about supporting needs from a speech pathology perspective. For example:

(a) I noted that Patient had better reading comprehension than oral comprehension.

(b) I noted that Patient 's impaired attention and level of distraction significantly affect ability to understand and process information.

(c) I recommended that others minimise environmental distractions and repeat important information.

(d) I noted that Patient needs a consistent and trusted person with whom can talk through problems.

(e) I noted that Patient needs support for complex language tasks such as negotiating and reasoning.

(f) I recommended that Patient be given support should continue to complete .

8.67 On , I emailed and other members of the team at the to provide a copy of the Communication Assessment Report and a copy of the Discharge Summary that I had completed for . Attached and marked **AC-33** is a copy of that email.

8.68 responded to the effect that they had not yet taken over the care of Patient but were starting the hand over process. She thanked me for the reports which she stated would assist with treatment planning.

Patient

8.69 Patient was first seen by me on with a history of .

8.70 Patient completed a communication assessment over sessions between .

8.71 Results of the communication testing indicated that Patient .

8.72 I noted in my initial assessment report, completed in , that Patient did not require individual therapy but participation in a social skills training was

recommended.

8.73 From a review of medical records, I can see that Patient attended social skills training sessions with me on . I do not recall discussing transition arrangements.

8.74 From a review of medical records, I can see that an ICW meeting occurred on . I did not attend this meeting but provided advice that Patient did not need individual therapy but recommended Patient attend social skills group.

8.75 From a review of medical records, I can see that an ICW meeting occurred on . I did not attend this meeting but provided information about Patient s participation in the social skills group.

8.76 On , I compiled a Speech Pathology Discharge Summary for Patient . Attached and marked **AC-34** is a copy of that Discharge Summary.

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

8.78 For example, I noted that Patient would benefit from "thinking aloud" with someone to assist with social problem solving.

8.79 I also recommended that Patient join a social group or hobby to assist socialisation.

Patient

8.80 Patient was first seen by me on or about the .

8.81 Patient completed a communication assessment over sessions between [12]. An initial communication assessment report was completed in .

8.82 Results of the communication testing revealed that Patient 's listening, speaking, reading comprehension and written expression skills were all below average.

8.83 Results also revealed that Patient 's social problem solving skills were below average.

8.84 From a review of medical records and a brief review of CIMHA, I can see that Patient frequently participated in social skills group sessions between . [13] These sessions targeted social skills, conflict resolution and self-awareness. We did not discuss the transition arrangements for Patient during these sessions.

8.85 From a review of medical records, I can see that I contributed to a number of ICW meetings [14] in relation to Patient though I did not personally attend. I cannot see that my contributions related to or informed Patient s transition planning.

On or about , I compiled a Discharge Summary for Patient . Attached and marked **AC-35** is a copy.

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

(a) I noted that Patient would function adequately with familiar people but may have impaired comprehension skills when speaking with unfamiliar people or when anxious.

(b) I noted that when speaking on familiar topics, Patient would likely function adequately, but would have greater difficulty when speaking on unfamiliar or complex topics.

(c) I noted Patient s reading comprehension and written expression difficulties.

(d) I noted difficulty interpreting others' perspectives in social situations.

(e) I recommended that Patient seek out others with whom could 'talk out loud' to gain assistance with social problem solving.

12
13
14

Patient

8.87 I saw Patient to complete a communication assessment between [15]. I completed an initial Communication Assessment Report in .

8.88 Results of the communication testing indicated Patient s listening, speaking, reading and writing skills . Results indicated .

8.89 From a review of medical records, I can see that Patient attended social skills groups with me between and further sessions between . These sessions targeted social skills, conflict resolution and self-awareness. We did not discuss the transition arrangements for Patient during these sessions.

8.90 From a review of medical records, I can see that an ICW meeting was held on which I am listed as attending. The ICW notes reflect that I presented Patient s assessment results.

8.91 From a review of medical records, I can see that an ICW meeting was held on . There is no list of attendees for this meeting. The ICW notes reflect that I presented on Patient 's participation in the social skills groups.

8.92 On or about , I compiled a Speech Pathology Discharge Summary for Patient . Attached and marked **AC-36** is a copy of the Discharge Summary for Patient .

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

8.94 For example:

(a) I recommend supporting Patient s auditory comprehension and verbal expression difficulties.

(b) I note that Patient needed support to complete reading comprehension tasks.

[15]

(c) I note that Patient had social skills difficulty including understanding other's points of view.

(d) I recommend that Patient seek assistance and 'think out loud' with others in social problem solving tasks.

Patient

8.95 From a review of medical records, I can see that, I completed a communication assessment with Patient between [16].

8.96 Results of the communication testing indicated

8.97 From a review of medical records, I can see that Patient attended individual speech pathology sessions with me on .

8.98 From a review of medical records, I can see that an ICW meeting was held on . The attendance list does not reflect that I attended this meeting. The ICW notes reflect that Patient was .

