Oaths Act 1867

Statutory Declaration

QUEENSLAND }
TO WIT }

I, **DR ANNE BRENNAN** of Toowong, in the State of Queensland, do solemnly and sincerely declare that:

Introduction

1. I am a child and adolescent psychiatrist. I hold the following qualifications:

   (a) MBBS – University of Queensland 1978
   (b) FRANZCP – 2004
   (c) Certificate in Child and Adolescent Psychiatry - 2004

2. Initially I practised as a general practitioner. I developed an interest in child and adolescent psychiatry and worked as a Principal House Officer at Mater Children's Hospital ("MCH") 1992/1993. I then worked as a medical officer at the Barrett Adolescent Centre (BAC) under Dr Trevor Sadler in 1993 and 1994. Following this I joined the training program in psychiatry in 1995 with much of the training being undertaken on a half time basis for family reasons. I was awarded the Fellowship of the RANZCP and the Certificate in Child and Adolescent Psychiatry in 2004.

3. My first consultant position was for three months in the Royal Children's Hospital Child and Family Therapy Unit and then a year as the first psychiatrist with Kids In Mind Private at the Mater Children's Hospital. In 2005 I opened my own practice in Toowong and worked in private practice for about 8 years until I closed the practice in July 2013. (I also did a part time three month locum in 2010 in the Adolescent Inpatient Unit at the RBWH.) Due to the number of patients on my books I took several months to close my private practice to ensure all the patients

were advised and referred for ongoing care. After I ceased seeing my private patients I still had occasion to write correspondence and medico-legal reports concerning them and otherwise take steps to see to their ongoing care.

4. Following closure of BAC I was asked to work as full time consultant psychiatrist in the Inpatient Child and Adolescent Mental Health ward of the MCH. I worked there until 30 June 2014. With the impending closure of MCH, as Lady Cilento Children's Hospital was to open, I moved to Royal Children's Hospital where I worked as consultant psychiatrist in Consultation Liaison and in the on line service of the Child and Youth Mental Health Service ("eCYMHS") to regional areas including Atherton, Cairns, Innisfail and Moranbah. Following the internal Queensland Health (Kotze) Inquiry into the closure of BAC I took six months leave. On 16 February 2015 I resigned from Children's Health Queensland Hospital and Health Service ("CHQHHS"). My email read "*With the expectation, as of last week, that there will be further inquiry into the closure of BAC as well as three inquests, I have emailed Stephen Stathis and confirmed that I wish to resign as I do not want to resume high level risk assessments/clinical work until such investigations are concluded. If one month's notice to resign is required under my contract, then I hereby give such notice.*"

Response to issues set out by Commission of Inquiry in Notice to Produce Statement

5. ***Question 1(a) - Appointment as Acting Clinical Director of BAC***

(a) On 10 September 2013 I was phoned by Dr Peter Steer of CHQHHS. He advised that on the following morning Dr Trevor Sadler would be stood down pending a CMC investigation. He said a decision to close BAC had been communicated to staff and patients in a meeting at BAC on 6 August 2015.

(b) He indicated that he would like me to take over the clinical care of inpatients and day patients at BAC as of the following day and to

act as the clinical director of the unit in the transition process.

(c) I was also phoned by Mr John Wakefield CHQHHS and Dr Mark Matussi WMHHS and Ms Sharon Kelly ED of WMHHS.

(d) I received an email from Dr Wakefield following as email from Dr Mark Matussi confirming the appointment. This is attached marked **AB–1**.

Question 1(b) dates I was in the role

6. I acted in this role from 11 September 2013 to 30 January 2014.

7. After the closure of BAC in January 2014 I remained employed by WMHHS until 9 March 2014 when my contract expired. During that time, I was a consultant psychiatrist at Ipswich CYMHS and assisted with assessing the progress of young people who had been on a waiting list for BAC.

Question 2(a) - Outline and explain my role in this position

8. I was not given a formal job description apart from the position title.

9. I was verbally asked to take over the clinical care of the patients at BAC. I was told that Dr Hoehn would assist in this task.

10. Dr Hoehn explained the governance structure. She provided a hand written chart of the structure which is attached marked **AB-2**.

Question 2(b) - do I have a copy of my contract

11. I do have a copy of my contract. The written appointment with scope of practice documents are attached marked **AB-3**. Nothing in the contract or in the Scope of Clinical Practice or in the Queensland Health Clinical Services Capability Framework, which is referred to in the Scope of Clinical Practice document, set out in any detail what my duties were in the position of Acting Clinical Director.

Question 3 - Who was my supervisor and to whom did I report?

12. Dr Elisabeth Hoehn CHQHHS provided supervision initially in her role as acting Clinical Director, Child and Youth Mental Health Service, CHQHHS – which role she filled in for Dr Stephen Stathis. Dr Hoehn continued to provide oversight and liaison with CHQHHS after Dr Stephen Stathis resumed the role as Director, although as the Director I would discuss some matters with him. I also reported to the West Moreton Hospital and Health Service ("WMHHS") executive which held a meeting about the Barrett Adolescent Service every Wednesday morning during the time I was there, and to the Director of Clinical Services WMHHS, which was firstly Dr Darren Neillie, then Dr Terry Stedman. I was in regular phone contact with Dr Stathis and when necessary I spoke with Dr Steer.

Question 4 - What instructions were given to me with respect to how to carry out my role

13. No specific instructions were given as to how to carry out my role. [redacted] So for example when [redacted] was reported to me on 8 November 2013, I reported this directly to Dr Neillie. Support was offered by the WMHHS executive and CHQ. I was asked to report to the WMHHS executive on a weekly basis and more often as needed. At times during my employment I was asked by the executive to perform certain tasks. I had access to the executive whenever I requested it.

14. Dr William Kingswell discussed with Dr Hoehn and myself the need to transition all patients from the centre as soon as possible. I was always under the impression that although the WMHHS executive wished the closure to occur quickly, subject to the safety of patients.

Question 5 - How was staff morale at the time I commenced my role? What steps were taken to offer support and guidance to staff at BAC?

15. From the many conversations I had with staff and observations of them it was my view when I started that staff morale was low. Most staff members were not supportive of closure. Staff morale appeared

affected by:

(a) the distress and behaviour of the patients, which was elevated beyond the usual state as a result of a number of factors including the closure announcement, the removal of Dr Sadler and issues arising out of an alleged assault;

(b) the suspension of Dr Sadler and the CMC investigation into issues at the Centre;

(c)

(d) the low morale of other staff;

(e) insecurity regarding their own employment prospects;

(f) the heavy workload due to staff resignations and lack of skills in casual and/or agency staff;

(g) the ever present anxiety for them about the future care of the patients.

16. Allied Health staff were supported by Ms Lorraine Dowell, a senior occupational therapist. In addition I met with a number of allied health staff to discuss concerns and issues impacting them.

17. A Nurse Unit Manager was appointed to relieve the workload of the A/CNC by taking on a number of administrative duties such as management of the roster of staff and to provide support to staff. Again I also met with a number of nurses to discuss concerns and issues impacting them.

West Moreton Human Resources

18. WM HR offered support and put up many posters with details of the services available and contact details if staff had concerns about employment and other industrial issues. It seemed to me from

comments by staff that there was inconsistency in messages given about what would happen to staff after the closure. In addition there was a lack of trust by staff in the HR support as the HR support person was the same person seen to escort the Queensland Health investigator looking into the issues raised with the CMC.

19. The registrar, Dr Tom Pettet was supported by myself and Dr Hoehn. Dr Hoehn met him on a weekly basis for an hour and organised a transfer in early December 2013 to a more suitable training position for the latter part of his 6 month Child Psychiatry term. I would talk to Dr Pettet every day to discuss patient care and whether he had any concerns or problems. I would also provide education to him as a trainee. Dr Neillie also met with the registrar to support him and to ensure that his training was appropriate.

20. Education staff had meetings with Mr Peter Blatch but I was not aware of their support arrangements.

21. To maintain a functional unit, I took the view that it was imperative to support staff as best I could within the time constraints of a heavy work load where the focus needed to be on patient care and development of comprehensive transitional care plans.

22. While attending a conference in Melbourne on 11 October 2013 I missed most of the day of conference proceedings as I spoke by phone to nursing staff as the CMC investigation began. I often stayed back after work listening to and supporting nursing staff. Attached to this statement marked **AB-4** are copies of texts illustrating the interaction while I was at the conference.

