Oaths Act 1867

Statutory Declaration

I, **Angela Clarke** care of Corrs Chambers Westgarth by email to Level 42 One One One, 111 Eagle Street, Brisbane, in the state of Queensland, do solemnly and sincerely declare that:

Background and experience

1 What are your current professional role/s, experience, qualifications and memberships? Provide a copy of your most recent curriculum vitae.

1.1 Attached and marked **AC-1** is a copy of my most recent and current curriculum vitae.

1.2 My roles, qualifications and memberships are outlined in my curriculum vitae.

2 What positions (or acting positions) did you have at the Barrett Adolescent Centre (BAC). Specify the period in which you held these positions. Outline the nature of the duties you performed in each position.

2.1 I commenced with BAC, West Moreton Hospital and Health Service (WMHHS) in October 2000 (0.5 Full Time Equivalent) as an acting PO3 Speech Pathologist. At that time, I held a substantive PO2 (base-grade) position at Ipswich Child & Youth Mental Health service (CYMHS).

2.2 In January 2002, I was interviewed for the BAC position and was successful.

2.3 In 2006, I applied for advancement from PO3 to PO4 under the Queensland Health (**QH**), Allied Health Conditional Advancement scheme, and was successful.

2.4 In 2009, under the QH Health Practitioner Translation process, I applied for advancement from PO4 to HP6, and was successful.

2.5 I only had one role at BAC and that was Speech Pathologist though my professional level increased (as described above).

2.6 The duties/responsibilities I undertook in my role were largely the same throughout my period of employment (10 October 2000 until 28 January 2014).

2.7 Specific functions I fulfilled at BAC included:

(a) Formal and informal (psychometric) assessment of consumers' communication functioning, including core language development, literacy, and functional language skills, such as social skills.

(b) Diagnosis of communication impairment with reference to the ICD-10 classification system.

(c) Provision of verbal and written feedback within the treating team, to consumers, to families and carers, and to external agencies.

(d) Participation in team meetings/case reviews to provide information and advice on management of consumers with communication impairments and special needs in the areas of speech, language and communication.

(e) Providing advice to colleagues on the modification of standard mental health programs to meet the individual consumer's speech, language and communication needs, in order to minimise the impact of communication impairment on the consumer's capacity to engage in treatment and recovery.

(f) Assisting consumers attempting to re-integrate into a mainstream high school in the community, including meeting with school staff to discuss how to support the consumer's language, learning and social needs.

(g) Implementing individual rehabilitation programs for consumers with communication impairments.

(h) Implementing group rehabilitation programs for consumers with communication impairments, in particular, social skills groups.

(i) Co-facilitating group rehabilitation programs for consumers implemented by colleagues within the multidisciplinary team.

(j) Providing professional development/in-service training to colleagues at BAC including allied health, nursing and to teaching staff at BAC on co-morbidity of communication impairments (speech, language, literacy) and mental health disorders.

(k) Undertaking data collection, literature reviews, quality activities, and training to

support professional development.

(l) Provision of clinical placements for undergraduate, masters and new-graduate[1] speech pathologists.

(m) Participating in performance planning and review processes and professional supervision (individual and peer).

(n) Participation in service reviews, organisational change processes, and so on as required by my employer.

(o) Development of business cases and funding applications to support service development.

3 Were you aware of the circumstances surrounding Dr Sadler's departure, removal or suspension from the BAC on or about September 2013? If so, when did you first become aware and by what means? Give details of those circumstances including the reasons for his departure, removal or suspension.

3.1

Redlands

4 Were you involved in the Extended Mental Health Treatment Unit Redlands User Group? If you were involved

4.1 I can confirm that I was involved in the Extended Mental Health Treatment Unit Redlands User Group (User Group).

[1] WMHHS has a program of new graduate speech pathologists whom rotate between clinical units within the HHS. Between October 2012 and on or about December 2013 new graduate speech pathologists were working at BAC. The responses in this Witness Statement relate to my work with the patients of BAC and do not include work done by the new graduates. Some patients received a speech pathology service delivered by new graduate speech pathologists and that intervention is not included in this statement.

