**OATHS ACT 1867**

**STATUTORY DECLARATION**

**SUPPLEMENTARY STATEMENT**

**QUEENSLAND**
**TO WIT**

I, **Matthew Beswick**, c/o Roberts & Kane Solicitors, level 4, 239 George St, Brisbane in the State of Queensland do solemnly and sincerely declare that:

The following supplementary statement is provided in response to correspondence from the Barrett Adolescent Centre Commission of Inquiry to Roberts & Kane Solicitors dated 1 February 2016 requiring me to provide a supplementary statement responding to additional questions.

The references to "questions' are to those in the Notice to Provide a Written Statement dated 29 September 2015 previously issued to me.

**Response to Schedule of Further Questions**

**Profession Experience (Further to question 4)**

1. **In response to question 4 (at para 4(b)) you say, "*In or about 2011 I was given the opportunity to act in the position of CN on a continuous basis for about 18 to 24 months until the closure of BAC*".**

   (a) **Who offered you this opportunity, when and how?**

      i. It is my recollection that NUM Risto Ala'outinen offered me the contract to act up as Clinical Nurse (CN). I cannot now recall whether I had submitted an expression of interest to undertake higher duties.

      ii. I cannot recall the exact date of when I was offered this opportunity to act up as a CN but as previously stated I believe it was in or about 2011.

(b) **To your knowledge, why were you offered the position of CN in an acting rather than permanent capacity?**

i. To my knowledge substantive CN positions which became vacant at the BAC from about the time the relocation of the BAC to Redlands was being considered were not being filled on a permanent basis.

ii. I am aware that in relation to one of the permanent CN positions, the person who held the substantive position was absent from the BAC for a number of years. As the person had not relinquished the position, it could only be filled in an acting capacity.

iii. Once the closure of the BAC was announced no permanent positions were being offered.

iv. I understood that these were the reasons why I was not offered a permanent CN position.

(c) **At any time, did you request to hold the position of CN in a permanent rather than an acting capacity? If so, when, whom and how did you ask, and what response were you given?**

i. I had earlier applied for a permanent CN position and was unsuccessful but merit listed, which meant that if a permanent position became available in the following 12 months I would have been appointed as a permanent CN.

ii. Once I undertook the acting CN position, I did not request to hold a permanent CN position because I accepted that there were simply no CN positions being offered on a permanent basis.

iii. I made it known that I would apply for any permanent positions when they became available.

**Duties and responsibilities (Further to questions 5 and 7)**

2. **In response to question 5 (at para 5(b) ix), you refer to a "*patient management plan*", which was "*a reference guide for all staff about the care needs for the patient*".**

   (a) **To your knowledge, was it the practice of the BAC to provide a copy of the patient management plan to the receiving service when a patient was transitioned out of the BAC?**

      i. The patient management plan was an ongoing plan used to manage the patient during their admission at the BAC. It was not a transition plan.

      ii. Before closure of the BAC was announced, the treating team would liaise closely with the receiving services. This may have included providing a copy of the patient management plans. However, these plans were usually specific to the management of the patient at the BAC.

      iii. As the receiving service operated differently to the BAC, the receiving service would develop their own management plan. This is why receiving services were involved in the discharge planning of patients well before discharge.

   (b) **To your knowledge, did the BAC provide a copy of the patient management plan to the receiving service of patients transitioned out of the BAC in anticipation of its closure?**

      i. Before the closure I would have been involved in liaising with receiving services regarding a patient's transition out of the BAC. After the closure announcement was made, I was no longer involved in transition planning, and am unable to say whether a patient management plan was provided to receiving services. As noted above, the patient management plan was not a transition plan.

   (c) **Who was responsible for drafting these plans? Were they reviewed and updated? If so, how often and by whom?**

      i. The patient management plan was drafted with input from any number of

members of the treating team. Regardless, the plans were reviewed by the treating team to ascertain appropriateness and whether any changes were required. The review of the management plan was ongoing at least weekly or more frequently if required. The review occurred primarily in the weekly case conference.

3. **In response to question 5 (at para 5(b) vii), you refer to *"the multidisciplinary team"*.**

(a) **Which positions composed the multidisciplinary team?**

i. The multi-disciplinary team (MDT) which I also refer to as 'the treating team' consisted of the consultant psychiatrist, psychiatric registrar, clinical nurse, care coordinator and/or associate care coordinator, psychologists, speech pathologist, occupational therapists, social worker, teachers and dietician.

