EXHIBIT 49

Oaths Act 1867

Statutory Declaration

I, **Lesley Dwyer** of c/- Corrs Chambers Westgarth, Level 42 One One One, 111 Creek Street, Brisbane, Queensland, in the state of Queensland, do solemnly and sincerely declare that:

1 Provide a summary of Ms Dwyer's qualifications and experience including a copy of Ms Dwyer's current and most recent Curriculum Vitae.

1.1 Attached and marked **LD-1** is a copy of my Curriculum Vitae. My qualifications and experience are outlined in my Curriculum Vitae.

2 On what date was Ms Dwyer appointed as Chief Executive Officer of the West Moreton Hospital and Health Service (WMHHS)?

2.1 I commenced my position as Health Service Chief Executive of West Moreton Hospital and Health Service (**WMHHS**) on 30 July 2012.

3 Explain Ms Dwyer's role and responsibilities in this position including but not limited to her reporting relationships and provide a copy of Ms Dwyer's position description and contract of employment.

3.1 My role and responsibilities in the position of Health Service Chief Executive was to manage WMHHS, ie oversight and responsibility for the functions of WMHHS as set out in section 19 of the Hospital and Health Boards Act 2011 (**HHB Act**).

3.2 Pursuant to section 33 of the HHB Act, in managing my functions as Health Service Chief Executive for WMHHS, I was subject to direction by the West Moreton Hospital and Health Board (**WMHHB**)

3.3 Attached and marked **LD-2** is a copy of the Position Description for Health Service Chief Executive.

3.4 Attached and marked **LD-3** is a copy of my employment contract..

4 Outline Ms Dwyer's role and involvement with the Barrett Adolescent Centre (the BAC).

4.1 BAC was a business unit within The Park Centre for Mental Health (The Park), which was itself a business unit within West Moreton Mental Health Services.

4.2 I was not involved in the day to day operation of BAC. I had executive responsibility for the delivery of services at BAC, as I did for the other services streams at WMHHS.

Operation and Management of the BAC

5 Provide detailed information about Ms Dwyer's involvement in the operation and management of the BAC between her commencement as Chief Executive Officer in or about July 2012 and the decision to close the BAC made on or about 6 August 2013 (the Closure Decision), including:

(a) When and how did Ms Dwyer first become aware of any intention to close the BAC;

5.2 At the time of my appointment as Health Service Chief Executive, I was aware that there was a current project to build a facility at Redlands for adolescent mental health services and that BAC would be closed. I was also aware that the Redlands project was experiencing difficulties. I had heard there were issues regarding koalas on the site and that potentially the site was too small or had other physical constraints. I was not aware of the specific problems but I understood there was a significant question mark over whether the project was viable.

5.3 On 29 August 2012 I received a memorandum dated that date from Glenn Rashleigh, Director – Capital Delivery Programs, Health Infrastructure Office officially confirming the cancellation of the replacement Adolescent Mental Health Unit at Redlands. Attached and marked **LD-4** is a copy of that email.

5.4 On 11 September 2012, the Deputy Director-General Health Services and Clinical Innovation, Michael Cleary and the Executive Director, Mental Health Alcohol and Other Drugs Branch (MHAODB) visited BAC. I accompanied them and we were shown around BAC by the Clinical Director BAC, Dr Trevor Sadler and Sue Daniel. In the course of the walk around, Dr Kingswell and Dr Cleary asked questions around alternative services and it was in the course of these discussions that I became aware that MHAODB was still looking to close BAC, ie notwithstanding the cancellation of the Redlands project, and were focussed on the issue of alternative service options.

5.5 Dr Kingswell advised that there capacity in the system and closing BAC would not create a bed capacity problem, ie there was capacity for patients who would otherwise be at BAC to be accommodated in beds in other services, and an alternative service model should be directed to a contemporary model of care provided to patients in their local area rather than a State-wide single site.