4.2 My role in the User Group commenced in or about October 2009 when I was nominated by Dr Sadler to be a part of the User Group. Attached and marked **AC-2** is a copy of an email sent from Dr Sadler stating that he had nominated me to be part of the User Group.

4.3 I recall that I was copied into numerous pieces of correspondence about User Group meetings. I also attended a number of meetings at BAC or Redlands Hospital to discuss how we worked as a team and how this should influence the design of a new unit or how the 'new BAC' would operate.

4.4 For example:

(a) On 26 November 2009, I attended a 'User Group' meeting at BAC where we met with staff from QH, Metro South Health Service District and Architects from the Project Services Team at the Department of Public Works. We participated in a guided tour of BAC. Attached and marked **AC-3** is a copy of the minutes from this meeting.

(b) On or about 16 August 2010, I was sent an email from Kerry Ann Ward from the Department of Public Works regarding the dates for future User Group meetings and the topics for discussion (User Group Schedule). Attached and marked **AC-4** is a copy of an email between Kylie Bruce and I discussing that email and attaching the User Group Schedule.

(c) On 3 September 2010, I attended a User Group meeting at BAC (User Group Meeting A2) during which I undertook (in consultation with Kevin Rodgers from the Department of Education and Training) to produce a list of the space requirements for the school. Attached and marked **AC-5** is a copy of the minutes from this meeting.

(d) On 16 September 2010, I attended a meeting at Redlands (User Group Meeting A3) and tabled the space requirements for the school that I had developed in consultation with Mr Rodgers. Attached and marked **AC-6** is a copy of the minutes from this meeting.

(e) On 30 September 2010, I attended a meeting at BAC (User Group Meeting A4) and can see from my review of the minutes (which are attached and marked **AC-7**) that we continued to discuss the design concept.

(f) On 28 October 2010, I attended a meeting at Redlands (User Group Meeting A5) and can see from my review of the minutes (marked as Attachment **AC-8**) that we continued to discuss the design aspects of the new facility.

(g) I am aware that in accordance with the User Group Schedule there were meetings held on 19 August 2010 (User Group Meeting A1), 11 November 2010 (User Group Meeting A6) and one final User Group meeting on 21 December 2010 (User Group Meeting A7). From my review of the minutes, I can see I was an apology for these meetings.

(h) On or about 4 February 2011, I attended an all-day peer review meeting held at Butterfield Street (QH admin centre). This meeting included senior staff from BAC and the BAC School, the architects who were working on the 'new BAC', and staff and architects involved in designing and staffing other inpatient facilities. The purpose of this meeting was for the staff and architects of those other facilities to review and comment upon the proposed plan for the 'new BAC'.

(a) In the planning of the proposed 15 Bed Adolescent Extended Treatment Mental Health Treatment Unit at Redlands Hospital, were you aware of any delays in the planning process? If there were delays, what were these and what caused them?

4.5 In the planning process of the proposed 15 Bed Adolescent Extended Treatment Mental Health Treatment Unit (**Redlands Unit**), I recall being told informally, that the community around the proposed Redlands site were concerned at the loss of koala habitat, as there were a large number of eucalyptus trees on the site; which may have caused delays in the planning process.

(b) Explain the reasons why this alternative was not adopted?

4.6 I recall being verbally advised at some point that senior management of QH had indicated that the alternative was too expensive.

Closure of the BAC

5 On what date did you first become aware of the decision to close the BAC and by what means?

5.1 I was aware from around the time of my involvement on the User Group that BAC would be relocated to a site at Redlands. In around mid-2012, I recall receiving, by

way of an 'All Staff' email, a copy of a memo which advised of a decision by the government to cancel a number of projects which had not reached a certain level of planning. I took this to include the Redlands Unit but I did not at that time consider that, as a consequence, BAC would be closed. I have not been able to locate that email for inclusion in this Statutory Declaration.

