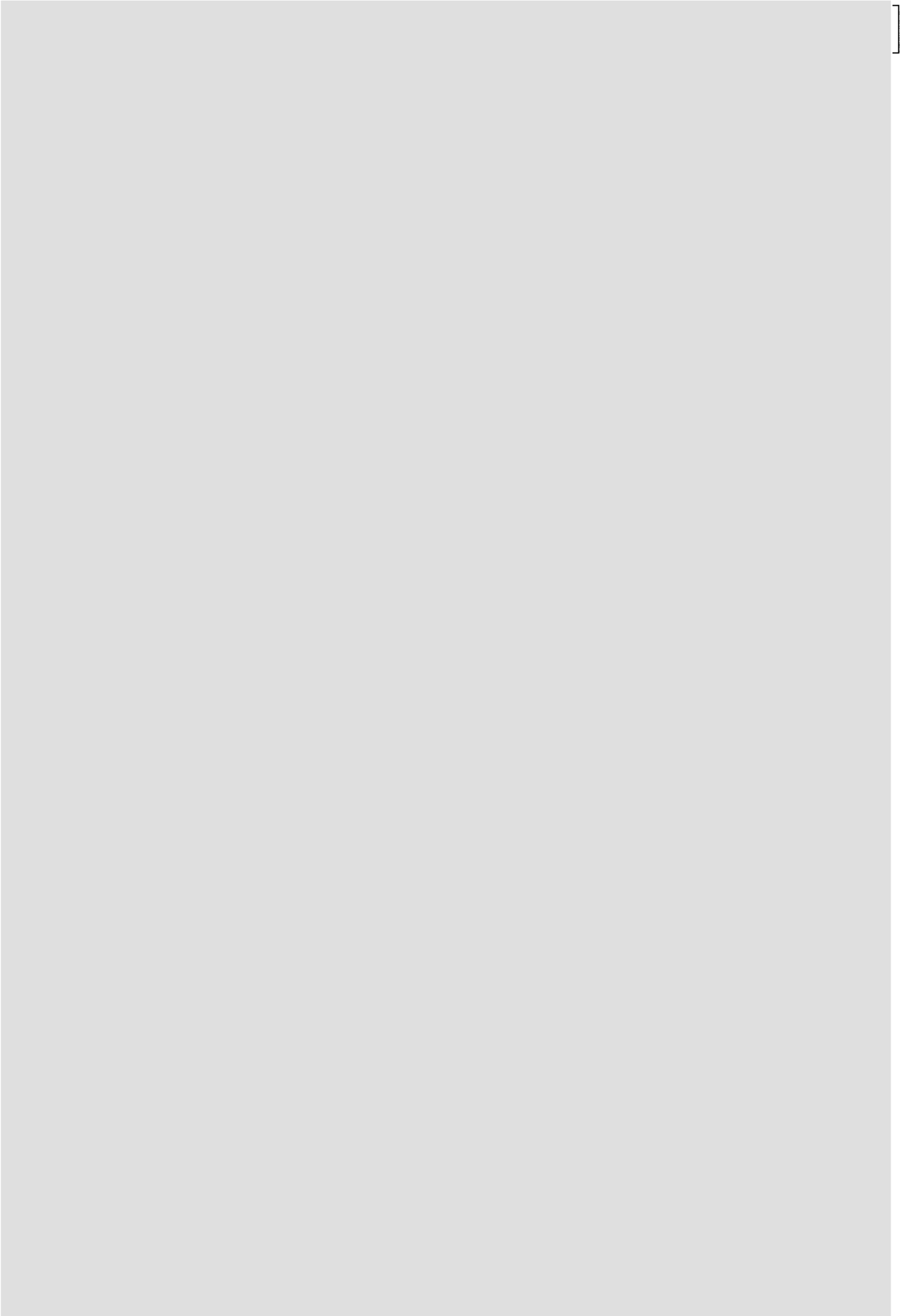


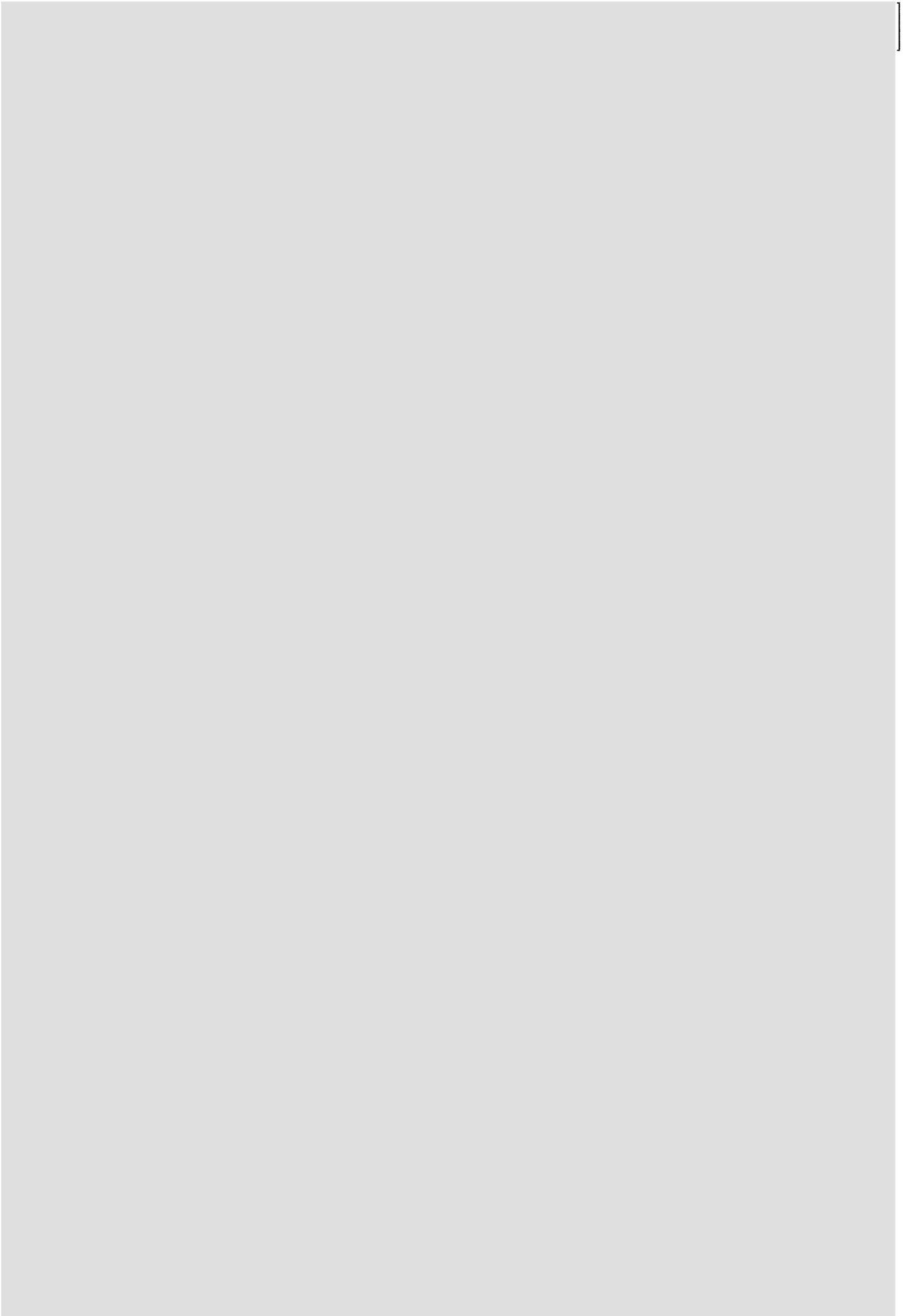


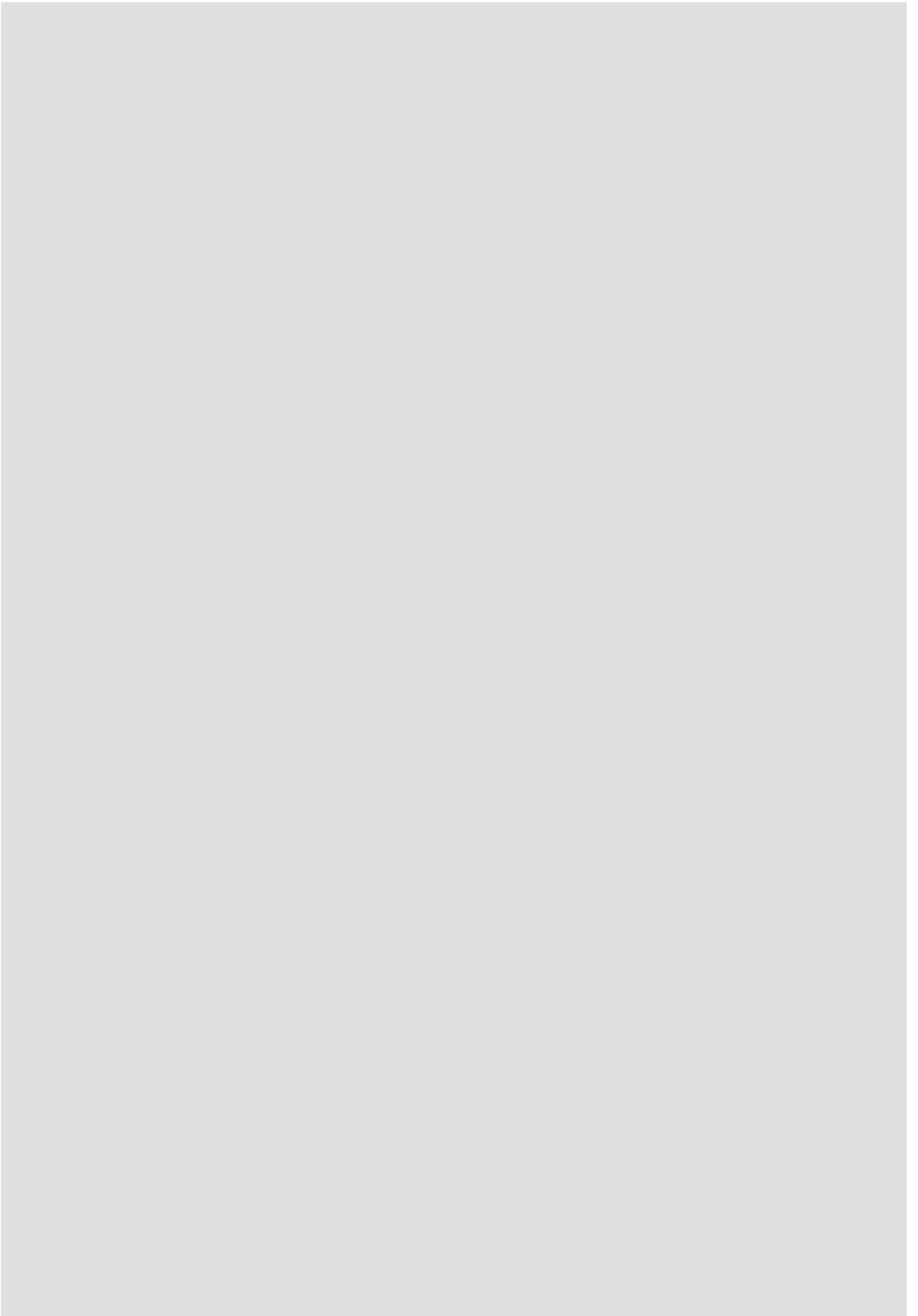


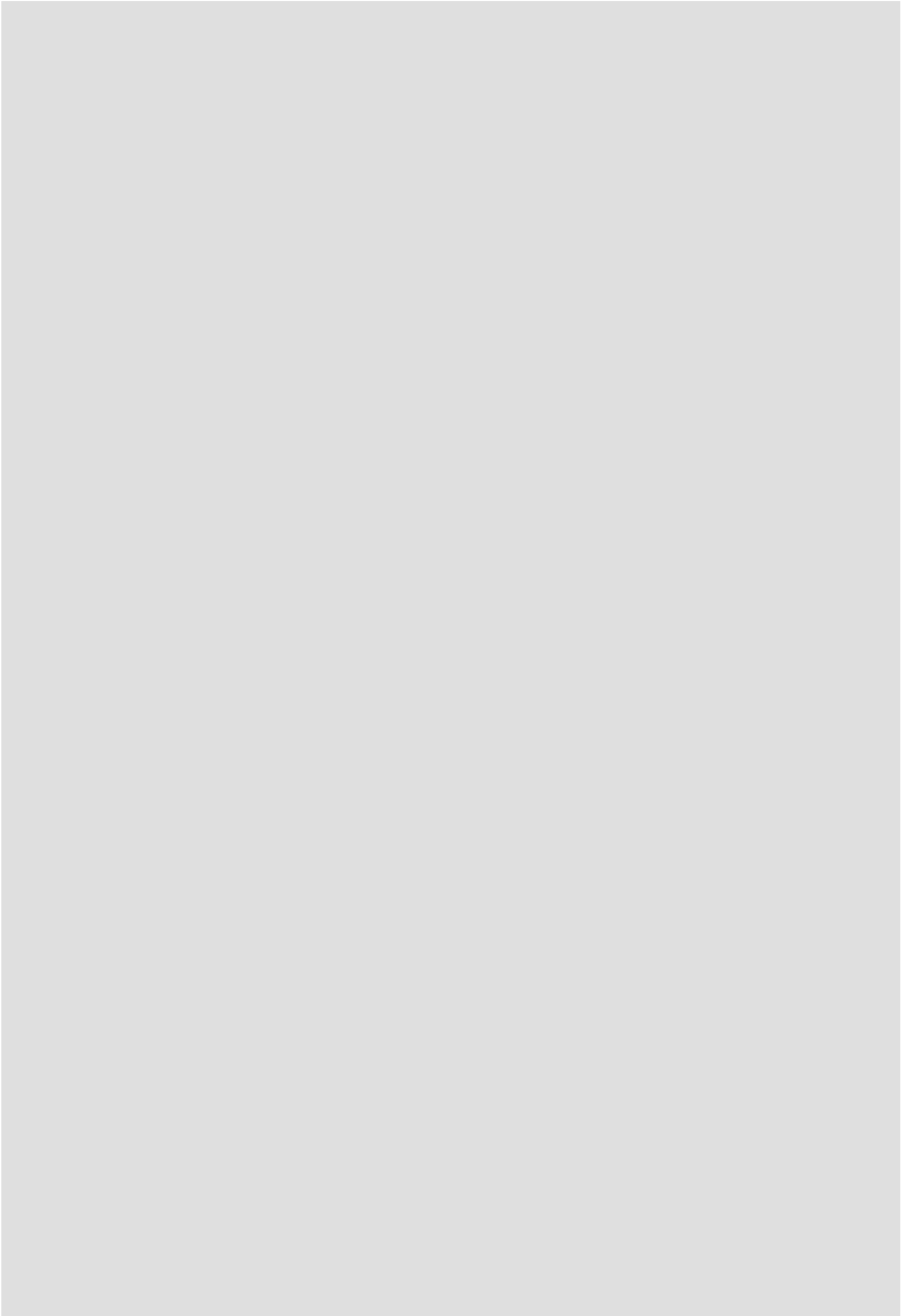


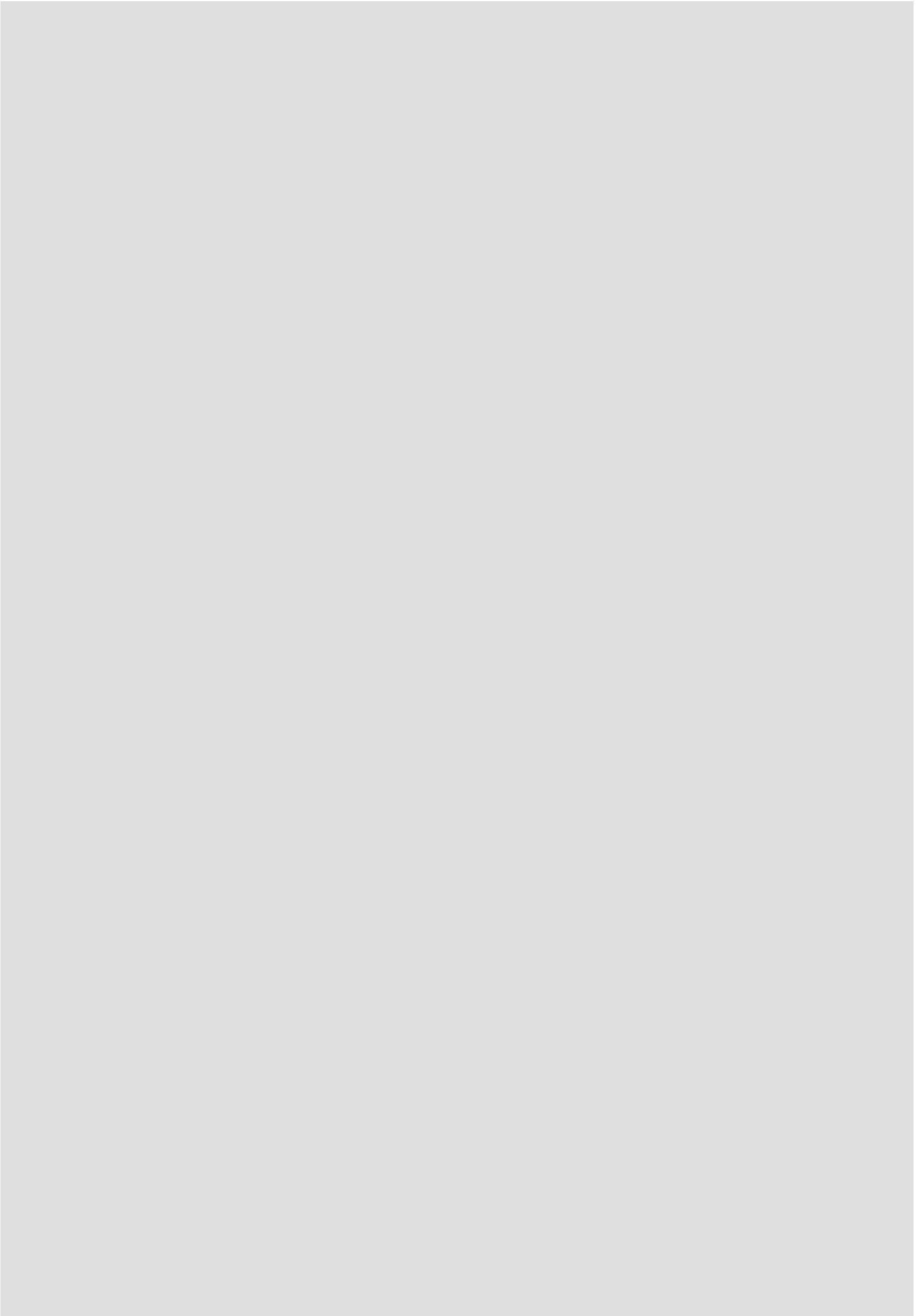


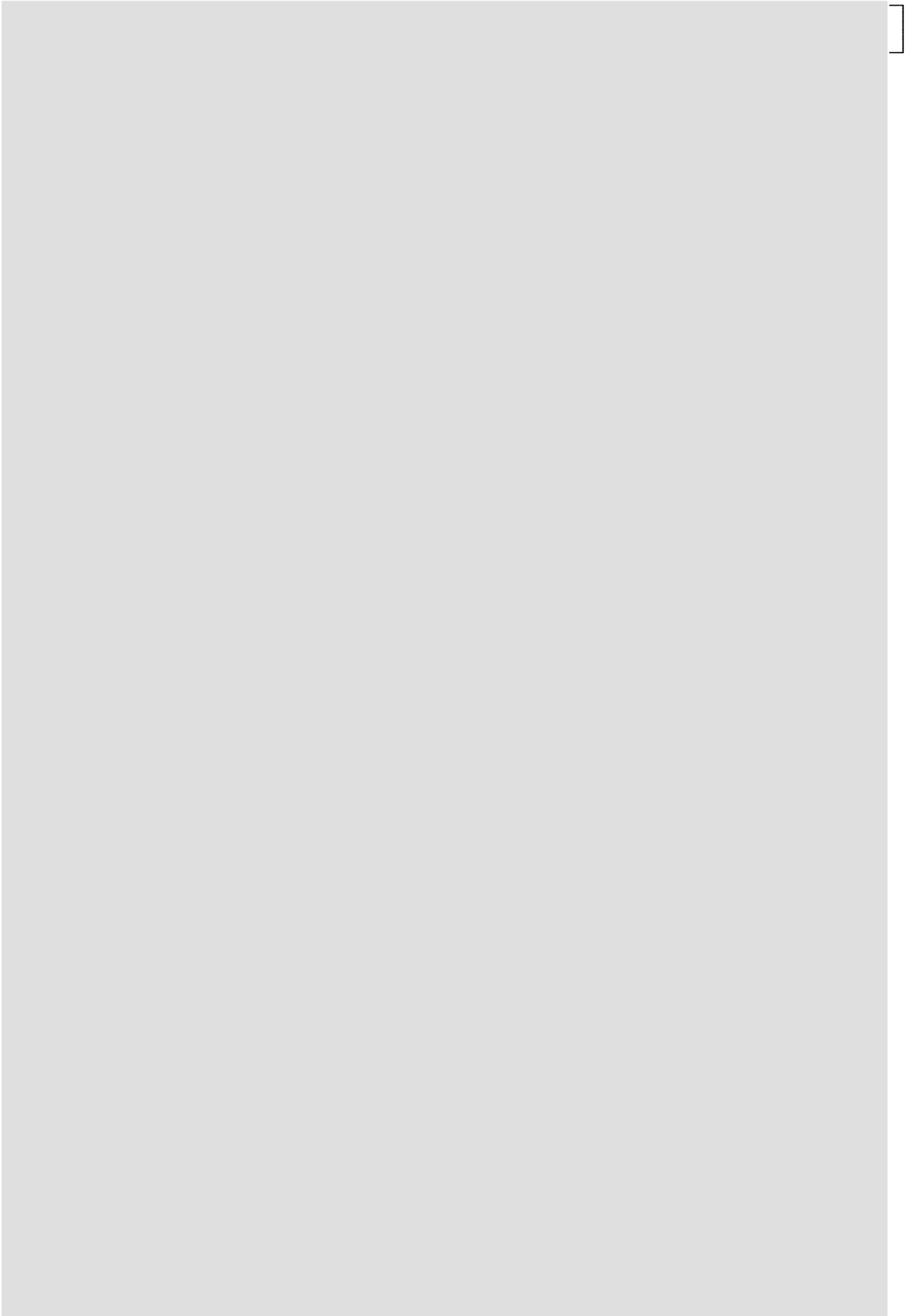




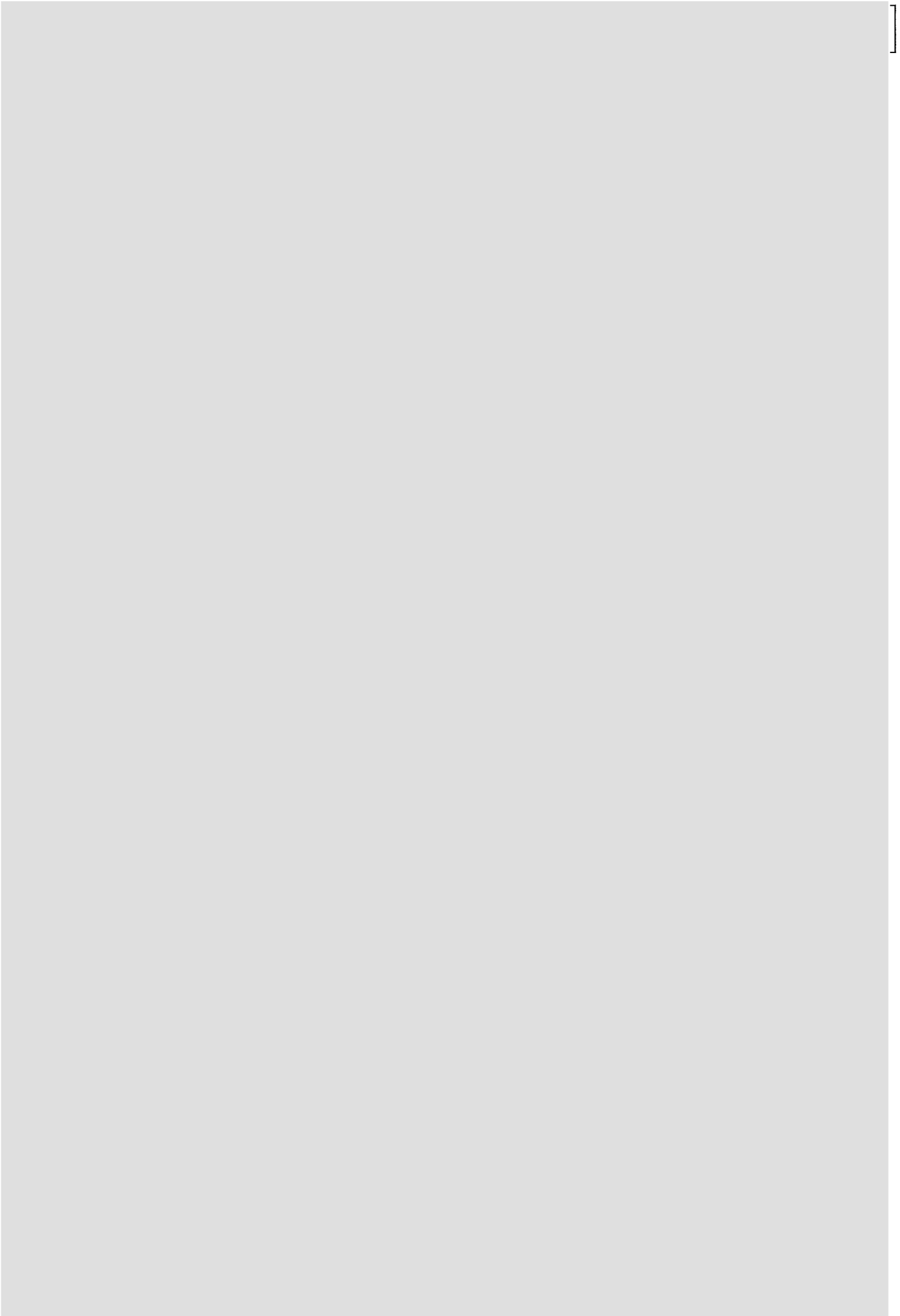


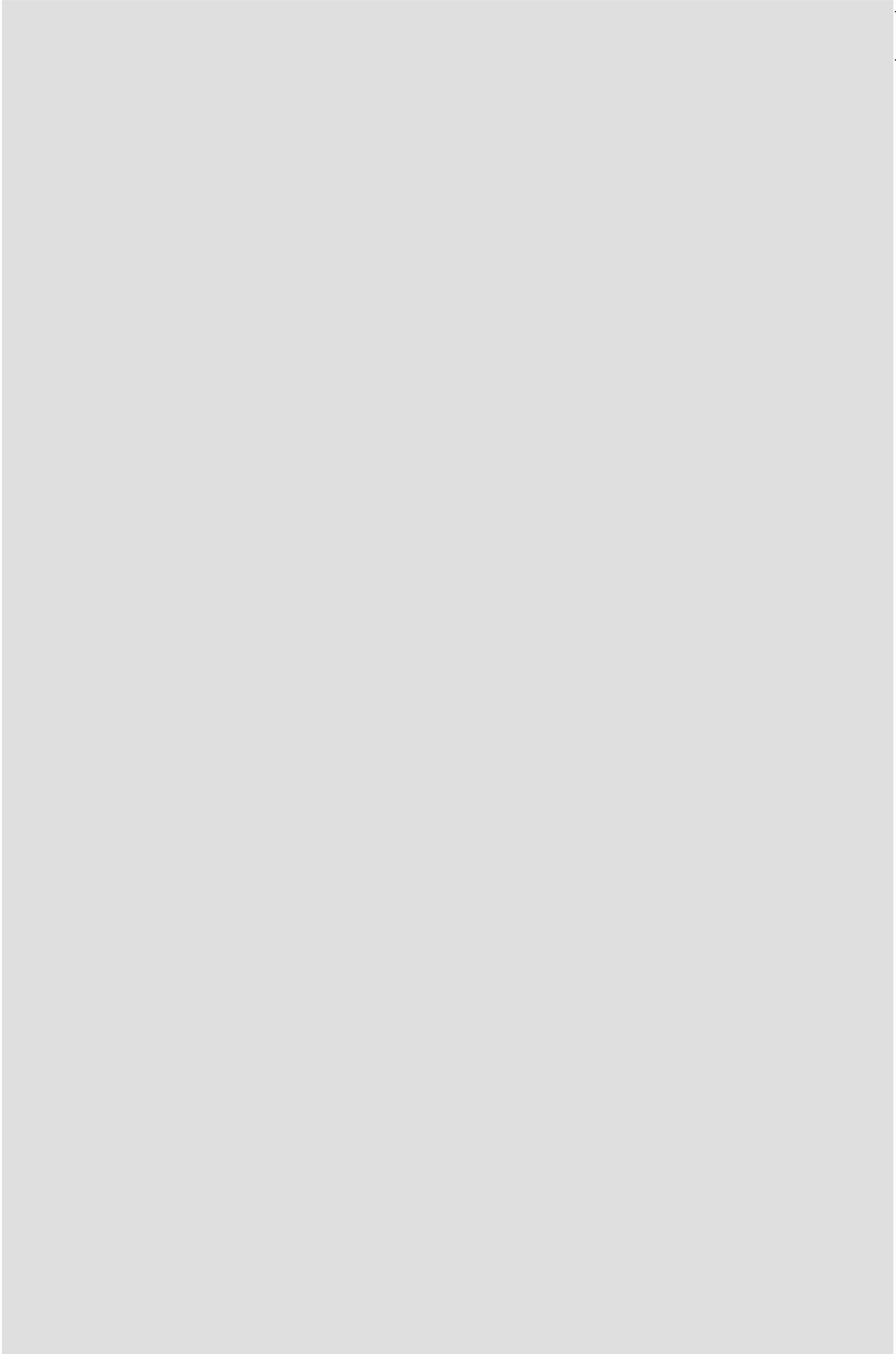


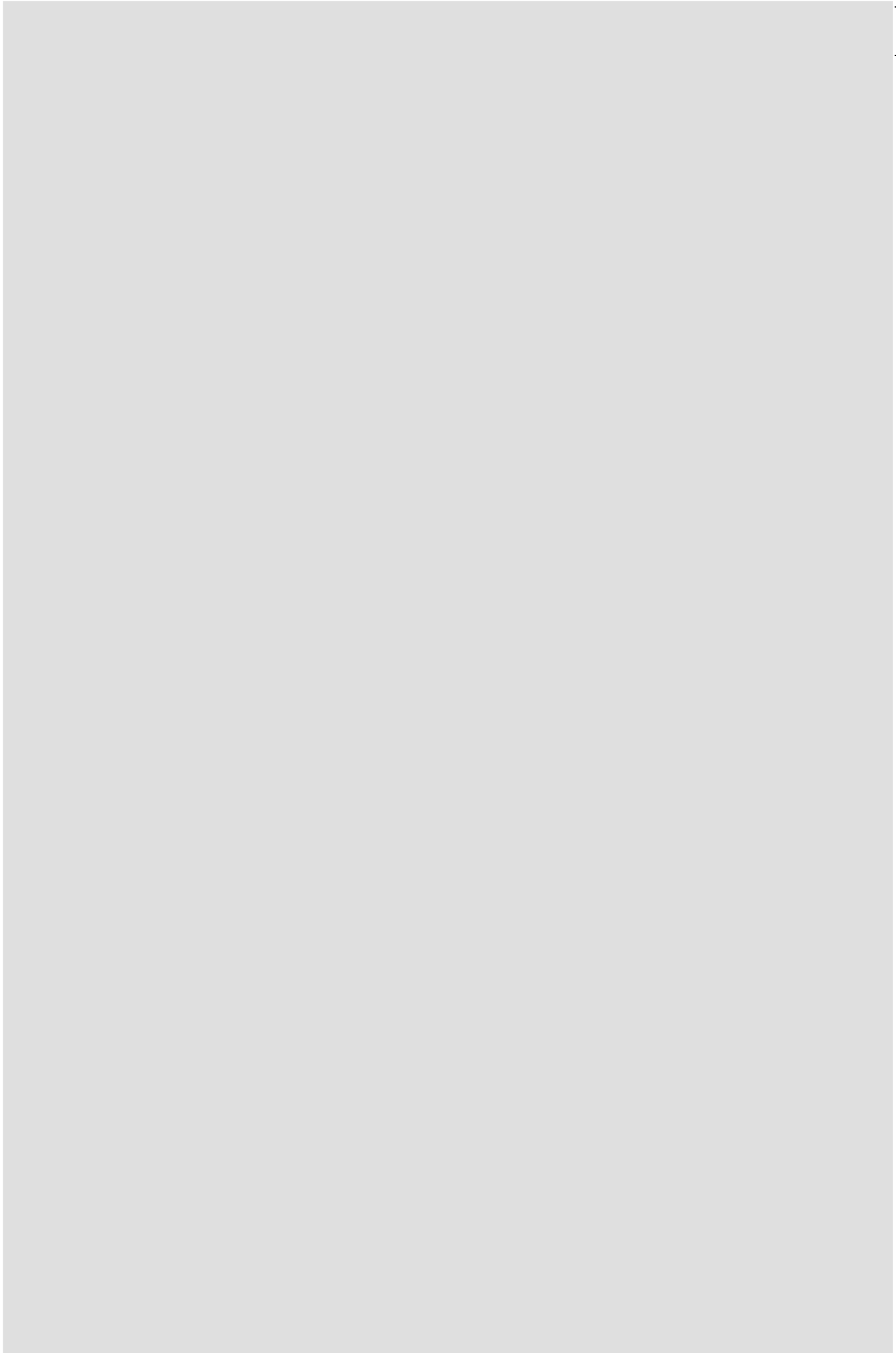


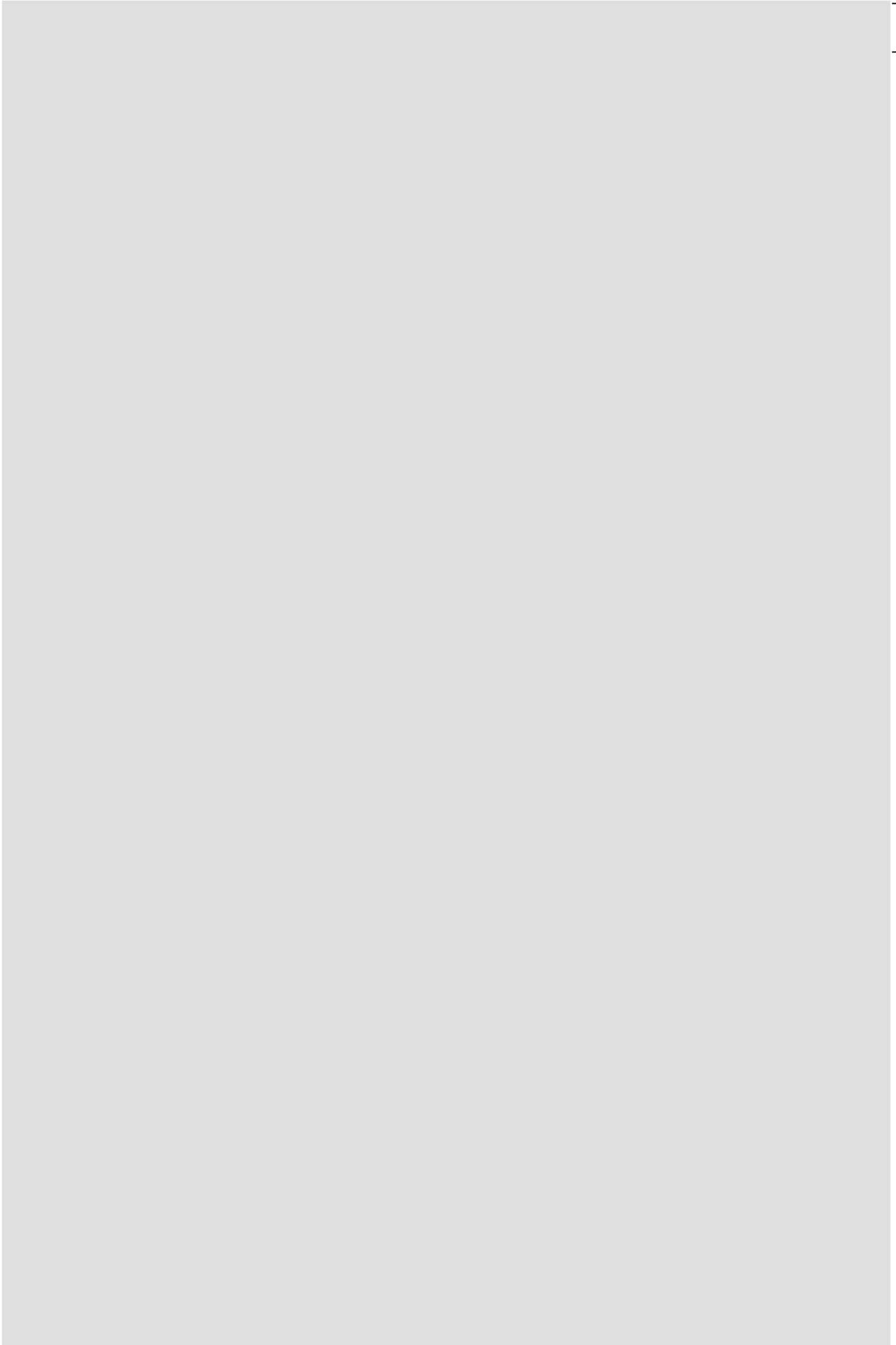


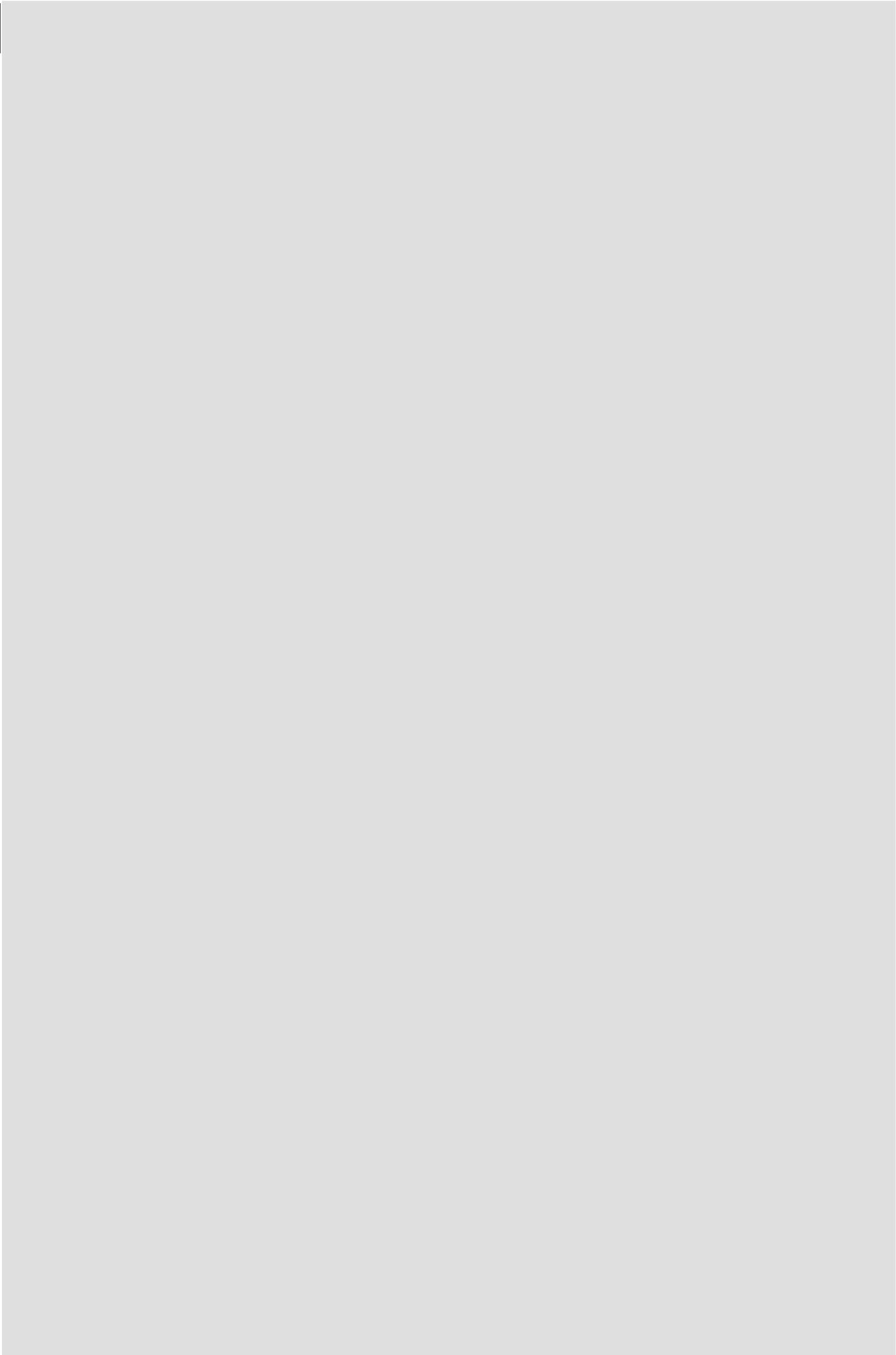


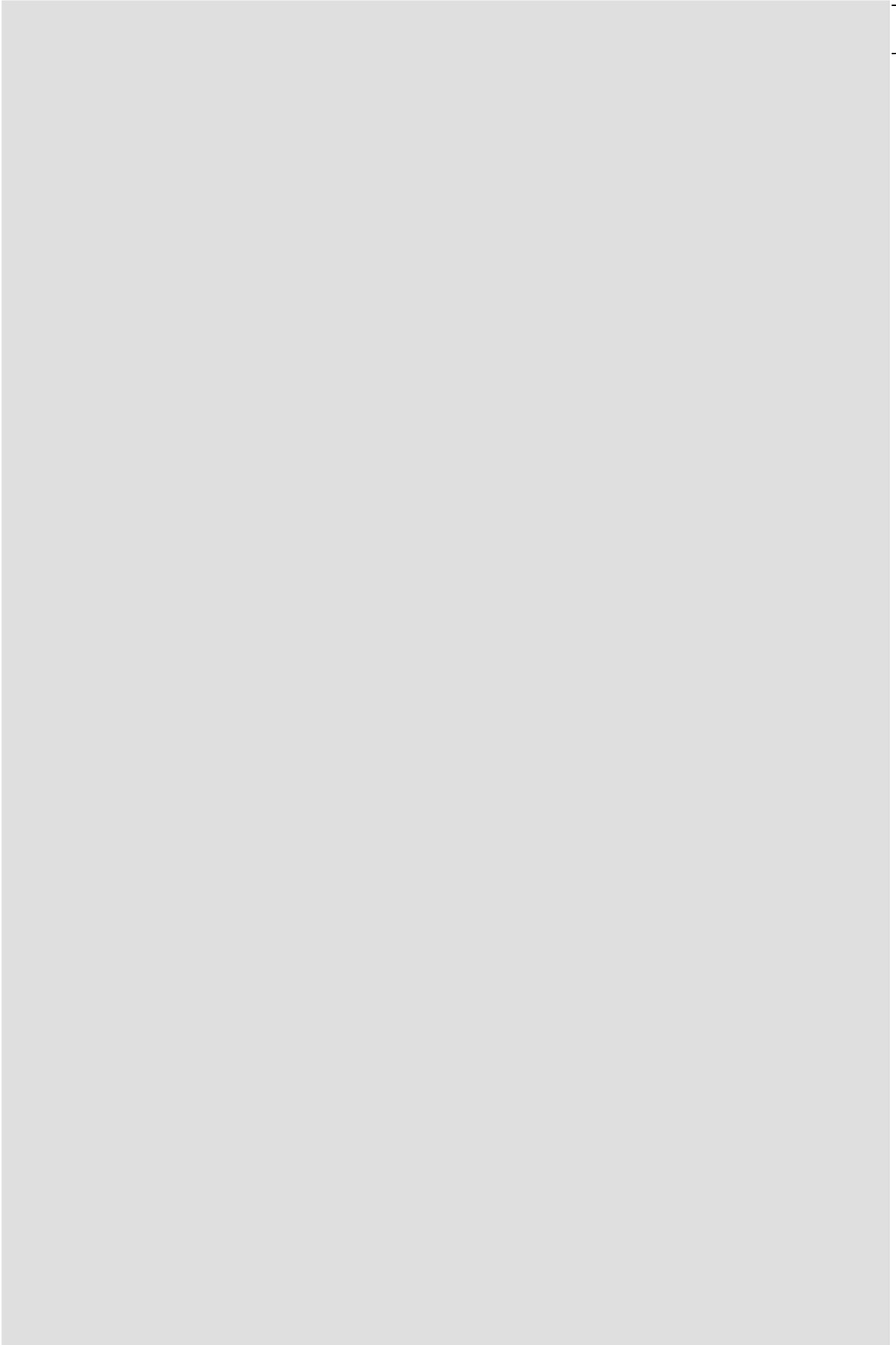