5.6 

5.7 On 12 September 2012 I received an email from Dr Sadler stating that in his opinion 'if there was to be any rebuilding in the future' a site at the planned Springfield Hospital should be considered. He stated that he had written to Dr Kingswell in April 2012 asking him to consider an alternative plan should the Redlands project not go ahead and to consider a rebuild of the patient accommodation at the current BAC site. Attached and marked **LD-5** is a copy of that email.

5.8 On 4 October 2012 I received an email from Executive Director Infrastructure & Ipswich Hospital Expansion, Ray Chandler attaching a Report on the Condition of the Barrett Adolescent School and Accommodation dated 21 September 2012 which gave high level estimates of costs to undertake works to the BAC building to bring it back to good

condition. Attached and marked **LD-6** is a copy of that email and report.

5.9 The costs detailed in the report were relatively modest by comparison to a major capital project, however only represented minimum work to 'make good' the building and did not reflect the work that would have been needed to improve the clinical suitability of the building. There was no money in the budget for this work, and in any event, a capital upgrade of the building did not make sense when the BAC was considered an outdated model of care and unlikely to continue in more than the short term.

5.10 On 26 October 2012 I was cc'd into an email from Executive Director Mental Health and Specialised Services, Sharon Kelly to Dr Kingswell, Dr Jagmohan Gilhotra and Dr Leanne Geppert (all from MHAODB) confirming discussions between them at a meeting the previous day. Ms Kelly noted in the email that MHAODB had sent a brief to the Minister for Health regarding BAC which 'did not clearly articulate that closure was the only option, however from our discussion and opinions I have gleaned from others the model for BAC is not aligned into the future planning for The Park or for Queensland Mental Health Plan, as such the option is to close BAC as early as December 2012 given that all or most of the consumers all go home for the Christmas break'. Attached and marked **LD-7** is a copy of that email.

5.11 I had not seen the brief referred to in Ms Kelly's email and I was not aware that a brief had been prepared regarding BAC. I also was not aware that any timeframe for closing BAC had been considered (other than previously when the plan was that BAC would be closed when the Redlands facility opened). Otherwise, the information in Ms Kelly's email was consistent with my understanding of the position, ie that BAC was not considered to be aligned with the Queensland Mental Health Plan and was not consistent with the redevelopment plan for The Park (which was at an advanced stage) by which The Park would become an adult forensic-only service.

5.12 The intention to close BAC had been formed before I was appointed Health Service Chief Executive. The cancellation of the Redlands project did not alter that intention, but did make it necessary to consider alternative models of care including where services would be provided. For that purpose, Sharon Kelly and her team prepared a Barrett

Adolescent Strategy Project Plan of which I was the Executive Delegate. Attached and marked **LD-8** is a copy of that Plan.

5.13 The Plan included the establishment of an Expert Clinical Reference Group (ECRG) to consider alternative models of care, and for the ECRG to report to the Planning Group, which would provide a report to me. I then reported to WMHHB as well as briefing the Director-General.

5.14 Any decision to close BAC required, in practical terms, the support of WMHHS, WMHHB, MHAODB, the Director-General and the Minister for Health.

(b) Ms Dwyer's knowledge of any future plans for the transfer of the BAC to another location;

5.15 As noted above, at the time I commenced as Health Service Chief Executive in July 2012 I was aware of plans to transfer adolescent mental health extended treatment services to a to-be-built facility at Redlands and close the service at BAC.

5.16 I am not aware of any other future plans for the transfer of BAC to another location.

(c) Any concerns Ms Dwyer had about the BAC;

5.17 I had concerns about physical aspects of BAC including:

(a) The building had been built in the 1970s and was old, dark and drab.

(b) The sleeping accommodation was less than ideal. There was a mix of single rooms and four-bed dormitories. Bathrooms were shared. Ideally all patients should have their own room and ensuite. This was the level of service in the other units within The Park.

(c) There were few private areas and therefore it was difficult for patients to find places for quiet time.

(d) The layout of the rooms made it difficult to carry out clinical observations of

patients.

5.18 I also had concerns about the model of care which BAC represented. Contemporary models of care are directed to providing care and support to patients in their local community in order to enable them to maintain established support networks and to engage or re-engage with their community as early as possible after acute inpatient treatment. In contrast to this, BAC involved a model of:

(a) Extended care which did not have rehabilitation as an element.