5.2 On 8 November 2012, I was listening to the ABC radio and the 3pm news bulletin featured an interview with Professor Brett McDermott who had just given evidence at the Queensland Child Protection Commission of Inquiry. I recall that Professor McDermott indicated during the interview that he thought that BAC would close.

5.3 In light of the public announcement by Professor McDermott on 8 November 2012 and with a view to securing another position, I sent an email to WMHHS Senior Speech Pathologist, Wendy Comben, on 9 November 2012. Attached and marked **AC-9** is a copy of this email.

5.4 In this email, I highlighted that BAC had "hit the news" on 8 November 2012 with reports of closure in December 2012.

5.5 Whilst I cannot specifically recall a meeting with the then WMHHS Chief Executive, Lesley Dwyer, she must have come to speak to BAC staff on 9 November 2012. This is because I noted in my email to Ms Comben that Ms Dwyer had spoken to BAC staff that day and advised that no decision has been made and they "were just looking at different models". I also highlighted in my email to Ms Comben that Ms Dwyer had advised that BAC could not stay at The Park Centre for Mental Health (The Park) and that there was no current plan to rebuild.

5.6 In my email, I speculated to Ms Comben that the time frame for the closure was not 1 - 2 years, but more likely 1-2 months. As such, I indicated that I was seeking her assistance in finding another position within WMHHS.

5.7 On 16 November 2012, shortly after Professor McDermott had made his announcement, I sent an email to a number of friends and family in relation to the 'Get Up' petition that had been started. Attached and marked **AC-10** is a copy of that email.

5.8 I indicated that the petition had received thousands of signatures and that Dr Sadler had been informed on 15 November 2012 that the patients of BAC would not be

moved and that, in the New Year, WMHHS would commission an independent review of BAC. I highlighted that the WMHHS Executive had made it clear that there were no funds to rebuild BAC.

5.9 I am aware that the Minister for Health, The Honourable Lawrence Springborg, formally announced the closure of BAC on 6 August 2013.

5.10 I believe the means by which I was advised of Minister Springborg's announcement was via email on 7 August 2013 from Dr Leanne Geppert, Acting Director of Allied Health and Community Mental Health. Attached and marked **AC-11** is a copy of that email and attachments.

6 In relation to the circumstances surrounding the decision to close the BAC:

(a) Were you made aware of the reasons for the closure decision? If so, explain how you were made aware of the closure decision and any reasons for that decision;

6.1 As I understood them, the reasons for the closure decision were as follows:

(a) BAC was located at The Park which was becoming an adult forensic only service. It was considered to be an unacceptable safety risk to have the adolescent consumers of BAC co-located with an adult forensic service, particularly with the opening of the Extended Forensic Treatment and Rehabilitation Unit.

(b) BAC was an inpatient, long-stay facility. As a tertiary-referral service, it accepted consumers from within and outside South East Queensland, meaning, at different times, we had consumers from Far North Queensland, the Sunshine Coast and Gympie, Western Queensland and other regions. One of the reasons given for the closure of the BAC was that this model of service (with consumers leaving their home districts to reside at BAC) was inconsistent with the Fourth National Mental Health Plan 2009-2014, which advocated for community-based treatment models, with services provided as close as possible to the consumers' home.

(c) The BAC was an aging facility and required updating if staff and consumers were to remain using the facility.

6.2 I recall that I may have been made aware of the reasons when I attended a meeting with other staff and Executive Director Mental Health and Specialised Services (**MH&SS**), Sharon Kelly, following both the announcement by Professor McDermott

and by the Minister for Health. Ms Dwyer may also have been present at these meetings.