23. Although the high level of distress and demoralisation of staff following the investigation began to reduce, the threat or perceived threat of unemployment or unsuitable employment caused morale to decline again.

Dr Sadler

Question 6 - Outline the circumstances in which I took over from Dr Sadler

24. Dr Steer told me [redacted] and that Dr Sadler would be stood aside on the morning of 10 September 2015 and that an investigation would commence.

25. I was not given any details at the orientation meeting with the executive on the morning of 11 September 2015.

26. I subsequently heard the Minister for Health, Mr Lawrence Springborg announce in Parliament that a number of failures in clinical governance and clinical incidents over a twelve month period had been brought to his attention, [redacted] and that a senior member of the clinical team was stood aside.

27. Dr Sadler phoned me on 10 September 2015 and gave me his version of events that had occurred. He said that he expected it would all be sorted out in a matter of weeks. I was not expecting to still be A/Director when BAC closed.

28. [redacted]

Question 7 - What handover occurred between Dr Sadler and I?

29. In phone call on 10 September 2015 Dr Sadler said he would give a written handover for each patient to Dr Neillie. I was never given any written handover by Dr Sadler.

30. I did not receive any handover information directly from Dr Sadler.

31. On the first day I went to Barrett an oral handover about each patient's

current presentation, a brief synopsis of their history and information focused on patients considered to be at acute risk on that day was provided by A/CNC Vanessa Clayworth, Dr Tom Pettet and other clinical staff to me.

32. Within the first few days of starting CN Susan Daniel collated a folder of patient information for both Dr Hoehn and myself.

33. On 16 September 2013 I convened a long case conference to hear from the care coordinators and individual therapists for each young person. A detailed discussion about each patient took place.

Transition Arrangements

Question 8 - Who constituted and appointed the clinical care transitional panel I headed – what was the expertise of each member and the function of the Panel?

34. In consultation with the executive I chose the staff to constitute the core membership of the transition panels. As each patient had different needs, other people including BAC staff and non BAC professionals, were invited on a case by case basis.

Rationale for small panel

35. It was clear from the initial case conference that took approximately 7 hours that we would be unable to progress if the meetings were as large as case conferences with all available staff there on the particular day, but coming and going depending on other duties.

36. There was also a real concern as to confidentiality. Most of the young people were highly anxious about transitional care proposals. It was unfair and unsafe for them to be exposed to a potential plan before we had a good understanding of the new facility or service and whether the young person met the criteria for accessing that service, and most critically, whether the young person was emotionally and psychologically ready to consider such options. There was also the dilemma of parents

hearing "along the grapevine" what was proposed when in fact it was a discussion only at that stage.

37. There were many times when deliberations and case discussions were shared with carers, media and others in an inappropriate way. For example someone disseminated a rumour that Barrett would close on 13 December 2013. This was a date I had mentioned in a meeting with staff as being under consideration as to whether we could have all patients in a new service by the same time as the Barrett school closed, although it was understood ongoing contact would occur. The circulation of this rumour caused such distress that Sharon Kelly the executive director of WMHHS, contacted each parent by email on 19 November 2013 to advise this was incorrect.

38. This situation necessitated a small group with respect for confidentiality but who could involve other staff and families as much as possible to optimise outcomes.

39. Persons constituting Panel and the person's expertise:

    (a) **Vanessa Clayworth -A/CNC**

        (i) An experienced mental health nurse with particular experience and skills with adolescents and familiarity with the Barrett patients.

    (b) **Megan Hayes -Occupational Therapist**

        (i) An occupational therapist with good IT skills and experienced in multidisciplinary team work.

    (c) **Carol Hughes - Social Worker**

        (i) A social worker with understanding of Government agencies including Centrelink, Commonwealth Rehabilitation Services, Disabilities Queensland and knowledge of the Barrett patients.

(d) **Laura Johnstone - Project Officer**

(i) An administrative officer with experience in projects in mental health, who, I had been informed, had expertise in accessing information about government services.

(e) Education Representative

(i) **Justine Oxenham**

(ii) A teacher who participated on the panel for a limited period.

(iii) **Kevin Rodgers -Principal BAC School**

(iv) Principal of the Barrett school who participated in the panel until 16 October 2013.

(v) **Debbie Rankin**

(vi) A teacher and later acting Principal when Kevin Rogers was on leave.

(f) **Susan Daniels- Clinical Nurse**

(i) A clinical nurse with community liaison experience.

(g) **Care Coordinators (nurses)**

(i) The CC and assistant CC were invited to participate for their assigned young person as they had the responsibility for communicating with the families but also were often the person who knew the young person and their family best. Some CCs did invaluable work in supporting their particular young person (s) to embrace new services and experiences. This necessitated phone calls, emails, home and service visits as well as the most important component which was one to one, day to day emotional support at BAC.

(h) **Angela Clarke -Speech Pathologist**

(i) A speech pathologist who, although she was not officially on the panel, provided assistance in liaising between panel members and education providers.

(i) **Carers, family members and community service providers** were invited on a case to case basis.

Function of the Panel

40. The functions of the panel were:

(a) To explore the full range of possible care options for each individual young person.

(b) To develop a list of options for each one and then to assist the care coordinator and the young person and their families to choose what best suited them. To identify such services, panel members spent several hours every day calling government and non-government agencies, attending meetings with them on and off site, and preparing referral documents to selected service providers;

(c) To make referrals and to communicate to receiving services matters such as details of the patient's history (biological, psychological, social, educational) including current and past presentations, response to previous interventions, current management, risk assessments, advice on risk management and any other matters potentially relevant to their ongoing care;

(d) To maintain contact with young persons and their families and service providers to monitor responses as attempts to transition were commenced (when time frames permitted such trials of services);

(e) To keep WMHHS updated as to progress of transition plans and transition care.

41.

care panel was convened at WMHHS and senior representatives of multiple health disciplines teleconferenced in for it. This was a formal process with prior patient and parental consent. An arrangement was put in place such that the outcome could be externally reviewed by Professor Brett McDermott if either parent or the young person was unaccepting of the recommendations. That review was not required as the outcome was positive for all. (formal document)

42. The transition panel convened and attended large meetings with Metro South HHS and Metro North HHS to firstly identify available care options and then to facilitate transition of young people to those services.

Question 9 - Outline the role of the Panel and I in relation to how care, support, service quality and safety risks were identified, assessed, planned for, managed and implemented before and after the closure of the BAC

43. This response is mostly based on memory of events from 2 years ago so may lack specifics re dates and names of services. It will definitely under represent the number of agencies that were contacted and recontacted.

44. General statements are of limited value in trying to answer this question as the young people had specific and differing needs and risks.

45. In order to develop a transitional care plan for each individual patient, it was necessary to first get to know and understand them, their history, their family, their strengths, difficulties and hopes for the future. It was also important to understand their previous involvement with services and therapists in order to identify services that were developmentally appropriate and accessible both physically and financially, that could deliver good quality care in the least restrictive environment, while providing an appropriate level of security and addressing any risk of harm. Such care should promote recovery and growth; protect, restore and develop relationships with family, friends and community; and engage each adolescent in educational and /or vocational activities commensurate with their capabilities and interests.

46. The focus was to be on recovery and to avoid a sense of abandonment, to focus on strengths and problem solving and preservation of hope.

47. The initial aim was to formulate such plans as early as possible to allow a cross taper of care with in-reach to new services, as well as the opportunity for the adolescents to initially reject services and try others, and to allow time and space for them to grieve for the loss of BAC and all that it meant for them in real terms and emotionally, psychologically and symbolically for them.

48.

49. The education staff were asked to write up an individual education plan for each young person.

50. The CCs were asked to work with each young person to complete a questionnaire about their aspirations, and to establish at least weekly contact with parents.

51. Every young person was discussed every week in case conference. When appropriate to do so, their transitional plans were discussed.

52. Apart from the acute inpatient mental health units in the child, adolescent and adult sectors, community adult mental health clinics, CYMHS clinics and mental health day programs in , and , we tried to identify broader community supports, and accommodation providers.

53. There was a lack of information available so we obtained information through:

    (a) data bases of community services both from government and from agencies including lifeline who in the past had published such data.

    (b) yellow pages from Telstra;

    (c) NGOs such as Life without Barriers, Nextt, Naemi.

