**OATHS ACT 1867**

**STATUTORY DECLARATION**

**SUPPLEMENTARY STATEMENT**

**QUEENSLAND**
**TO WIT**

I, **Susan Daniel**, 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 13 January 2016, requesting I provide additional information in a supplementary statement.

The references to "questions' are to those in the Notice to Provide a Written Statement dated 1 October 2015 previously issued to me.

**Response to Schedule of Further Questions**

**Professional Experience**

1. **Further to questions 1, 2, 3, 4 and 5, and your Curriculum Vitae (CV):**

   (a) **Your CV lists the same key duties for the positions of Acting Nurse Unit Manager (NUM), Acting Clinical Nurse Consultant (CNC), and Acting Nurse Practice Coordinator (NPC). Please outline and explain the distinction (if any) between these positions in terms of duties and responsibilities.**

   i. To clarify, I held the substantive position of Clinical Nurse Community Liaison (CL) at the BAC from November 2007 until the position was abolished in or about October/November 2013. Prior to this I held the substantive position of Registered Nurse (RN) from October 1996 to November 2007.

   ii. During my employment at the BAC, I acted in the position of Nurse Practice

Signed: ....

Coordinator (NPC)/Clinical Nurse Consultant (CNC) from time to time as noted in my CV.

iii. There was a position name change from NPC/CNC to NUM sometime during the 2000s.

iv. To my knowledge, there was no distinction between the roles of the NPC/CNC and NUM as they operated at the BAC at that time.

(b) **Your CV lists the same dates for the positions of Acting NUM, Acting CNC and Acting NPC. Did you hold these positions concurrently for the dates listed? If not, when did you hold each of these positions?**

i. As explained in my response at 1(a) of this supplementary statement, the position of NPC/CNC and NUM were the same. Therefore, there was no overlap.

(c) **Your response to question 11 says that you undertook the aspects of the CNC role as CL. Aside from this, did you ever hold the positions of Acting NUM, Acting CNC or Acting NPC concurrently with the position of CL? If so, when did you do so?**

i. I took on aspects of a senior clinical nurse role which fell within the role of a CNC while I held the substantive position of CL because there was no substantive position of CNC at the BAC until it was created just prior to closing.

ii. I did not concurrently hold more than one position at a time. This is not something that would normally occur.

(d) **To your knowledge, who (if anyone) occupied the position of Community Liaison (CL) whilst you were acting in other positions?**

i. When I acted up in other positions I recall Vanessa Clayworth, Jeannine Garbutt and Adrian Walder acted in my substantive position of Clinical Nurse Community Liaison (CL).

ii. I cannot now recall when they acted in the position of CL.

**2. Further to question 3:**

(a) **How many shifts did you carry out per week in the positions of Acting NUM, Acting CNC and Acting NPC?**

i. I worked the same number of shifts, that is, 5 shifts per week when I acted in the role of NUM (previously called NPC/CNC).

**3. Further to question 6 and your CV:**

(a) **Your response to question 6 states, "As CL, I reported to the NUM and Unit Director". However, your CV states that you only "Met with Unit Director and Nurse Unit Manager with updates on consumers on the admission waiting list", which was one aspect of your role as CL. Also, your CV states that you "Provided feedback [about referees] to the interdisciplinary team". Please outline and explain more fully who you reported to and took instructions from in relation to each aspect of your role as CL?**

i. The position of CL reported professionally and operationally to the NUM of the BAC.

ii. As a member of the interdisciplinary team I reported to the team members which included, among others, the NUM and Unit Director. I took instructions from the interdisciplinary team which included the NUM and Unit Director.

iii. I have used 'interdisciplinary' and 'multidisciplinary' to describe the treating team which I consider to be the same. I will refer to this as MDT.

**4. Further to questions 1, 2, 4, 11, 33 and your CV:**

(a) **Your response to Q1, 2, and 4, and your CV, indicate that you remained employed as CL at the BAC until July 2014. Your response to Q11 and 33, says that you went on stress leave "at the end of October/beginning of November"**

Signed: ….