6.3 I recall that there were many sources of information at the time. For example, nursing meetings were held in which senior nurses provided information to BAC nurses who then shared it with Allied Health colleagues who had fewer sources of information. Information was also coming via Education Queensland staff who sought out information from QH and later relayed information to the BAC teaching staff.

6.4 I also recall receiving a number of 'Fast Facts' Sheet providing information on the closure and transitional arrangements for current BAC consumers and other eligible adolescents while future services are being finalised.

6.5 From my review of the emails, I can see that I received BAC Fast Facts number 10 on 21 November 2013 from Acting Clinical Nurse Consultant - BAC, Vanessa Clayworth, and Fast Facts number 11 on 6 January 2014 from Lorraine Dowell. BAC Fast Fact Sheets 10 and 11 and the emails under cover of which I received them are attached and marked as **AC-12**.

(b) What information, material, advice, processes, considerations and recommendations related to or informed the closure decision; and

6.6 I do not know what information, material, advice, processes, considerations and recommendations related to or informed the closure decision because I did not make the decision to close BAC.

(c) What was the decision making process related to the closure decision?

6.7 I am unable to answer this question because I did not make the decision to close BAC nor was I involved in the process of decision making related to the closure decision.

Transition arrangements

7 From October 2012 until early 2014, a number of BAC patients were transitioned to alternative care arrangements in association with the closure or anticipated closure of the BAC (transition clients). Did you have any involvement in developing, managing and implementing the transition plans for the BAC patients (including, but not limited to identifying, assessing and planning for care, support, service quality and safety risks)? If so:

7.1 I had minimal direct involvement with developing, managing and implementing the transition plans for BAC patients (including identifying, assessing and planning for care, support, service quality and safety risks).

7.2 During the relevant period, my role was primarily to continue to provide individual and group therapy and support to a number of patients in BAC. This involved individual therapy sessions for communication disorders and running the weekly social skills group.

7.3 Every Monday, the BAC treating team met to have a case conference at which a general discussion related to all consumers occurred.

7.4 On Wednesdays I would participate in Intensive Case Workup (**ICW**) meetings for certain consumers if it was relevant to my case load. If the ICW meeting discussed a patient that I was not currently seeing, I would not attend. Often I would also email my relevant contribution prior to the meeting if I could not attend.

7.5 In term three of 2013 (from July to October) I took leave from BAC in order to undertake work elsewhere and was at BAC on Mondays only. I was undertaking some limited clinical work with BAC consumers, such as the social skills group, but my other work hours at BAC were spent writing discharge summaries.

7.6 From memory, intense transition planning for the BAC patients began in September/October 2013. From October until December 2013, I was at BAC only two days a week.

7.7 I was not part of the transition panel which I believe was comprised of at least the following key BAC representatives: Acting Clinical Director, Dr Anne Brennan; Occupational Therapist Megan Hayes; A/Clinical Nurse Consultant Vanessa Clayworth; and Social Worker Carol Hughes.

7.8 I understand that the transition panel met on days that I did not work at BAC.

(a) identify the transition clients with whom you were involved; and

7.9

7.10

7.11

(b) explain the transition arrangements put in place and how those transition arrangements were developed in the period from October 2012 to January 2014.

7.12 I am unable to provide details of the transition arrangement put in place for specific patients or how they were developed as I was not a member of the transition team and transition arrangements were not within my area of responsibility.

8 Explain any information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements

8.1 Whilst I was not directly involved with transition planning for the patients identified above, the information, material, advice and recommendations relevant to my area of clinical practice that I believe may have related to or informed the transition arrangements was comprised of:

(a) Communication Assessment Reports that were either completed by myself or a new-graduate speech pathologist, which I later re-uploaded onto Consumer Integrated Mental Health Application (**CIMHA**) with a view to informing subsequent service providers;

(b) The Speech Pathology Discharge Summaries that I completed for patients and uploaded onto CIMHA and/or provided to other relevant stakeholders. These Discharge Summaries summarise results from the language and social skills assessments that were conducted and the speech pathology interventions. They also make a number of recommendations aimed at informing the future service providers about the speech pathology needs of these consumers;

(c) Some correspondence with third party stakeholders with a view to ensuring that the ongoing speech pathology needs of the key consumers within my care could be met.