Meetings with stakeholders

54. Initially we convened a large stakeholder meeting to which we invited many NGOs, service providers and agencies. I set out the type of communications in the paragraphs below.

55. We met with individual agencies subsequent to that initial meeting.

(a) Department of Child Safety ( );

(b) Personal Helpers and Mentors Service (PHaMS);

(c) HHS;

(d) HHS including Transitional Housing Team and Adolescent Unit ;

(e) Complex care panel State wide).

56. **Phone calls and/or emails**

(a) House;

(b) Community Living Association ;

(c) Synapse;

(d) House;

(e) BABI;

(f) IIYS;

(g) Youth Service;

(h) Headspace: ;

(i) Private Psychiatrists;

(j) General Practitioners;

(k) Private occupational Therapists;

(l) Private Psychologists.

57. **Site Visits**

(a) Villas;

(b) new adolescent mental health unit;

(c) Iona House, ;

(d) House.

58. Escorted young people to visits at:

(a) CYMHS;

(b) CYMHS;

(c) Youth Service;

(d) PAMHS clinic;

(e) Department of Housing;

(f) CYMHS;

(g) IIYS;

(h) Inpatient unit.

(i) Villas

(j) Private accommodation at

(k) CCU

(l) Hothouse

59. I and the panel worked collaboratively. We shared the tasks but Megan Hayes (MH), Vanessa Clayworth (VC) and Carol Hughes (CH) did most of the work identifying services, clarifying their eligibility or admission criteria and their proposed funding models.

60. I attended all (bar one) of the off-site and on site meetings with HHSs and phoned most service providers that were not excluded on first round of contacts.

61. Quality of services was assessed by personal experience of the service, reading material provided by the service and asking them specific questions especially around safety and answering their questions of us.

Inspection of services

62. At the time of my involvement there were young people receiving services from the Barrett Adolescent Centre. Many were day patients or outpatients. We identified who required accommodation as part of the transition arrangements. Most accommodation providers we contacted were unable to accept for whom we were seeking accommodation for a variety of reasons such as safety and eligibility criteria. Speaking with service providers and inspecting their facilities during site visits was a critical part of evaluating the suitability of the service.

63. One of the new services under Statewide Extended Adolescent Treatment and Rehabilitation services ("SWEATR") was a 4 bed therapeutic residential service at Greenslopes operated by Aftercare. . I was concerned about the level of risk and considered it inappropriate. The building was not purpose built. The staff did not have the necessary expertise and it had a time limit of 6 months.

64. After closure of BAC there was no provision for BAC or WMHHS staff to monitor or manage risk apart from a few days following closure. While working for WMHHS at Ipswich CYMHS I initiated a phone review of each young person on/or about 29 January 2014. I de-identified the information and communicated it to the executive. Attached marked **AB-5** is a copy of the document I prepared.

65.

66.

67. Once care was handed over to a receiving service, that service assumed responsibility for risk management.

68. Mental health care can be complex and it is difficult to discuss risk management for an outpatient attending on a weekly basis and residing at home, in the same terms, as an inpatient who is so unwell as to require the Mental Health Act for their protection when they are recurrently at risk of serious self-harm.

69.

70. In addition a Risk Screening Tool dated 15 January 2013 authored by CC Moira McLeod CN was available to mental health staff on CIMHA. A copy of a POS is attached marked **AB-6**.

71. Similarly advice re risk management and risk assessments was conveyed orally and in writing to all services where young people would reside temporarily or on a medium term basis. These documents should be in the clinical records of the BAC for each patient.

72. Risk assessments on each young person were updated every week in case conference and during crises risks were re-evaluated on a daily or more frequent basis.

73. When I was leaving WMHHS I did another phone review of the young people. If I was unable to contact them or their parent, I spoke with their care provider. I produced another document for WMHHS which is attached marked **AB-7**. This document was intended to highlight to WMHHS any emerging issues and was emailed to the executive.

74. Evaluation of risk while at BAC would not necessarily predict risk in a different environment and when the stresses in life changed.

75. Following [redacted] in April I was very concerned about the well-being of the other young people. I said so to Dr Stathis and forwarded him the follow up information I had collated on the 3 March 2014 to facilitate a more careful check on their well-being by someone with the authority and means to access that information.

Question 10 - Outline and explain any information, material, advice, processes, considerations and recommendations that related to or informed the transition arrangements

76. I have provided information elsewhere in this statement that is relevant to this question.

77. The WMHHS executive advised in a meeting on 11 September 2013 that the closure target date was the end of January 2014 but this was with the proviso that BAC would remain open until adequate and appropriate care was in place for each young person. As the number of staff reduced and the level of anxiety increased I recall emailing Leanne Geppert advising that a specific date should be circulated to avoid the uncertainty affecting everyone.

78. As noted earlier I said to BAC staff at one point that we should aim to transfer all young people into their new services by 13 December 2013 as that was the end of the school year. This fact was miscommunicated to some families and public resulting in distress and complaints that BAC was closing early.

79. The rationale behind my idea was that the young people needed time to try new services, and be able to" return to base " at BAC, if necessary, to discuss their challenges, obtain support and if appropriate try again and if not, then to re explore other options. For those such as [redacted] and [redacted] it would have provided a slower cross taper of care arrangements and in particular for [redacted]

80. Unfortunately because of a number of factors such as delays in obtaining funding packages, and the condition of some of the patients, there was little opportunity for the patients to return to Barrett after moving to the new service before it closed.

81.

82. Fact sheets were distributed by WMHHS executive to families of patients updating them on progress regarding transitional care and other issues relating to closure of BAC.

83. On 12 December 2013 Dr Sandra Radovini, Chief Psychiatrist Victoria, addressed a meeting of parents. This focussed more on new services rather than transition of current BAC patients.

Question 11 - What consultation did I or the Panel have with any Human Service Agency or relevant stakeholder

84. ***Question 11(i)*** **- This is partly covered in 8.**

Face to face meetings

85. Face to face meetings were held with, to my recollection, the following:

(a)

(b)

(c) Michelle Bond Education Queensland (with Dr Hoehn) at Spring Hill about all patients.

(d) Debbie Rankin A/Principal BACS and Mr Peter Blatch Regional director Education Queensland (with Sharon Kelly) at WMHHS.

(e)

(f)

(g)

(h)

(i)

(j)

(k)

(l)

(m)

(n)

(o)

(p)

86. ***Question 11(ii) - consultation with alternative services/care providers for transition clients of the BAC***

(a)

(b)

(c)

(d)

(e)

(f)

(g)

87. ***Question 11(iii) - consultation with transition clients or families carers and friends***

(a)

(b)

(c)

(d)

(e) [redacted]

(f)

(g)

88. [redacted]

89. I met several friends of young people when they visited at BAC.

Question 11 (iv) - consultation with staff working at BAC

90. I worked Monday to Friday during the term of my contract. During this

time I had a few days off on leave and was away from the Centre with BAC related duties on other days. On the days I was there I spoke to nursing staff every day and was given a handover on all inpatients and some day patients. I also met with education and allied health staff most days. All staff were invited to a daily morning meeting where every patient was discussed with the staff who were present, prior to the patients coming in and having a meeting. In addition the staff were invited to a weekly case conference. I attended all but two case conferences and most daily meetings.

91. VC attended daily, MH worked part time and attended all meetings when at work.

92. CH attended morning meetings and had good rapport with school staff.

93. Apart from those formal meetings, my door was open to all and I had frequent visits from several staff. I often stayed back late to talk with nursing staff and sometimes with allied health staff. I had limited contact with education staff.

Question 12 - Outline and explain the date and nature of any such consultation

94. Every working day for 4 months was spent in consultations.

95. The consultations with agencies were to identify possible services, criteria for acceptance of patients, the nature of the services the agency could provide, support available through the agency, as well as any risks associated with the agency providing services to the patient.

96. The consultations with staff members were to identify concerns about the impact of the transition on patients, concerns about the impact of the transition on staff, understand the peculiar needs and characteristics of patients and their families and communicate information.

97. Consultations with patients and family were carried out in person or by telephone to understand the family dynamics, the needs and aspirations

and concerns of the patient and making suggestions about services so as to develop a recommendation which met the needs of the patient and was acceptable to all parties.