**2013. To your knowledge, after you went on stress leave, who occupied the position of CL? Were you on stress leave until July 2014? If not, when did you return from stress leave and where were you physically undertaking your work as CL?**

i. At the time I went on stress leave I was told that my position as CL was abolished.

ii. I was on stress leave until July 2014 when my employment ceased at The Park, Centre for Mental Health.

iii. After the BAC closed, I returned to The Park for one day so as to qualify for redundancy. I cannot now recall when this occurred.

iv. I did not undertake work as CL as my position had been abolished.

**Role of CL & Stages of Admission**

**5. Further to question 5, and your CV:**

(a) **Please outline and explain the different stages of admission into the BAC, such as referral, assessment, wait list and admission.**

i. Referral:

(1) Referral enquiries were directed to me as CL. I advised the referrer to submit an application form and where possible provide supporting documentation about the referred client's history. The referred client's details and information would be entered into CIMHA and a clinical record was created.

ii. Assessment:

(1) Referred clients were assessed for suitability by reviewing collateral information from the referrers/CIMHA, clinical notes, the carer and the consumer.

(2) Usually I and another clinical staff member would conduct an assessment interview. Interviews would typically include the referred client, his or her parent/s or carer/s and in some cases the mental health service referrer or a Child Safety Officer or a member of the adolescent's Education Department.

(3) After the interview, I conducted a tour of the unit with the referred client, parent/s or carer/s (and in some cases the referrers) to assist the referred client and their guardians in making an informed decision about their choice of treatment at the BAC.

(4) The referred client's readiness and willingness to participate in the treatment process was encouraged while considering the BAC for treatment.

(5) I collated the available documentation including CIMHA data and details from the interview into a report with a formulation and recommendations/plan.

(6) I presented the case to the multidisciplinary team (usually including an Education Department representative) for discussion and determination of suitability regarding admission.

(7) I then communicated the outcome to the referrer.

(8) Assessment collateral was made available to staff prior to admission to assist their understanding of the patient's issues, needs and related care.

iii. <u>Wait List:</u>

(1) If accepted, the referred client was placed on the wait list.

(2) Responsibility for the clinical care of the referred client remained with the referring service until admitted to the BAC.

(3) I requested updates from the mental health referrer, and in some cases from a Child Safety Officer or their care provider. This enabled me to appropriately prioritise the wait list clients for upcoming vacancies and helped to ensure a sustainable balance of high acuity clients at any given time. The use of CIMHA also enhanced access to up-to-date information on wait list clients.

(4) Wait list times were dependent on vacancies. Vacancies were dependent on discharges.

(5) Discharges occurred after a graduated separation from the unit with community support and integration.

(6) Admission timeframes varied, depending on each adolescent's individual recovery rate.

(7) Admission timeframes were longer than acute units, due to the impact of an adolescent's developmental delays which were often present in those clients referred to the BAC. These adolescents tended to be more treatment resistant within the community setting therefore needed longer more intensive treatment and rehabilitation.

(8) In my opinion based on my observation, once developmental delays were addressed, the adolescent seemed to be better equipped to combat their mental health issues.

iv. Admission:

(1) Admissions may be for a limited assessment period, a longer stay treatment program, or attendance as a day patient.

(2) Admission began with the assessment of the client which helped identify strengths and deficits.

(3) A strengths-based recovery approach was used at the BAC, whilst assisting

the adolescent in learning how to manage, overcome deficits and reach their tasks of adolescent development.

(4) When the adolescent gains a greater degree of confidence and skills, family therapy may be initiated.

(5) Throughout the admission adolescents, who were geographically able, were encouraged to have weekend leave with their families. This enabled families and the adolescent to practice any skills learned and monitor further progress within the community setting. The Department of Communities/Child Safety were asked to provide, for adolescents in their care, a supervised community residence for weekend leave. Such leave helped adolescents combat any dependency on BAC, or institutionalisation.

(6) Towards the end of admission, community integration is commenced. This graduated exposure to the community provided the adolescent with the opportunity to practice their skills, have their progress and risk monitored and ease them away from any dependency that might occur from longer admission. It provided feedback on how the adolescent, caregivers and community service providers were managing.

(7) Community integration often included part-time attendance at a school, other than the BAC School (in some cases, those adolescents whose residence was a significant geographical distance from BAC would attend a near-by school, until ready for discharge).