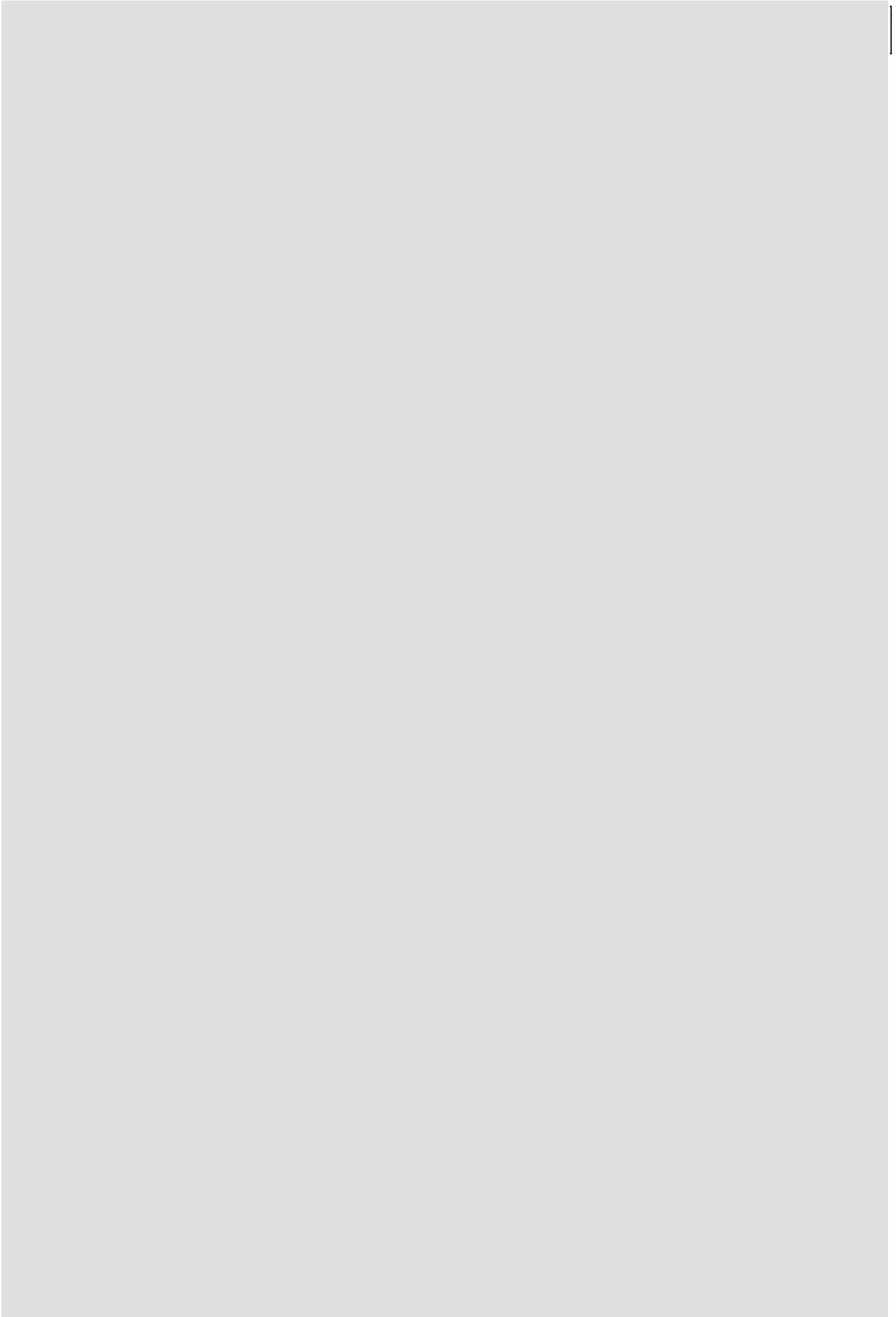


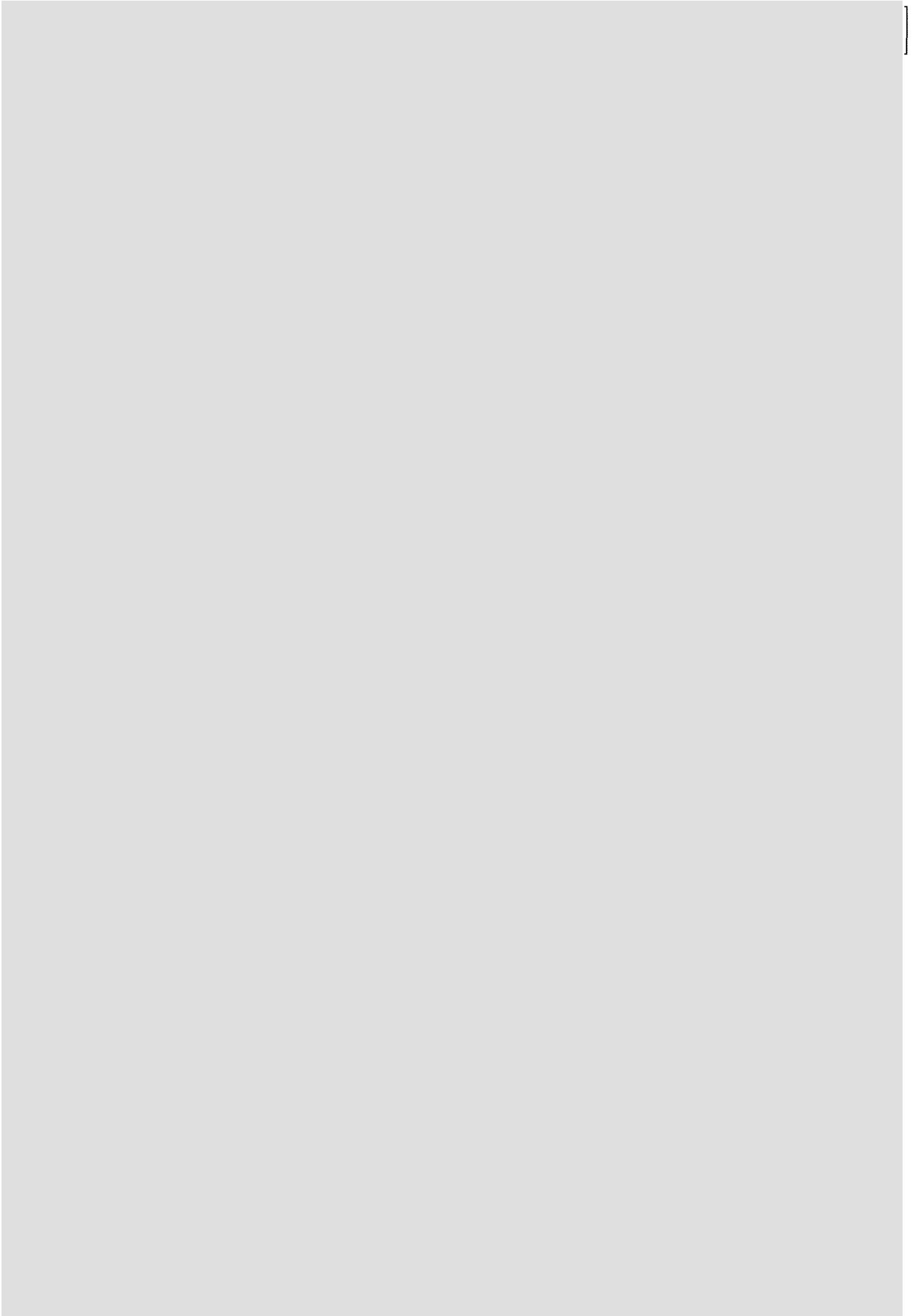




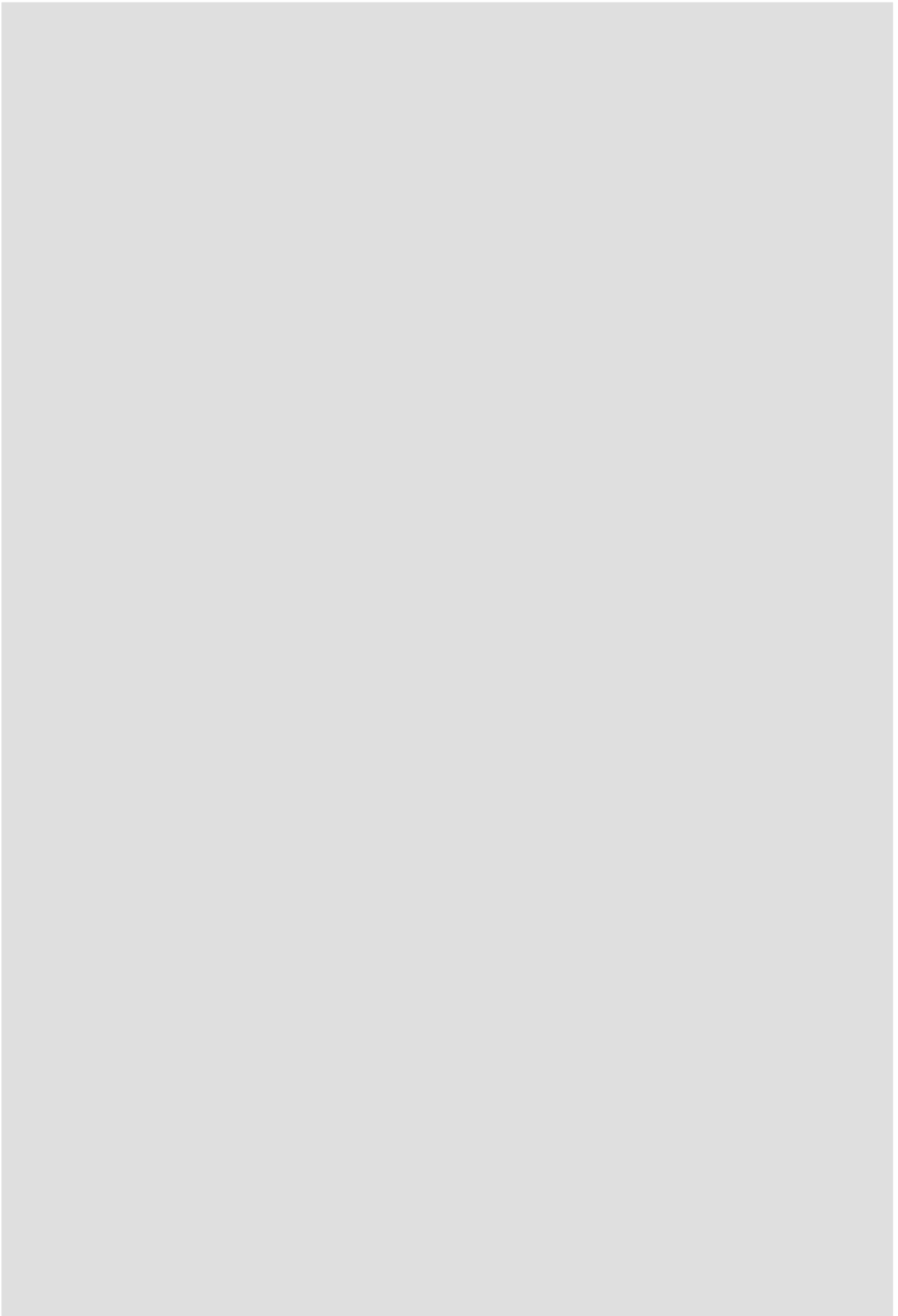


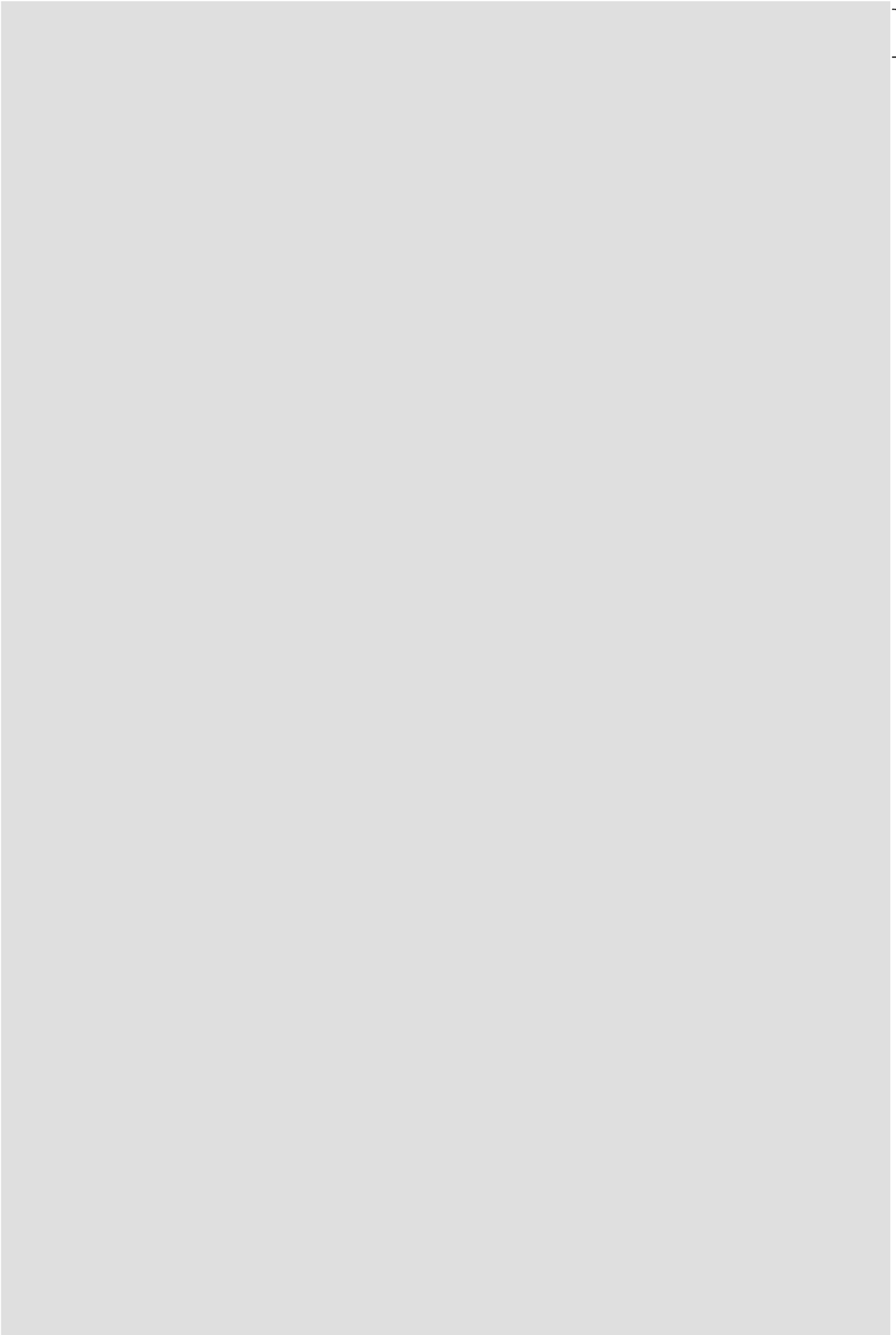




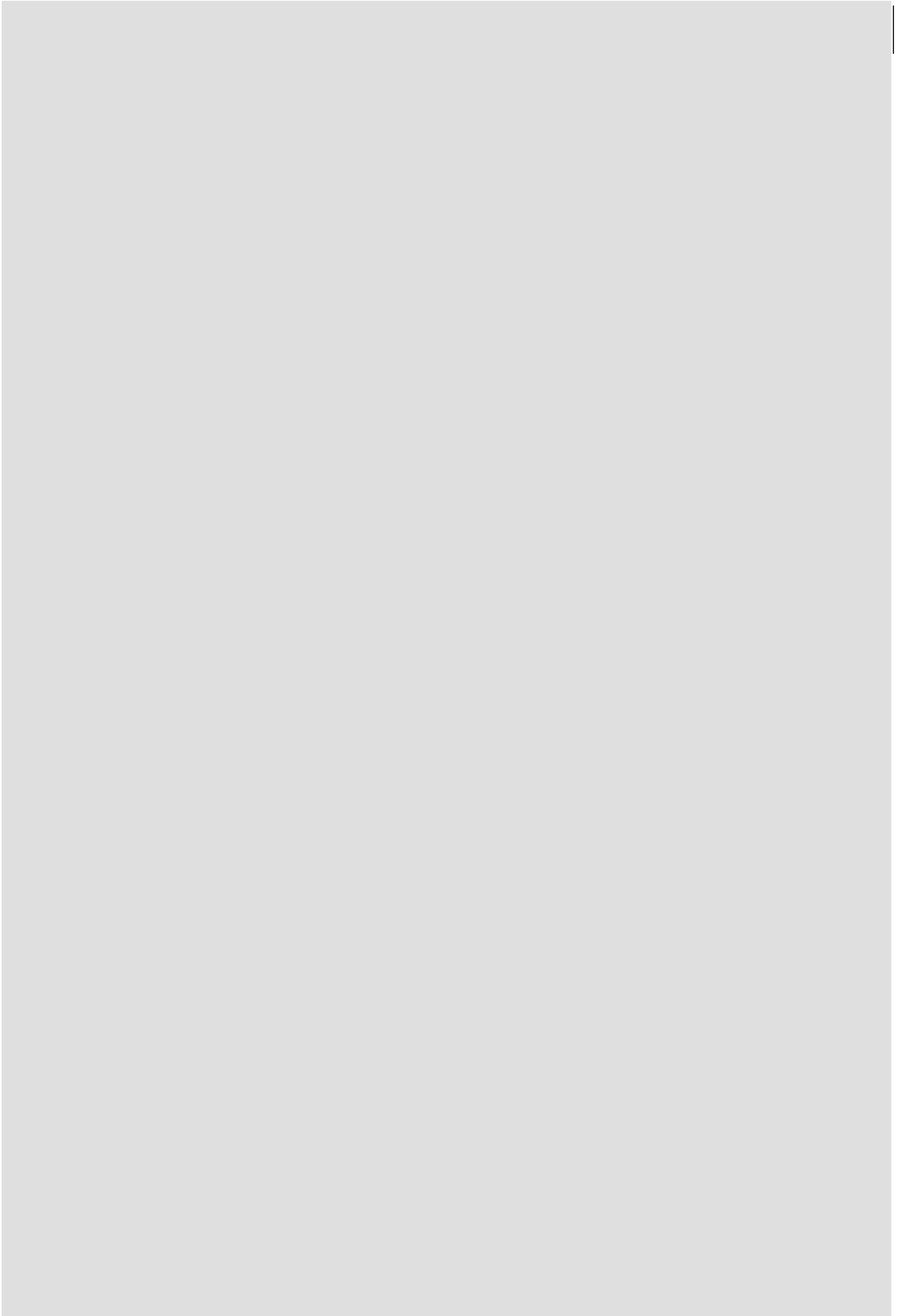












15<sup>th</sup> April 2014

Dr Simon Carter  
 Fiveways Surgery  
 Corner Gailey and Indooroopilly Roads  
 Taringa QLD 4068.

Dear Dr Carter

Re: [REDACTED]

This patient has recently been referred to [REDACTED] (CYMHS) Clinic by [REDACTED]. The family has nominated you as their preferred GP. The