(b) **What was the role of the multidisciplinary team?**

i. The role of the MDT was to care for, assess, plan, implement and review all aspects of a patient's care as a team.

(c) **Was there one multidisciplinary team for all patients or a specific multidisciplinary team for each patient?**

i. The MDT was the entire treating team. Each patient usually had a specific care coordinator, an associated care coordinator, a psychologist and a teacher assigned to their case. If a patient had specific needs, a relevant MDT member would be assigned to their case – for instance a patient with an eating disorder would also have a dietician assigned to them.

ii. While specific members of the MDT, or treating team, were assigned to specific patients, this did not mean that other nurses, teachers or psychologists were excluded from having input regarding those patients.

4. **In response to question 5 (at para 5(b)), you say you were Care Coordinator for Patient [redacted] and Associate Care Coordinator for Patient [redacted]. Please provide more specific details of what their care coordination involved, including the composition of**

**their multidisciplinary teams.**

(a)

(b)

(c)

(d)

(e)

5. **In response to question 7 (at para 7(d)), you refer to a *"weekly multidisciplinary Case Conference"*. What (if any) is the relationship between the multidisciplinary team to whom the Care Coordinator reported (referred to at para 5(b) vii) and the *"multidisciplinary Case Conference"*?**

   (a) The multidisciplinary Case Conference was the weekly event in which every patient was discussed. Ideally a patient's specific MDT members were present for the discussion about the patient. For example, the dietician played a role primarily with

the patients with disordered eating. Therefore, all eating disordered patients would be discussed when the dietician was present.

(b) In the multidisciplinary Case Conference, a Care Coordinator reported to all the staff present at the meeting even though some of the staff were not individually assigned to the patient being reported upon.

(c) An individual Intensive Case Workup was held for each patient every six to eight weeks. At an Intensive Case Workup generally only the clinicians directly involved in the patient's care attended.

**Allocation of Patients (Further to question 8)**

6. **In response to question 8 (at para 8(b)) you say, "*There was no specific allocation of patients to nursing staff until about 3 to 9 months before the BAC closed*". You explain (at para 8(d)), "*Before patient allocation was introduced it was usual for me to engage in the care of all the patients in the BAC on any given shift. After patient allocation was introduced, I was allocated a patient load of 2 to 4 patients depending on the acuity of the patients*".**

(a) **To your knowledge, why was specific allocation of patients to nursing staff introduced and by whom?**

i. I do not know why specific allocation of patients to nursing staff was introduced. The change to patient allocation was not discussed with me directly except to the extent that it was to be implemented.

(b) **Aside from yourself, during the 6 months prior to the BAC closing, which other nurses held the position of CN or Acting CN at the BAC?**

i. In the six months prior to the BAC closing:

(1) The only person I am aware of who held a substantive position of CN was Susan Daniel in her role as Community Liaison.

(2) The nurses who acted in the CN position, apart from me, were Peta-Louise Yorke, Mara Kochardy and possibly Vanessa Clayworth, Stephen Sault, Moira Macleod, Kim McManus and Peter Kop.

(c) **What effect (if any) did the specific allocation of patients to nursing staff have on the behaviour of the patients or the care of the patients?**

i. The nurse allocated to a particular patient is the patient's primary point of contact to report any issues. This provides some consistency for the patient and clarity around accountability as it clearly identifies which nurse is responsible for the care of the patient on the shift.

ii. Patient allocation is not without merit but the introduction of it at the BAC was an unnecessary complication in a very difficult and uncertain time for the patients and the staff.

iii. From the announcement of the closure onwards, most patients were experiencing increased stress and risk due to the closure. Also we had increased reliance on staff that were less familiar with our patients.

iv. The change to patient allocation resulted in patients being expected to primarily deal with staff that may not have significant understanding of their complex needs. For example, a patient may be distressed and need support from a core staff member, that is, someone who understands their case, is familiar to them and can help in an efficient and valuable manner. In my experience, adhering to patient allocation meant that often the patient had to initially deal with an unfamiliar staff member and explain themselves while distressed. It would take longer to address their situation. It was not uncommon for the allocated staff member to seek out a core staff member to deal with the situation. Patients often conveyed "how stupid this is" to me and other staff. From their perspective they could not understand why they could not approach the familiar staff member, in the first instance, who they knew could help them quickly and efficiently. This could sometimes result in increased distress and associated risk.

v. When I raised my concerns with the NUM I recall being advised that we were to stick to patient allocation. I believe this change added to the bewilderment, distress and alienation of many patients.