(8) The amount of leave to the community would increase, as the adolescent was able to manage, until discharge was deemed appropriate.

(b) **Please outline and explain the criteria, policies and procedures in relation to a consumer progressing from referral to admission, including who was involved in this decision making process, such as the "interdisciplinary team" mentioned in your CV.**

i. The criteria for referral:

(1) a referral had to come from a mental health provider;

(2) generally referrals came from Queensland as it was a state-wide service;

(3) adolescents aged between 13 to 17 years with severe and complex mental illness who may have impaired development secondary to their mental illness, who may have persisting symptoms in functional impairment despite previous treatment delivered by other components of child and adolescent health services which commonly included:

(a) depressive and dysthymic disorders;

(b) post-traumatic stress syndromes;

(c) social anxiety and other anxiety disorders;

(d) eating disorders;

(e) psychotic disorders;

ii. The criteria for assessment: -

(1) Information sought for assessment included:

(a) presenting complaint;

(b) history of presenting complaint;

(c) past psychiatric history

(d) medication history;

(e) risk history;

(f) legal history;

(g) drug and alcohol history;

(h) family history;

(i) developmental history including school, peer and early childhood; and

(j) premorbid personality.

(2) From this information a formulation was made to make recommendations to the treating team as to the referred client's suitability for admission. Considered within the formulation were perpetuating factors, precipitating factors, predisposing and protective factors and prognosis. The referred client's readiness to engage was also considered.

(3) The MDT decided, based on all the information, whether the referred client was suitable for admission.

iii. Priorities for admission were determined on the basis of levels of acuity, the risk of deterioration, the current mix of adolescents on the unit, the potential impact for the adolescent and others admitted at the time, length of time on the waiting list and age at time of referral.

iv. There was no current policy or procedure relating to the admission process as it was considered by the Service Improvement Coordinator to be well established practice which did not require a policy or procedure.

v. The core MDT consisted of Clinical (Unit) Director, nursing representative/s, psychologist, occupational therapist, social worker, speech therapist and where appropriate, education representative and dietician.

(c) **In relation to the role of CL, in your response to question 5, you describe it variously as "gatekeeper" for admissions, "first contact" for community referrals, "responsible" for ensuring a suitable mix of patients. In your CV, *inter alia*, you state that you, "Performed assessment interviews", "collated findings... into a report", as well as liaising with referees. Please clarify the exact role, authority and input of the CL in each stage of the admission process.**

i. Please refer to my response at 5(a) of this supplementary response which details my role and input as CL in each stage from referral to admission.

ii. It was my role as CL to conduct the steps from referral to admission outlined in my response at 5(a) and contribute referral information to the MDT. As part of the MDT I was involved in the determining the suitability of referred clients for admission. The ultimate authority to decide rested with the Clinical Director of the BAC.

**Model of Service Delivery**

**6. Further to your CV**

(a) **Your CV refers to "the new Models of Service Delivery (2000)". Did the BAC have a written and endorsed MOSD?**

i. I do not believe that the BAC had a written and endorsed MOSD.

(b) **If so: When was the MOSD developed? When was the MOSD endorsed? How accurately did the MOSD reflect day-to-day clinical practice at the BAC? Can Ms Daniel provide a copy?**

i. Not applicable given my response at 6(a)i of this response.

(c) **If not: Had there been efforts to develop a MOSD? Who was involved? When did this occur? Why was there no formal and/or endorsed model of service delivery? In the absence of a formal MOSD, what guided day-to-day clinical practice at the BAC?**

i. I recall that Dr Sadler prepared a draft Adolescent Extended Treatment and Rehabilitation Centre (AETRC) Model of Service which he emailed to the BAC staff seeking their input. I cannot recall whether he prepared it for the BAC, for the proposed service at Redlands or for review by other groups such as the expert clinical reference group.

ii. I cannot now recall when this occurred.

iii. I understood that the draft AETRC Model of Service Delivery prepared by Dr Sadler was unable to be endorsed because the endorsement body had disbanded.

iv. The day to day clinical practice at the BAC was based on a strengths-based recovery model whilst assisting the adolescent in learning how to manage, overcome deficits and reach their tasks of adolescent development. It is my understanding that this model was consistent with the National Framework for the Recovery-Orientated Mental Health Services framework utilised at The Park.