concerns leading to the referral included [REDACTED] occurring in the context of a diagnosis of [REDACTED]. Following a period of school refusal, [REDACTED] had an [REDACTED] admission to the Barrett Adolescent Centre in 2013 in order to address these difficulties. [REDACTED] also has a lifelong history of difficulty making and sustaining interpersonal relationships and social interests.

The provisional diagnoses made and other factors involved in [REDACTED] presentation (according to ICD 10 criteria) were:

- [REDACTED]
- [REDACTED]
- [REDACTED]

The intervention planned at this clinic will include individual therapy, parenting support and case management.

If you have concerns or any questions, please telephone Charlotte Hambly, Case Manager or me at the clinic on tel [REDACTED].

Yours sincerely

[REDACTED]

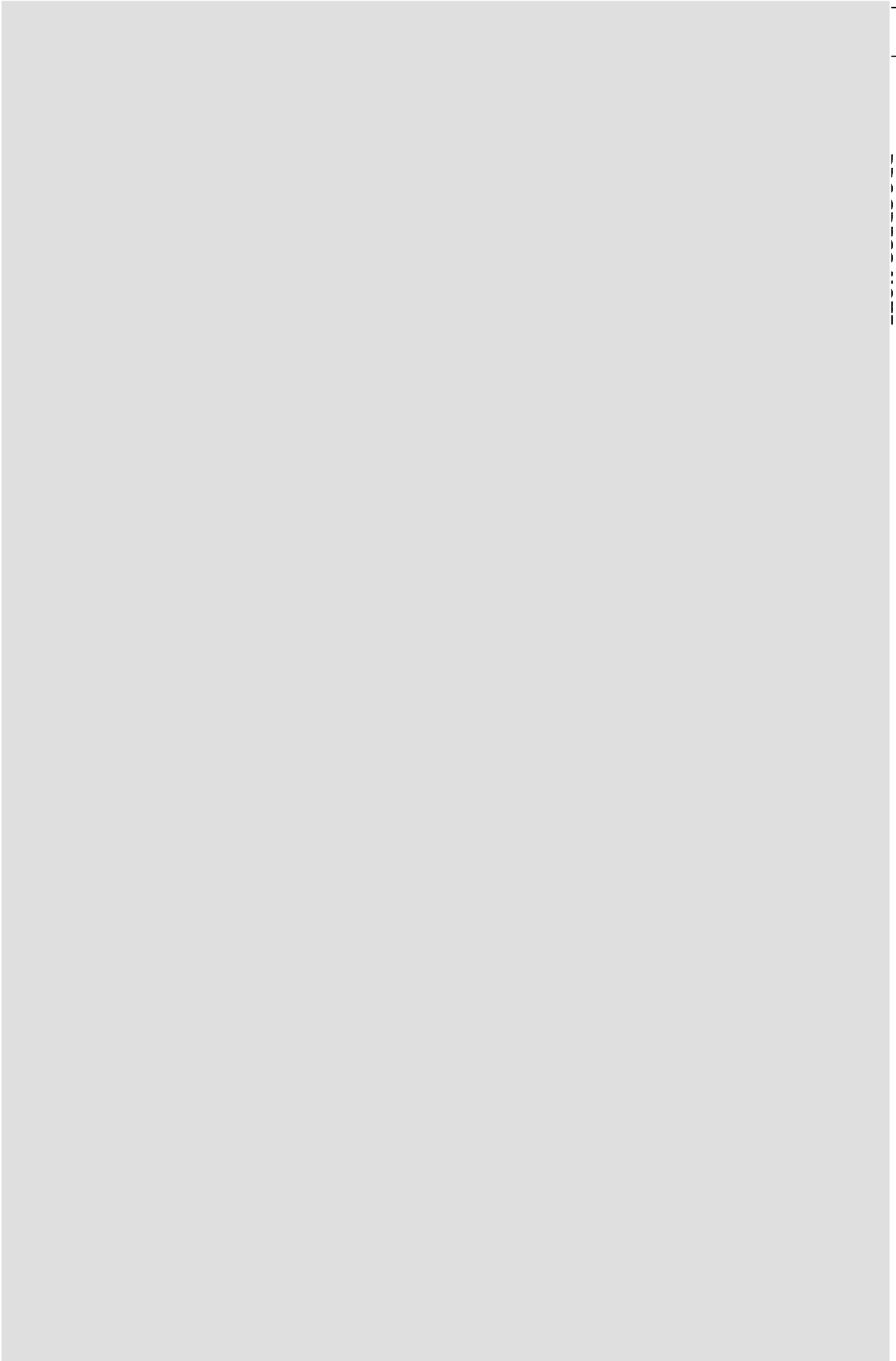
Consultant Child and Adolescent Psychiatrist

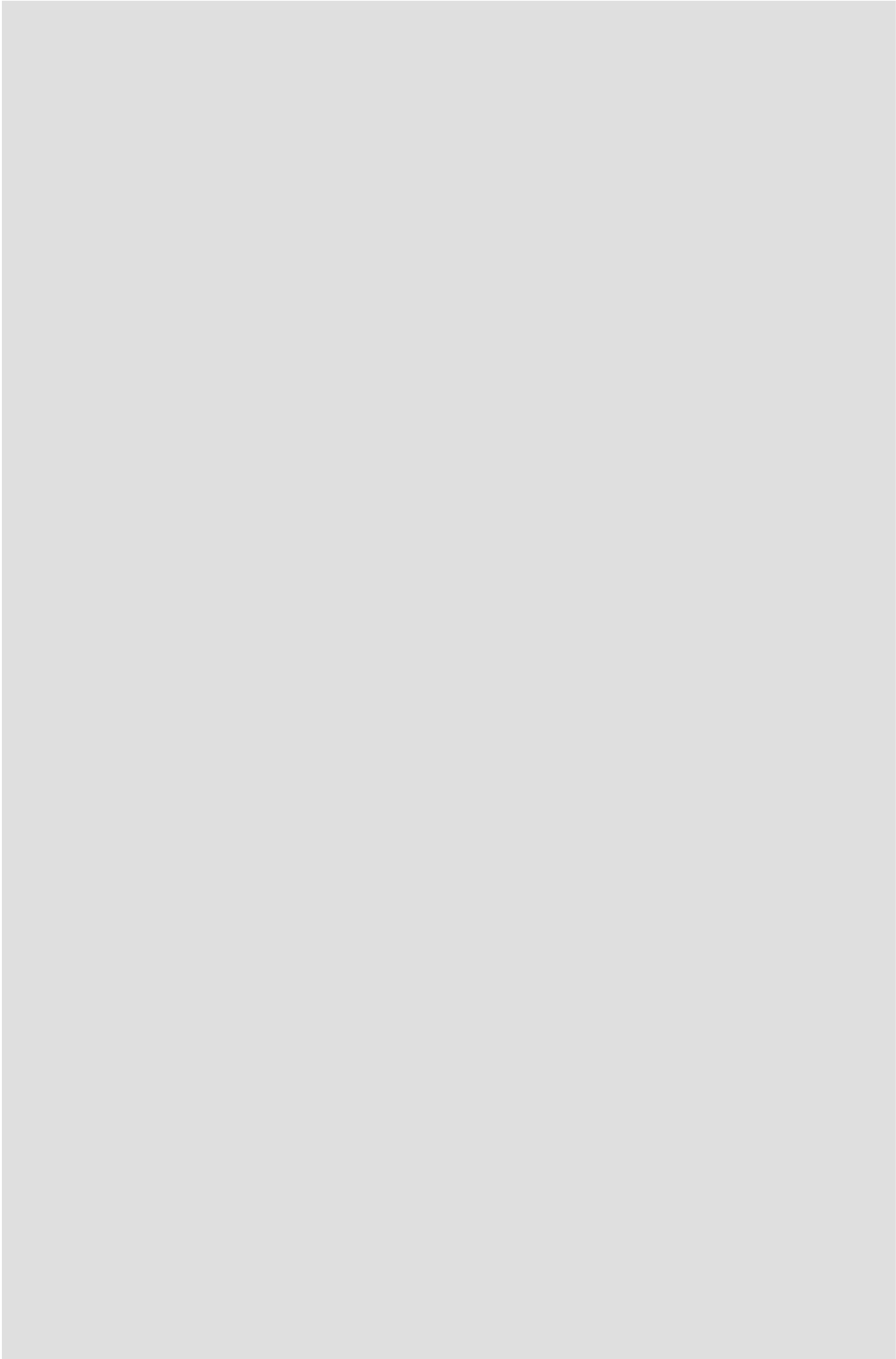
**Exceptional People. Exceptional Care.**  
 Mater Misericordiae Health Services Brisbane Limited