8.2 Patient was first referred to me in or about with a history of . Between in consultation with , I carried out a number of individual sessions to assess Patient 's communication (language and social problem solving) skills.

8.3 Results revealed that overall,

8.4 Attached and marked **AC-13** is a copy of the Communication Assessment Report that I completed with for Patient in .

8.5 From my review of Patient s medical records, I can see that between I saw Patient on occasions.[2] These sessions involved communication assessment or individual sessions targeting language skills. Patient also participated in a social skills group. I cannot recall discussing the transitional arrangements for Patient during these sessions.

8.6 I also participated in four ICW meetings for Patient [3] though from my review, I cannot see that I raised any issues relevant to transition during these meetings.

8.7 On , I compiled a Speech Pathology Discharge Summary for . Attached and marked **AC-14** is a copy.

8.8 The Discharge Summary makes a number of recommendations to future services relevant to supporting needs from a speech pathology perspective. For example:

(a) In terms of listening and speaking skills, I recommended that it was important to get Patient 's attention before speaking with and use the simplest vocabulary possible and shorten all instructions and messages.

(b) I indicated that information should be repeated exactly because paraphrasing is difficult for individuals with communication and intellectual difficulties as they try to interpret a 'new message'.

(c) I noted that Patient should be asked to repeat back what was required to do which would help to store it in memory, as well as confirming that had heard the message.

(d) Given Patient 's deficits in verbal expression, I stated that (speaking) skills can be supported if others can allow more time to formulate ideas into speech. I noted should be encouraged to share thoughts and ideas. That should be provided with structure by others asking "W" questions 'who' 'what' 'when' 'where' 'why' and 'how' to help with speaking.

(e) I highlighted that Patient would need considerable support with all reading and writing tasks.

(f) In the context of social problem solving, I stated that Patient needs a trusted adult to 'think out loud' for when has problem situations - so that can hear how another would approach that difficulty.

(g) When in a familiar setting, amongst friends, speaking about familiar topics, I noted that Patient can appear to function at a higher level than testing would indicate; has developed many strategies to help cope with communication deficits, such as watching what others do and 'laughing along' with a group. However, I highlighted the importance of remembering that, on the whole, Patient 's abilities were much lower than same-age peers and needs significant support and assistance with communicating, learning and completing everyday interactions.

8.9 On , I left a message for Patient 's to contact me at BAC to discuss Patient 's discharge summary. Attached and marked **AC-15** is a copy of my progress note.

8.10 Also on , I emailed and attached a copy of the Discharge Summary I had prepared for Patient . I considered this may be helpful for the who would work with Patient in the future. Attached and marked **AC-16** is a copy of that email.

Patient

8.11 Patient was first referred to me in or about . A communication assessment was completed in by .

8.12 From my review of Patient 's medical records, I can see that between , I saw Patient on occasions [4]. On one further occasion, I attempted to assess Patient but did not attend for appointment. These were group therapy sessions aimed at improving social skills. I cannot recall discussing the transitional arrangements for Patient during these sessions.

8.13 Between , I also participated in ICW meetings for Patient [5] though from my review, I cannot see that I raised any issues relevant to transition during these meetings.

On , I made a progress note in CIMHA to the effect that I contacted to enquire about their . Attached and marked **AC-17** is a copy of that progress note.

8.14 I also indicated that I would approach the Team Leader of the team to enquire about adding Patient to the team's waiting list so that if were insufficient to meet needs, involvement from the may be possible.

Also on , I compiled a Discharge Summary for Patient . Attached and marked **AC-18** is a copy of the Discharge Summary.