(b) Extended periods of dislocation from the patient's family, friends, school or other social networks in their local community.

(c) For patients who had progressed in their treatment and were relatively well, continued proximity to acutely unwell patients.

5.19 I was also concerned about the appropriateness of co-locating vulnerable adolescents with patients with the index offences of some of the patients at The Park. Although stringent risk assessment processes were in place to evaluate whether and when to transfer high secure patients to lesser security arrangements, the risk presented by such patients cannot be completely eliminated. The planned commencement of the Extended Forensic Treatment and Rehabilitation Unit (EFTRU) and an incident in late 2012 when two patients of the High Secure unit absconded from The Park caused a close consideration of these risks and consolidated concerns that continued operation of BAC at The Park was not appropriate.

5.20 I was concerned about staffing at BAC. From the time I commenced as Health Service Chief Executive, it seemed to me that it was difficult to attract and retain staff for BAC. I attributed this to the fact that it was well known that the intention was for BAC to close when the Redlands facility was ready to open, but there was a lot of uncertainty as to when this would happen and, more recently, whether it would happen at all. Some staff had left BAC because they did not want to work in that location, others may have left

because of general uncertainty about the future of the BAC and in that environment of uncertainty it was difficult to attract new staff.

(d) Any complaints about the BAC that Ms Dwyer was aware of from Relevant Stakeholders. The term "Relevant Stakeholder" is a reference to a non-Government person, entity, association or organisation;

5.21 I am not aware of particular complaints about BAC prior to my appointment as Health Service Chief Executive at WMHHS. I am aware that there had been reviews of BAC in previous years which were critical of its model of care and the way it was operated but I was not aware of the specific details of those reviews.

5.22 At the walk around on 11 September 2012, Dr Sadler described limitations on therapeutic effectiveness caused by the physical layout and facilities of the building as outlined earlier in my statement.

5.23 The building had also been the subject of adverse findings on annual audits undertaken by the Australian Council on Healthcare Standards.

5.24 [redacted]

(e) Internal reviews or evaluations relating to the operation and management of the BAC during this time;

5.25 I am not aware of any internal reviews or evaluations relating to the operation and management of BAC between July 2012 and August 2013 save that the work undertaken by the ECRG would have included reviewing the model of care at BAC as part of its review of potential models of care going forward.

(f) Any external advice commissioned or received by the WMHHS relating to the operation and management of the BAC during this time.

5.26 The ECRG was established in late 2012 to consider models of care which included consideration of the BAC model of care.

5.27 I am not aware of any other external advice being commissioned or received by WMHHS relating to the operation and management of BAC during this time.

6 Provide information about the policy frameworks Ms Dwyer was operating under between her appointment in July 2012 until in or about mid-2014 including:

(a) How did the actions and targets set out in the Government's Blueprint for Better Healthcare in Queensland (ie. Government's plan to achieve a contemporary and sustainable health care system) and other key reform documents affect management of the BAC by WMHHS? (With regard to matters such as contestability/ greater efficiencies/ fiscal restraint/ workforce reforms/clinical service redesign);

6.2 The Blueprint was a high level policy document which underpinned everything done by WMHHS.

6.3 The principles in the Blueprint relating to contestability were not relevant to BAC or its management by WMHHS.

6.4 The principles in the Blueprint regarding achieving greater efficiencies underpinned the Turnaround Plan (discussed below).

6.5 The principles in the Blueprint regarding delivering best patient care underpinned considerations of a better model of care for adolescent mental health services which were ongoing from the time of the establishment of the Barrett Adolescent Strategy Project Plan. The work of the ECRG in considering alternative models of care was consistent with objectives of delivering better patient care in community setting and utilising safe, sustainable and responsible service models.

(b) How were other Queensland Health state-wide policies and plans (for example the Queensland Plan/or Mental Health 2007-2017) implemented?