**7. In response to question 8 (at para 8(e)) you say, *"It was usual for Care Coordinators to be allocated the care of the patients for whom they were Care Coordinator"*.**

(a) **To your knowledge, why was this usual?**

i. It was usual because it made sense to allocate the staff member best equipped to care for a specific patient. This staff member was usually the care coordinator and it also provided consistency of care.

(b) **Were Associate Care Coordinators usually allocated the care of patients for whom they were Associate Care Coordinator?**

i. It was common to do so if the care coordinator was not already allocated to the patient.

ii. Having patient allocation often involved balancing multiple complex factors. Even if a care coordinator or associate care coordinator was rostered on shift but not allocation to the patient, they would be available to assist the allocated nurse.

**8. In response to question 8 (at para 8(e)) you refer to the *"treating team"*.**

(a) **What (if any) is the relationship between the multidisciplinary team to whom the Care Coordinator reported (referred to at para 5(b) vii.), and the treating team?**

(b) **Which positions composed the treating team?**

(c) **What was the role of the treating team?**

(d) **Was there a treating team for all patients or a specific treating team for each patient?**

i. Please refer to my response at question 3 of my supplementary statement.

**9. In response to question 8(e) you say, "*there may have been patients with a greater need who required more experienced nursing staff to care for them and this may have resulted in the Care Coordinator not being available for allocation to their patient*".**

(a) **To clarify, do you mean:**

i. **The Care Coordinator had to be allocated to a different patient because that Care Coordinator's experience was required for that other patient? Or**

(1) Yes this is what I meant.

ii. **The patient had to be allocated to a different Care Coordinator because their Care Coordinator did not have sufficient experience to meet their needs? Or**

(1) No.

iii. **Something else (and if so what else)?**

(1) Not applicable.

(b) **If your evidence is 9(a)(ii) please state, to your knowledge and understanding, why nurses were made Care Coordinators for patients whose needs they were not sufficiently experienced to meet?**

i. Not applicable

**10. In response to question 8 (at para 8(d)) you say, "*I also had team leader responsibilities*".**

(a) **Was "*team leader*" a position (i.e. like Clinical Nurse or Nurse Unit Manager) or a role that a nurse is allocated on a given shift? If the former, for what period did you hold such as position? If the latter, on what basis was the role allocated?**

i. The Team Leader is not a position.

ii. My reference to "team leader responsibilities" means that I was the nurse in

charge of the shift. The nurse in charge of the shift was usually the CN or acting CN.

iii. When a CN or acting CN was not rostered on a shift, a registered nurse was selected to undertake team leader responsibilities for the shift. In this instance it is referred to as undertaking higher duties.

(b) **What were the duties and responsibilities of a team leader?**

i. In my response to question 5 of my original statement I outline the duties and responsibilities of the CN role which included team leader responsibilities.

(c) **Did you simultaneously have the duties and responsibilities of Acting CN and team leader? If so, did you find this to be a manageable amount of responsibility?**

i. The team leader responsibilities fell within my role as acting CN.

ii. I believe I was able to manage this level of responsibility.

**Operations and management (Further to question 11)**

**11. In response to question 11 (at para 1 l(c)) you say, "*The working environment started to change when there was talk about the BAC facility moving to Redland Bay*".**

(a) **How did the work environment change?**

i. I described how the work environment changed at the BAC in my response at 11(c) to (j) of my original statement. I have described an environment of reducing skill level and/or skill mix, staff changes, reduction in job security/certainty and uncertainty of the unit's future.

(b) **Who told you this, when and how?**

i. I cannot recall who told me about the BAC facility moving to Redland Bay but it was openly discussed with the staff in the unit.

(c) **How likely did you understand the proposed move to be?**

i. I took it as a given that it would happen.

(d) **When did you understand that the move would occur?**

i. I do not recall the specific dates or timeframes.