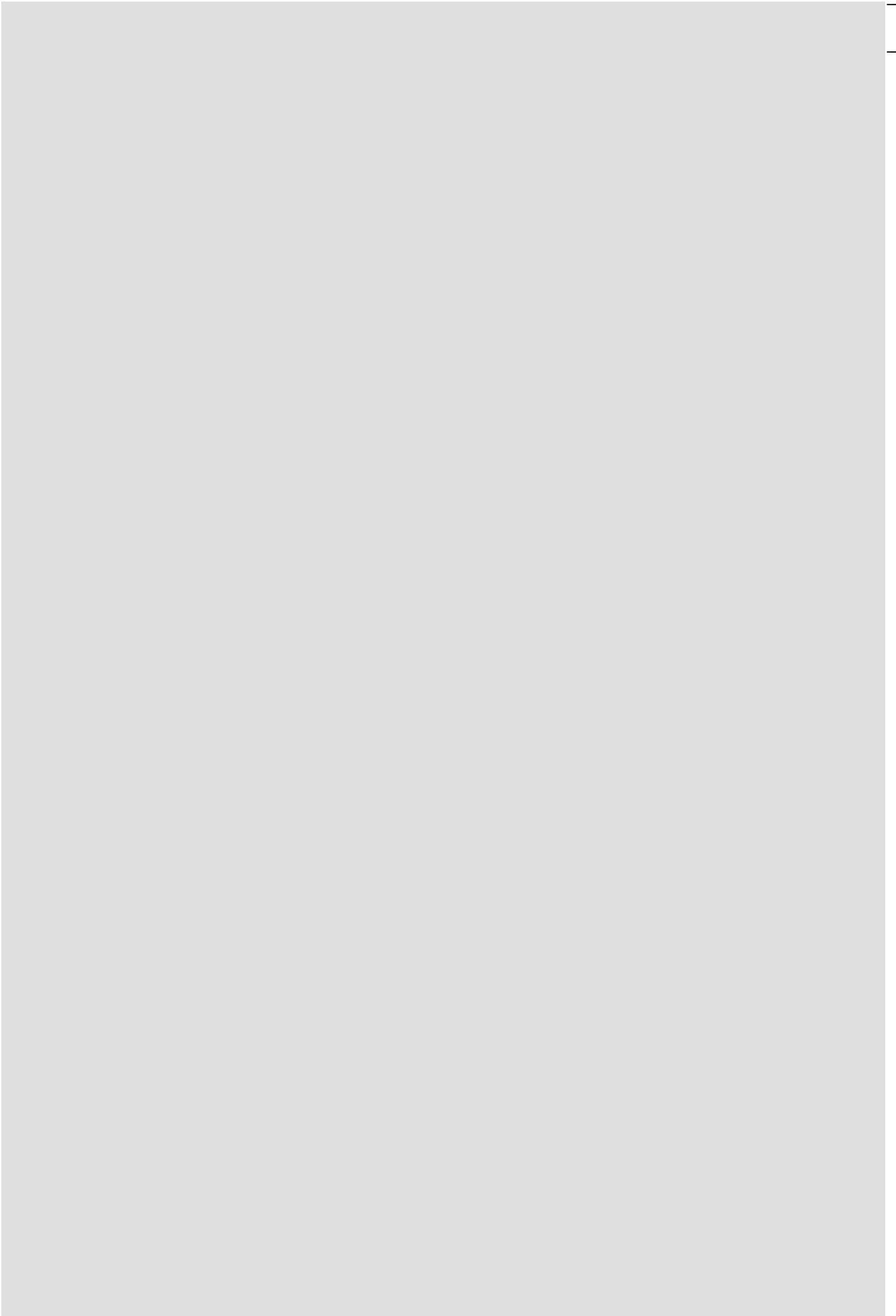
ACIL 035 768 822

Mater Child & Youth Mental Health Service - Yeronga Clinic  
 51 Park Road, Yeronga 4104 Queensland, Australia  
 PO Box 3125 Yeronga 4104 Queensland  
 Phone: [REDACTED]