**Transitional Arrangements**

7. **Your response to Q19 says that you "created a checklist as a guide for requirements that would be needed for each patient". Do you have a copy of this checklist in your possession or control? If so, please provide a copy to the Commission. If not, please set out the contents of the checklist to the best of your recollection.**

(a) I do not have a copy of the checklist.

(b) I am unable to recall the contents of the checklist.

8. **Your response to Q19 refers to transitional planning and a transitional planning group. To your knowledge, please outline and explain what was involved in transition planning, and what tasks the transitional planning group undertook as a whole and, in their capacity as a member of that group, individually.**

(a) Before the BAC closure decision, the MDT was involved in transitioning patients

from the BAC to the community.

(b) In my role as CL I was part of the MDT and from time to time I was involved with the team in transitional planning.

(c) After the decision to close the BAC was announced, I was approached by Dr Brennan to be part of a transition planning group. I offered to prepare a checklist for each of the patients being transitioned however, this was not something I ordinarily undertook as CL.

(d) I used my best endeavours to prepare a checklist to assist in transitioning patients from the BAC to the community. The checklist was accepted by Laura Johnson, a Project Officer appointed for the Redevelopment of Mental Health and Specialised Services by Corporate Office to assist the transitional planning group.

(e) I cannot now recall the detail of the checklist; my involvement in transition planning; and the tasks the group undertook as a whole or individually.

9. **Your response to Q19 states, "My involvement in the transitional planning group included making desperate internet searches for possible community support services and numerous telephone calls to make referrals to other agencies or facilities with the hope of being able to jump wait lists", while your response to Q27 states, "The problem for the transition team was not how the plan was developed but how it could be implemented given the limited services available to meet the individual patient's needs".**

(a) **Please clarify the difference between the planning and implementation stages of transitional arrangements. In particular, were transitional plans developed in the abstract based solely on patient needs, or were transitional plans developed in light of available services?**

i. The planning related to assessing and identifying the needs of the individual patient and preparing a plan taking into account the patient's needs to transition them out of the BAC to some other appropriate service.

ii. The implementation related to the carrying out of the plan.

iii. The transitional team prepared a plan for each patient based on their need taking into account the services currently available.

iv. My answer to Q27 was given in the context of the question which enquired as to whether the transition plans for individual patients adequately took into account those patients specific care, support, health, education/vocation needs. To be clear, the limited availability of relevant services did not create a problem in identifying the individual patient's needs. The difficulty arose in determining the services that would meet those needs. That difficulty impacted on the planning and implementation stages of the transitional arrangements.

(b) **To your knowledge, who was involved in the implementation, as opposed to the planning, of transitional arrangements?**

i. It is my understanding that various members of the MDT were involved in the implementation of the transitional arrangements. Actions were allocated to individuals in the transition plan.

ii. Some of the actions were followed through by members of the transition planning team, for example, referrals or liaisons with other agencies regarding intake.

iii. To the best of my recollections actions relating to transitional arrangements were noted on the Case Review Meeting Clinical notes within CIMHA and the transitional progress of each patient was reviewed by A/CNC Vanessa Clayworth and Acting Clinical Director Dr Anne Brennan in the weekly Clinical Review Meetings.

**10. Your response to Q19 says that Dr Brennan approached you about who should be involved in transitional planning in Sept 2013. Your response to Q19 says that you went on stress leave once the transitional planning for each individual patient was concluded, which your response to Q28 says was at the end of Oct/beginning of Nov**

**2013. Your response to Q25 says that the BAC was to close around 14 Jan 2014. Please clarify when the planning and implementation stages of the transitional arrangements occurred.**

(a) I was involved in the transitional planning and once concluded my position as CL was abolished.

(b) I was not present at the BAC for much of the implementation of the transition plans.

(c) I am unable to clarify when the planning and implementation stages of the transitional arrangements occurred. The question suggests that there was a date when planning started and finished and then a date when implementation began and finished. This would have been different for each patient and I cannot now recall this detail.

(d) I believe that Laura Johnson, a Project Officer appointed for the Redevelopment of Mental Health and Specialised Services by Corporate Office was assigned to document the plans/activity discussed in the transitional planning meetings. This documentation may provide the detail sought in this question.