8.15 The Discharge Summary makes a number of recommendations to future services about supporting needs from a speech pathology perspective. For example:

(a) In terms of verbal and written expression, I noted that Patient 's deficits in verbal expression skills can be supported if others can allow more time to formulate ideas into speech. Within the education setting, it would be helpful if others can provide examples and models to support preparation of oral language

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5

tasks.

(b) With a view to enhancing expressive language skills, I noted that Patient should be encouraged to share thoughts and ideas; ask opinion, ask to describe important events or past experiences. I indicated that support should be offered with written language tasks and that there was a need to be aware that will likely impair Patient s expressive language functioning.

(c) In relation to social problem solving, I highlighted that Patient will benefit from 'thinking out loud' with others about problem situations and getting feedback on how others would approach a difficult situation. I stated that it was important to emphasise subtle information or social cues may have missed, support acceptance of different points of view and validate emotional reactions.

8.16 Also on , I re-uploaded onto CIMHA a copy of the Communication Assessment Report that had been compiled for Patient by This was with a view to informing subsequent service providers. Attached and marked **AC-19** is a copy of that report.

8.17 On , I received an email from from the stating that she was hoping to set up a meeting for at between people who had supported and those who would be responsible for elements of care on discharge from BAC. Attached and marked **AC-20** is a copy of that email.

8.18 The email proposes that the meeting take place on and states that the purpose of the meeting was to:

(a) Ease as much as possible, the angst caused by the transition process for Patient and family by introducing them within a comfortable environment and with the support of the people that they know already to the future stakeholders of their care.

(b) Introduce those responsible for Patient 's future care to each other and to ensure that those people are familiar with Patient s history and the requirements of future care.

8.19 Also on , I spoke with , at the and noted that a meeting had been arranged for

8.20 Attached and marked **AC-21** is a copy of the progress notes I made in CIMHA and Patient s medical record about this conversation.

8.21 On , I also spoke with to enquire whether the family support worker or the team could resume a role in Patient 's management at the high school. Attached and marked **AC- 22** is a copy of the progress note I made in CIMHA.

8.22 On I attended to meet with to discuss supporting Patient Attached and marked **AC-23** is a copy of the progress note I made in CIMHA relevant to that meeting.

8.23 Following a Care Review on , I telephoned Patient to discuss respite options for Patient at and Patient s functioning . Patient advised that Patient was not following the plan that had been agreed upon in the joint BAC/ meeting on and was not sharing concerns with Patient . Patient expressed anger that request for Patient 's admission to BAC , the transition support provided was inadequate/support was only available when Patient was 'rock bottom' and that day patient status was 'too expensive'. Patient , declined my offer to pursue options of respite .

8.24 Following that telephone conversation on , I raised Patient 's concerns with Dr Brennan and one of Care Coordinators, . Upon review of the clinical record for the purposes of completing my Statutory Declaration, I can see that attempted to make contact with Patient on , another of Patient 's Care Coordinators, contacted her on and Dr Brennan spoke with Patient on to agree upon a management plan. Attached and marked **AC-24** is a copy of the progress note that I made in Patient 's clinical record subsequent to my telephone conversation with Patient

Patient

8.25 Patient was first seen by me on or about with a history of .

8.26 Between individual sessions were carried out to assess Patient 's language and social problem solving skills.

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8.28 Attached and marked **AC-25** is a copy of the Communication Assessment Report that I completed with for in .

8.29 From my review of Patient 's medical records, I can see that between , I saw Patient on occasions [6]. These sessions were either individual therapy sessions targeting language deficits, or group social skill sessions. We did not discuss the transition arrangements for Patient during these sessions.

8.30 I prepared the speech pathology section of the Case Review Progress Summary for an ICW meeting for Patient that took place on [7] though from my review, I cannot see that I raised any issues relevant to transition during this meeting.