12. **In response to question 11 (at para 1 l(c)) you say, "*I recall that those staff members who were not likely to transition to the new facility [Redlands] were encouraged to obtain alternative employment prior to the move*" and (at para 1 l(d)), you say "*some nurses decided that [Redlands] would be too far to travel and found employment elsewhere*".**

(a) **Who encouraged the staff to find alternative employment?**

i. I do not recall who encouraged the staff to find alternative employment. It was my intention to relocate when the unit moved to Redlands.

(b) **How many nurses left the BAC around this point in time for this reason?**

i. I do not recall specifically. I recall being disappointed that we lost some promising staff members, at least two were directly linked to the move to Redlands.

13. **In response to question 11 you express a number of concerns you had about the staffing of nursing positions, including appointment of existing, contract, agency and nursing pool staff to act in permanent positions (para 11(e) and (h)), the appointment of successive acting rather than permanent NUMs (para 11(f)), and the decline in skilled and experienced nursing staff (para 11(e), (i) and (j)).**

(a) **Did you express your concerns about the staffing of nursing positions to anyone? If so, to whom, when and how?**

i. I did express my staffing concerns and believe I expressed them to the NUM at the time. I cannot now recall to whom or when I reported my concerns. I am

confident I expressed my concerns verbally to the NUM as I always had good working relationships with my NUMs and expressed my opinions frankly and freely.

(b) **Which position was responsible for the staffing of nursing positions at the BAC?**

i. On a day to day basis the roster was made by the NUM and any extra staff were provided via the Central Staffing Office (CSO) at The Park. The extra staff provided are staff that I refer to as 'not core BAC staff' and filled roster shortfalls, sick leave, extra staff needed during times of increased acuity.

ii. I do not know whose responsibility it was to appoint nursing staff to positions at the BAC.

14. **In response to question 11 (at para 11(f)) you say, "*In or about 2012 the permanent [NUM] retired and this vacancy was not permanently filled ... there were three maybe four different nurses acting in the NUM position from this time until the BAC closed. This was far from ideal because the NUM was the nursing leader for the BAC*". What (if any) was the effect of having an acting rather than a permanent NUM on the performance of nursing staff and care of patients. Provide examples.**

(a) I believe each NUM tried their best to fulfil the NUM role at the BAC and each of them brought different strengths to the role.

(b) Newly appointed NUMs generally have an adjustment period as they adapt to the role. This takes time. In the period from May 2012 to 24 January 2014 the BAC had four different nurses acting in the NUM role. This meant there were four separate adjustment periods which consumed a lot of time.

(c) At least two of the acting NUMs had no long term experience in management positions such as the NUM role. Because of this it took time for them to adjust and function as an experienced NUM. There was also a reluctance for the acting NUMs to make any changes while in the settling in period, which was understandable.

(d) Different NUMs had different styles of management which meant that the staff had to adjust to different management and communication styles. Our last permanent NUM knew his staff's capabilities and, likewise, we knew his management style, which provided a level confidence and stability within the unit.

(e) The nature of acting appointments as opposed to permanent appointments is that staff (NUM and other nurses) are uncertain how long they will remain in the position and to what degree to invest personal effort in establishing long term professional relationships.

(f) I have raised these issues not as criticisms of the individuals involved but to demonstrate the impact of the turnover of NUMs in the BAC.

15. **In response to question 11 (at para 11(k)) you say, "After the announcement to close the BAC, the consultant psychiatrist Dr Sadler was removed from his position at a time when there was a significant drain on expertise within the BAC. Dr Sadler's leaving upset both patients and nursing staff who were already traumatised by the closure announcement". What (if any) was the effect of Dr Sadler being removed at the point in time on the performance of the nurses and care of the patients? Provide examples.**

(a) Dr Sadler's departure left a great hole in the unit. This profoundly affected me and I have no doubt that it affected other staff, patients and families alike. The unit lost its leader at a significant time as he left shortly after the closure announcement. It was like adding insult to injury.

(b) Dr Sadler was replaced by a competent, honest and hardworking clinician, Dr Anne Brennan. Even though he was replaced by a quality clinician, his absence was disruptive in the extreme.

(c) It is very difficult to quantify and point at specific examples of the effect his removal had on the performance of the nurses and care of the patients. I feel it is true to say that most/ if not all of the staff held Dr Sadler in high regard and importantly felt that

he was being removed on grounds without merit. "If he can be stood down then who is safe?" From my conversation with many staff I feel it is fair to say this was on many people's minds. If someone can make a decision to remove him at this crucial juncture it is difficult to believe that the patients' best interests were behind decisions that are coming "from above".