Question 13 - To what extent were transition arrangements made by Dr Brennan and or the Panel, accepted or rejected by the various parties identified in issue 11

98. The process that we followed was that, having established from discussions with the patients and their families the needs and aspirations of the patients, we identified suitable services which were able to accept a request to provide services to a specific patient, before proceeding to develop the recommendation to the patient and his or her family. The result of the work done before providing the recommendation meant that there were very few occasions when a recommendation was not fulfilled by a service agency once accepted by a patient.

99. Recommendations were accepted by the hospitals, health services and community agencies that ended up supporting the young people after transition. These included but were not limited to:

(a)

(b)

(c)

(d)

(e)

(f)

(g)

(h)

(i)

100. Many service Providers who were approached were unable to accept the referral of a young person from BAC because they did not have appropriately trained staff or could not ensure safety or because criteria were not met.

101. [redacted]

102. [redacted]

103. [redacted]

104. [redacted]

105.

106.

Question 13 (iii)

107.

108.

109.

Question 13 (iv)

110. There were many staff at BAC who had concerns about some of the transition plans. There were others who were supportive but felt unable

or unwilling to speak up as there was a perception that one did not care enough about the young people if one was prepared to progress these plans. There were some staff who were supportive of most recommendations.

111. It is too simplistic to categorise staff as supportive or not. There were some facets of some recommendations that worried some staff at some times. That is why there was continuous discussion and reworking of plans until they seemed the best possible with the resources available.

112.

113. On 6 January 2014 there was concern by some staff about the transfer of so I called a meeting of all staff present on the ward including the young person's care co-ordinator to ensure there was agreement before proceeding.

Question 14 The transition arrangements in place and how they developed

114. To assist the Commission I will summarise the condition of the 16 patients who were either inpatients or outpatients and day patients. Where it was possible we tried to do a graduated transition but when new placements or services were delayed, this compromised this approach.

115.

116. [redacted]

117. [redacted]

118.

119.

120.

121.

122.

123.

124.

125.

126.

Question 15 - Any administrative or other deadline imposed for the transition arrangements

127. There was a general guideline that BAC was expected to closed by the end of January with the repeated reassurance from the Board and the WMHHS executive that BAC would remain open till all young people had adequate and appropriate care in place. The reality was that as the numbers of patients decreased, the unit did not function well. There were increasing risks for some still resident at BAC.

128. Staffing became a challenge as numbers of patients declined in terms of level of skill, particularly if there were agency staff without adequate numbers of trained/experienced staff, and in terms of gender.

129. On my arrival at BAC there was an atmosphere of intense distress and uncertainty. Staff were not only concerned for the well being of the patients, most were very concerned about their own futures in terms of employment. Some were also worried that there may be negative repercussions for them professionally following the investigation. There was constant discussion about date of closure as this was highly relevant to their seeking new employment or holding out for redundancies.

Question 16 Outline the support I and the Panel received from any HSA or other stakeholder

130. **This has already been dealt with in my response to issue 13.**

131. Dr Elisabeth Hoehn CHQHHS was supportive, strategic and always available by phone day or night and on weekends.

132. [redacted]

133. Dr David Crompton from Metro South HHS, Dr Jacinta Powell from TPCH, Janelle Bowra CNC from [redacted] Emma Hart CNC and Dr Elisabeth Tovey, psychiatrist, from [redacted] unit and various members of their staff were very supportive.

134. The executive WMHHS Leanne Geppert, Sharon Kelly, Terry Stedman, Will Brennan, Michelle Giles and Padraic McGrath were available and supportive.

135. The Department of Chid Safety was proactive and sought to clarify whether there were any young people not in the care of the Department who possibly could/should have been.

136. There were occasions when support was not ideal. In an executive meeting on 30 November 2013, Padraic McGrath reiterated the view that nursing staff should not be taken from BAC to staff other units, yet there were inadequate nursing staff in terms of numbers or skills on some shifts. This became more problematic as closure became more imminent and as the number of patients declined.

137. Ms Kathy Shapley was appointed to provide support to families of patients as I was already fully committed in consultations and meetings about transitional care and day to day clinical care. Nadia Beer was appointed to provide family and consumer support.

138. Following closure I was left to complete discharge summaries without Administration Officer support.

139. There was no support following closure. I commenced in a new role and

on my own initiative checked on the progress of the young people who had left BAC.

140. [redacted]

Question 17 - Was I aware of concerns about the transition arrangements and on what date did I become aware and what steps did I cause to be undertaken as a result ?

141. [redacted]

142.

143.

144.

145. [redacted]

146. WMHHS (Leanne Geppert) proposed a suggestion box for staff but instead I offered to all staff that they could come to me at any time with their concerns and they could leave me anonymous notes. Many called in including all allied health staff, many nurses and two teachers on frequent occasions. I do not have dates for the calls which occurred over the duration of the transition process. No one left notes. I used the matters raised to guide the plans which were developed for individual patients.

Question 18 - Concerns of HSA or other stakeholder, alternative provider, transition client, friend of carer or member of BAC staff

147. These have been largely dealt with in the above paragraphs. In addition Dr Elisabeth Hoehn kept a risk register which she gave to WMHHS executive. This related to all matters not just transition plans.

148. In general the HSAs were concerned about issues such as suitability, practicality, accessibility, costs, risks to the patient, risks to the service and its other clients, social isolation. The [redacted] facility was concerned about the risk that funding may not be sustained.

149. [redacted]

150. Concerns were expressed by BAC staff most days in meetings and informal discussions. These were taken into account in formulating and altering transition plans.

151. Some of the above concerns were documented in patient files. Sserious concerns led to alteration of plans prior to documentation and implementation.

152. I reported concerns about keeping the remaining patients safe due to staffing levels and concerns about the impact of delays in funding arrangements to WMHHS. I reported concerns about escalating clinical risks. On one occasion this resulted in a late Friday afternoon executive meeting including Dr Steer and Dr Hoehn from CHQ phoning in. Risk management was discussed.

153. Kathy Shapley was appointed to liaise with parents about their concerns and CCs were asked to be in at least weekly contact with parents to support them, hear their concerns and keep them updated about any changes in their child's transition arrangements.

Post Transfer

Question 19 - Outline the procedures developed by the Panel or I to follow up and monitor the outcome of the transition arrangements

154. While BAC remained operational, staff were in constant contact with receiving services. Most young people were re-engaged with services they had previously or continuously been involved with. The panel or I made phone calls to check on their progress.

155.

156. . The nature of the transition was such that follow up of the transition arrangements other than early contact to help the patient settle in was not considered desirable by the receiving services and I understood that view.

157. There were few staff left at BAC after 24 January 2014 to provide monitoring post transfer. For one week, CN Brenton Page followed up

the last patient to leave the unit.

158. I made frequent phone calls in the month following closure about the high risk young people who had transitioned to other accommodation and responded to any calls from concerned families or care providers.

159. On 29 January 2014 I compiled information about every young person and was satisfied that all were doing well at that stage. This was provided to the WMHHS executive who gave a de-identified version of it to the WMHHS Board. A copy is attached marked **AB-5**.

160. I repeated this exercise on 3 March 2014. In this version I highlighted newly identified issues. A copy of this version is attached marked **AB-7**.

161. Generally in medicine follow up is the responsibility of clinical staff who have the responsibility for the ongoing care of the patient. If a patient is transferred from one hospital to another and the first hospital is no longer going to be involved in the treatment of the patient, there is no expectation that the entity handing over care will follow up the patient. In circumstances where BAC had closed and the staff had left, I do not believe there was any expectation of follow up by me or anyone at BAC. Nevertheless I felt a personal obligation to contact the receiving services as noted in paragraphs 146 and 147 above.

162. After the of ir and in July 2014 when I heard about the death of in and again on 6 August 2014 when Dr Stathis called to inform me of the I asked Dr Stathis to urgently review the progress of all the young people who had been at BAC and another young person who had been a patient there before I arrived there.

163. On 25 August 2014 I wrote to Dr Stathis as I wanted someone to ensure the safety of a young person who had left BAC 9 months earlier. My email is attached marked **AB-10**.

Other Matters

Question 20

164. Patients on the waiting list for BAC were contacted to ensure they knew or their mental health provider knew that BAC was closing or had closed and to ensure that they had advice about alternative services. This is confirmed in the email attached marked **AB-11**.