8.99 From a review of CIMHA notes, I can see that during the relevant period, Patient attended a number of social skills group sessions. Specifically, attended sessions on ; and further sessions between . These sessions targeted social skills, conflict resolution and self-awareness. We did not discuss the transitional arrangements for Patient during these sessions.

8.100 On or about , I compiled a Speech Pathology Discharge Summary for Patient Attached and marked **AC-37** is a copy.

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

[16]

[17]

about supporting needs from a speech pathology perspective. For example:

(a) I note that Patient would benefit from others repeating information and explaining vocabulary terms.

(b) I note that Patient could use better expressive language skills to mask auditory comprehension difficulties.

(c) I note that Patient struggled to understand and manage problem situation.

(d) I recommend that seek out a trusted person to think out loud with in difficult situations.

Patient

8.102 From a review of medical records, I can see that I completed a communication assessment with Patient between [18].

8.103 I completed a Communication Assessment Report in . Attached and marked **AC-38** is a copy of the Communication Assessment Report.

8.104 Results of the communication testing indicated

8.105 From a review of medical records and CIMHA, I can see that Patient attended social skills group sessions between ; and again between . These sessions targeted social skills, conflict resolution and self-awareness. We did not discuss the transitional arrangements for Patient during these sessions.

8.106 From a review of medical records, I can see that between , I contributed to ICW meetings for Patient in that I reported on the findings of the communication assessment and Patient 's participation in the social skills groups.

[18]

8.107 On or about , I compiled a Discharge Summary for Patient . Attached and marked **AC-39** is a copy.

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

(a) I note Patient needed support to develop complex language skills such as negotiation and reasoning.

(b) I recommend that Patient become involved in a sporting group or hobby to support socialisation.

8.109 On , I emailed to notify that I had completed the Discharge Summary for Patient and uploaded it onto CIMHA. Attached and marked **AC-40** is a copy

8.110 responded to me on the same day to the effect that she did not yet have consent to liaise about patients privately as she was waiting on written consent from the .

Patient

8.111 From a review of records, I can see that Patient completed a communication assessment in and a report was completed in .

8.112 Results of the communication testing indicated that

8.113 From a review of medical records and CIMHA, I can see that Patient attended social skills group sessions between and between .

8.114 From a review of medical records, I can see that three ICW meetings were held during the relevant period. [19] I attended one of these meetings[20] and contributed to notes from both the meetings and provided an overview of Patient s communication skills and a

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summary of participation in social skills group sessions.

8.115 On or about , I compiled a Discharge Summary for Patient . Attached and marked **AC-41** is a copy.

8.116 The Discharge Summary makes one key recommendation to future services about supporting needs from a speech pathology perspective. Specifically, I noted that may benefit from ongoing support to develop complex language skills such as negotiation and reasoning.

Patient

8.117 From a review of medical records, I can see that Patient was first seen by me in with a history of I completed a communication assessment with Patient between [21].

8.118 I completed a Communication Assessment Report in .

8.119 Results of the communication testing indicated that Patient had significant impairment in communication functioning with most areas of development well below the average range for age.

8.120 From a review of medical records and CIMHA entries, I can see that Patient attended social skills group sessions in

8.121 From a review of medical records, I can see that there were ICW meetings held during the relevant period.[22] I cannot see that I attended these meetings but the notes indicate that I provided information as to the outcomes of the communication assessment and Patient 's participation in social skills group.

8.122 On or about , I compiled a Discharge Summary for Patient . Attached and marked **AC-42** is a copy.

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

[21]

about supporting needs from a speech pathology perspective. For example:

(a) I note Patient 's severe communication impairments.

(b) I recommend others gain Patient 's attention before speaking to , to use simple short sentences when giving instructions or information.

(c) I recommend others support Patient 's verbal expression.

(d) I recommend making information explicit and obvious as was unable to detect social inferences.

(e) I note that Patient needed considerable support with reading and writing tasks.

(f) I note that Patient needed considerable support to complete complex language tasks.

8.124 On , I emailed a copy of the Discharge Summary to . Attached and marked **AC-43** is a copy of that email.

Patient

I saw Patient to complete a Communication Assessment Report on various dates between .[23] Attached and marked **AC-44** is a copy of that report.

8.125 I cannot see, from CIMHA, that I saw Patient individually following assessment period, nor does it appear that attended any social group skills sessions.

8.126 There are no records in CIMHA to indicate attended the social skills groups.

8.127 I can see that I am listed on CIMHA as attending Intensive Case Workup meetings, on , but there are no minutes on CIMHA so I am unable to comment on what input I made.