8.31 , I compiled a Speech Pathology Discharge Summary for Patient in which I made a number of recommendations with a view to informing Patient s future speech pathology needs. Attached and marked **AC-26** is a copy. In summary my recommendations were as follows:

(a) In terms of listening and speaking skills, I recommended that Patient might need information repeated so that follow directions or complete tasks

[6]

accurately.

(b) In social settings, I noted that Patient may have difficulties comprehending difficult conversations if there is a lot to listen to, or when is feeling anxious.

(c) I cautioned that Patient 's listening skills are weaker that speaking skills and that others may base their assessment of language and learning abilities on speaking skills. I noted that this may be compounded as Patient has good vocabulary and will often speak about topics with which is familiar, making appear a very competent communicator.

(d) I noted that Patient 's written language system was stronger than spoken language system. Because of this, Patient will benefit if important information is given in written form as reading comprehension is stronger than verbal comprehension.

(e) I also noted that Patient showed some ability to infer additional information in situations and provide simple solutions to problems. However, struggles with other areas, such as understanding others' perspectives, offering plausible solutions to difficult problems, and using information already had and applying to new solutions.

(f) I highlighted that Patient needs consistent opportunity to "think out loud" with others to get feedback from others and how they would approach difficult situations. In addition, emphasis should be placed on explaining other's responses and reactions in problem situations.

(g) In the context of social skills, I recommended that Patient should be supported and encouraged into a social/community group in order to maintain the gains in social skills made during his time at BAC.

Patient

8.32 Patient was first seen by me on or about , with a history of . Patient completed a communication assessment between . A report completed on or about

[7] .

....

ANGELA CLARKE **WITNESS**

[redacted]

8.33 From my review of Patient [redacted]'s medical records, I can see that I saw Patient [redacted] for a social skills group session on [redacted] though we did not discuss the transitional arrangements for Patient [redacted] during this session.

8.34 I prepared the speech pathology section of the Case Review Progress Summary for an ICW meeting for Patient [redacted] that took place on [redacted] though from my review, I cannot see that I raised any issues relevant to [redacted] transition during this meeting.

8.35 On [redacted], I compiled a Speech Pathology Discharge Summary for Patient [redacted]. Attached and marked **AC-27** is a copy.

8.36 The Discharge Summary makes a number of recommendations to future services about supporting [redacted] needs from a speech pathology perspective. For example:

(a) In terms of listening skills, I recommended that Patient [redacted] needs to minimise potential weaknesses with listening and comprehending by using 'good listening skills' strategies.

(b) I noted that Patient [redacted] can work well, independently and learns best in a quiet, distraction-free environment.

(c) I highlighted that Patient [redacted] needs support to develop the complex language skills that allow one to social problems and maintain interpersonal relationships.

(d) I also noted that Patient [redacted] needs a consistent, trusted person with whom [redacted] can talk through problems and who can model ways to deal with difficult solutions.

(e) I recommended that future involvement in a sporting group or hobby so that Patient [redacted] has opportunity to mix with peers and develop social networks.

Patient [redacted]

8.37 Patient [redacted] was first seen by me in [redacted] with a history of [redacted]

8.38 On [redacted], I met with Patient [redacted] to gain collateral information related

to Patient 's history of education, language and learning skills. I noted that I would subsequently arrange to see Patient for testing.

8.39 From my review of Patient 's medical records, I can see that I saw Patient on the to commence testing of language and social problem solving skills. During I can also see that I subsequently saw individually on two occasions for the purpose of completing testing.[8]

8.40 Later in , I completed a Communication Assessment Report for Patient which revealed . Attached and marked **AC-28** is a copy of the Communication Assessment Report for Patient .

8.41 Between , I saw Patient [9] though I do not recall discussing the transitional arrangements for Patient during this session.

8.42 From my review of CIMHA, I also attended/or contributed to a number of Intensive Case Workup meetings in relation to Patient . For example, on , I attended to discuss the findings of Patient 's communication assessment and on , I attended to update the team on Patient 's participation in the social skills group.