Question 21

165. The attachments to this statement are:

(a) **AB-1** - Email from Dr Mark Mattuisi dated 10 September 2013;

(b) **AB-2** – handwritten organisation structure written by Dr Hohen;

(c) **AB-3** – letter appointing me and letter with Scope of Practice both dated 11 September 2013;

(d) **AB-4** – a number of texts from when I was at a conference in Melbourne;

(e) **AB-5** – a list of patients and their status as at 29 January 2014

(f) **AB-6** a POS note;

(g) **AB-7** – an updated list of patients and their status highlighting emerging issues made on 3 March 2014;

(h)

(i) **AB-9** – email to Sharon Kelly dated 9 December 2013;

(j)

(k) **AB-11** – email from Dr Brennan to Leeanne Geppert and Dr Stathis regarding follow up of patients on waiting list and assessment list

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

Taken and Declared before me, at Brisbane)
this 23rd day of October 2015)
)

.....
~~Justice of the Peace/C.Dec /~~ Solicitor

ATTACHMENT LISTING

Bound and marked 'AB-1' to AB-11' are the attachments to the Statutory Declaration of **DR ANNE BRENNAN** declared 23rd October 2015.

Attachment	Document	Date	Page
AB- 1	Email from Dr Mark Mattuisi	10.09.13	1 - 2
AB-2	Handwritten organisation structure written by Dr Hohen		3
AB-3	Letter appointing me and letter with Scope of Practice	11.09.13	4 – 13
AB-4	A number of texts from when I was at a conference in Melbourne		14
AB-5	A list of patients and their status as at 29 January 2014		15 – 18
AB-6	A POS note	20.01.14	19
AB-7	An updated list of patients and their status highlighting emerging issues made on 3 March 2014	03.03.14	20 – 22
AB-8		28.11.13	23
AB-9	Email to Sharon Kelly	09.12.13	24
AB-10		28.08.14	25
AB-11	Email from Dr Brennan to Leeanne Geppert and Dr Stathis regarding follow up of patients on waiting list and assessment list	13.02.14	26

.....
Dr Anne Brennan

.....
Solicitor / ~~Justice of the Peace~~

Attachment AB-1

From: "John Wakefield" **Subject: Re: Cover for Adolescent Service**
Date: 10 September 2013 8:48:10 pm AEST
To: "Mark Mattiussi"
Cc: "Darren Neillie"
lisabeth Hoehn"
"Sharon Kelly"

Thanks Mark. A big thank you to Elisabeth and Anne for helping to provide a solution at very short notice. Regards John On 10/09/2013, at 5:49 PM, "Mark Mattiussi" wrote:

Hi Elisabeth and Anne,

Thank you very much for offering to cover the adolescent service at very short notice and thank you John for your support in this regard.

We have arranged the following:
1. Elisabeth has SoCP by mutual recognition with CHQ from today and is therefore able to provide cover immediately and into the future
2. Anne has an appointment with WMHHS and SoCP Interim commencing tomorrow. This will cover off indemnity and payment for the role. Anne there is other paperwork for you to sign waiting at The Park Centre for Mental Health for tomorrow. These include Option A contract and other commencement paperwork.

I understand from discussions that Elisabeth will be covering the service tonight and that Darren and Elisabeth have discussed this already today.

I understand that Elisabeth and Anne will meet Darren on site tomorrow (Wed). To facilitate contact I can provide the following mobile numbers.

Darren Neille Anne Brennan

From a medical governance perspective everything is good to go and all have their respective paperwork (or in train). Should you require anything from me please do not hesitate to contact me. My details are below in the signtaure block.

I will be at The Park tomorrow afternoon so I will endeavour to catch up with you then and put faces to names, voices and emails. I am very grateful for the support and flexibility provided by all.
Thank you.

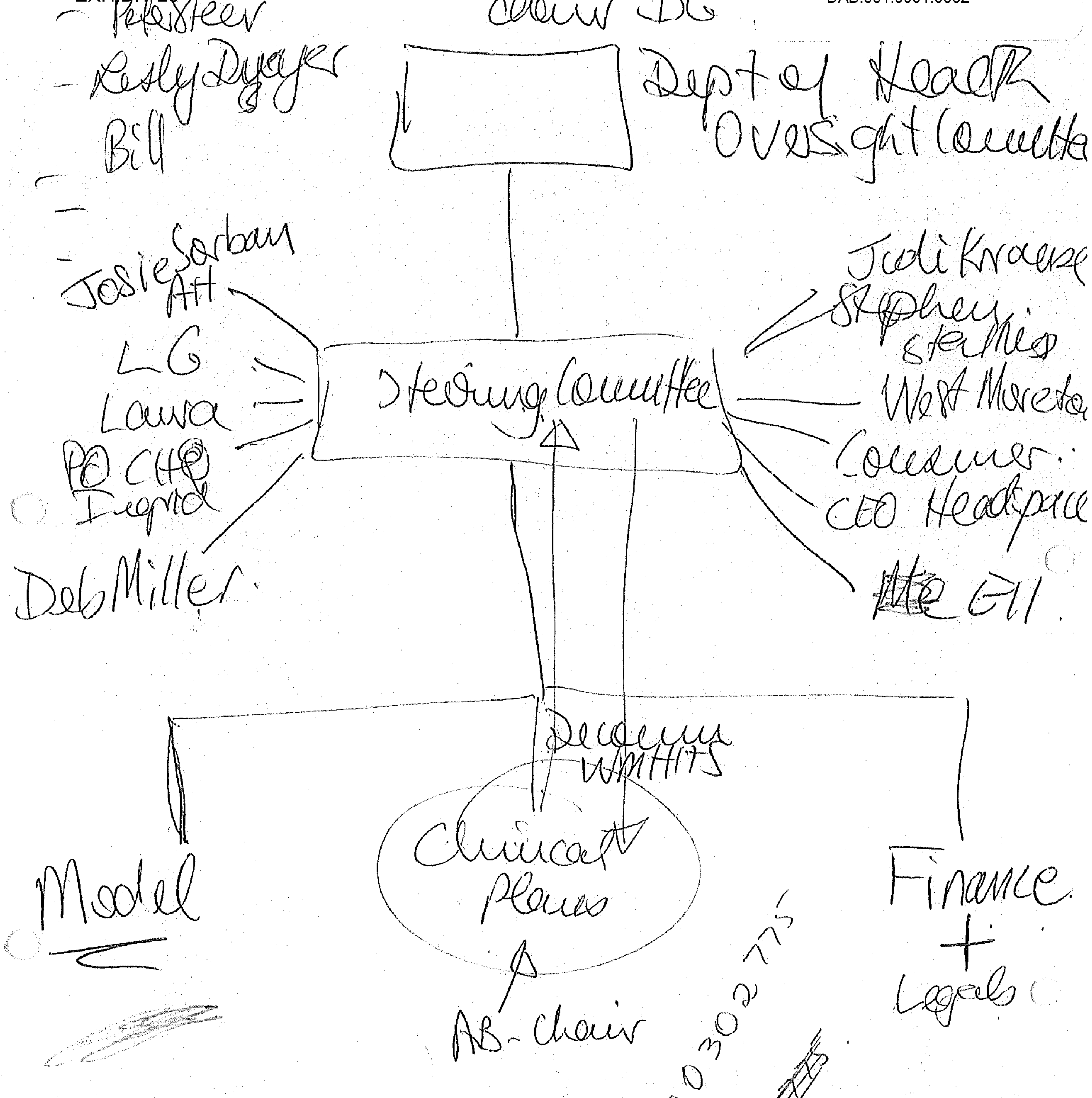
Regards, Mark

Dr Mark Mattiussi

MBA, MBBS (Qld), FRACMA
Executive Director Clinical Governance, Education and Research

West Moreton Hospital and Health Service

PO Box 73, Ipswich, QLD 4305 www.health.qld.gov.au



Wednesday

- 9:10 Am patient meeting
- 9:30 See Team
- 10 - 11:30 update
- 11:30 - 12:30 — Ox Mx

1-3 pm
Planning Panels

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Medical Administration
Telephone:
Facsimile:
Our Ref: Brennan_Letter of Offer

Dr Anne Brennan

Dear Dr Brennan

I welcome you to Queensland Health and am pleased to inform you that approval has been given to offer you employment in the following position, subject to satisfactory registration with the Medical Board of Australia, with associated entitlements.