(d) The nursing staff, despite Dr Sadler's departure, the unit's imminent closure, the loss of staff, their concerns about job security, concerns about the patients' safety and future, continued to provide a high standard of care to their patients in the most difficult times.

(e) Dr Sadler's departure did impact on the care of patients. The patients had to establish a rapport with a new consultant who did not know them and would be making major decisions about their future care.

(f) The patients' therapy was disrupted.

**Closure Decision (Further to questions 12, 13 and 14)**

**16. In response to question 12, you say, "*I recall attending a meeting when it was announced that the BAC was to be closed*".**

(a) **Where was the meeting held?**

i. I don't recall.

Signed: .....

(b) **Who organised the meeting?**

i. I believe it was organised at the executive level.

(c) **At the meeting, who addressed the attendees?**

i. A few executives whose names I cannot recall.

(d) **Who was invited to the meeting?**

i. Clinical staff and teachers.

(e) **Who attended the meeting?**

i. The meetings were well attended and I believe most staff attended.

17. **In response to question 13 you say, *"The closure decision was communicated to staff at the workplace"*.**

(a) **Do you recall the means by which it was communicated, i.e. email, announcement at a meeting?**

i. I recall it being communicated by Dr Sadler, face to face, to the patients and staff.

ii. He advised the staff prior to advising the patients so that we could support the patients.

(b) **If you do not recall who communicated the closure decision, do you recall which position made the announcement?**

i. Not applicable

18. **In response to question 14 you say, "*The explanation I recall being given was that a building report was obtained about the BAC facilitates which concluded that the buildings ... needed to be closed*". Who gave you this explanation, when and how?**

(a) This explanation was information presented at a meeting held by executive level staff.

I do not recall when it was presented.

19. **In response to question 14 you say, "*I recall being told that the model of care used at the BAC did not fit within the National Mental Health Service Planning Framework [NMHSPF] to treat patients close to home*".**

(a) **Who told you this, when and how?**

i. I do not recall all sources that repeated this line. I recall hearing it in the media from Mr Springborg. I believe it was mentioned by executive staff in one or more of the closure meetings. I cannot recall the dates of the meetings.

(b) **Were you familiar with the NMHSPF? If so, please outline and explain what it was, and why the model of care used at the BAC did not fit within it?**

i. I know of the NMHSPF but am not familiar with the detail in the document.

ii. I am unaware of whether the model of care used at the BAC did not fit within the NMHSPF.

(c) **Outline and explain the model of care used at the BAC. To your knowledge, was there a written model of care?**

i. I do not recall seeing a written copy of the BAC model of care delivery.

ii. We were a tertiary facility meaning that all admissions were via referral from other services. We closely examined any referral for prioritisation and that they had a mental health problem that we were equipped to help them with. Patients were treated by the treating team with constant assessment and review as previously outlined. Service delivery was flexible and included voluntary and involuntary inpatient services, day patient services and outpatient services. Patient and family engagement were crucial and our model included family therapy to help treat the young person as a part of their family. Service integration involved us involving community services prior to admission, during treatment and in planning discharge from the BAC.

iii. Our model involved the school and they similarly engaged with external schools to identify a patient's prior learning, educational needs during their stay. This included supporting their reintegration to schooling locally and/or closer to home on discharge. This flexibility extended to involving distant education, flexi-schools, home schooling and mainstream schooling.

**Transition Arrangements (Further to question 19)**

**20. In response to question 19 (at paras 19(a) and (b)) you say, "*I was not involved in the planning of the transitional arrangements of the BAC patients associated with the closure of the BAC*" and "*I knew it was happening but I did not participate in transitional planning meetings*".**

(a) **To your knowledge, what was happening in terms of the planning of transitional arrangements of the BAC patients associated with the closure of the BAC?**

i. Transitional Plans were being made by staff specifically assigned to the transition role.

ii. It was a deliberate decision to separate the transition role from mine (as covered in my response at 19(c) in my original statement). I recall that transition staff had to make difficult decisions based on the sub-optimal choices available to them when choosing transition arrangements. Not being directly involved makes it difficult for me to offer much in the way of specific details.