6.6 The Queensland Mental Health Plan (**QMPH**) established a plan for the development of mental health services including setting funding priorities over the ten year period of the QMPH. A substantial allocation of funds was made under the QMPH for a Redevelopment Project for The Park Centre for Mental Health (**The Park**) which included both major capital works and a clinical services re-design, consistent with the principles in the QMPH to de-institutionalize mental health services by reducing inpatient models of care in favour of community based care where clinically appropriate, and decentralising care by locating those community based care services in local communities rather than being centralised at The Park, This meant that The Park would become the State-wide facility for adult forensic patients and all other services would be relocated. This included both adult and adolescent non-forensic services.

6.7 I believe that the funds for the capital works for the Redlands project would also have come from funding priorities established under the QMHP but I did not have any direct involvement.

6.8 The work of the ECRG in reviewing the model of care for adolescent extended mental health treatment was undertaken in the context of the principles of the QMPH, in particular the principles of delivering care to patients in their local community, and of providing care in the community rather than in an institutional setting where possible. .

(c) What other protocols/policies were in place or were used to govern management of the BAC? Did these policies require change in the way care was provided?

6.9 Prior to the establishment of HHHSs, Queensland Health developed protocols and policies for all health services on all aspects of the delivery of health services, management of staff, administration of facilities, financial delegations and reporting, and all other aspects of management and operation of matters connected to the public health provision. BAC was managed in accordance with those protocols and policies.

6.10 Once WMHHS was established, it commenced a process of reviewing all such protocols and policies, making any amendments necessary to suit the protocols to the specific

operating environment of WMHHS. The process occurred over a period of time. These protocols cover all aspects of the operation of BAC and the other services within WMHHS.

6.11 There would also have been local procedures and workplace instructions specific to BAC such as leave protocols but I am not aware of the specific details of those.

6.12 In addition, WMHHS operated under certain State-wide policies of the Department of Health created to reflect statutory requirements, such as mandatory reporting of suspected child abuse.

(d) How were Commonwealth health plans and frameworks taken into account in relation to the operation and management of the BAC. For example the:

(i) National Health Reform Agreement and activity-based funding;

6.13 The National Health Reform Agreement had been signed by all States and Territories prior to my appointment as Health Service Chief Executive. Early work had been done at Commonwealth level in relation to activity based funding for integrated mental health and some of the clinicians at The Park were involved in that work. This was not relevant to BAC as it was not subject to activity-based funding, rather it was block funded.

(i) Fourth National Mental Health Plan: an agenda for collaborative government action in mental health 2009;

(ii) National Mental Health Service Planning Framework;

(iii) National Standards for Mental Health Services;

(iv) National Partnership Agreement on Mental Health Reform;

(v) 2011-12 National Mental Health Reform Budget Measures;

(vi) National Practice Standards for the Mental Health Workforce.

6.14 The strategic direction, policy frameworks and model of care for mental health services in Queensland are prepared and directed by the MHAODB. It would be my expectation that in doing so, MHAODB ensures there is alignment with these planning frameworks and standards.

6.15 Framework documents such as the National Standards also inform the manner in which day to day care is provided to mental health patients. It would be my expectation that WMHHS clinical and other staff involved in delivering care to patients do so in accordance with those standards.

6.16 I am not a mental health clinician by background and as Health Service Chief Executive, my role was in respect of governance of all services provided by WMHHS. I relied upon the Executive Director Mental Health and Specialised Services and her team to manage their division in accordance with those principles and to escalate to me any individual matters which breached policy requirements.

(e) How were service agreements between WMHHS and Queensland Health which incorporated services provided by the BAC, managed by WMHHS?

6.17 A Service Agreement was entered into annually between WMHHS and the Department of Health. The Service Agreement sets out the services which WMHHS is required to provide and the funding which will be made available to WMHHS to provide those services. It includes access targets, activity targets, capital allocations and KPIs for the service. The Service Agreement was adjusted quarterly through a process known as 'funding windows'.

6.18 BAC was a business unit within The Park, which in turn was a business unit within West Moreton Mental Health Services. In respect of BAC, the Service Agreement would have specified the services to be provided and the funding allocation. I cannot recall any KPIs specific to BAC being included in the Service Agreements.