22
23

Patient

8.128 From a review of medical records, I can see that I completed a communication assessment with Patient between [24]

8.129 I completed a Communication Assessment Report in Attached and marked **AC-45** is a copy of that report.

8.130 Results of the communication testing

8.131 From a review of medical records and CIMHA notes, I can see that, Patient attended social skills group sessions between on These sessions targeted social skills, conflict resolution and self-awareness. We did not discuss the transition arrangements for Patient during these sessions.

8.132 A Speech Pathology Discharge Summary was not completed for Patient as comprehensive Communication Assessment Report had been completed in and my contact with since that time had been minimal. , Patient s Communication Assessment Report was accessible on CIMHA.

9 For each of those transition plans:

(a) state who was responsible for overseeing the transition plans; and

9.1 I believe that for all the patients mentioned above, there were dedicated Care Coordinators and Associate Care Coordinators who would have been initially responsible for overseeing the transition plans. I believe that the transition panel held responsibility for overseeing the transition plans.

(b) were there any arrangements to review, follow up and monitor the outcome of the transition arrangements? If so, what were those arrangements?

9.2 I am not aware of specific arrangements to review, follow up and monitor the outcome of the transition arrangements.

[24]

10 Did you have any discussions with the medical or other staff at receiving alternative services regarding the transition clients' transitional arrangements, treatment plans, clinical and educational needs or other matters? If so, explain the nature of these discussions, including the date on which they occurred, with whom and for what purpose.

10.1 I mainly recall having discussions with staff at n relation to Patient . I also attended an for Patient as already described.

10.2 With a view to informing subsequent service providers, I uploaded patient discharge summaries onto CIMHA or sent them to external stakeholders as I completed them. I also re-uploaded, for as many consumers as possible, copies of their original speech pathology assessment report.

10.3 With a view to informing subsequent service providers, I also emailed copies of each completed handover summary to members of the transition planning group and the Patient's Care Coordinator so that reports could be included with documentation being prepared for receiving services.

10.4 I cannot recall if I also provided families/carers with copies of the speech pathology reports, but it is likely that I did so in some cases.

11 In relation to the transition arrangements did you have any consultation(s) with transition clients and or their families, friends or carers? If so, explain the date and details of such consultation(s).

11.1 Other than as outlined above, I cannot recall that I had any specific consultations with transition clients.

11.2 Similarly, I cannot recall that I had any specific consultations with their families or carers about transition arrangements.

12 Were you aware of any concerns regarding the transition of any transition clients from the BAC to an alternative service provider? If so:

(a) Explain such concerns.

12.1 It is my recollection that there was a pervasive level of concern for all of the consumers

who were to be affected by the closure of BAC. I believe that this concern informed all interventions, planning and management of patients carried out by clinical staff.

12.2 Concerns for the transfer of the BAC patients related to:

(a) The severity of their mental illness and the existence of poly-morbidity (patients typically had numerous mental health concerns and multiple diagnoses).

(b) Vulnerability factors (such as lack of carer and social supports, history of learning and communication impairments, immaturity, past history of abuse, neglect and trauma).

(c) The prevalence of risk factors such as drug and alcohol misuse, and deliberate self-harm and suicidal ideation in many of the BAC patients.

(d) The fact that all of the BAC patients had already received services in community mental health agencies and this intervention had not met their needs (prompting referral to BAC).

12.3 For some patients, their age meant that they were no longer eligible or suitable for CYMHS which meant a transition to Adult Mental Health Services, which had a different model of care to that provided at BAC.

12.4 As BAC was closing, I recall that there were time pressures for putting into place plans for these complex consumers. In addition, the closure meant that there would be no opportunity for ongoing liaison or shared care between the treating team of BAC and the treating team at the receiving service to allow for transition support.

12.5 I recall that discussions amongst BAC staff about concerns, along the lines that I have just described, were common-place at BAC during 2013 and intensified after the announcement by Minister Springborg (regarding the closure).

12.6 It is my memory that members of the transition team spoke of their frustration as external agencies would accept a referral for a consumer, only to revoke this acceptance on the basis that the consumer was either too impaired, or not impaired enough to meet the service's referral criteria.

12.7 I recall that Dr Brennan discussed raising this issue (trying to place complex consumers with other service providers) with senior management of WMHHS and QH

but I am unsure in what manner she did this.

(b) If there were concerns, who were these concerns expressed by and to whom?

12.8 I was aware that parents of BAC patients, members of the community, psychiatrists in private practice and other mental health clinicians outside BAC raised the concerns listed above, repeatedly with senior management of WMHHS, senior management of QH, and with Minister Springborg. I knew this because:

(a) Staff members who had regular contact with parents (such as Care Coordinators and teachers from the BAC School) told me that that some parents had told them that they were raising their concerns with senior management of WMHHS and Members of Parliament.

(b) It was reported in various media outlets, including Brisbane Times, that parents and members of the community were raising their concerns with those media outlets.

(c) A letter written by a private psychiatrist to the Minister for Health stating that BAC had helped patients and that its closure would put lives at risk was read out in a Case Conference. I cannot now recall when that Case Conference occurred and I was not provided with a copy of that letter.

