TRANSCRIPT OF PROCEEDINGS

THE HON RONALD SACKVILLE AO QC, Chair
THE HON ROSLYN ATKINSON AO, Commissioner
MS ANDREA JANE MASON OAM, Commissioner
MR ALASTAIR JAMES McEWIN AM, Commissioner

THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

10.30 AM, WEDNESDAY, 17 FEBRUARY 2021

DAY 2

Dr Kerri Mellifont QC, Senior Counsel Assisting
Janice Crawford, Counsel Assisting
Ben Power, Counsel Assisting

CHAIR: Good morning, everybody, and welcome to the second day of the 11th Public Hearing of the Royal Commission. I shall ask Commissioner Mason to give the Acknowledgment of Country today.

COMMISSIONER MASON: Thank you, Chair.

We acknowledge the First Nations people as the original inhabitants of the lands on which this hearing is sitting.

Nganana tjukarurungku kalkuni Anangu kuwaripa tjara nyinantja tjuta, ngura nyangangka.

We recognise Meeanjin, Brisbane.

Nganana ngurkantananyi ngura Meeanjin-nga Brisbane-ta.

We recognise the country north and south of the Brisbane River as the home of both the Turrbal and Jagera nations.

Nganana ngurkantananyi karu panya Brisbane River-nya alintjara munu ulparira Anangu nguraritja tjuta nyinantja munu kuwari nyinanyi Turrbal-nga munu Jagera-nya.

And we pay respect to the Gadigal people of the Eora Nation. Their land is where the City of Sydney is now located.

We pay deep respects to all Elders past, present and future and especially elders, parents and young people with disability.

I would now like to read the First Nations content warning.

This hearing will include evidence that may bring about different responses for people. It will include accounts of violence, abuse, neglect and exploitation of First Nations people with disability. It will also include references to First Nations people who have passed away. If the evidence raises concerns for you, please contact the National Counselling and Referral Service on 1800 421 468. You can also contact Lifeline on 13 11 14, Beyond Blue on 1300 224 636 or for First Nations viewers your local Aboriginal Medical Services for social and emotional wellbeing support.

Thank you, Chair.

CHAIR: Thank you, Commissioner Mason. Yes, Dr Mellifont.

DR MELLIFONT: Ms Crawford will be taking the first witness.

MS CRAWFORD: This is the second of three days on which we shall be looking at evidence regarding the Melanie case study. On Friday we shall move to the case

study of Winmartie. We again note that there is a non-publication order preventing publication of the names or information which will or is likely to reveal the identity of Melanie, her mother, her foster or former foster father and the victim of the manslaughter offence. The first witness today is Mr Brett Holmes.

CHAIR: Good morning, Mr Holmes. Thank you very much for coming to the Royal Commission to give evidence. I understand you will take an affirmation. If you would be good enough to follow the instructions of my Associate, she will give you those instructions now. Thank you.

MR BRETT HOLMES, AFFIRMED

EXAMINATION-IN-CHIEF BY MS CRAWFORD

CHAIR: Ms Crawford will now ask you some questions. She is in our Brisbane hearing room, just so you can follow where everybody is, and Commissioner Atkinson is following this remotely, Commissioner Mason is in the Brisbane hearing room and Commissioner McEwin is with me in the Sydney hearing room.

MS CRAWFORD: You provided a statement to the Commission on 18 December 2020?

MR HOLMES: That's correct.

MS CRAWFORD: Is there anything in that statement that you wish to correct or amend?

MR HOLMES: No.

MS CRAWFORD: I ask to tender the statement of Mr Holmes at Tab 1, Tender Bundle B.2, tendered and marked as Exhibit 11.4.1.

CHAIR: Yes, that can be done, thank you.

EXHIBIT #11.4.1 - STATEMENT OF MR BRETT HOLMES

MS CRAWFORD: There are also attachments to Mr Holmes' statement at tabs 1 through 47 of tender bundle D.2. I ask to tender those attachments in evidence and for them to be marked as Exhibits 11.4.2 through to 11.4.48 respectively.

CHAIR: That too can be done.

MS CRAWFORD: Thank you, Chair.

Mr Holmes, you are the General Secretary of the New South Wales Nurses and Midwives' Association; that's correct, isn't it?