(f) Did WMHHS receive any form of Directive from Queensland Health concerning the operation of the BAC? If so, what were these Directives,

when were they received, and what administrative processes were associated with actioning them?

6.19 To the best of my knowledge, WMHHS did not receive any form of Directive from the Department of Health specifically relating to the operation of BAC.

(g) Who was responsible and what was the arrangement for engagement of staff at the BAC? Were they directly employed by WMHHS or on secondment from the Department of Health or a Human Services Agency? The term "Human Services Agency" is a reference to a Government Department or arm of a Government Department with portfolio responsibilities for key human services including but not limited to Education, Child Safety, Disabilities Services, Community Services and Housing.

6.20 Responsibility for engagement of staff at BAC

6.21 At the time of establishment of WMHHS, all employees were employees of the State of Queensland. They remained employees of the State of Queensland until WMHHS became a Prescribed Employer pursuant to section 80 of the HHB Act on 1 July 2014. From that date, staff became employees of WMHHS. Therefore, the position is that:

(a) Any BAC staff who left WMHHS prior to 1 July 2014 would have been employees of the State of Queensland for the duration of their employment.

(b) Any BAC staff who remained with WMHHS after BAC closed, ie were redeployed within WMHHS would have been employees of the State of Queensland during their employment at BAC but would have become employees of WMHHS if they remained in employment elsewhere within the service from 1 July 2014.

6.22 WMHHS used secondments of staff from other HHSs or from the Department of Health where appropriate, for example where a particular project required additional workforce commitment or where a need for a specific skill was identified as not being available

within existing WMHHS capacities. It may also be used where a new position is being created but has not yet been established as a permanent position and therefore a permanent position cannot be offered. For example, Dr Leanne Geppert was initially seconded to WMHHS from MHAODB to fill the position which was later permanently established as the Director of Strategy role. She was not an employee of BAC but was involved with matters relating to BAC during 2013 and 2014.

6.23 Staff of the Barrett School were employees of the Department of Education.

6.24 No BAC staff were employed by the Departments of Child Safety, Disability Services, Community Services or Housing.

The Closure Decision

7 When did Ms Dwyer hear about the planned closure of the BAC? How and by whom?

7.1 As previously outlined:

(a) I was aware from the time I commenced as Health Service Chief Executive that it was planned to close BAC and transfer adolescent extended mental health treatment to a new facility at Redlands.

(b) In August 2012 I received formal confirmation that the Redlands facility would not be built.

(c) I was aware at that time that it was not intended that BAC remain at The Park, given the redevelopment which was being done at The Park and which was at a relatively advanced stage by that time. I was advised by Dr Kingswell on 11 September 2012 that BAC would still close, ie notwithstanding the Redlands facility was not proceeding. My understanding at and from that time was that the work that was required was in relation to investigating other options for the BAC patient cohort and services going forward.

(d) I was present at a meeting of the WMHHB on 24 May 2013 at which the WMHHB resolved to support the closure of BAC.

(e) I was present at a meeting with the Minister for Health, Laurence Springborg, WMHHB Board Chair, Mary Corbett and Executive Director Mental Health and Specialised Services, Sharon Kelly on 15 July 2013 at which the Minister expressed support for the closure of BAC.

(f) On 6 August 2013 the Minister formally announced the closure of BAC.

7.2 On that basis, I am unable to state a particular date on which I became aware of the planned closure of BAC, as my understanding always was that BAC would close although, as a decision to close a facility such as BAC required, in practical terms, the support of WMHHS, WMHHB, MHAODB, the Director-General and the Minister for Health, I would not say that closure was certain until a formal decision of the Minister had been made and announced.

8 Was Ms Dwyer consulted prior to hearing of the decision to close the BAC?

8.1 As previously stated, a decision to close BAC had been made before I was appointed as Health Service Chief Executive. I was not consulted in relation to that decision.

8.2 In September 2012 I was advised that it remained the intention of the Department, through MHAODB, that BAC be closed. I was not consulted in relation to that.