12.9 I also recall that BAC staff raised their concerns at some of the meetings that were held with senior management of WMHHS including the Executive Director of Mental Health and Specialised Services, Sharon Kelly and the Health Service Chief Executive, Lesley Dwyer which I attended.

(c) On what date and by what means did you become aware of these concerns?

12.10 I recall being concerned from around the time that the comment was made by Professor Brett McDermott in November 2012.

12.11 My concerns were informed by my clinical experience working with adolescents with complex and severe mental health disorders.

(d) What steps, if any, did you cause to be undertaken as a result of those concerns?

12.12 I was present at staff meetings with WMHHS management where staff concerns for the closure of BAC and the impact on BAC patients were raised.

13 If there were transitional plans in place for the transition clients, what progress did each client make in respect of the plans? If progress was unsatisfactory, what arrangements, if any, were made for alternative management?

13.1 I am unable to comment on whether, if there were transition plans put in place for the transition clients, what progress each client made in respect of the plans. I am also unable to comment on whether if the progress was unsatisfactory, what arrangements were put in place for alternative management.

14 Did you attend BAC consumer transition of care planning meetings? If so, in relation to these meetings:

(a) Explain the function/purpose of these meetings. What did they involve?

14.1 I understand that what is referred to as 'consumer transition of care planning meetings' is not the weekly case conference meetings that had traditionally been held at the BAC on Mondays and which dealt with day-to-day aspects of patient care.

14.2 I do not recall attending consumer transition of care planning meetings.

(b) How often did the group meet?

14.3 I am unable to comment on how often the group met.

(c) Who attended?

14.4 I believe that Dr Anne Brennan, Vanessa Clayworth, and a member of the Allied Health staff may have attended the meetings.

(d) What were the resolutions or findings or actions determined as a result of those meetings?

14.5 I am unable to comment on what the resolutions or findings determined as a result of those meetings as I was not present at the meetings and the outcomes were not communicated to me.

15 Were you involved in the Complex Care Review Panel? If so, in relation to this Panel:

(a) Explain the function/purposes of the Panel.

15.1 I was not a part of the 'Complex Care Review Panel' (**CCRP**). I understand that this

refers to a meeting which was convened to plan the transition of one adolescent. I understand that CCRP does not refer to the weekly Care Review meetings (which BAC had previously called ICW meetings).

(b) How often did the group meet?

15.2 I am unable to comment on how often the CCRP met.

(c) Who constituted the Panel?

15.3 I do not recall specifically who was part of the CCRP but believe that Dr Brennan and Vanessa Clayworth from BAC may have attended.

(d) What were the resolutions or findings or actions determined as a result of those meetings?

15.4 I am unable to comment on what the resolutions or findings or actions determined as a result of the Allied Health staff attending the meetings.

16 If you were involved in the Complex Care Review Panel which convened to support the transition of care for patients, outline for each patient:

(a) Was a Consumer Care review Summary (CCRS) developed for each patient?

16.1 I do not know whether a Consumer Care Review Summary was developed at the CCRP.

(d) What did this involve? Please provide copies.

16.2 Not applicable.

(d) How were high risk situations identified and mitigated?

16.3 I am not aware how high risk situations were identified and managed.

17 (d) How was the clinical risk during the transition of care of the patients from BAC to alternative care options managed?

17.1 I am unable to comment on how the clinical risk was managed during the transition of care of the patients from BAC to alternative care options.

18 Outline and elaborate upon any other information or knowledge (and the source of

that knowledge) that you have relevant to the Commission's Term of Reference. I believe that for the staff, patients and families of BAC, the process of closure began in November 2012 with Professor Brett McDermott's comment to the media. Some 14 months later in January 2014, I am aware that the final cohort of patients were transitioned from BAC.

18.1 During this 14 month period, I personally experienced distress and sleeplessness, hypervigilance regarding the short-term safety of patients, worry for the long-term welfare of patients and their families, anxiety at losing my job and guilt for being concerned for myself in the context of the distress of patients and their families.

18.2 I note further that my distress continued well beyond the final closure, with persistent concerns for the welfare of former BAC patients, the grief [redacted] and ongoing reviews and inquiries.

18.3 Finally, going back before [redacted] and the closure process, WMHHS had undertaken an extensive review of all staff positions with the Health Service, including Allied Health positions (which was known as the Turnaround Plan). It resulted in the loss of many positions across the service. As mentioned, all Allied Health staff (and other staff across WMHHS) were required to write business cases for their positions, attend meetings with project officers for the review, and so on. There was therefore a pervasive experience of uncertainty and threat of job losses prior to Professor McDermott's comment to the media in November 2012 and the subsequent closure decision.