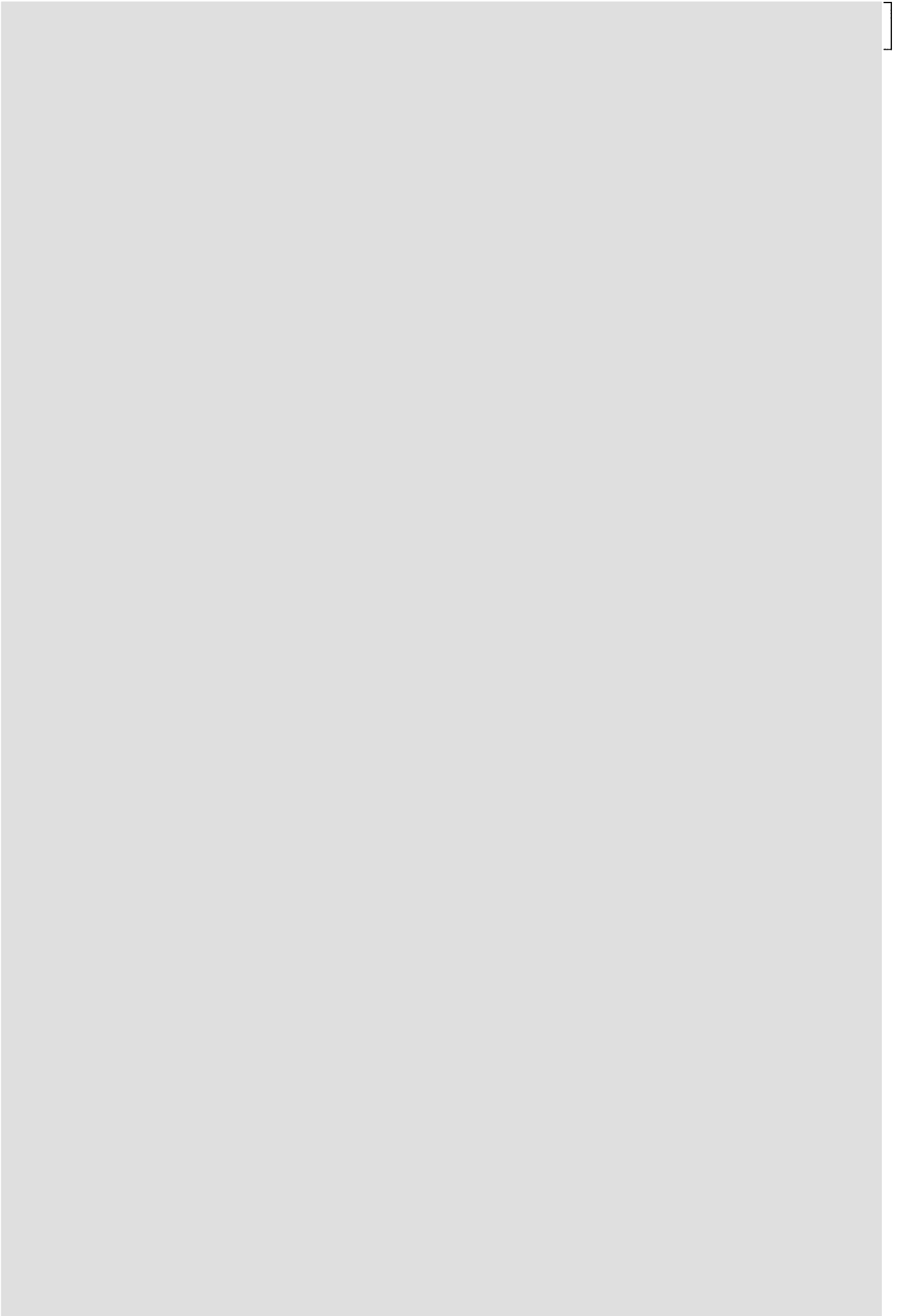


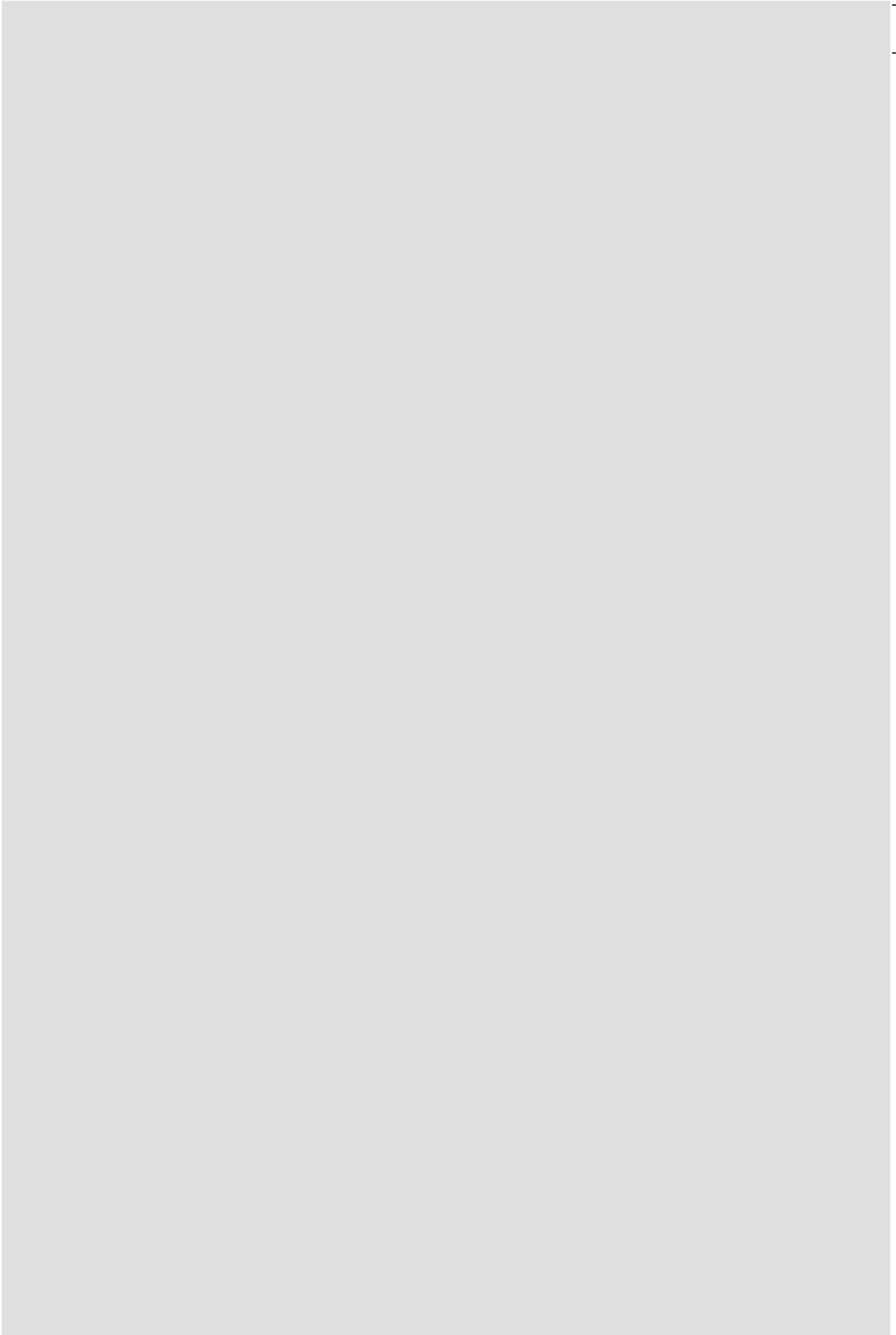


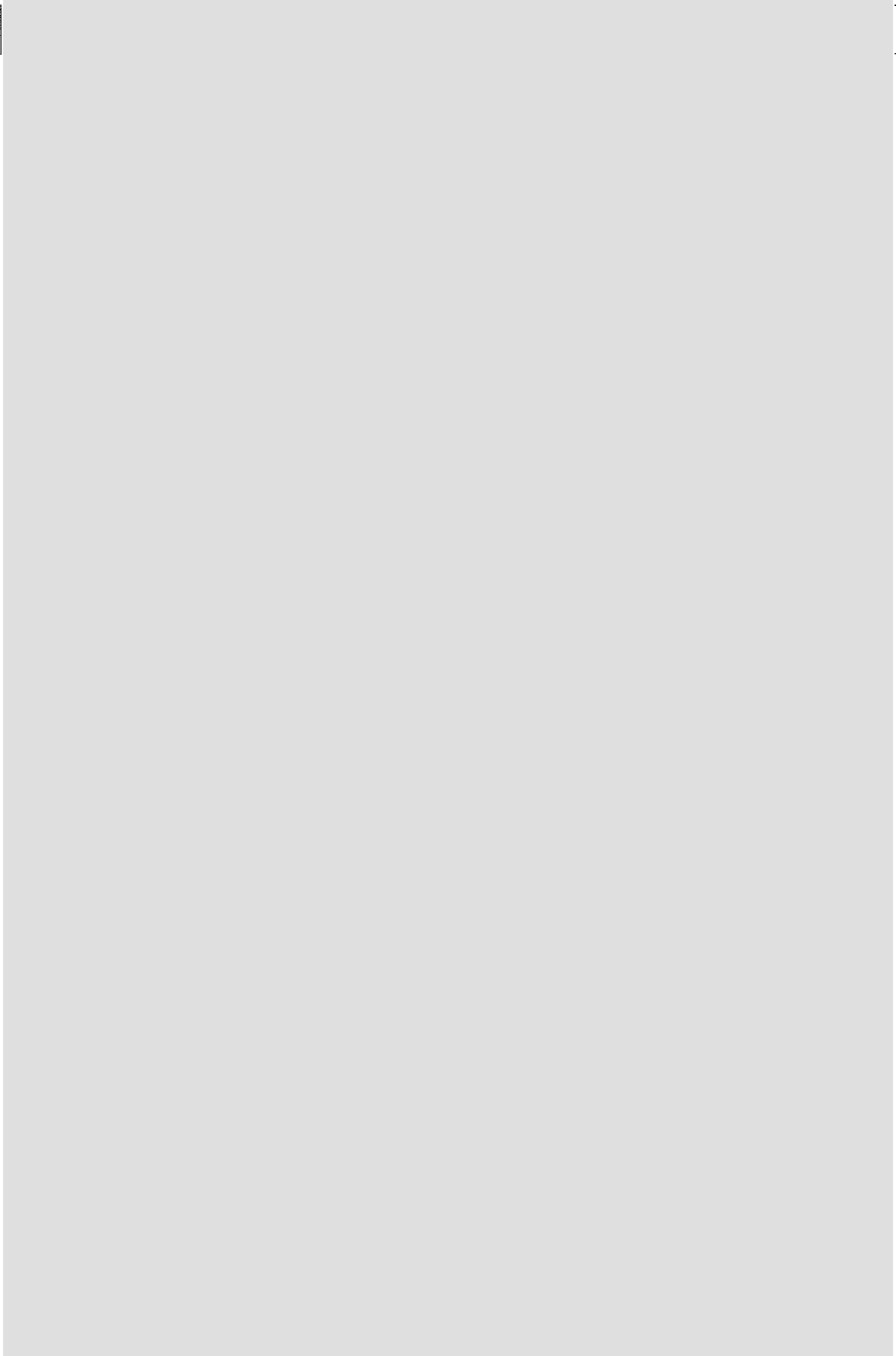


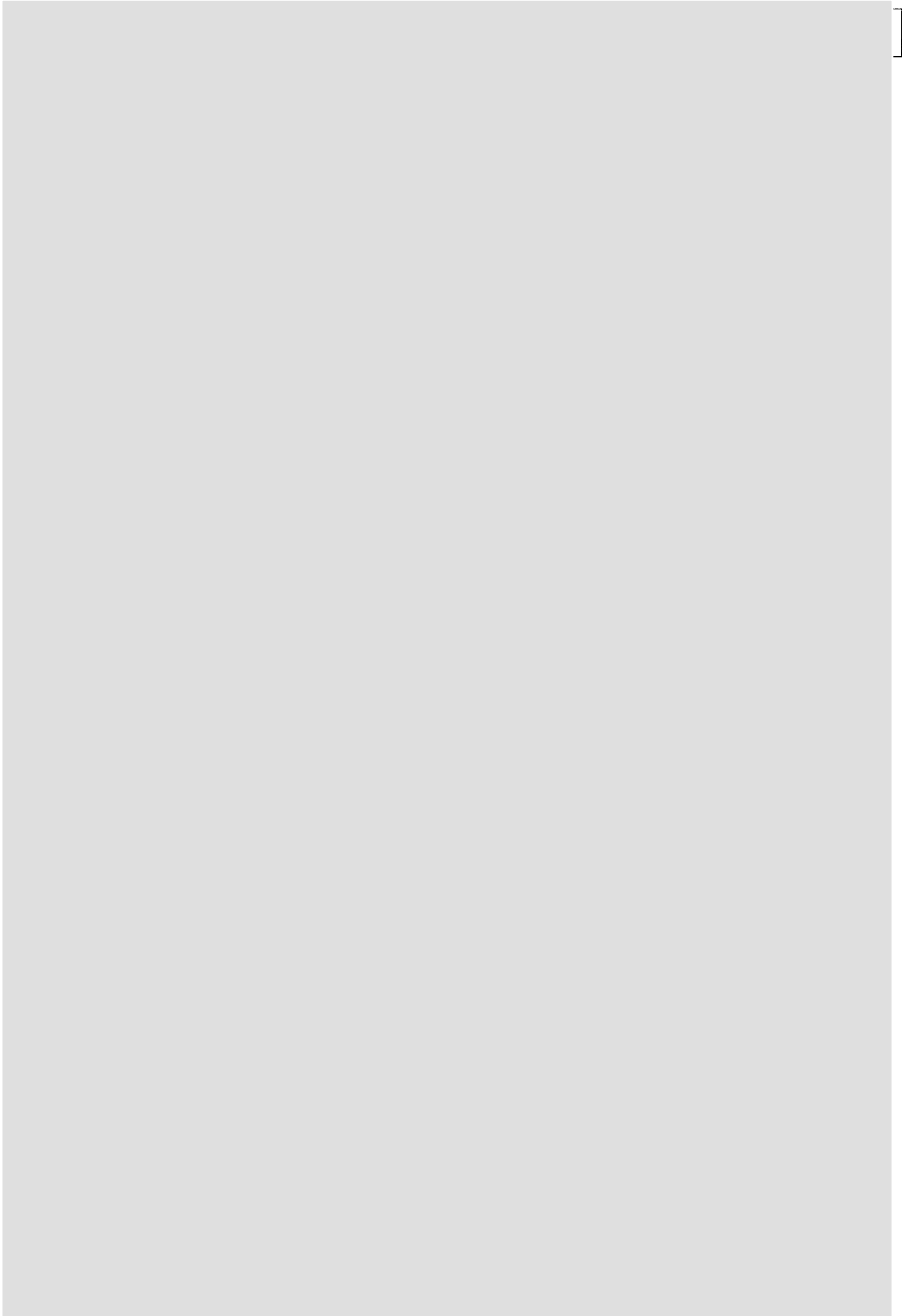


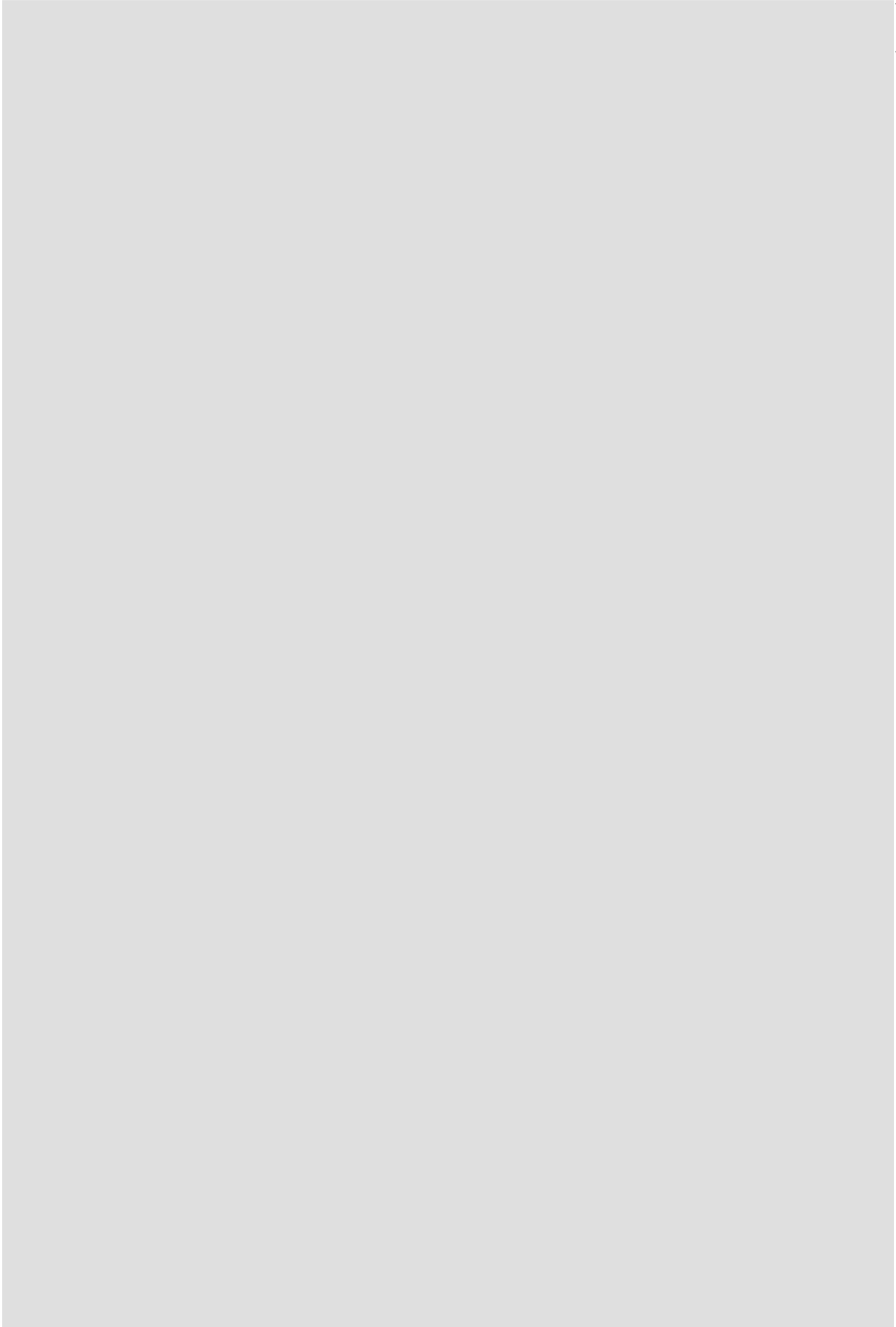


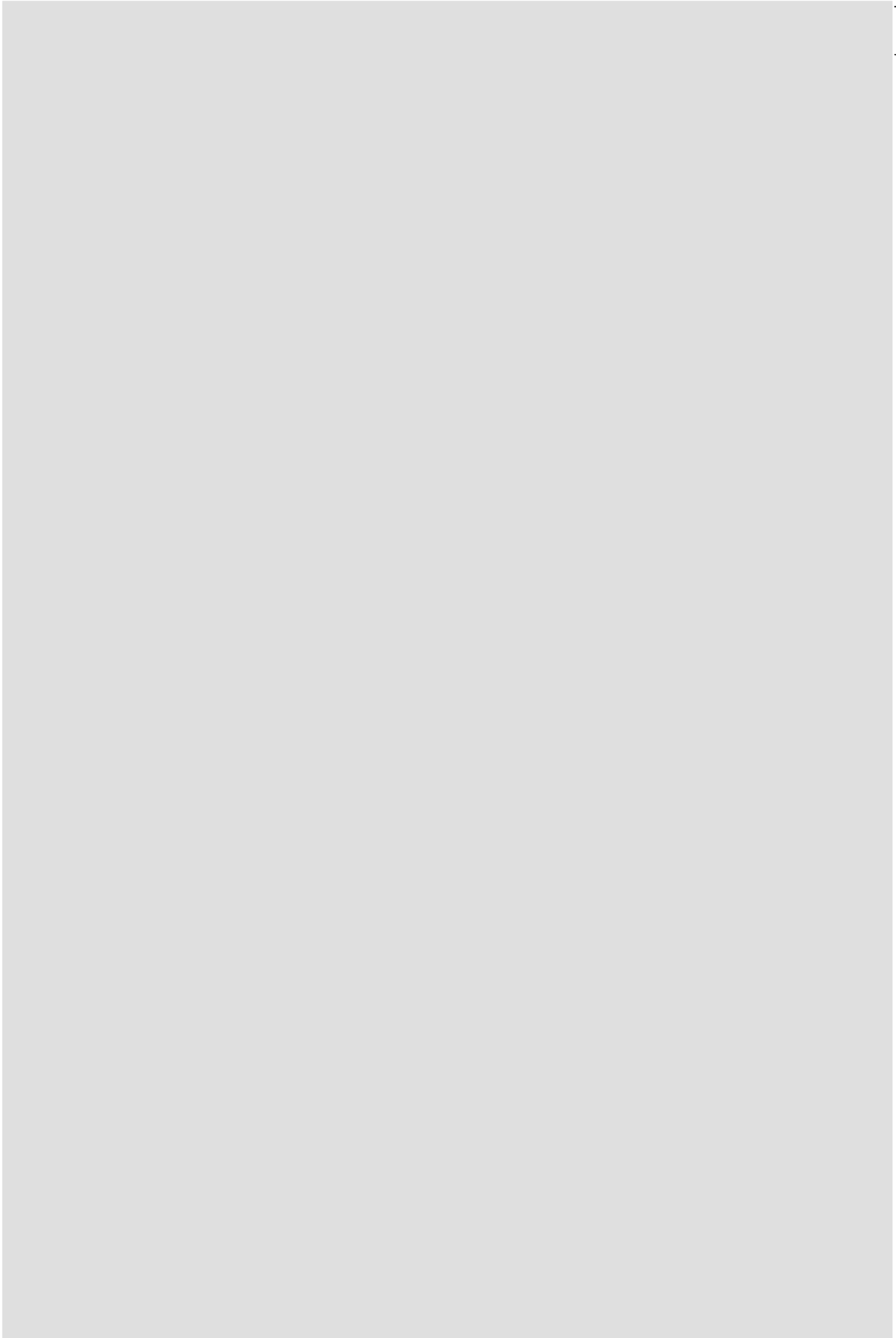