Position Details

Position Number:	32009799
Position Title:	Staff Specialist/Clinical Director
Unit/Department/Division:	Adol WT
Location:	Ipswich Hospital, West Moreton Hospital and Health Service
Classification:	MMOI2.3 Level 27
Award	District Health Services - Senior Medical Officers' and Resident Medical Officers' Award - State 2003 in conjunction with Queensland Health Framework Award - State 2012, the Medical Officers' (QH) Certified Agreement No. 3 (2012) and the Medical Officers' (QH) Memorandum of Understanding 2009

Employment Details

Employment Status:	Temporary Full Time
Hours per fortnight:	40
Gross Salary:	$3,765.30 per Fortnight

Office
Medical Administration
Ipswich Hospital
West Moreton Hospital & Health Service
Chelmsford Avenue
Ipswich Qld 4305

Postal
PO Box 73
Ipswich Qld 4305

Phone

Fax

Professional Development Assistance:	In accordance with clause 4.6 of the Medical Officers' (Queensland Health) Certified Agreement (No 3) 2012, you will be entitled to Professional Development Assistance of $20,000 per annum (pro-rata basis) payable fortnightly with salary. Senior Medical Officers will accrue 3.6 weeks of Professional Development Leave each year, on a pro-rata basis, up to a maximum of 10 years. Professional Development Leave is not paid out on termination or reinstated on return to Queensland Health.
Provider Number:	You are required to obtain a provider number from Medicare Australia for the West Moreton Hospital & Health Service.
Administrative Application of Private Practice Entitlements:	In accordance with the Terms of Administrative Application of Supplementary Benefit for Staff Specialists, you will receive a supplementary benefit of 50% equivalent to the prescribed percentage of base salary and all purpose allowance and confirmed through execution by the parties of a standard contract. Please contact Trish Downs, Patient Administration on [redacted] regarding the supplementary benefit contract.
Scope of Clinical Practice:	You are required to submit an application for Credentialing and Scope of Clinical Practice. C & SoCP – Julie Simpson [redacted]
Appointment Expenses:	Assistance with appointment expenses to this role can be discussed with the Judy Bond on [redacted]
Fringe Benefit Tax	The Fringe Benefit Tax (FBT) consequences for employees participating in salary sacrifice arrangements will differ depending on the eligibility or otherwise for the FBT exemption cap for public hospitals. Employees are to be aware that if they are rotating to a "for profit" private hospital that they will not be eligible for the exemption cap during this period and may need to review their salary packaging arrangements to avoid incurring a personal FBT liability. For further information, please refer to attachment A. Individual financial management is the responsibility of the employee. Further information on the Queensland Health salary packaging arrangements can be found at: http://www.remserv.com.au (employer code is "health").

Period of Employment

Commencement Date:	11 September 2013
End Date:	09 March 2014

Please find the Equal Employment Opportunity (EEO) Employee Census Form attached to your Acceptance of Offer. The Queensland Government is committed to actively promoting and providing equal employment opportunities for people who identify with groups that have historically been disadvantaged in employment. It would be appreciated if you would complete the EEO Employee Census Form and return it with your signed Acceptance of Offer.

Orientation arranged by supervisor
All new employees are required to attend the Orientation Program. Your supervisor will advise you of the arrangements for you to attend the Orientation Program. Welcome and Orientation information is available on-line at www.health.qld.gov.au/orientation/default.asp and can also be obtained in printed form from your workplace manager or supervisor.

If you have any questions regarding your appointment, please contact Judy Bond on

Congratulations on your appointment. I look forward to your contribution to the delivery of our health services and I hope you find your work enjoyable and rewarding.

Yours sincerely

Sharon Kelly
Executive Director Mental Health and Specialist Services
West Moreton Hospital and Health Service

10 September 2013

Office
Medical Administration
Ipswich Hospital
West Moreton Hospital & Health Service
Chelmsford Avenue
Ipswich Qld 4305

Postal
PO Box 73
Ipswich Qld 4305

Phone

Fax

Acceptance of Offer

Medical Recruitment Coordinator
Ipswich Hospital
PO Box 73
IPSWICH QLD 4305

I acknowledge your letter dated 10 September 2013 and accept the appointment to the position of Staff Specialist, Adol WT at The Park.

I confirm my acceptance of the offer of employment is in accordance with the Letter of Offer, *General Terms and Conditions of Employment* and other details as provided in the *New Employee Starter Kit*.

I agree to acquaint myself with, and abide by, the *Code of Conduct for the Queensland Public Service* and all policy, regulations, standards, procedures and work practices that operate within Queensland Health at any given time.

Signature: Date:

Name:
Dr Anne Brennan

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Medical Administration
Telephone:
Facsimile:
Our Ref: S:\Medserv 2013\Credentialing

Dr Anne Brennan

Dear Dr Brennan

I wish to advise that scope of clinical practice in the West Moreton Hospital & Health Service and its facilities have been granted to you as follows:

Scope of Clinical Practice	Psychiatry ▪ Specialist Psychiatrist
Telehealth	Yes
Special Conditions	Nil
Supervision Requirements	Nil
Location(s)	West Moreton Hospital and Health Service
Queensland Health Clinical Services Capability Framework (CSCF)	Your clinical practice must be consistent with your granted SoCP and the Queensland Health Clinical Services Capability Framework (CSCF) level(s) for each clinical service within the facilities where you will be providing clinical services. Further information on the CSCF is located at: • http://www.health.qld.gov.au/privatehealth/clinical_framework.asp (internet). • http://qheps.health.qld.gov.au/wm/html/clinical/credentialing.htm (intranet) Dentists – this is only applicable to dentists providing clinical services in operating theatres.
Period	**Commencement Date:** 11 September 2013 **End Date:** 9 December 2013
Acknowledgement	If in anyway you disagree with the Scope of Clinical Practice (SoCP) granted, please respond within 20 days otherwise it is determined that you agree with this SoCP.

This interim scope of clinical practice remains valid until 9 December 2013 provided you maintain continued registration with the Australian Health Practitioners Regulation Agency.

During this interim period, the Credentialing and Scope of Clinical Practice Committee will meet and formally consider extending your Scope of Practice for the period up to 3 Years. At the end of this time a new application for scope of clinical practice will be required.

You must notify the Medical Administration Office:

(i) When your circumstances change to necessitating review of these credentials and scope of clinical practice;

(ii) If you become aware that you have developed a condition which would limit your ability to safely practice your specialty;

(iii) If you experience a restriction or withdrawal of credentials and scope of clinical practice at another health care facility or have an application for credentials and scope of clinical practice refused;

(iv) If there is a change to your Registration status. This includes but is not limited to the provision of an undertaking to the Australian Health Practitioners Regulation Agency (AHPRA); if new conditions are imposed or reprimands are given by AHPRA;

(v) If your contact details (i.e. home/business/email/telephone details) change.

Appeals Procedure

A practitioner whose application for credentialing and Scope of Clinical Practice has been denied, withheld, limited or granted in a different form to that requested has the right to appeal the decision. Appeals should be made in writing by the practitioner to the West Moreton Health Service Chief Executive within 30 days of receipt of notification that anticipated Scope of Clinical Practice has been limited or not been granted.

The *2012 Clinical Services Capability Framework (CSCF v3.1)* for *Public* and *Licensed Private Health Facilities* version 3.1 provides a standard set of capability requirements for most acute health facility services provided by Queensland Health and private health services. When applied across the health service, these underlying standards and requirements safeguard patient safety and are integral to our risk management programme.

Mandatory Requirement for evidence of CPD/CME/MOPS Participation

All medical practitioners in the West Moreton Hospital & Health Service must demonstrate their participation in a Continuing Professional Development (CPD) program in the form of evidence of participation in a College or equivalent conducted program for consideration by the committee when applying for renewal of credentials.

HQCC Standards

You must familiarise yourself with the '*Information for Medical Officers: Health Quality and Complaints Commission (HQCC) Standards Summary*' which is enclosed. You must comply with these standards at all times.

Renewal of Scope of Clinical Practice

Prior to the above expiry date, a new application form will be required for continuation of your credentials and scope of clinical practice to be approved.

Yours sincerely

Dr Mark Mattiussi
Executive Director Clinical Governance, Education and Research
West Moreton Hospital & Health Service

10/1 Sept/13

Encl.