19 Identify and exhibit all documents in your custody or control that are referred to in your witness statement.

19.1 All documents referred to in my witness statement are exhibited.

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 by **Angela Clarke** at Brisbane in the State of Queensland this 20TH day of November 2015
Before me:

[redacted]
.....
Signature of authorised witness

[redacted]
.....
Signature of declarant

A Solicitor/ ~~Justice of the Peace/ Commissioner for Declaration~~

STATUTORY DECLARATION OF ANGELA CLARKE

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AC-4	Email from Angela Clarke to Kylie Bruce dated 16 August 2010 attaching: • Document entitled '15-bed Adolescent Extended Mental Health Treatment Unit at Redlands Hospital Schedule of User Group Minutes', undated	WMS.0026.0001.00320 WMS.0026.0001.00321	10-12
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Angela Clarke **Witness**

AC-11	Email from Leanne Geppert to Angela Clarke, copied to Michelle Giles and Lorraine Dowell, dated 7 August 2013 attaching: • West Moreton Hospital and Health Service and Children's Health Queensland Hospital and Health Service document entitled 'What is the Barrett Adolescent Centre (BAC)?', undated • West Moreton Hospital and Health Service – Expert Clinical Reference Group Recommendations Barrett Adolescent Strategy dated July 2013 • West Moreton Hospital and Health Service and Children's Health Queensland Hospital and Health Service Media Statement dated 6 August 2013	WMS.0016.0001.18672 WMS.0016.0001.18629 WMS.0016.0001.18709 WMS.0016.0001.18688	31-42
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Angela Clarke

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..... [redacted] .....
Angela Clarke

[redacted] ....
Witness

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Angela Clarke

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Witness

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Angela Clarke **Witness**

Curriculum vitae prepared for the Commission of Inquiry into the Closure of the Barrett Adolescent Centre.

1. Applicant details	
Last Name:	Clarke
First Name:	Angela
Current Work Address:	The Park Centre for Mental Health Cnr Ellerton Drive & Wolston Park Road, Wacol 4076 Assertive Mobile Youth Outreach Service Old Child & Family Therapy Unit, Bramston Terrace, Royal Brisbane & Women's Hospital, Herston 4029
Email Contact:	

2. Education		
Date:	Qualification achieved:	Institution:
November 1994	Bachelor of Speech Pathology	University of Queensland

3. Employment History		
Current position:	Advanced Speech Pathologist (HP5)	
Employer:	The Park Centre for Mental Health, West Moreton Hospital and Health Service (WMHHS) ▪ Re-deployed from the Barrett Adolescent Centre	
Employment period:	From: 03/02/2014	To: ongoing
Responsibilities:	Provision of assessment, intervention, group therapy programs, and advice to teams in managing adult forensic mental health consumers with impaired communication functioning.	
Current position:	Senior Speech Pathologist (HP4)	
Employer:	Assertive Mobile Youth Outreach Service (Adolescent Extended Treatment Team), Children's Health Queensland Hospital and Health Service (CHQHHS) ▪ Acting in this position since the merger of Mater Health Services and Children's Health Qld in December 2014. Substantive position remains with Mt Gravatt Child & Youth Mental Health Service, formally Mt Gravatt Kids in Mind Service.	
Employment period:	From: 01/12/2014	To: ongoing
Responsibilities:	Provision of speech pathology assessment, diagnosis and intervention to young people who present with communication impairments in the context of mental health difficulties in collaboration with a community-based multidisciplinary team. Provision of consultation, liaison and advice on managing communication impaired clients to the team; to clients' families; and to external stakeholders, e.g. Education Qld and Disability Services Qld.	
Previous position:	Senior Speech Pathologist (HP4)	
Employer:	Mater Kids In Mind Service (KIMS), Mater Health Services ▪ Yeronga Kids in Mind Service; then Mt Gravatt KIMS	
Employment period:	From: 07/12/2012	To: 01/12/14
Responsibilities:	Provision of speech pathology assessment, diagnosis and intervention to children and young people who presented with communication impairments in the context of mental health difficulties in collaboration with a community-based multidisciplinary team. Provision of consultation, liaison and advice on managing communication impaired clients to the team; to clients' families; and to external stakeholders, e.g. Education Qld and Disability Services Qld.	

Curriculum vitae prepared for the Commission of Inquiry into the Closure of the Barrett Adolescent Centre.