**11. Your response to Q25 says that "the time for transitioning patients was significantly reduced compared with the time it usually took to transition a patient', and "there was a scurry to find places as quickly as possible for the patients". Your response to Q27 says that the transition plans were adequate, but the problem was in their implementation. Please clarify whether or not you consider the lack of time or the lack of available services, or both, to have contributed to the adequacy of the transitional arrangements, as implemented.**

(a) If BAC had not closed, some patients would have required a longer stay to better prepare them in skills for discharge into the community.

(b) Please see my response at 9(a)(iv). There was a lack of service options available for adolescents who required increased supervision and support in an adolescent-suitable accommodation, as well as support in accessing services catering to the

adolescent's needs such as vocational and social avenues.

(c) In my opinion, in some cases (Patients , discharge to the community was a retrograde step as there was no service like BAC yet established. I believed these patients needed more admission time in an adolescent extended rehabilitation centre similar to the BAC.

**12. Your response to Q8, 23 and 24 say that you were involved in Patient transitional arrangements. Please evaluate the adequacy of Patient transitional arrangements.**

(a)

(b) I am unable to provide more detail without reviewing the patient's clinical record.

(c)

**Dr Sadler & Dr Brennan**

**13. Further to questions 11, 17 and 18:**

(a) **In response to question 11 you state "Dr Sadler was terminated from his position at a most critical time for the BAC".**

i. **In what way did Dr Sadler's termination impact on the running of the BAC?**

Signed: .....

(1) I cannot now recall whether his termination impacted on the running of the BAC. When I stated that he was terminated at a most critical time, I meant that we, the staff at the BAC, had recently learned that it was to close and the person who was most central in the multi-disciplinary team and had been at the BAC for a long time was removed. I recall his leaving was a significant blow to staff and patient morale.

ii. **Did Dr Sadler's termination impact in any way on the ability to transition patients out of the BAC given the impending closure? If so, how and why?**

(1) I do not believe that his termination impacted on the transitioning of patients out of the BAC.

iii. **Did you have any concerns about Dr Sadler's termination at this point in time? If you had such concerns, did you voice them to anyone and, if so, to whom and how?**

(1) I considered Dr Sadler to be a major player and influential in the Expert Clinical Reference Group which was looking at alternatives to the BAC. It seemed to me that once Dr Sadler was out of the way, the interest in an alternative unit seemed to take a back seat to unit closure.

(2) I cannot recall whether I voiced my concerns to senior management. Even if I had, I don't believe it would have had any impact anyway.

(b) **In response to question 17 and 18 you said that Dr Brennan was employed to occupy Dr Sadler's position whilst he was on leave.**

i. **How did this change of Clinical Director impact on the transition arrangement process? Were there difficulties in the handover? If so, please identify any difficulties.**

(1) I understood from Dr Sadler that he had commenced transition planning for the patients prior to him being stood down and that it had been discussed at

the weekly clinical review meetings.

(2) I am unable to say whether there were difficulties in the handover. A handover would usually occur at a number of levels such as between the exiting and incoming Clinical Director and at team meetings.

(3) I cannot recall whether I participated in a handover with Dr Brennan.

(4) I do recall that Dr Sadler was hopeful that the unit would transition to another location which, I understand, was raised by him at the Expert Clinical Reference Group meetings. Because of this, his approach to transition may have been different.

(5) Once he was stood down, things were full speed ahead with a more single minded and, in my view, a short-sighted approach to exiting the patients.

(6) I believe Dr Brennan performed her task to the best of her abilities. She appeared to be under a lot of pressure and stress to achieve results within the timeframe.

ii. **The Commission understands that Dr Elizabeth Hoehn was engaged to assist and support Dr Brennan upon Dr Sadler being stood down. Please outline what involvement (if any) you had with Dr Hoehn in relation to the transitioning of patients.**

(1) I do not recall having any involvement with Dr Hoehn in relation to the transitioning of patients.