8.43 On or about , I completed a Discharge Summary for Patient . Attached and marked **AC-29** is a copy.

8.44 The Discharge Summary makes a number of recommendations to future services about supporting needs from a speech pathology perspective.

8.45 For example, I note that Patient has average language skills but would benefit from having a trusted person with whom could 'talk out loud' about social difficulties.

Patient

8.46 Patient was first seen by me on or about with a history of .

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9

8.47 From my review of Patient s medical records, I can see that I saw Patient for social skills group sessions on . These sessions targeted social skills, conflict resolution and self-awareness.

8.48 From a review of CIMHA notes, I can see that Patient also attended social skills groups on . I cannot recall discussing the transition arrangements for Patient during these sessions.

8.49 On I completed, individual assessment sessions with Patient to assess Patient 's language and social problem solving skills.

8.50 A Communication Assessment Report was completed in . Attached and marked **AC-30** is a copy of the Communication Assessment Report that I completed for Patient in and uploaded onto CIMHA with a view to informing subsequent service providers.

8.51

8.52 I did not complete a specific Discharge Summary for Patient as Communication Assessment Report had been completed in late and transition from BAC.

Patient

8.53 Patient was first seen by me on or about with a history of atypical

8.54 From a review of medical charts, I can see that I saw Patient on occasions in early to assess Patient 's language and social problem solving skills. Results of the communication testing indicated that

8.55 From my review of Patient s medical records, I can see that I saw Patient for social group skills session in and social skills group sessions in late [10]. These sessions targeted a range of social skills and high-level language skills as well as facilitating supportive decisions, conflict resolution styles and friendships. I cannot recall discussing transition arrangements for Patient during these sessions.

8.56 From my review of Patient 's medical records, I can see that I prepared the speech pathology section of the Case Review Progress Summary for an ICW meeting for Patient that took place on though from my review, I cannot see that I raised any issues relevant to transition during this meeting.

8.57 On or about 21 October 2013, I compiled a Speech Pathology Discharge Summary for Patient . Attached and marked **AC-31** is a copy.

8.58 The Discharge Summary makes a number of recommendations to future services about supporting needs from a speech pathology perspective. For example:

(a) I highlighted that although there was no significant deficits noted in formal communication testing, Patient has not met some of the communication milestones typical of same-age peer group, indicating that some ongoing support is required.

(b) I also highlighted that Patient 's written language system was stronger than spoken language system. Because of this, I recommended that Patient may benefit from being provided with important information in both written and verbal form.

(c) I noted that the main area of concern for Patient relates to ability to use language to negotiate and manage interpersonal relationships.

(d) I also noted that results in the formal assessment for social problem solving were in the low range.

(e) I also noted that Patient needs the opportunity to "think out aloud" with someone in order to get feedback on how they would approach a difficult solution.

[10]

(f) I recommended that Patient should be supported and encouraged into a social/community group in order to maintain the gains in social skills made during his time at BAC.

Patient

8.59 Patient was first seen by me on or about with a history of

8.60 Patient completed a communication assessment with me between .

8.61 Results of the communication testing indicated had

8.62 Between and , I can see that I saw Patient on occasions for either individual or group therapy. [11] I do not recall discussing transition arrangements during these sessions.

8.63 These sessions continued to work on activities to enhance listening and memory skills, and general language activities.

8.64 From a review of Patient s medical records, I can see that I prepared the speech pathology section of the Case Review Progress Summary for an ICW meeting for Patient that took place on though from my review, I cannot see that I raised any issues relevant to transition during this meeting.

8.65 On or about I compiled a Speech Pathology Discharge Summary for Patient Attached and marked **AC-32** is a copy of the Speech Pathology Summary for Patient

8.66 The Discharge Summary makes a number of recommendations to future services

[11]