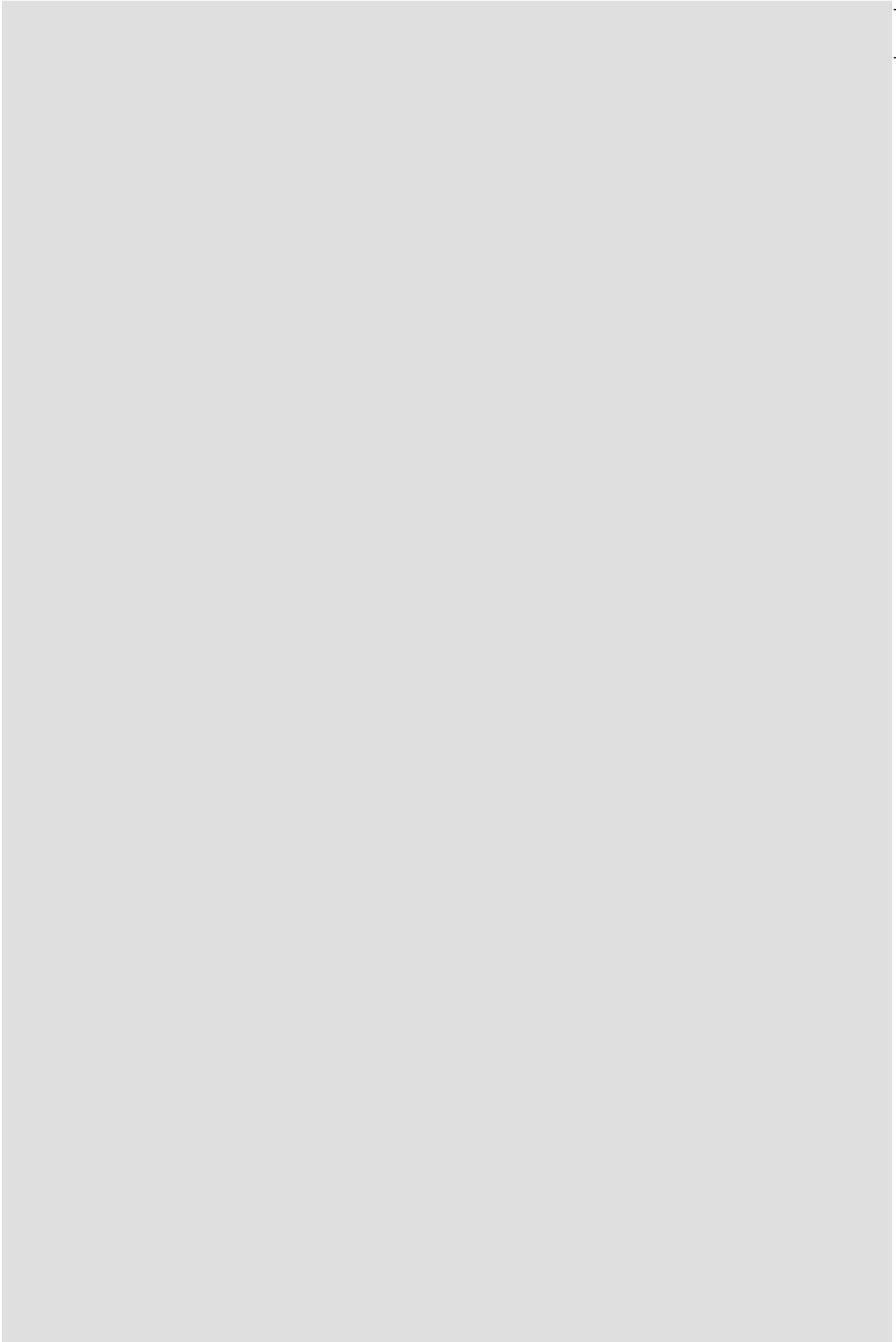


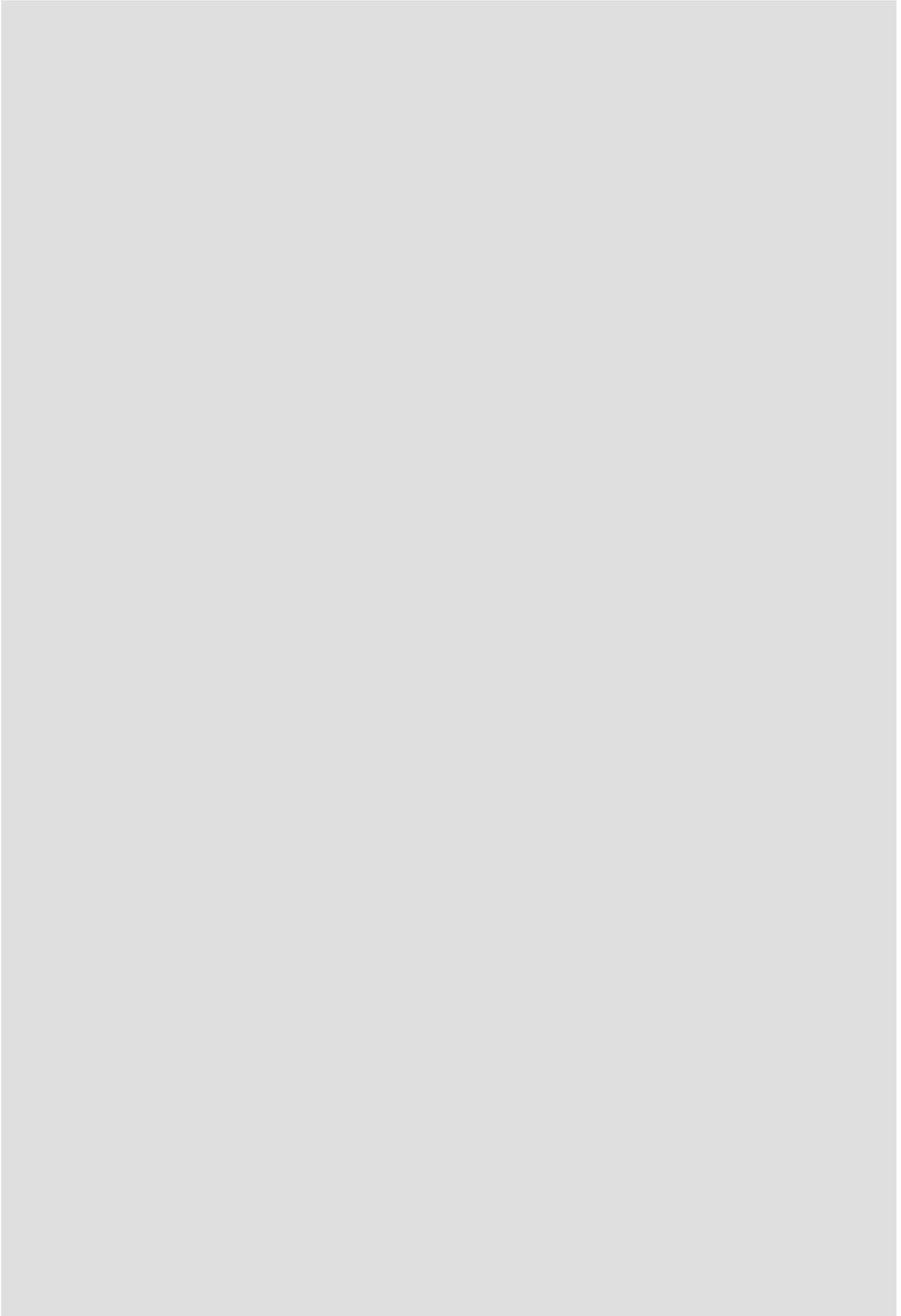






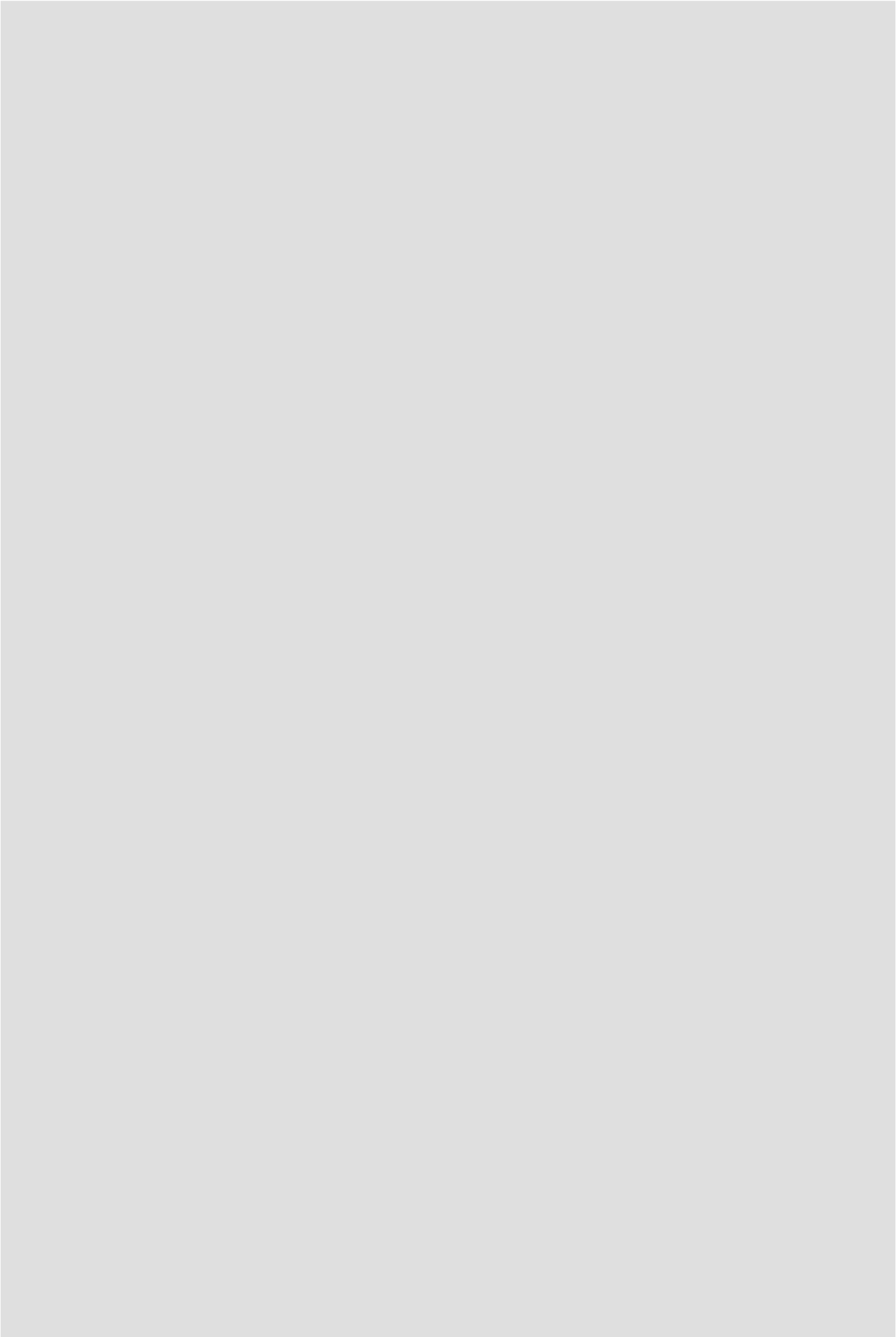


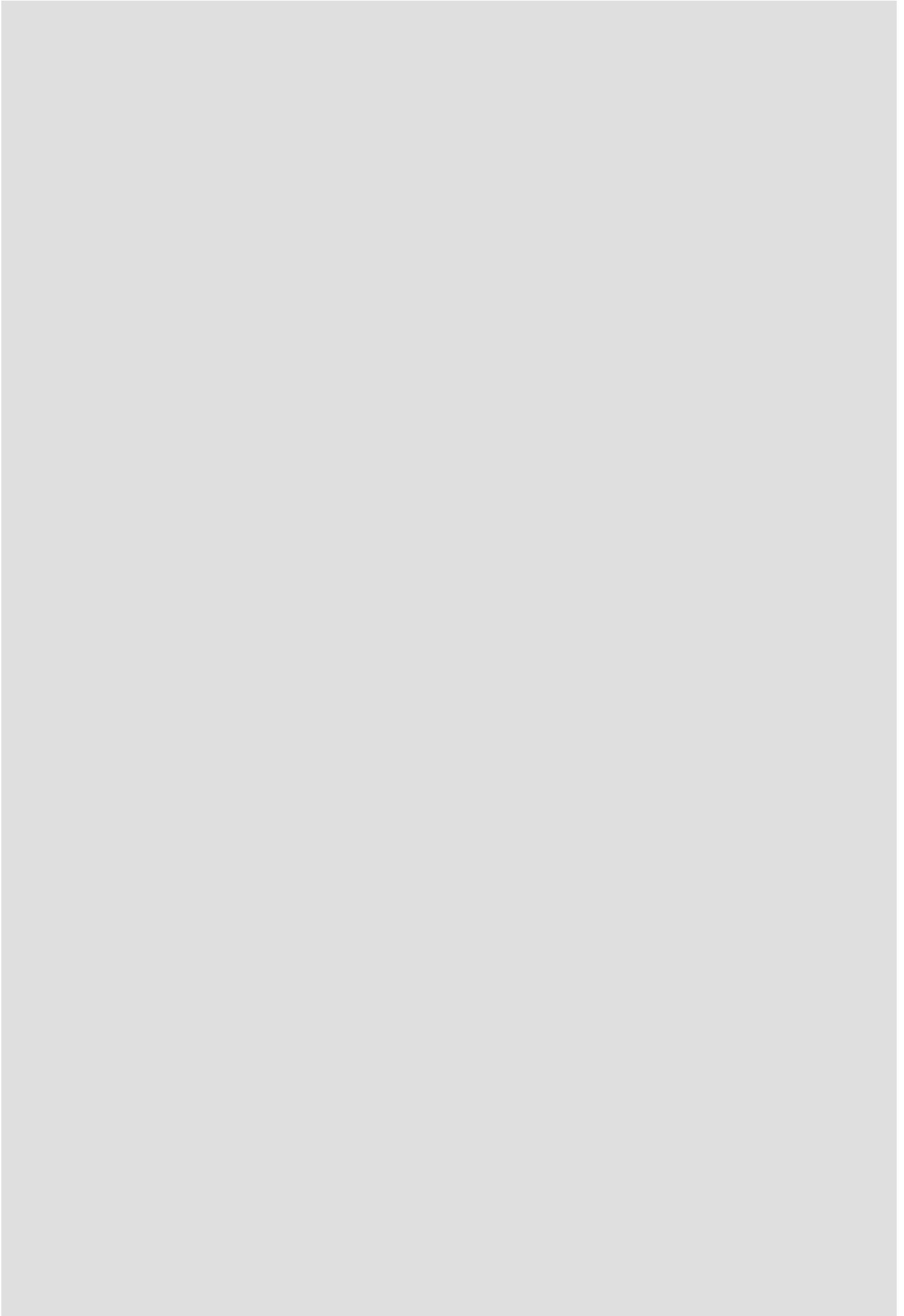


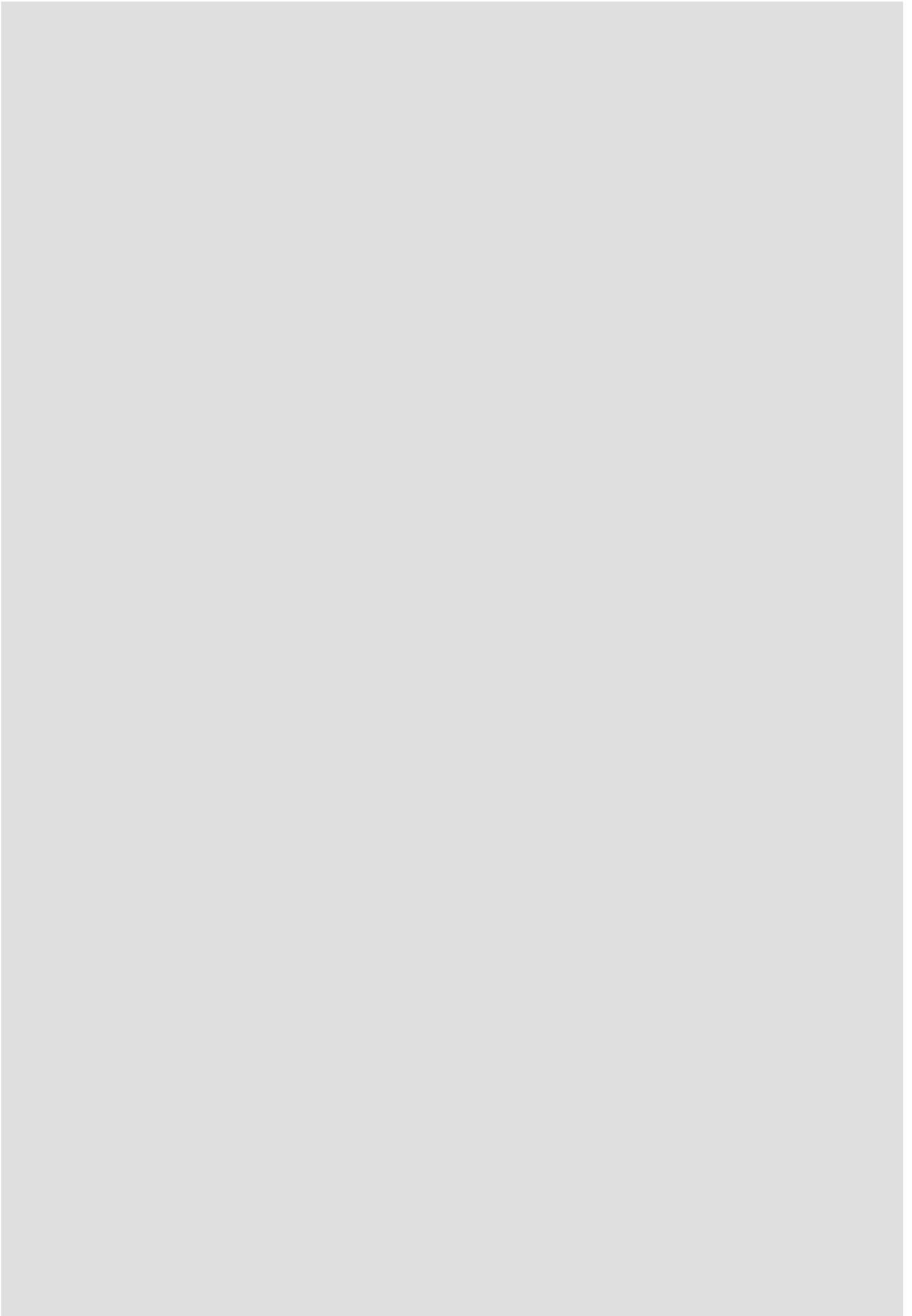


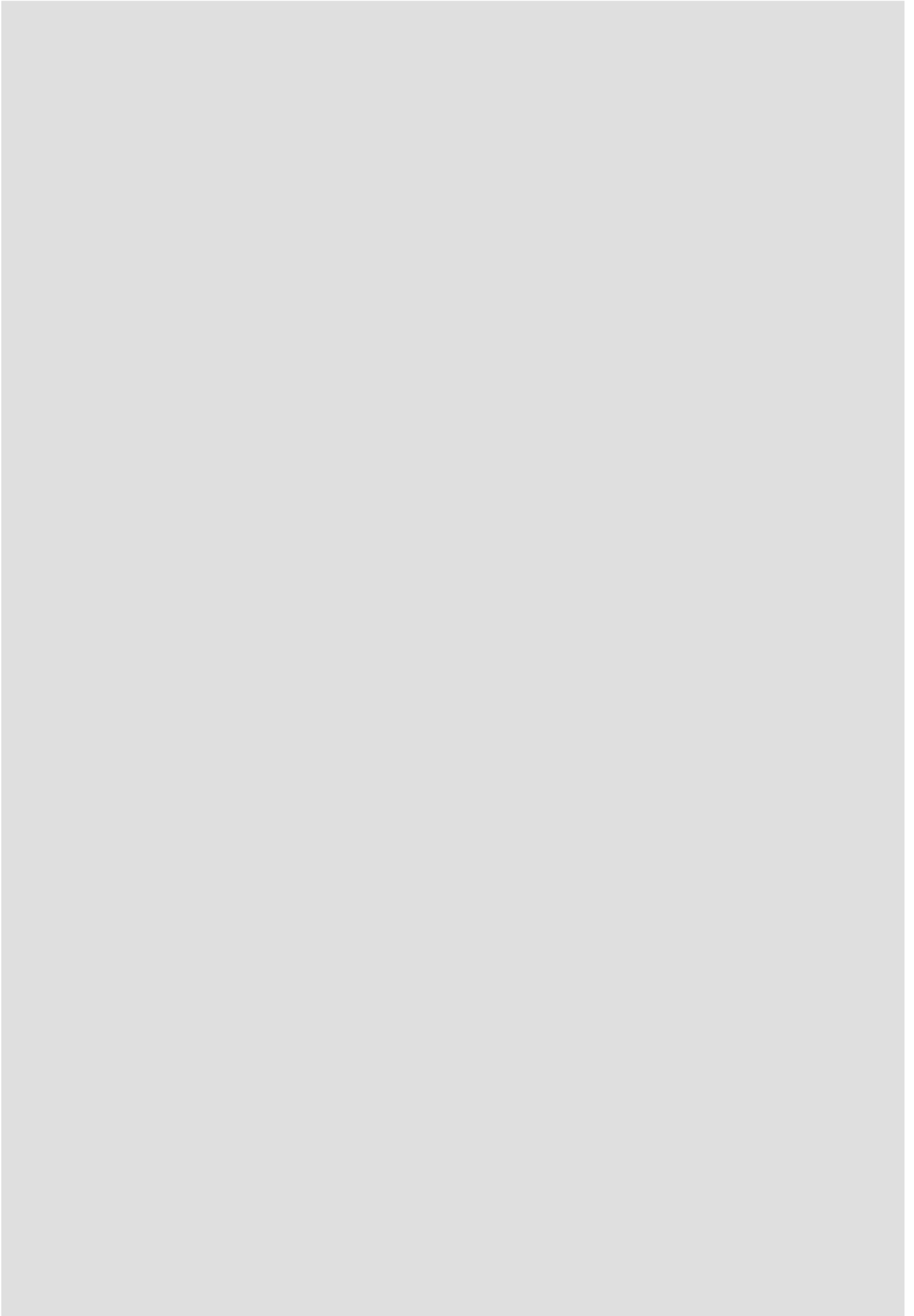