(b) **Who told you what was happening, when and how?**

i. I do not recall a specific formal method of being informed. My recollection involves patients sharing information with non-transitional staff like myself. Subsequently I supported the patients as best I could as they dealt with the impact of the arrangements.

(c) **To your knowledge, who was involved in planning transitional arrangements?**

i. I was aware that Dr Anne Brennan and Acting CNC Vanessa Clayworth were part

of the transitional planning team. I don't know who else was involved.

21. **In response to question 22 (at para 22(a)) you say, "*I was under the impression at that time that the transition could take as long as it needed so as to get it right*". What was the basis of your impression?**

    (a) This impression was based on information that I believe was provided by executive level staff. This means someone at executive level from Ipswich. However, it is possible that I didn't receive it directly from the source but may have been advised of same by someone on the transition team.

22. **In response to question 22 (at para 22(b)) you say, "*a date for closure was communicated to the staff. We were told that they were 'aiming to have it shut by [proposed date]'. This proposed date would change from time to time*".**

    (a) **Who communicated this to staff, and how?**

        i. I do not recall.

    (b) **What were the different proposed dates? How many different proposed dates were there? How often did the proposed date change?**

        i. I believe there were approximately three dates. I do not recall what they were or the timing of changes.

    (c) **To your knowledge, on what basis was the proposed date being changed?**

        i. My understanding is that the process was difficult due to the sub-optimal choices having to be made. Therefore, dates were changed to allow some more time.

23. **In response to question 25 (at para 25(c)) you say, "*The timeframes seemed to me to be accelerated compared with the timeframes taken prior to the closure announcement*". Please provide examples.**

    (a) Prior to the closure announcement, discharge from BAC was usually based on a patient's functioning improving to a point that meant they no longer required inpatient

treatment and could be managed in the community. Due to the closure patients that were not yet deemed ready for transition were required to be transitioned. This is what I mean by "accelerated".

**Effect of closure decision (Further to question 30)**

**24. In response to question 30 (at para 30(d)) you say, "*Some [inpatients] reported to me that their transition plans were inappropriate and inadequate for them. They felt it would not work and was not enough to keep them safe*".**

(a) **Which inpatients reported this to you, when and how?**

i.

ii.

(b) **Did you report their concerns to anyone at the BAC? If so, to whom, when and how?**

i. I informed the transition team. I don't recall to whom, when or how. It was common knowledge that the transition decisions were made with sub-optimal choices available. I believe the team knew they were making the best choices from a range of sub-optimal choices.

**25. What (if anything) was done to address the reaction of patients, their families and staff to the closure decision, and who was involved in addressing this issue?**

(a) I do not recall all the steps taken to address the reactions of patients, families and staff. I do recall a newsletter being published. Nursing staff largely supported each other and the patients. I do not recall official attempts to support staff.

**26. In response to question 30 (at para 30(1)) you say, "*The staff were very stressed as there was an ongoing investigation ... Many of the staff were interviewed during the investigation*".**

(a) **Why was this a source of stress for the staff?**

i. It was a source of stress because we were told that an investigation was underway because a complaint had been made about the staff at the BAC.

ii. When I attended the interview it felt like an interrogation. This is consistent with the reports of most of my colleagues. People were shaken and some required sick leave.

iii. Being involved in an investigation is generally understood to be traumatic. I found it very stressful to see my colleagues return from their interviews in a distressed state prior to being interviewed myself.

iv. I recall during my interview I told the interviewer that he was intimidating me and the QNU representative intervened which led to him modifying his behaviour. During the interview and again at the end of the interview I voiced my concern about the investigator's raised voice and pressured speech.

v. I was distressed by the interview, and it is my understanding that the manner in which other nursing staff were interviewed caused them distress.

(b) **Did the conduct of this investigation affect the performance of staff and / the care of the patients?**

i. The conduct of the investigation affected the performance of the staff as staff were absent from the unit to attend interviews over a number of days. Following the interviews some staff took sick leave and others returned to the unit clearly shaken. Staff were replaced to address the shortfall in nursing staff numbers but of course the replacement staff were not necessarily experienced adolescent mental health nurses.

ii. I cannot say that it impacted on the care of patients but the potential was there for this to occur.

**27. In response to question 30 (at para 30(0)) you say, "*Some of the teaching staff developed a negative even hostile attitude towards many of the nursing staff*".**

(a) **Which of the teaching staff are you referring to?**

i. Most of the teachers at the BAC school.