8.3 I was not consulted in relation to the work undertaken by the ECRG or the Planning Group. I was aware of the scope of the work they were undertaking but I was not consulted in the course of their work.

8.4 In May 2013, the report and recommendations of the ECRG and the Planning Group were presented to me. Sharon Kelly prepared a Board Paper entitled the Barrett Adolescent Strategy – Recommendations recommending the WMHHB support the closure of BAC which Ms Kelly presented and I supported, at a meeting of the WMHHB on 24 May 2013 where the recommendations of the ECRG and the Planning Group

were considered and the WMHHB resolved to support the closure of BAC.

8.5 I was at a meeting on 15 July 2013 at which the Minister for Health confirmed support for the closure of BAC.

9 What did Ms Dwyer do upon hearing of the closure?

9.1 When it was confirmed to me by Dr Kingswell in September 2012 that it remained the intention to close BAC, I undertook the following actions:

(a) I spoke with Sharon Kelly and agreed there was a need to develop an alternative model of care which was evidence based and in line with contemporary models of care. This commenced the process of establishing the ECRG.

(b) We also agreed there was a need for a process to be established for governance over the review process and subsequent implementation. This led to the development of the Barrett Adolescent Strategy Process Plan.

(c) I advised the WMHHB of the position, both by email to the Board Chair on 9 November 2012 and in my Chief Executive report to the Board for the Board Meeting held on 23 November 2012.

(d) I asked that Ms Kelly prepare, or have prepared a communications plan.

10 What meetings did Ms Dwyer attend regarding the closure of the BAC? Provide details of any meetings with the Department of Health, internal WMHHS, Save the Barrett, the BAC patients or families and carers of the BAC patients that Ms Dwyer attended?

10.1 Sharon Kelly and I met with BAC staff on 9 November 2012 after Dr McDermott made a public statement to the effect that BAC would be closed. This was to reassure staff and reiterate that The Park site had been designated for forensic secure patients and WMHHS would be looking at other models of care but that we would keep staff involved

in that process. We spoke about the supports available for staff. Staff were upset some were angry at the prospect of BAC being closed.

10.2 I attended meetings of the WMHHB at which the future of BAC was an agenda item and in respect of which I had provided information in my Chief Executive Report to the Board for the meeting. In that regard, I attended meetings of the WMHHB on 23 November 2012, 14 December 2012, 25 January 2013, 22 February 2013, 26 April 2013, 24 May 2013, 28 June 2013 and 26 July 2013.

10.3 Sharon Kelly generally prepared a report regarding BAC for those meetings which I approved prior to their inclusion in the Board papers.

10.4 In respect of the board meeting on 23 November 2012, my Chief Executive Report to the Board included information regarding BAC. Attached and marked **LD-9** is a copy of that Report.

10.5 I attended three meetings with the Minister for Health:

(a) A meeting on 14 December 2012 where Sharon Kelly and I accompanied the WMHHB Board Chair, Mary Corbett to a meeting with the Minister to discuss West Moreton Mental Health Services generally. The meeting was not specifically about BAC but it was discussed as one of the business units within Mental Health Services. Attached and marked **LD-10** is a copy of the Briefing Note to the Director-General and Briefing Note for the Minister in relation to that meeting.

(b) A meeting on 15 July 2013 where Sharon Kelly and I accompanied Ms Corbett to a meeting with the Minister for Health specifically to discuss BAC, at which the Minister expressed support for the closure of BAC. Attached and marked **LD-11** is a copy of the Briefing Note to the Director-General and Briefing Note for the Minister in relation to that meeting

(c) A meeting was scheduled with the Minister on 2 December 2013 where Dr Corbett and I, together with CHQHHS Board Chair, Susan Johnston and

CHQHHS Chief Executive Peter Steer were to meet with the Minister. The purpose of that meeting was to present the transition model and for the CHQHHS to present the ongoing State-wide model. I am now unsure whether the Minister was present for some or all of the meeting. Ministerial advisors were present.