**Closure Decision & Support**

**14. Your response to Q11 says that you were disappointed with the ending of the CL position, and the offer of the position as CNC, prior to the closure of the BAC. Did you think that the CL position was still required? If so, when did you think that the CL position should have ceased. What position do you think you should have been offered?**

(a) I did not say that I was disappointed with the ending of the CL position and offer of the position as CNC. I was, in fact, offered a CN position on the floor of the BAC not a CNC position. In my response at 11(g) of my original statement I said that the offer of a CN position on the floor of the BAC was 'completely insensitive'.

(b) I believed that the CL position was still required as I had outstanding reports to complete. These reports had been put on the backburner while I worked on the transition plans. I would have appreciated time to close these.

(c) I had held and valued the CL position for several years and would have appreciated not leaving it in this state.

(d) I had also been led to believe that we would have some further communications with those on the referral and admission wait lists as stated in the WMHHS BAC Staff Communiqué 1 dated Thursday 3rd October 2013 (marked and attached to my first statement at [[QNU.001.003.0021]]), as follows: "For adolescents currently on the waiting list, we will work closely with their referring service to identify their options for care".

(e) To the best of my knowledge this did not occur.

(f) I was disappointed that the position of CNC at the BAC was only created when nearing its closure.

(g) Had a CNC position been created at an earlier time, it would have been a huge operational support in keeping the BAC up-to-date with clinical quality improvement activities.

**15. Your response to Q32 says that you were offered a job in the forensics unit, after the closure of the BAC, which you did not feel "comfortable or confident" to accept. Where was the forensics unit? What position do you think you should have been offered?**

(a) The forensic units were part of The Park – Centre for Mental Health. The Park –

Centre for Mental Health was in the final transitions from being an Extended Care Mental Health Rehabilitation Facility with a broad patient focus to a primarily forensic focus. I had only worked in the forensic wards as a student some 19 years ago.

(b) I felt that I should have been offered a 9 to 5 position in Child and Youth Mental Health Services as it was more closely aligned to my position description, rather than being offered shift work at the BAC until it closed then a position in a forensic ward. When this was not forthcoming I asked my union representative to liaise on my behalf with senior management to consider a redundancy package.

**16. Your response to Q33 says that you were not provided any formal support. Do you think that you should have been provided support? If so, what support should you have been provided, and who should have provided you that support?**

(a) On reflection, it is possible that the NUM (Alex Bryce) offered me access to the Employment Assistance Scheme (EAS) which I may have declined choosing to seek support avenues of my own. I really cannot recall.

(b) I am aware that Sharon Kelly offered me access to EAS when looking at my employment options. I don't know that there was anything else to offer. Perhaps the voluntary redundancy could have been offered 'when' my position became redundant as staff had previously been asked what their preferences were by human relations.

**17. Your response to Q11, states that you went on stress leave. Your response to Q11 says that you were finding it difficult to perform your job. Your response to Q11 also says that you were told your position of CL was no longer required and you considered the suggestion that you work as CN to be "insensitive'. Your response to Q19 says that you "took sick leave due to the stress and concern I held for the safety and well-being of the patients" and you "felt emotionally drained and unable to perform [your] role". Please clarify the reason/s you were finding it difficult to perform your job and the reason/s you went on stress leave. Did you receive medical**

**treatment in relation to your stress?**

(a) As to the difficulties I experienced in performing my job, I have nothing to add in addition to my responses in my original statement and my responses at 9(a)(iv), 11 and 14(a) to (g) of this supplementary statement.

(b) I did receive treatment in relation to the stress symptoms from appropriately qualified people.

**18. Your response to Q33 says that you have not returned to nursing practice. Why have you not returned to nursing practice? What is your current occupation?**

(a) I have not returned to nursing practice as I am presently not well enough to return.

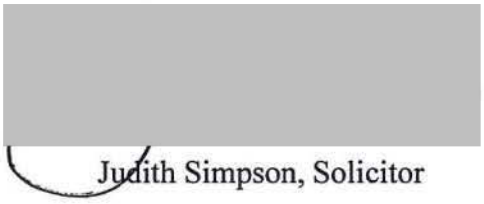
(b) I am currently not employed but at the end of 2015 I undertook some voluntary administrative work of about 10 hours per week to "test the waters" and regain my confidence.

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

..

Susan Daniel

Taken and declared before me at Brisbane this 10th day of February 2016



Judith Simpson, Solicitor