MR HOLMES: That is correct.

MS CRAWFORD: You have been in that position for some time, haven't you?

MR HOLMES: Since 2002.

MS CRAWFORD: As I understand, you are not aware specifically of the details relating to the treatment of Melanie?

MR HOLMES: That's correct.

MS CRAWFORD: But you do agree that you have insights into the issues with nursing staff and systems of staff ratios and safety at the Forensic Hospital in New South Wales?

MR HOLMES: I do agree with that.

MS CRAWFORD: In your statement, you said that you were aware and did agree that the use of seclusion wasn't of therapeutic benefit to a patient?

MR HOLMES: That's correct.

MS CRAWFORD: But with respect to long-term seclusion, there are other considerations, you said?

MR HOLMES: That's right. It obviously should only be used in the extraordinary circumstances where there are no other options available to properly manage the patient.

MS CRAWFORD: You are aware, aren't you, that there were some workplace health and safety concerns relating to Melanie being in long-term seclusion?

MR HOLMES: Yes, and those were identified but they were not the focus of my interventions when I became involved around another male patient being held at the Forensic Hospital.

MS CRAWFORD: Is it true to say that one of the reasons why long-term seclusion

was a treatment of choice within the Forensic Hospital was because there were issues within the nursing staff of their concerns for their own safety and for their ability to protect other patients?

MR HOLMES: Absolutely. That was raised with the Association on quite a number of occasions and the incidence of violence and injuries at the Forensic Hospital was very high and the seriousness of some of those injuries were quite extreme.

MS CRAWFORD: When you talk about other incidents, are you talking about incidents within the women's unit at the Hospital or within the men's units at the Hospital?

MR HOLMES: There were incidents that I'm aware of in both. The details of those incidents in relation to Melanie I'm not fully aware of.

MS CRAWFORD: Is it your understanding that it was within that unit culture where there had been aggressive incidents that the nursing staff were taking a very protective approach to their treatment and interactions with patients?

MR HOLMES: I have no doubt that the nurses took very seriously the issue around balancing their own safety and the care of their patients and it's unfortunate that systems and practices were not in place to allow the reduction in seclusion that was desired by both the Ministry of Health and people involved in the care of these patients.

MS CRAWFORD: So there was a high level policy direction about reducing the amount of time that patients would spend in seclusion within the Forensic Hospital?

MR HOLMES: Yes. And in the attachments that I've included there were at least two independent inquiries about the use of seclusion and I suppose those --- the contents of those reports indicate that there were serious concerns about the use of seclusion and what were the causes and what were the solutions to that.

MS CRAWFORD: The Hospital itself had been a relatively recent new build?

MR HOLMES: That's right, 2008, opening in 2009. It was a new facility for New South Wales.

MS CRAWFORD: Your organisation was involved in some of the discussions around the environmental requirements for a forensic unit of that nature, weren't you?

MR HOLMES: We certainly were involved in relation to the initial staffing issues around that and discussions about the model of care, which was to reflect a similar model of care in other high secure forensic units, both in Melbourne and in the UK. I'm not aware that we were directly involved in the health and safety sign-off on the build of the Forensic Hospital. It became clear after its occupation that the process

around the build was a public/private partnership, with the building being maintained and owned by a private organisation and that --- that identified a number of issues for our members, where patients could access weapons by punching holes in walls, extracting the wooden battens, getting access to electrical cabling and using certainly the wooden battens on occasion as weapons.

MS CRAWFORD: And so is it your understanding that over the years there have had to be modifications made to the building itself because of those safety concerns?

MR HOLMES: That's right. Numerous repairs have had to be made. And modifications were needed around issues like the glass that was to be used in units, inadequate in the first build, and we had to advocate on a number of occasions about trying to improve the safety of the actual environment by the introduction of higher quality safety glass, the repairs to be done to doors which had been able to be taken off their hinges, and I understand at least there was one occurrence where Melanie was being located, that one of her doors was severely damaged during her care.

MS CRAWFORD: With that background in mind, does that explain the issue of nursing staff perhaps being reluctant to have patients come out of seclusion without the necessary supports being given to them to manage those risks that have been identified?