10.6 I attended a meeting with the Director-General of Health, Tony O'Connell and the Deputy Director-General of Health Services and Clinical Innovation, Michael Cleary on 17 June 2013. Ms Kelly and Dr Geppert were also in attendance. Mr O'Connell and Dr Cleary confirmed in principle support for the closure of BAC and development of a new model of service.

10.7 [redacted]

10.8 On 30 August 2013 I met with Alison Earls of Save the Barrett and the [redacted] of Patient W. Clinical Director CYMHS at CHQHHS, Stephen Stathis also attended. Ms Earls and the [redacted] of Patient W talked about the importance of BAC and raised concerns as to what would happen to adolescents with mental health problems if there was not a BAC-type facility in the future. They asked for the decision to be closed to be reconsidered. We acknowledged their concerns and spoke about the development of a more contemporary model.

10.9 I attended a meeting with the then Leader of the Opposition, Anastasia Palaszczuk, the local State member, Joanne Miller, the Minister for Health, Laurence Springborg and Deputy Director General Health Services and Clinical Innovation, Dr Michael Cleary. The meeting was at BAC on 11 December 2012. My recollection is that the Opposition

called the meeting and had arranged for some staff, at least two of the then BAC inpatients and at least two parents who spoke about the importance of BAC in providing a safe place for their child.

10.10 I had two meetings with representatives of the Department of Education. In that regard:

(a) On 2 August 2013 I met with Sharon Kelly, Deputy Director General Education, Patrea Dawson and Regional Director, Peter Blatch from the Department of Education. The purpose of the meeting was to advise that the closure of BAC was to be announced and to discuss the transition arrangements from an education perspective, in regard to the ongoing support for the adolescents. We were advised that closure of the Barrett School had to be gazetted and that there was a requirement of six months for this. I also recall Ms Dawson saying that she would have to brief the Minister for Education.

(b) On 2 December 2013 , Dr Cleary and Dr Kingswell met with Assistant Deputy Director General Education, Margaret Pethiagoda and others from the Department of Education. We wished to raise concerns that there were plans not to close the Barrett School but to move it to Yeronga. We wanted to advise that based on our transition plan it was likely that only one of the BAC patients was likely to require on-going education support. We spoke about the proposed model of care being proposed for adolescents for the future which was being developed by CHQHHS. We also raised concerns around instances of Barrett School staff undermining the clinical judgment of Dr Brennan in her role as Clinical Director BAC. We also advised that there was no requirement for Department of Education to run a holiday program over the 2013/14 Christmas period as WMHHS had arranged for Aftercare to provide a holiday program.

11 To Ms Dwyer's knowledge, what considerations, recommendations, Relevant Stakeholder concerns, documents, expert advice, and/or reports, were taken into account in coming to the decision to close the BAC, and what weight was given to/how influential was each?

11.1 I have no personal knowledge of the considerations, recommendations or other matters in relation to the decision to close BAC and transfer adolescent extended mental health treatment services to Redlands.

11.2 In relation to the decision to proceed with the development of alternative services following the cancellation of the Redlands project, my understanding of the what considerations, recommendations, Relevant Stakeholder concerns, documents, expert advice, and/or reports, were taken into account in coming to the decision to close were:

(a) Previous reviews of BAC which were critical of aspects of its operational model.

(b) The reasons, as outlined above, that it was undesirable for the service to remain on The Park campus given the change in adult services being implemented at the campus through the Redevelopment Plan.

(c) The constraints of the BAC building on the ability to provide optimal care for patients.

(d) Recognition that the model of care at BAC did not align with contemporary models of care for adolescents requiring mental health services and in that regard its lack of alignment with the QMPH as it reflects contemporary approaches to the treatment of mental illness.

(e) From my perspective, the decision of MHAODB that BAC was not to continue at The Park nor was the model of care in place at BAC to be continued, for those reasons.

(f) The considerations and recommendations of the ECRG.

(g) The recommendations of the Planning Group.

(h) The views expressed by parents, carers and interested members of the public.

(i) The views of BAC staff.