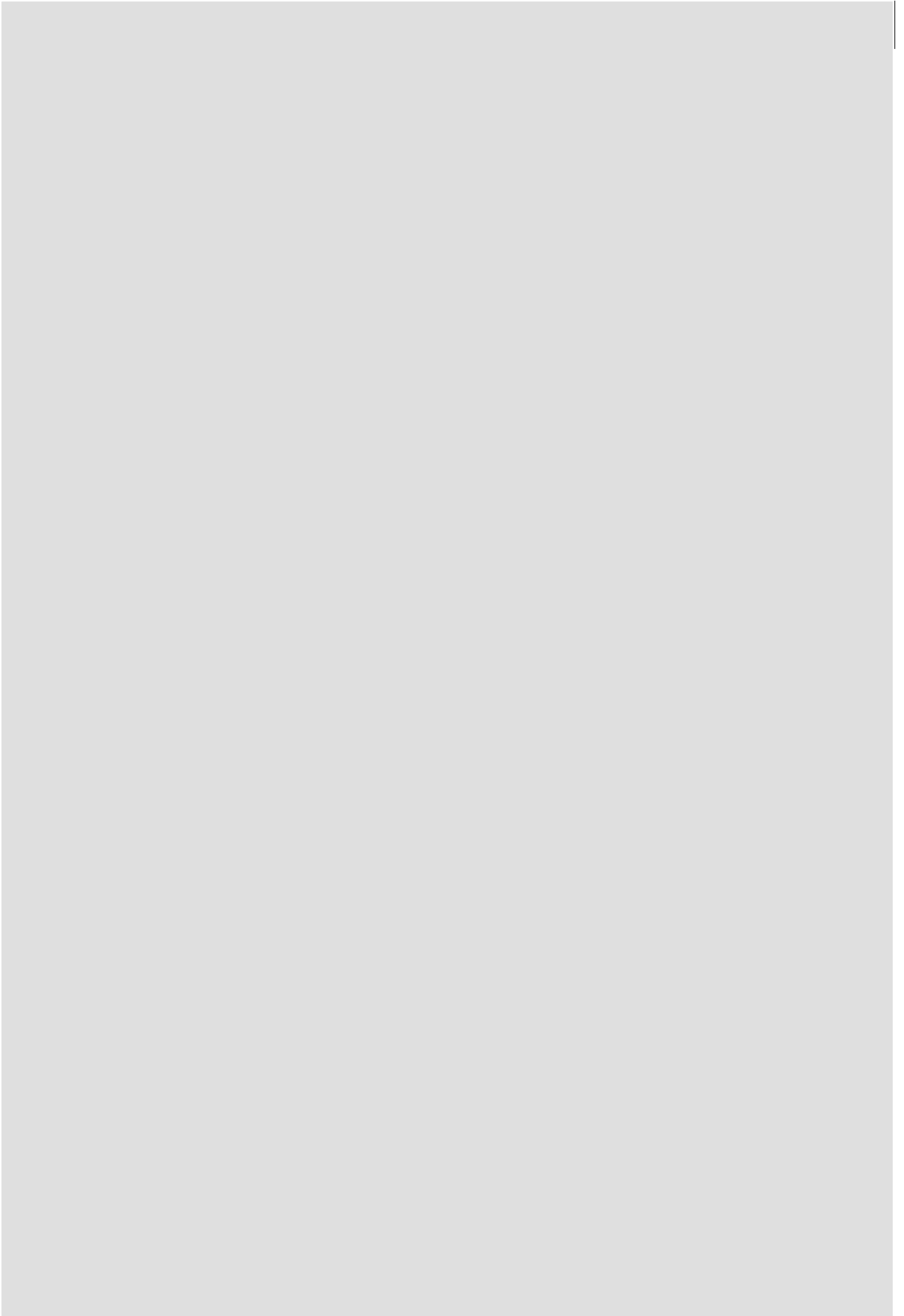




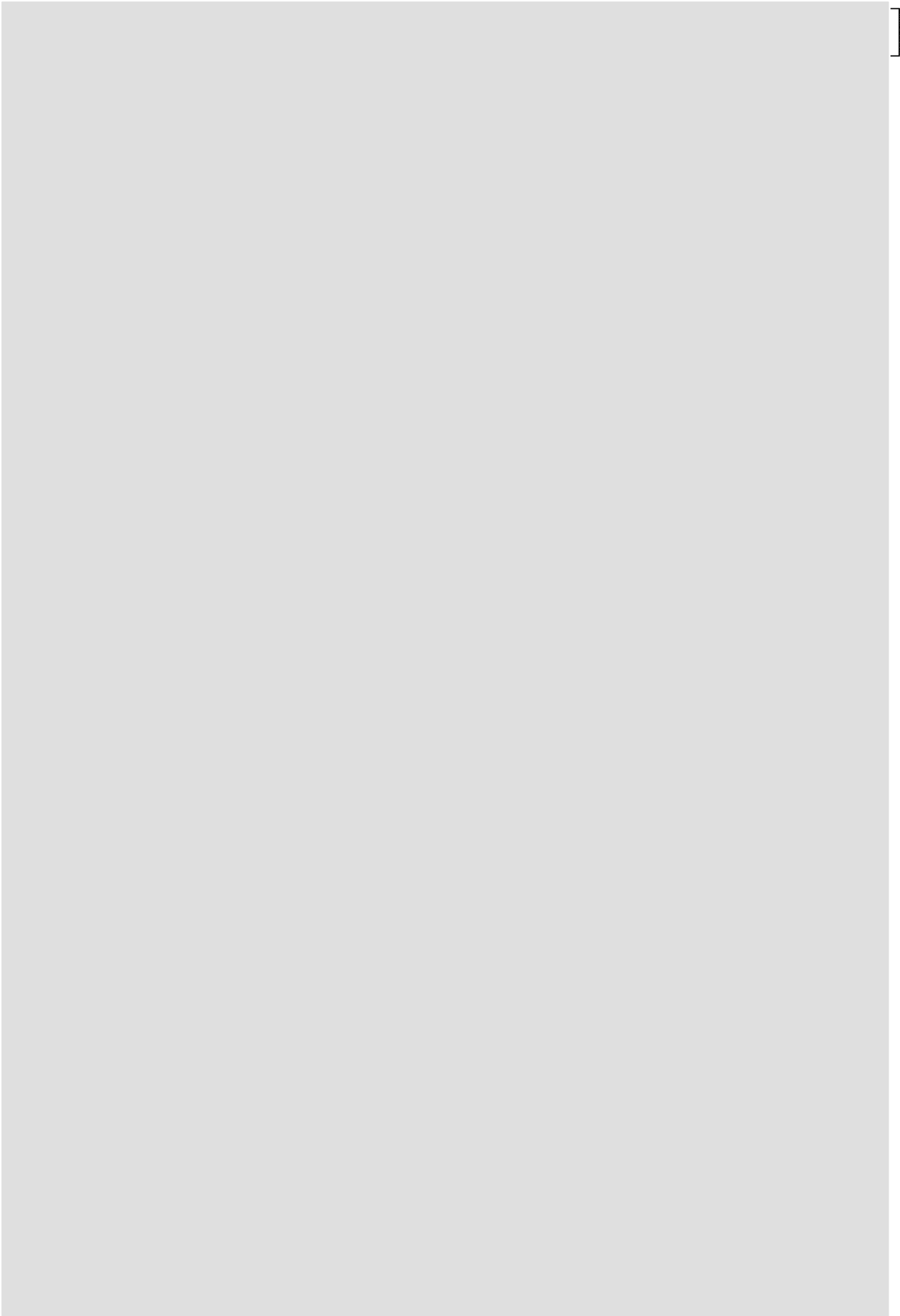




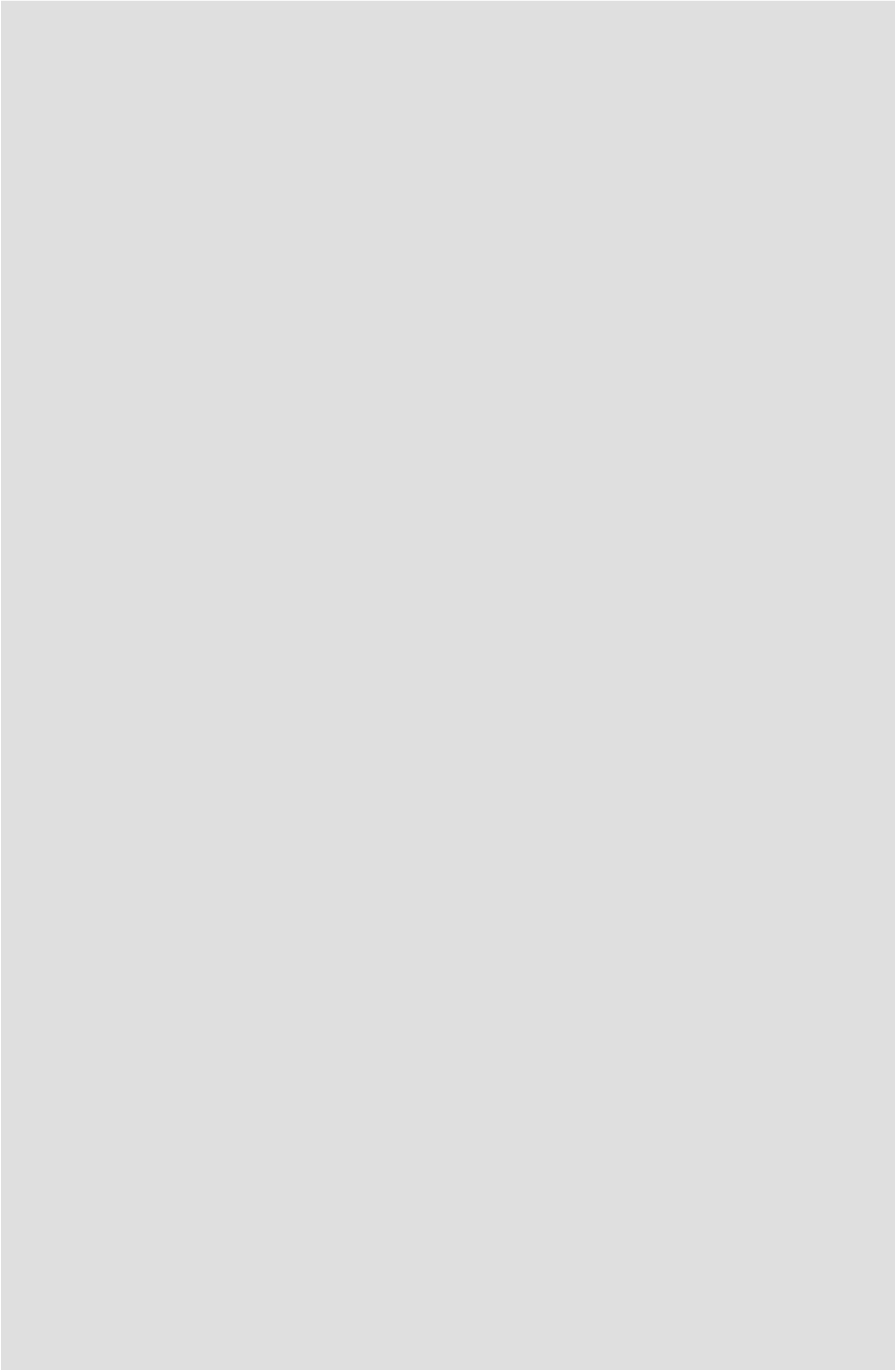


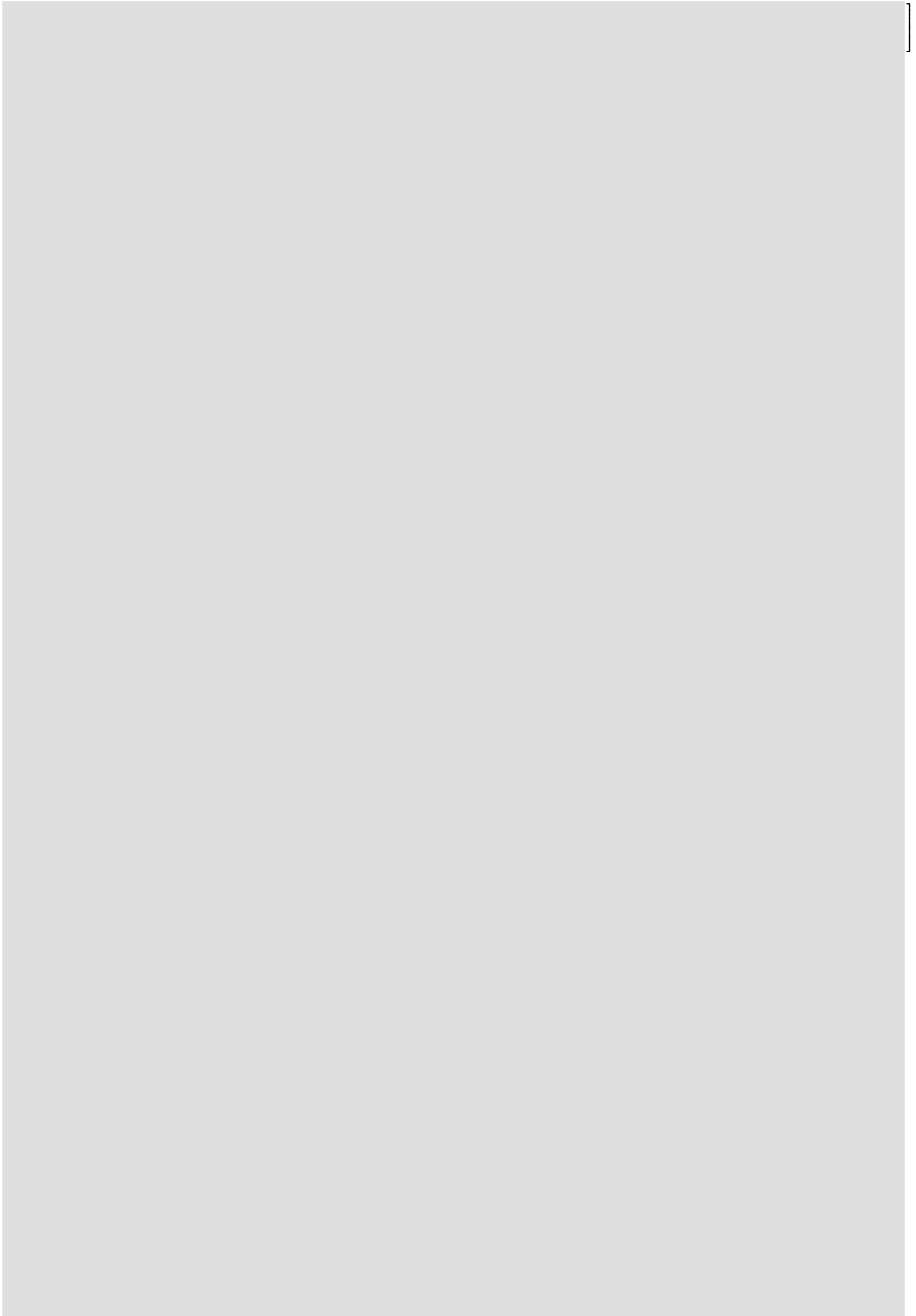




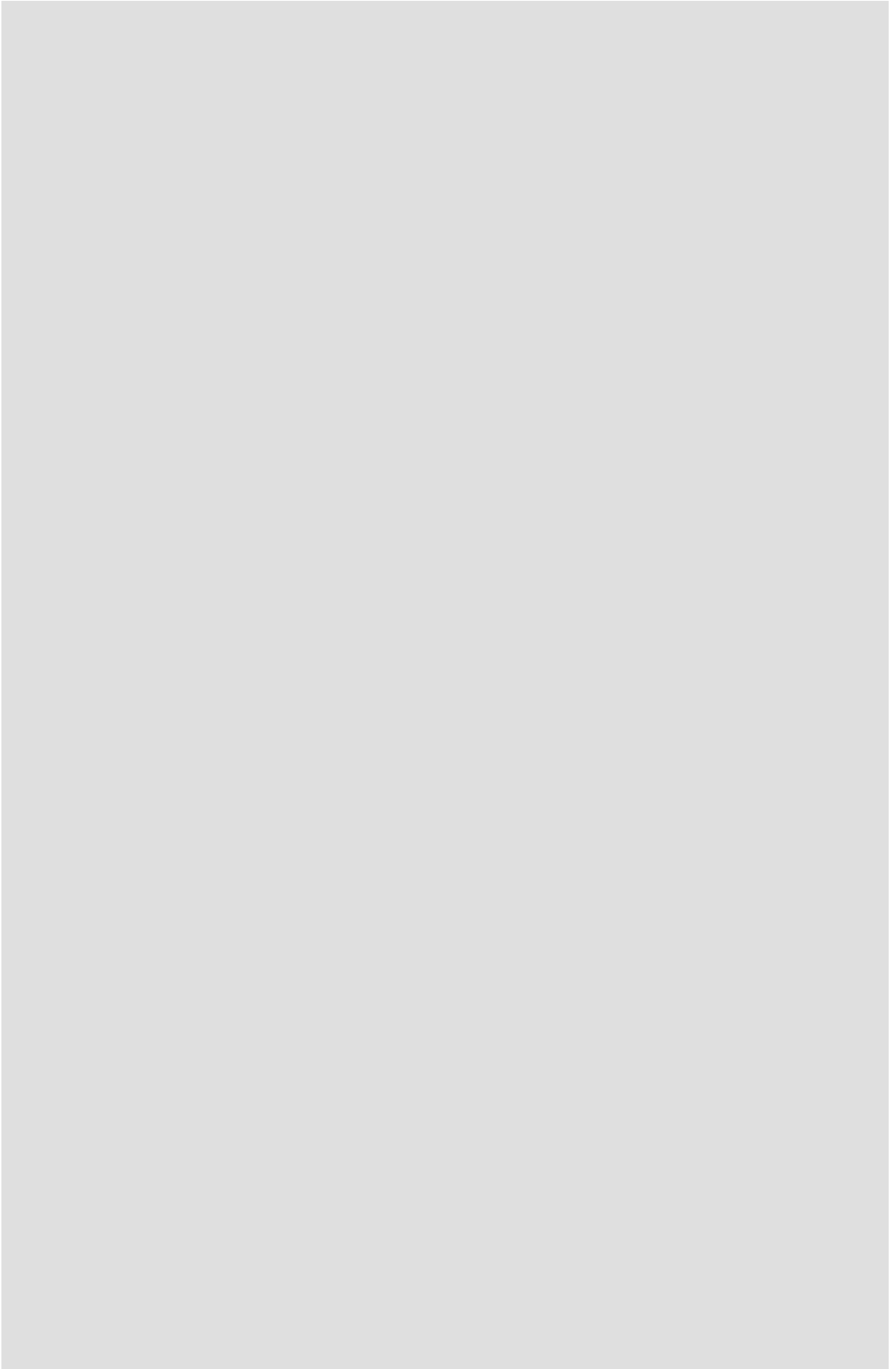


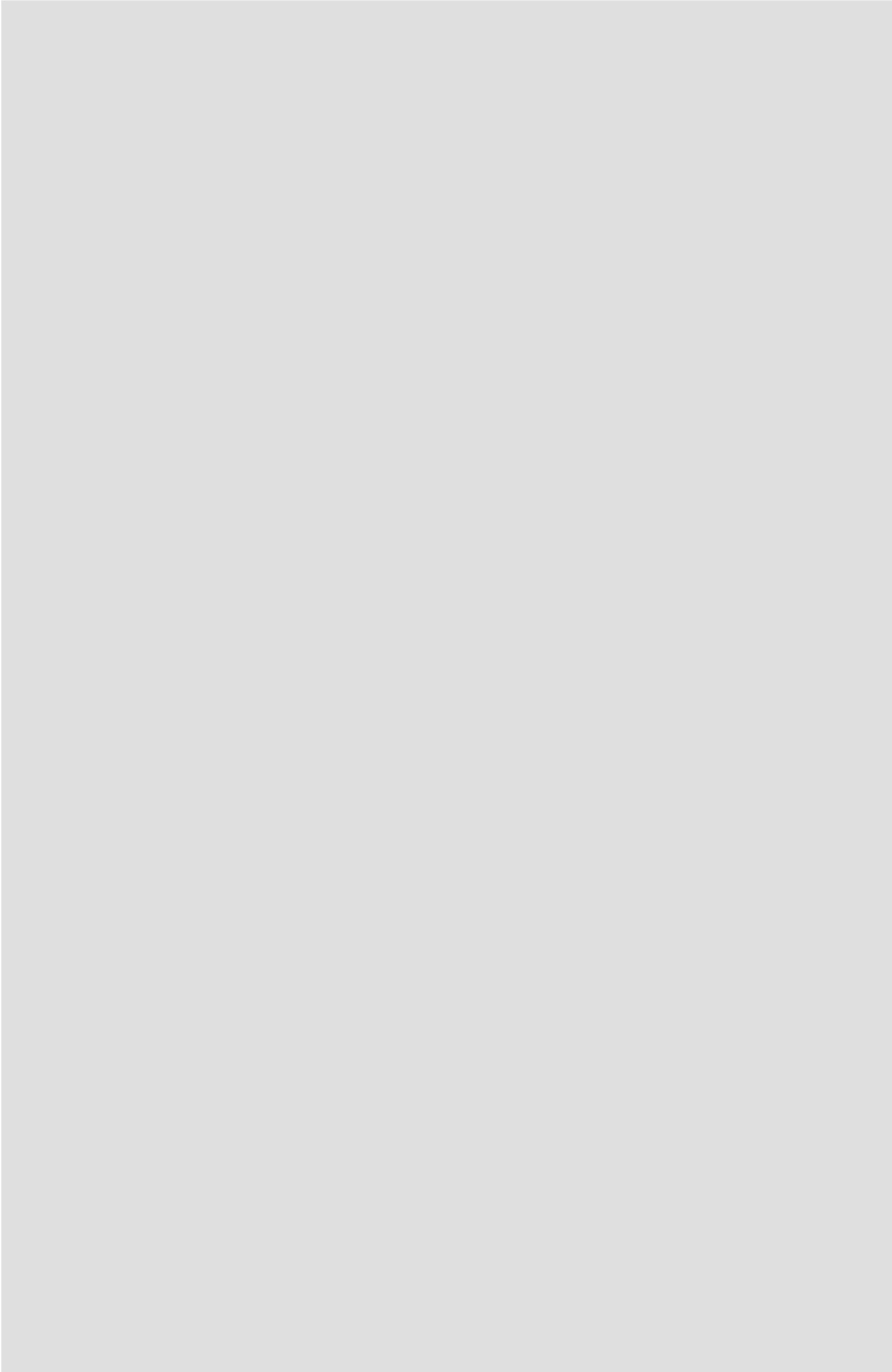














SW039