MR HOLMES: Yes, I believe that is true. Naturally, if nurses are concerned that they cannot maintain a safe place for themselves or other patients, as a result of that patient in seclusion not being able to be properly contained, then they would be reticent to transition that patient out of seclusion, and particularly if there were going to be insufficient numbers of staff to be able to respond, and, if necessary, return the patient to seclusion. It's obviously a difficult position to be in but ultimately both the employer and the employees have a responsibility to maintain the safety of the workers who are trying to deliver the care, as well as meet their professional obligations to the care of the patient.

MS CRAWFORD: When you say that the obligation to maintain the safety of the workers, would you agree with me that maintaining that obligation to the workers at the same time as supporting a patient's right to be treated in the least restrictive environment possible, that those two things are not contradictory; that it is possible to do both?

MR HOLMES: It is possible to do both if you have adequate resources of both an environment that's suitable and that you have got adequate numbers of appropriately trained staff, with the high level of skills needed to manage a situation which is caring for a high risk of violence patient.

MS CRAWFORD: Is that a problem that arises with a lack of responsiveness within the organisation to have staff available in order to manage those risks, because you don't know what you need in advance?

MR HOLMES: The model that was set up at the Forensic Hospital relied on taking staff from other wards to respond to emergency situations. So every time there was an emergency, a minimum of one staff from each other ward at the Hospital were part of the emergency response team. And if it then followed a second call, a second person from each of the wards would be taken to respond to that emergency situation. So that becomes very difficult when you do not have enough staff, and what we faced at the Forensic Hospital over many years was a constant situation of almost 30 full-time equivalent vacancies which were then having to be replaced by casual, agency or overtime. In fact, the situation became so bad that they put a cap, a maximum, on the amount of overtime that their regular staff were supposed to be able to do in any fortnight, capping that at 32 hours. But it became a situation, of course, where you also are relying on people with relatively early skills in their nursing career. The Forensic Hospital recruited many new graduates to fill their vacancies and over time we saw a cycling of people through that system. We would be told that there would be 30 full-time equivalents and they were recruiting, they would then tell us, but we have filled those or we've almost filled those, we have at least got it down to eight, but that was via using new graduates straight out of university. That in itself indicates a level of risk.

Now, those people were obviously dedicated, new registered nurses who were interested in getting their experience and qualifications expanded by going to the Forensic Hospital. But if anyone has worked with forensic patients, they are the most complex people to look after and, of course, it was going into a high risk environment. So it's not unusual that there would be a level of concern by staff about how they would be able to manage a situation where a person who had been violent, secluded, and then to be released from that seclusion, if they were not confident that they had the staff, either the numbers or those with the skills, to be able to manage the situation when a patient that has been very violent, released from seclusion.

CHAIR: Mr Holmes, could we go back a step to provide context perhaps for some of your remarks. You have told us I think that the Forensic Hospital opened in 2009. Can you just give us a description, please, of the Forensic Hospital; that is, how many beds, who are the patients, or at least who were the patients at the beginning and whether that has changed over time?

MR HOLMES: So the Forensic Hospital is a 135-bed secure environment for both male and female adults and adolescents. Those people within the hospital include forensic patients that have committed serious violent offences but found not guilty of an offence by reason of mental illness or unfit to plead because of mental illness.

CHAIR: I wasn't so much thinking of you reading your statement. I wanted your overall assessment of what the hospital was intended do in 2009/2010. Because you have said that it is possible to do both things that Ms Crawford put to you if there is a proper environment and numbers of appropriately trained staff. I'm just trying to get a feel for what the original idea was with this Forensic Hospital. I think we understand the overall character of patients or at least the classification. But what was your understanding, being in the same position you are now as you were then,

what was the idea of this hospital, how was it going to work?

MR HOLMES: It was to be a secure mental health unit that could manage the most dangerous and the most difficult patients with mental illness in the state. We had previously had forensic patients in a number of other secure units around the state, but the new Forensic Hospital was to be a new model of care where they would be contained in an environment which was trying to move away from a custodial environment to a therapeutic environment. It relied on nursing staff to provide both the therapeutic and the security response in the first instance to the care of those patients, so that there were no correctional officers, there were no security guards inside the hospital providing direct contact with patients.