11.3 I am not in a position to comment on the weight which relevant decision makers placed on these various considerations.

11.4 I was not the decision maker in relation to closing BAC. I supported the decision to close BAC and in relation to that, the matters to which I attributed greatest weight were:

(a) The fact that BAC was not a contemporary model of care. I am not a mental health clinician, however I was advised, and was able to confirm by considering the operations of BAC, that the BAC model was care was contrary to the contemporary model which emphasised community-based, locally provided, non-institutional care for patients not requiring acute admission.

(b) The risks and undesirability of having vulnerable adolescents in close proximity to adult forensic patients in the clinical mix toward which The Park was in the process of developing.

(c) MHAODB's instructions to WMHHS that BAC was to close, and in that context, Dr Kingswell's advice that there was sufficient capacity within mental health services to provide adequate inpatient care for this cohort of patients notwithstanding the loss of bed capacity which closing BAC would involve.

(d) The fact that the ECRG identified alternative options for the care of this cohort of patients and endorsed that the risks for this patient cohort could be effectively managed if BAC closed.

(e) The fact that the Planning Group endorsed the work of the ECRG and recommended proceeding. I attributed particular weight to this factor, as the Planning Group comprised a broad-based, highly experienced clinician group who between them had extensive knowledge of what services were available in the system at the time, insight into what could realistically be developed, currency of knowledge about alternative models of care and current experience of the particular workability of different current care models.

(f) I supported closure on the basis that alternative service options were to be

developed and I was confident that BAC would not be closed to patients until alternative arrangements which were deemed clinically appropriate, were in place.

11.5 There were contrary views put forward, in particular by some staff and some parent/carer contacts for patients. I took these concerns seriously, in particular the fears expressed by some parent/carers as to whether closure of BAC would result in their adolescent being unsafe or unsupported. However, I considered the other factors above provided assurance that this would not occur.

11.6 I considered the option of improving the existing BAC building or rebuilding it on The Park campus but did not accept such an option because:

(a) For the reasons set out above, continued location of the adolescent service at The Park was not viable irrespective of improvement/replacement of the building.

(b) There was no capital funding for a new building or upgrades, and in the absence of support from MHAODB, none would be available.

(c) This option would not address the lack of alignment with the QMPH and that BAC was not a contemporary model of care.

(d) The recommendations of the ECRG and the Planning Group reflected that the development of alternative service models aligning with contemporary models of care would result in better services for this cohort of patients.

12 What was Ms Dwyer's knowledge of and involvement in the Turn Around Plan for Mental Health & Specialised Services?

12.1 At the time of my appointment as Health Service Chief Executive, West Moreton's predecessor entity (West Moreton Health Service District) had operated at a very significant budget overrun for a long time.

12.2 One of the priorities of my appointment was to bring the newly created WMHHS back into budget. Given the extent of the budget overrun historically, it was clear to me that significant cost reduction and internal efficiency improvement would be necessary to achieve this. The Turnaround Plan was developed at my instigation and under my direction and supervision, to achieve that outcome.

12.3 The Turnaround Plan applied to the whole of WMHHS, not just West Moreton Mental Health Services (WMMHS). Each service stream was required to prepare its own turnaround plan or equivalent. A turnaround plan was prepared for WMMHS.

12.4 In relation to Mental Health Services, it was clear to me that there was a broader need to review services, ie matters beyond just budget overrun although connected with it. These were:

(a) The uncoupling of the Darling Downs West Moreton Health Service District into two separate districts some years earlier had not been followed by an appropriate rationalisation of roles within WMHHS. There were roles in which the amount of work or breadth of responsibilities had significantly reduced but the role had not been adjusted, so there was excess capacity in the role which was not being used.

(b) The uncoupling had distorted some reporting lines due to particular roles staying with one District rather than the other. As a result, the reporting structures were not necessarily optimal or logical.

(c) The changes which were ongoing at The Park, such as the winding down of the Extended Treatment and Dual Diagnosis services and devolution of those patients to Community Care Units elsewhere, the development of the Extended Forensic Treatment and Rehabilitation Unit, construction of a new Community