Information for Medical Officers: Health Quality and Complaints Commission (HQCC) Standards Summary

The HQCC was established in 2006 by the Queensland Parliament under the Health Quality and Complaints Commission Act 2006 (the Act) as an oversight body. The HQCC performs the following key functions:

- Manages complaints
- Monitors and promotes quality improvement in health services

The HQCC has developed Standards to monitor the safety of health services delivered in Queensland. The Standards were selected based on: burden of disease; severity of impact on users; frequency of occurrence; major process/system failings in patient safeguards; and legislation.

The Standards monitor the health services' compliance with the following:

Review of Hospital-Related Deaths
Referral of reportable deaths to the Coroner; the accuracy and comprehensiveness of the Cause of Death certificate; and implementation of quality improvements based on lessons learnt from death reviews.

Acute Myocardial Infarction (AMI) Management (on and following discharge)
The long-term care of patients following initial management of their acute myocardial infarction, to reduce the incidence of secondary disease.

Surgical Safety
1. The appropriate use of surgical antibiotic prophylaxis to prevent surgical site infections
2. Correct site surgery strategies, to prevent incorrect surgery
3. The selection, timing and duration of antithrombotics, and the use of mechanical compression devices (i.e. graduated compression stockings (GCS) and intermittent pneumatic compression (IPC)), to prevent venous thromboembolism (VTE).

Hand Hygiene
Implementation of effective hand hygiene strategies to reduce healthcare associated infection rates.

Credentialing and Scope of Clinical Practice
Implementation of strategies to ensure that practitioners are credentialed and perform within their defined scope of clinical practice.

Complaints Management
The complaints management system complies with the national guidelines, addresses consumers' issues, and encourages quality improvement processes that improve patient outcomes.

Providers' Duty to Improve
The health service has a responsibility to put activities in place to improve quality of care, assess and manage clinical risk and reduce harm to patients.

More information on the HQCC Standards can be obtained from the Central Qld HSD Clinical Governance & Quality Systems Unit on 49206463 or by accessing the HQCC Website www.hqcc.qld.gov.au.

Queensland Government

West Moreton Hospital and Health Service

Enquiries to: Medical Administration
Telephone:
Facsimile:
Our Ref: S:\Medserv 2013\Credentialing

Dr Anne Brennan

Dear Dr Brennan

On the recommendation of the West Moreton Hospital and Health Service Credentials & Scope of Clinical Practice Committee, following the meeting held **17 September 2013**; I wish to advise that scope of clinical practice in the West Moreton Hospital and Health Service and its facilities have been granted to you as follows:

Scope of Clinical Practice	**Psychiatry** ▪ Specialist Psychiatrist
Telehealth	Yes
Special Conditions	Nil
Supervision Requirements	Nil
Location(s)	West Moreton Hospital and Health Service
Queensland Health Clinical Services Capability Framework (CSCF)	Your clinical practice must be consistent with your granted SoCP and the Queensland Health Clinical Services Capability Framework (CSCF) level(s) for each clinical service within the facilities where you will be providing clinical services. Further information on the CSCF is located at: • http://www.health.qld.gov.au/privatehealth/clinical_framework.asp (internet), • http://qheps.health.qld.gov.au/wm/html/clinical/credentialing.htm (intranet) Dentists – this is only applicable to dentists providing clinical services in operating theatres.
Period	Commencement Date: **11 September 2013** End Date: **11 September 2016**
Acknowledgement	If in anyway you disagree with the Scope of Clinical Practice (SoCP) granted, please respond within 20 days otherwise it is determined that you agree with this SoCP.

Your scope of clinical practice remains valid until **11 September 2016** provided you maintain continued registration with the Australian Health Practitioners Regulation Agency.

Office
Medical Administration
Ipswich Hospital
West Moreton Hospital & Health Service
Chelmsford Avenue
Ipswich Qld 4305

Postal
PO Box 73
Ipswich Qld 4305

Phone Fax

You must notify the Medical Administration Office:

(i) When your circumstances change to necessitating review of these credentials and scope of clinical practice;
(ii) If you become aware that you have developed a condition which would limit your ability to safely practice your specialty;
(iii) If you experience a restriction or withdrawal of credentials and scope of clinical practice at another health care facility or have an application for credentials and scope of clinical practice refused;
(iv) If there is a change to your Registration status. This includes but is not limited to the provision of an undertaking to the Australian Health Practitioners Regulation Agency (AHPRA); if new conditions are imposed or reprimands are given by AHPRA;
(v) If your contact details (i.e. home/business/email/telephone details) change.

Appeals Procedure

A practitioner whose application for credentialing and Scope of Clinical Practice has been denied, withheld, limited or granted in a different form to that requested has the right to appeal the decision. Appeals should be made in writing by the practitioner to the West Moreton Hospital and Health Service Chief Executive within 30 days of receipt of notification that anticipated Scope of Clinical Practice has been limited or not been granted.

The *2012 Clinical Services Capability Framework (CSCF v3.1)* for *Public* and *Licensed Private Health Facilities* version 3.1 provides a standard set of capability requirements for most acute health facility services provided by Queensland Health and private health services. When applied across the health service, these underlying standards and requirements safeguard patient safety and are integral to our risk management programme.

Mandatory Requirement for evidence of CPD/CME/MOPS Participation

All medical practitioners in the West Moreton Hospital and Health Service must demonstrate their participation in a Continuing Professional Development (CPD) program in the form of evidence of participation in a College or equivalent conducted program for consideration by the committee when applying for renewal of credentials.

HQCC Standards

You must familiarise yourself with the '*Information for Medical Officers: Health Quality and Complaints Commission (HQCC) Standards Summary*' which is enclosed. You must comply with these standards at all times.

Renewal of Scope of Clinical Practice

Prior to the above expiry date, a new application form will be required for continuation of your credentials and scope of clinical practice to be approved.

Yours sincerely

Lesley Dwyer
Chief Executive
West Moreton Hospital and Health Service

26/9/B

Encl

Information for Medical Officers: Health Quality and Complaints Commission (HQCC) Standards Summary

The HQCC was established in 2006 by the Queensland Parliament under the Health Quality and Complaints Commission Act 2006 (the Act) as an oversight body. The HQCC performs the following key functions:

- Manages complaints
- Monitors and promotes quality improvement in health services

The HQCC has developed Standards to monitor the safety of health services delivered in Queensland. The Standards were selected based on: burden of disease; severity of impact on users; frequency of occurrence; major process system failings in patient safeguards; and legislation.

The Standards monitor the health services' compliance with the following;

Review of Hospital-Related Deaths
Referral of reportable deaths to the Coroner; the accuracy and comprehensiveness of the Cause of Death certificate; and implementation of quality improvements based on lessons learnt from death reviews.

Acute Myocardial Infarction (AMI) Management (on and following discharge)
The long-term care of patients following initial management of their acute myocardial infarction, to reduce the incidence of secondary disease.

Surgical Safety

1. The appropriate use of surgical antibiotic prophylaxis to prevent surgical site infections
2. Correct site surgery strategies, to prevent incorrect surgery
3. The selection, timing and duration of antithrombotics, and the use of mechanical compression devices (i.e. granduated compression stockings (GCS) and intermittent pneumatic compression (IPC)), to prevent venous thromboembolism (VTE).

Hand Hygiene
Implementation of effective and hand hygiene strategies to reduce healthcare associated infection rates.

Credentialing and Scope of Clinical Practice
Implementation of strategies to ensure that practitioners are credentialed and perform within their defined scope of clinical practice.

Complaints Management
The complaints management system complies with the national guidelines, addresses consumers' issues and encourages quality improvement processes that improve patient outcomes.

Providers' Duty to Improve
The health service has a responsibility to put activities in place to improve quality of care, assess and manage clinical risk and reduce harm to patients.