Previous position:	Senior Speech Pathologist (HP4) locum	
Employer:	Evolve Therapeutic Services, Mt Gravatt, Mater Health Services	
Employment period:	From: 28/02/14	To: 30/06/14
Responsibilities:	Provision of speech pathology assessment, diagnosis and intervention to children and young people in out-of-home care, who presented with communication impairments in the context of mental health difficulties in collaboration with a community-based multidisciplinary team.	
Previous position:	Advanced Speech Pathologist (HP6)	
Employer:	Barrett Adolescent Centre, West Moreton HHS	
Employment period:	From: 10/10/2000	To: 30/01/14
Responsibilities:	Provision of speech pathology assessment, diagnosis and intervention (both individual and group programs) to young people who present with communication impairments in the context of mental health difficulties in collaboration with a multidisciplinary team in a long-stay, tertiary rehabilitation centre. Provision of consultation, liaison and advice on managing communication impaired clients to the team; to clients' families; and to external stakeholders, e.g. Education Qld and Disability Services Qld.	
Previous position:	Clinical Educator, Specialist CYMHS Speech Pathology Student Clinics (Sessional)	
Employer:	University of Queensland, Division of Speech Pathology, School of Rehabilitation Sciences	
Employment period:	From: 01/06/06	To: 19/09/13
Responsibilities:	Supported undergraduate and masters' students to deliver a speech pathology service within a number of mental health services including: Northwest Community Mental Health Service, Evolve Therapeutic Services, and Mater Day Program.	
Previous position:	Senior Speech-Language Pathologist (HP4)	
Employer:	Metropolitan North Behaviour Support Service, Education Queensland	
Employment period:	From: 14/02/13	To: 12/02/14
Responsibilities:	Provision of assessment and intervention (individual and group) to students referred to this specialist behaviour service within Education Queensland.	
Previous position:	Speech Pathologist (PO2)	
Employer:	Ipswich Child and Youth Mental Health Service, West Moreton Health & Hospital Service	
Employment period:	From: 01/04/1996	To:09/10/2000
Responsibilities:	Provision of speech pathology assessment, diagnosis and intervention to children and young people who presented with communication impairments in the context of mental health difficulties in collaboration with a community-based multidisciplinary team. Provision of consultation, liaison and advice on managing communication impaired clients to the team; to clients' families; and to external stakeholders, e.g. Education Qld and Disability Services Qld	
Previous position:	Speech Pathologist (PO2)	
Employer:	Gayndah-Monto Community Health Service, Gayndah-Monto Hospital & Health Service	
Employment period:	From: 06/01/1995	To: 30/03/1996
Responsibilities:	Provision of a speech pathology service as a sole rural new-graduate clinician, from infancy to seniors within the community.	

Curriculum vitae prepared for the Commission of Inquiry into the Closure of the Barrett Adolescent Centre.

From: Trevor Sadler
Sent: 14 Oct 2009 12:43:21 +1000
To: Bricknell, Brett;Crompton, David
Cc: Simpson, Jacqueline
Subject: Nominees from the Barrett Adolescent Centre for the User Group for the AETRC

Hello David and Brett,

David, you invited me to nominate people from Barrett for the User Group. I mentioned at our first meeting that we are currently at the beginning of another 3 year cycle for joint Health/Education planning for the Centre. Obviously a big component of that plan is managing the transition to Redlands. The following staff have been very involved in that process, as well as visiting other units for design considerations etc.

Queensland Health
Risto Ala-Outinen NUM
Susan Daniel CN
Matthew Beswick A/CN
Vanessa Clayworth RN
Angela Clarke Speech Path
Kimmie Hoang OT

Department of Education and Training
Kevin Rodgers Principal
Debbie Rankin Teacher
Steve Marriott Teacher

These people have already given a lot of thought to the interaction of buildings, people and programs. I am sure they will be invaluable contributors to the process.

Kind regards,

Trevor

Dr Trevor Sadler
Director
Barrett Adolescent Centre
Clinical Leader
CYMHS Clinical Collaborative
The Park _ Centre for Mental Health
Locked Bag 500
Sumner Park BC
Queensland 4074

Metro South Health Service District
Proposed Adolescent Unit at Weippen Street, Redlands
Project no 51426

Project Services
Queensland Government
A business unit of the Department of Public Works

MINUTES. USER GROUP MEETING No 2 (PD stage)

Note that this was a guided tour of the existing Barrett Centre at The Park in Wacol.

Date / time: **26th November 2009** 1:30pm – 3:30pm
Location: **Barrett Adolescent Centre, The Park. Wacol**

Attendees

Risto Ala-Outinen (RA)	Nurse Unit Manager Barrett Adolescent Centre
Terry Carter (TC) - Chair	Project Manager Project Services
Angela Clarke (AC)	Speech Pathologist Barrett Adolescent Centre
Stephen Sault	Registered Nurse Barrett Adolescent Centre
Sue Daniel (SD)	Clinical Nurse/ Community Liaison Barrett Adolescent Centre
Anne Garton (AG)	Consumer Consultant, Pre-commissioning Team, QH
Neil Steward	Queensland Health Information Division
Stuart Hill (SHill)	Queensland Health Information Division, Brisbane South Cluster
Kim Hoang (KH)	Occupational Therapist, Barrett Adolescent Centre
Debbie Rankin	Teacher. Barrett adolescent school
Ian Janke (IJ)	Change/HR, Pre-commissioning team, QH
Dean Luton (DL)	Snr Architect Project Services
Penny MacGregor (PM)	Clinical Nurse, Barrett Adolescent Centre
Francis Maher (FM)	Manager, Pre-commissioning team, QH