(b) **Did the breakdown in the working relationship between the teaching and nursing staff affect the performance of the nursing staff and/ or the care of the patients?**

i. I did not say there was a breakdown in the working relationship between the teaching and nursing staff.

ii. There was a tension between most of the teachers and the nurses that had not previously been present but we continued to perform our duties appropriately.

(c) **What (if anything) was done to address the breakdown in the working relationship between teaching and nursing staff, and who was involved in addressing it?**

i. The tension between most of the teachers and the nurses was certainly reported to the NUM. I am not aware of what steps were taken by the NUM.

**Support for staff (Further to questions 30, 32 and 33)**

**28. In response to question 30 (at para 30(k)) you say, "*For the staff, the decision to close brought great uncertainty about the future of our nursing career. It put a cloud over us*". Did this uncertainty affect the performance of staff and/or care of patients? If so, how?**

(a) As I have detailed in other questions it is difficult to separate the impact of individual elements of concern. It certainly added to the overall impact on morale and uncertainty. Having said that I think the nurses and other staff did an admirable job

in very trying circumstances.

29. **In response to question 32 (at para 32(a)) you say, "*The permanent nursing staff ... were invited to attend a meeting with management level representatives of WMHHS*".**

(a) **Who organised this meeting?**

i. I don't know who organised the meeting.

(b) **Which management level representatives of the WMHHS were present at the meeting?**

i. Julie Gotts from Ipswich Mental Health and Peter Howard from The Park were present as WMHHS representatives. There were other representatives there who I cannot now recall.

ii. There was also a representative from the prison service.

(c) **Were you told that the meeting was an interview prior to attending?**

i. No I was not.

30. **In response to question 32 (at para 32(b)) you say, "*I was told that there were 5 jobs for 10 people and that potentially 5 redundancies would be offered*".**

(a) **Who told you there were 5 jobs, when and how?**

i. I do not recall.

(b) **Were any or all of these 5 jobs suitable to you?**

i. They were suitable in the sense that I was capable of performing them. However, the jobs on offer would not have utilised my specialised adolescent mental health knowledge and experience.

(c) **Why were the redundancies only potential?**

i. If permanent staff members of the BAC accepted positions outside the WMHHS then it would reduce the number of redundancies being offered. For example, of the 10 permanent staff seeking employment, one staff member elected to take a job in the prisons and five were offered employment within the WMHHS, leaving four potential redundancies.

31. **In response to question 32 (at para 32(c)) you say, "*I was interested to know if I took job at the Mater Hospital Mental Health Unit whether this would affect the redundancy which precludes a person from working in Queensland Health for a period of time after taking a redundancy. After a number of email exchanges between me and a Human Resources officer at WMHHS I was advised that the Mater Hospital would count as Queensland Health". And (at para 32(e)), you say "I obtained advice from the Queensland Nurses' Union and was advised that if I had taken a job with the Mater Hospital it would not have affected my redundancy*".**

(a) **What was the name of the Human Resources officer?**

i. I don't know the name of the Human Resources officer.

(b) **Who was responsible for advising you about this matter?**

i. I do not know the name of the person responsible for advising me about this matter.

(c) **Where else could you have obtained advice about this matter?**

i. At the time I did not think I needed to obtain advice from anywhere else as I had no reason to believe the advice given was not accurate.

ii. Sometime later, it was suggested that perhaps the advice I was given was not correct. I ultimately sought advice from the QNU.

(d) **Please clarify how taking a job at the Mater Hospital would have affected your redundancy.**

i. It is my understanding now that taking a job at the Mater Hospital would not have affected the redundancy but this was not the advice given to me by the WMHHS representative.

ii. I believe my answer at 32(c) of my original statement answers this question.

(e) **Were you offered a job at the Mater Hospital?**

i. I was not offered a job at the Mater.

ii. I did not continue efforts to obtain employment at the Mater after receiving the advice from the WMHHS representative that it would negatively impact my redundancy.

**32. In response to question 32 (at para 32(d)) you say, "*I was offered a position at the Ipswich Hospital Inpatient Mental Health Unit*".**

(a) **Which was more suitable, the job at the Mater Hospital or the job at Ipswich Hospital?**

i. I was not offered a job at the Mater Hospital.