More information on the HQCC standards can be obtained from the West Moreton Hospital and Health Service Executive Director of Clinical Governance, Education & Research on 07 3810 1333 or by accessing the HQCC Website www.hqcc.qld.gov.au

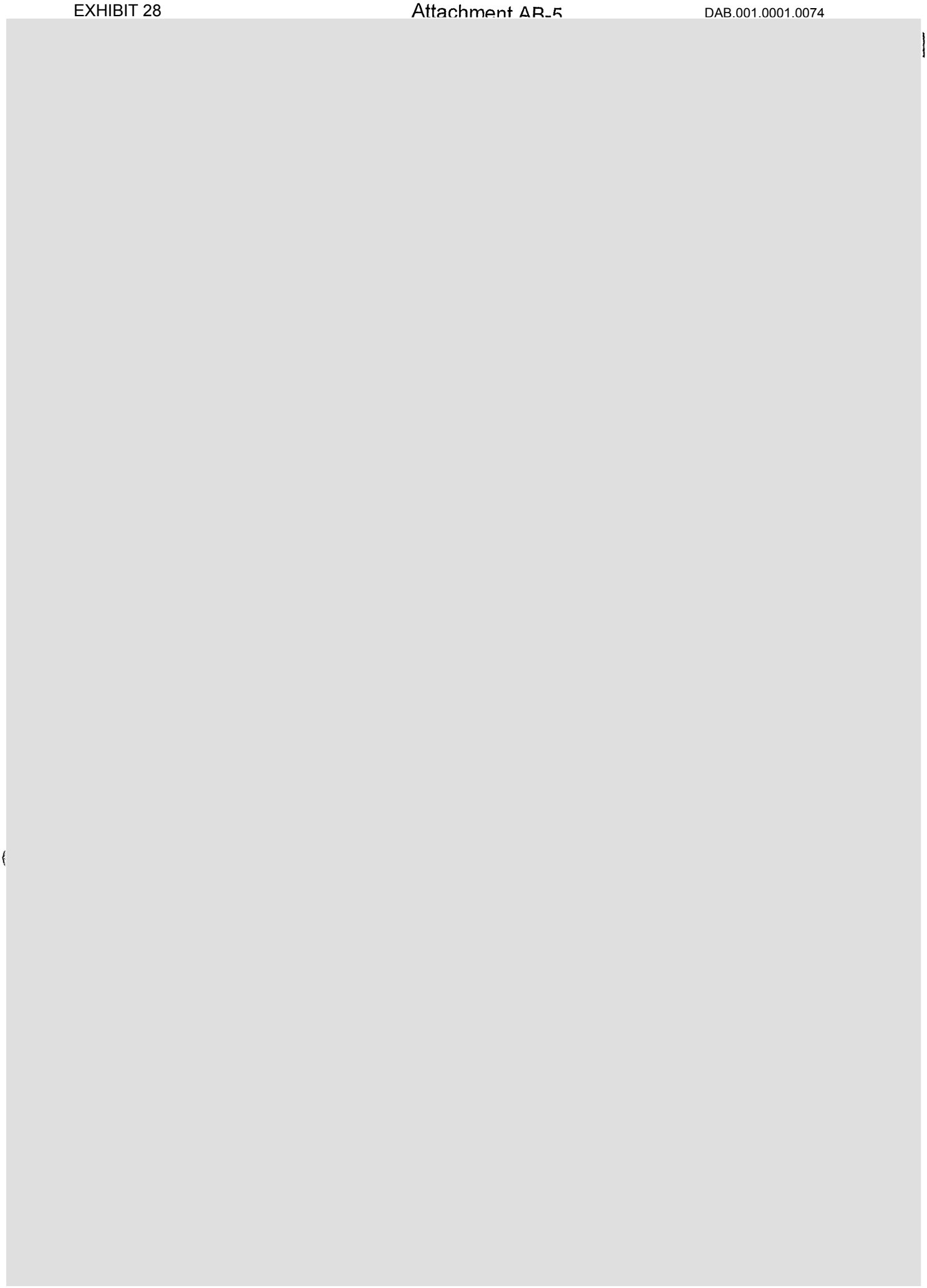
Sent to **Elizabeth Hoehn** on · 0 Oct 20· 3 · :53:44 pm
Trevor is only other person out here. I can't deal with him just now. I need to settle after debriefing Mara and Vanessa. I'm going to escape through staff door and come back once session starts.

Sent to **Peter Steer** on · 0 Oct 20· 3 7:59:46 pm
Hi it may be too late for you now but I am available. Otherwise talk tomorrow or next week. Anne

Sent to **Darren Neillie** on · · Oct 20· 3 8:4· :54 am That msg was from Anne brennan

Sent to **Leanne Geppert** on · · Oct 20· 3 8:45:32 am
Hi I think Vanessa alerted exec yesterday that BAC unsettled and may get worse over next few days as inquiry starts. I've been in constant phone contact from Melbourne and will be available all day if they need to talk to me. I'm just keeping you in the loop. Let me know if there's any concerns from your end that I can help with. Anne

Received from **Leanne Geppert** on · · Oct 20· 3 4:03:58 pm
Thanks Anne. We had a quick debrief yesterday with Vanessa and HR rep. Will continue to monitor today. Has been v difficult for staff because they haven't been able to be given much concrete info and we have spoken to HR about this grp being particularly vulnerable. Really appreciate your ongoing support. Hope you get some down time down there. Leanne



Attachment AB-6

POS Contact Summary for [redacted] on 20/01/2014 at 9:40 AM

Author phoned Case manager at CCU to inform Case Manager of [redacted] expected arrival time at CCU; 1100 hours. Author discussed with Case Manager [redacted] current presentation; NIL recent reported or witnessed self harm events, leave to home over the weekend, hand over documentation including bank details (sent via email). Author discussed with Case Manager [redacted] request that BAC staff visit her daily at the CCU until the end of the week; Case Manager to discuss with NUM of CCU.

Note: BAC has provided Pine Rivers with the following supportive documentation:

- Updated Risk Assessment
- Transfer of ITO
- Date of next MHRT hearing
- Copy of Management Plans
- Meal plan and dietetic handover, TBK results
- Initial Assessment completed by BAC
- Allied Health Reports available on CIMHA
- Copy of Medication Chart and script; 1 nights worth of leave medication
- Completed documents; Guardianship and HASP

Plan:

1. Await contact from Case Manager at CCU re BAC staff continuing to have contact with [redacted]
2. LCT's to be taken to medical records
3. Medication Chart to be ceased and filed
4. Medication to be returned to Pharmacy; The Park
5. Outcomes to be entered in to CIMHA by BAC staff (Case Coordinator/Associate Case Coordinator or Clinical Nurse)
6. Details to be updated on CIMHA by BAC Administration Officer
7. A/CNC to contact Representative for Commission for Children and Young People and Child Guardian

First signed by:	Discipline:	Date:	Time:
CLAYWORTH, Vanessa	Nurse - Registered	20/01/2014	10:18 AM

Note: This document has been signed 1 time(s). Multiple signatures will be listed on the last page where applicable.
Electronically signed documents within CIMHA form only part of the consumer's complete clinical record

This clinical note has been amended from the original version signed by CLAYWORTH, Vanessa on 20/01/2014 10:18 AM

Consumer ID:234933 PDF Ref No:361195

Attachment AB-7

Attachment AB-8

Attachment AB-9

Sharon Kelly2 - BAC

From: Anne Brennan
To: Kelly, Sharon
Date: 9/12/2013 5:48 PM
Subject: BAC
CC: Hoehn, Elisabeth

Hi Sharon
We have informed each of the about the components of their transition from BAC care packages in a step wise fashion so they could process this information without unacceptable risks to their personal safety.
I am concerned that the delays we are now experiencing in implementing these packages is impacting clinical care. I know we will discuss how to progress these on Wednesday.We will need clear direction then regarding duration of remaining care at BAC, availability or otherwise of funding for support within residential care settings and duration of such financial support if it is available.
The placement is not solely dependent on funding. The suggestion from the psychiatrist there today is that it may need to be addressed by the minister.We have one last option to explore in that regard, but I thought I should give you as much warning as possible.
I am happy to discuss these matters with you before Wednesday if that is helpful.
Anne

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health

Attachment AB-10

On 25/08/2014, at 5:17 PM, "Anne Brennan" < > wrote:

Dear Stephen

I am not in a position to contact treating team for nor to put clinical details in an email such as this. I am concerned about as there have been and I do not know how has been coping with that loss, and that has been relevant in past. Could you please contact Angela Hain and/or Una Window and/or treating psychiatrist to ensure they are aware as this date is imminent. They can read details in CIMHA.
I trust this alert is not inappropriate.
Thanks
Anne

Dr Anne Brennan
Child & Adolescent Psychiatrist
PO Box 2274, Toowong 4066

Attachment AB-11

Anne Brennan 2/13/2014 4:56 pm >>>

Hi Leanne and Stephen
All consumers on BAC waitlist and assessment list have been contacted,or the referring service has been or in some cases both. Spreadsheet attached.
Let me know if there is further action required.
Anne

A/Clinical Director
Barrett Adolescent Centre
The Park-Centre for Mental Health