Steve Marriott (SM)	Teacher Barrett Adolescent Centre
Bevelle Millar (BM)	Asst. Food Service Manager, Redlands Hospital
Karen Riedy (KRiedy)	Architect Project Services
Kev Rogers (KR)	Principal, Barrett Adolescent Centre
Trevor Sadler (TS)	Director, Barrett Adolescent Centre
Debra Samuels (DS)	A/Manager Operational Support
Marisa Stewart (MS)	Community Consultation, Pre-Commissioning team, QH

Distribution: TC, TS, MG, Pre-commissioning team.

General:

The existing buildings were built in the late 1970s and used as an adult ward.
The adolescent unit was first established in 1983 and since then there have been many modifications.

Typical day:

7:15-7:30 wake up
Go to kitchen to get breakfast and take to dining room – cereal/ toast/ fruit (sometimes cooked breakfast). Generally adolescents get their own breakfast. Kylie is the dietician.
Kitchen and dining are currently too far apart.
After breakfast- prepare for school, fix room and socialise. Adolescents are responsible for keeping their own rooms tidy.
9:00 staff meeting.
9:15 kids join staff meeting to discuss the day and any specific issues.
9:30 school starts.
Classes are generally half-hour with a 15 minute break- a break-out area at the school could be good instead of coming back to the main building.
The accommodation areas are locked during the day (until 3pm).
The kids don't currently make lunch to take but could do so in the new facility if the kitchen is big enough. It would be preferred because it would normalise the routine.
The school day usually starts with a half hour walk.
Then 15 minute morning tea. Morning tea is usually scones and/or cakes and/or fruit.
Then 30 min lesson, then 15 minute break, then 30+30 (1 hour) of lessons.
12:00-1:00 lunch time.
Lunch time includes time to eat, then free time.
1:00-3:00 garden work or PE (sometimes this is trip to swimming pool). There is also the option to do academic work.
School ends at 3pm.
3: 00-3:30 afternoon tea
3:30 free time - 2 hours of OT, activities, sport, allied health.
Some of the sports played in free time are soccer and basketball.
Occasionally some resident are too sick to go to school, but all are expected to attend if possible.
5:00 Evening meal
Occasionally there are some night outings for shopping/sport/music lessons etc
Visiting hours from after school until mealtime or from mealtime till 8:30. A specific visitors area would be useful.
9:15-9:30 Prepare for bed.
10:00 lights out.

Consultations with allied health professionals and doctors happen during the free 2 hours after afternoon tea but they happen during classes as well. The allied health/consultation/treatment/therapy rooms need to be convenient to the classrooms.

Weekend schedule:

Usually "lazy starts". No particular timetable.
Often recreational outings are organized. (parks, movie, hiring videos.
Usually only 6-8 kids present. Some kids have weekend leave.
Meals are at the same times as during the week.

Dining Room:

Existing dining room is a multi-purpose room.
The TV is too high and it makes the room feel unrelaxed, and the staff sometimes need to hide the controls.
The set up of everybody eating around one large table can be stressful. Sometimes it is stressful for adolescents to eat in front of others.
There is a piano.

Day room:

A public phone is in the public area so users can be observed from the nurse station (the content of the calls is not monitored). Need for adolescents to be able to make telephone calls to home. The staff need to be able to see if an adolescent becomes distressed on the telephone call and be able to intercept if necessary. The adolescents also need privacy to talk to their family on the phone.
There are a variety of spaces for different activities- TV/ pool table/ table tennis/ computers x 3 (Currently there are about 5 internal areas and 3 external areas)
Currently no internet access but this might be possible in the new facility. Kids would benefit from internet outside of business hours as well as during the day.
Residents toilets accessed from day room.
Day room opens to external activities area.
A lot of storage space is required for the new facility.

Residents kitchen:

Currently about 3.5x6m but this is too small to accommodate residents or having cooking lessons/ preparing food.
Meals delivered to or prepared in kitchen and the distributed through servery.
The kitchen should be closer to the dining area.
The current cooking appliances are poor quality and the new ones should be better.
The new kitchen should have a lockable cupboard for sharp knives etc.
The current kitchen is too hot (not enough windows).
Need a sandwich making bench.
Need a servery.
Need a spot for kids to return their plates
The current kitchen does not have enough storage.

Accommodation:

There is a mixture of dormitory and single-bed rooms with shared ensuites.
The corridor is monitored with a camera but this would be better done as line-of-sight monitoring. Generally staff need to be able to see who is coming and going and make sure boys stay out of the girls rooms and vice versa.
One of the rooms in the accommodation wing is dedicated as an art/craft room. This is very useful for night-time art activities.