(b) **Was the job at the Ipswich Hospital suitable?**

i. It was suitable as it was a job in mental health nursing for which I was experienced. However, I had recent considerable experience in adolescent mental health nursing which was not being utilised in this position.

**33. Further to question 33, did you need support? If so, what support did you need and who do you think was responsible for providing it?**

(a) I needed collegial support which we provided to each other.

**Operations and management (Further to question 34)**

**34. In response to question 34 (at para 34(b)) you say, "*The holiday program was taken off the BAC staff and given to an external provider which bewildered the patients*".**

(a) **Whose decision was it to outsource the holiday program?**

i. I don't know.

(b) **To whom was the holiday program outsourced?**

i. I don't know the name of the organisation.

(c) **How did this affect the care and transitioning of patients?**

i. I don't think it directly impacted their transitioning.

(d) **Did you share your concern about the outsourcing of the holiday program to anyone at the BAC? If so, to whom, when and how?**

i. I verbally shared my concern with the NUM. I do not recall when I did this.

**35. In response to question 34 (at para 34(c)) you say, "*The rules changed about who would accompany the patients*".**

(a) **Who changed these rules?**

i. I don't know who made the decision.

(b) **Were you consulted in relation to this change?**

i. No.

(c) **How did this change affect the care and transitioning of patients?**

i. It affected which patients could attend outings.

ii. The rule requiring the CN to remain on the ward often resulted in certain patients

being no longer eligible to attend outings as I detailed in my response at 34(c) of my original statement.

iii. The decision that the patient was not eligible to attend outings contributed to the patient feeling restricted, missing out and apart from the wider community and co-patients.

iv. The requirement to keep the CN on the ward altered the skill mix available to supervise outings such that often they could not proceed.

v. There was another change which dictated that outings were to be planned well in advance and approved by senior nursing staff. This removed the CN's capacity to provide impromptu outings as needed from time to time. For example, the ward community experienced tension build up due to certain patients experiencing significant outward displays of distress on the ward. In such circumstances our prior practice was to include an option to have the other patients attend an impromptu outing (when safe to do so) to allow some respite and diffusion of the tension in a safe and timely way. The requirement that outings were to be preplanned removed the impromptu outing option from the experienced clinicians. This contributed to the stress experienced by patients during the transition period.

(d) **Did you share your concern about this change to anyone at the BAC? If so, to whom, when and how?**

i. I voiced my concern to the NUM.

**36. In response to question 34 (at para 34(d)) you say, "*It seemed to me that rules were being made on the run*". And, refer to these rules are "*one size fits all*".**

(a) **Please provide examples.**

i. The introduction of patient allocation, CNs not attending outings, outings needing to be pre-planned and the changes to the holiday program were all examples of

inflexible rules being made.

(b) **Who was making the rules to which you are referring?**

i. I do not know who made the decision. It was communicated by the NUM and our input was not sought about this change.

**Confidential Investigation Report**

37. **Exhibited to the Statement of Sharon Kelly is a report entitled Confidential Investigation Report ("Report"), which reports on an investigation conducted by Glen Pearce [WMS.6000.0007.00649]. The Report says that as part of the investigation you gave an interview on 18 October 2013 [WMS.6000.0007.00649 at .00656]. A summary of this interview is annexed to the Report at Annexure 41 [WMS.6000.0007.00244 at .00369]. Do you have anything to change or add to the summary of your interview?**

(a) In addition to my responses at 26(a), I attended the interview on 18 October 2013 without having been provided with any details about the complaint under investigation.

(b) The answers I gave during the interview were based on my memory only. I was not provided with any relevant documentation before or during the interview to assist my memory.

(c) It would have been of great assistance to me had I been given the details of the allegations before I went to the interview and been provided with the relevant patient notes to inform the responses I gave.

(d) I recall during the interview that on many occasions I indicated to the interviewer that I would need to refer to my notes to fully and accurately respond to some of the questions asked. The interviewer did not show me any notes or documents during the interview.

(e) The summary mostly accords with my recollection but does not make note of my frequent requests to refer to my notes in order to answer questions.

And I make this solemn declaration conscientiously believing the same to be true, and by virtue of the provisions of the Oaths Act 1867.



Matthew Beswick

Taken and declared before me at Brisbane this 12th day of February 2016



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Judith Simpson, Solicitor