Multi-purpose Room:

This room is used for meetings and video-conferencing.
The one-way mirror can not be used properly because there is no audio monitoring available.

Sensory Room:

Size around 3x3m.
Soft furnishings.
UV lighting.
Locked cupboard.
Day and evening access required.

Sand Play Room:

Size around 3x3m.
This should be part of the general therapy area (not secluded from it).
Shelves for figurines.
Day and evening access required.

Smoking Area:

Resident adolescents are not allowed to smoke (although this can cause problems)
Staff smoking area must be out of sight.

High Acuity Rooms:

TV protected behind screen.
Privacy important.
Daylighting provided in internal room.
No ligature points.
Sound proofing important.

Outdoor Equipment Storage:

6 canoes, trailer etc
6 bikes and bike trailer

Laundry:

Residents do their own laundry (washing and ironing). Need clotheslines.

School:

Class rooms should be insight of each other.
The main class room currently has multiple uses. English/ computers/ drama/ music production (sound recording).
The English room would work better as a separate room- 4x6m min.
The kitchen is too small for group activities- (up to 6 residents).
The library is about 3x4m but should be at least 30sqm to work effectively.
The reception is about 3x4m which is too small to house all the records required and is too far from the entry. Medical charts are stored in the reception room.
A private visitor waiting area is required.
A room for visiting trainees (assisting the OT's) would be useful.
Other rooms- I.T. Learning/ Psychologist/ Staff Lunch/ Kids Lunch.

An area for family therapy would be useful. It would also be useful to be able to see and hear inside the room and record sessions.

Consultations with doctors and psychologists happen in the consultation rooms, the therapy rooms or outside (walking).

They also regularly use the oval adjacent and owned by the police and have previously had access to a gym on site (which is missed).

There is an external garden, vegetable growing area about 50 x 30m.

From: Angela Clarke
Sent: 16 Aug 2010 14:28:04 +1000
To: Bruce, Kylie
Subject: Re: Redlands meetings
Attachments: Proposed Schedule 4 Aug 10.T Carter.doc

Smiles, Angela

Angela Clarke
Speech Pathologist
Barrett Adolescent Centre
(Mon, Wed, Thurs, Fri)

"If all my possessions were taken from
me, with one exception. I would choose to keep
the power of communication, for by it,
I would soon regain all the rest" Daniel Webster

>>> Kylie Bruce 16/08/2010 1:33 pm >>>
Hi Angela,

Thanks for your assistance earlier.

I don't believe that I received the email from Kerry Anne Ward - would you mind forwarding to me.

Thanks
Kylie

>>> Angela Clarke 16/08/2010 12:37 pm >>>
Hi everyone,
hopefully you all saw the email that came around today from Kerry Anne Ward re the Redlands meeting. In particular, it lists the dates of future meetings and the topics for discussion - note however, that under attendance, it lists us as "1 other Barrett rep (allied health or other therapeutic professional").
When we have confirmed our wording on Wednesday, i will send it as an attachment to both Kerry Ann Ward and Dean Luton, as well as sending a separate email to Trevor to let him know that no allied health can make it this meeting, but we are keen not to be forgotten in this process.
Smiles,
Angela

Angela Clarke
Speech Pathologist
Barrett Adolescent Centre
(Mon, Wed, Thurs, Fri)

"If all my possessions were taken from
me, with one exception. I would choose to keep
the power of communication, for by it,
I would soon regain all the rest" Daniel Webster

15-BED ADOLESCENT EXTENDED MENTAL HEALTH TREATMENT UNIT AT REDLANDS HOSPITAL SCHEDULE OF USER GROUP MEETINGS

Basic requirements for meetings
Each meeting will be for 2 hours and require a room for up to 10 people around a table, with data projection. Meetings will be informal "workshops". Architect will facilitate the meeting and produce minutes.

Attendance
Meetings need to be attended by a Core Group. Additional contributors are to attend particular meetings as listed below.

It is recommended that the Core Group consists of:

- Dr Sadler or his nominee
- A Barrett centre nursing staff rep.
- A school / educational rep.
- 1 other Barrett rep (allied health or other therapeutic professional)
- Redlands hospital mental health rep.
- District CYMS rep.
- 1 rep from Pre-Commissioning Team
- MHCWP Project Manager

It would be appreciated if the same people remain in the Core Group throughout the project.

Meeting no.	Topics covered	Contributors required	Followed immediately by FPTM
1. **19/08/10**	• Explanation and planning of the process. • Overview of history of the project. • Critically examine the brief and address the gaps in it. • Study the features of the site and its surroundings. • How do the main elements relate to each other and to the site (residential, therapeutic, educational, administrative, recreational, etc.)? • What existing models could be useful? • Future expansion?	Core Group	
2. **2/09/10**	• Presentation by architect of initial floor plan and site plan. • Critical appraisal of plans by user group.	Core Group	