CHAIR: Was the Association comfortable with nurses performing the security role in addition to the caring role?

MR HOLMES: Well, we certainly had a number of concerns about that. But at the time of the opening we certainly accepted that there were other models where that was working, both in the UK and in Victoria. As a former mental health nurse, I had worked in areas where there were almost no security guards; in fact, the security for the hospital where I worked, at [REDACTED], was really perimeter security as well. So I had experienced looking after severely mentally ill patients, so I understood the concept of nurses delivering that acute response. I think over time what we have seen is a range of changes that have occurred both in the severity of the illness of the people that are being cared for, and I suppose the make-up of the nursing staff that are caring for mentally ill patients.

CHAIR: What was the original objective, as you understood it, of the Hospital so far as nursing staff was concerned in relation to their training? Was there any particular training that nurses were meant to have in order to come into this, as you are describing it, rather challenging and difficult environment?

MR HOLMES: The expectation from us was that they would be recruiting experienced mental health nurses and that they would be recruiting experienced mental health nurses with a forensic background, so that there would be the transfer of skills from those people who had previously worked in forensic hospitals, either from the UK or elsewhere in Australia, to work with these patients, and that the use of nurses with mental health training would be a priority. The reality has turned out to be somewhat different, particularly with the need to use so many new graduates into the mental health facility.

CHAIR: I will get Ms Crawford to resume, which I'm sure she is anxious to do, but just one more question. What is mental health training for nurses, or to train mental health nurses?

MR HOLMES: Well, there's two cohorts, I suppose. I'm in the old cohort where we undertook an 18-month on-the-job psychiatric nursing certificate, and that ceased in about 1985 or 1986. Since then it's a postgraduate certificate, diploma, degree or

master's degree that people can undertake. But there are many, many nurses working in mental health that do not have those qualifications now. We advocate strongly that anyone that is working in mental health should have the opportunity to undertake the highest level of education in mental health nursing that they can. But the reality is that many people start out on an experiential basis and as I understand it, and I'm sure the management from the Forensic Hospital will give you more detail on the level of training that they provide to the new graduates when they arrive, but there is an orientation process and then they are placed on the wards. So they are learning a lot of the skills and experience of working with mental health patients in the most acute situation.

CHAIR: Thank you. Yes, Ms Crawford. Sorry to take so long.

MS CRAWFORD: Thank you, Chair.

Mr Holmes, just to talk a little bit more about the inexperienced staff, are you aware of any additional supports that are put in place for them when they start at the Forensic Hospital, if they are new graduates?

MR HOLMES: I'm told that they are given a significant orientation. They at the minimum also must be provided with a training module for the prevention of violence and they should not practise before they have undertaken that particular level of training. That is about de-escalation and then, if necessary, managing a violent situation. So they are then provided an on-the-job opportunity for expansion of their skills, as far as I know. But I have not examined the content of the orientation or of their education modules that they would have access to.

MS CRAWFORD: Are you aware, for example, if there is any period of time that they might be supernumerary on the ward? You said that once they have done the orientation and perhaps the behavioural management aspect of their training, that they are put on the ward. Are they put on the ward supernumerary or are they put on the ward with an expectation that they can perform the full function of a nurse within that environment?

MR HOLMES: I don't know whether they have a supernumerary period. I'm not aware.

MS CRAWFORD: Are you aware of whether or not there is any additional support for the existing staff if they are to take on a number of new graduate nurses, if they have any additional support about doing that?

MR HOLMES: There are a number of roles, clinical nurse specialists, clinical nurse educators and nurse educators that are at the Hospital, there are also some clinical nurse clubs, so there are a number of high level categories of staff who have responsibilities for supporting staff, supporting staff with additional education and with clinical guidance of them. I noticed that in at least one of the reports it was identified that there was a paucity of clinical supervision of staff. In the best possible

world, anyone working in a forensic hospital should have access to clinical supervision so that they can regularly review their practice in a safe environment with another clinical expert who is able to give them feedback and support and recommend development or change of practice.

MS CRAWFORD: Can you explain to the Commissioners what the violence prevention and management training includes for forensic hospital nurses?

MR HOLMES: Essentially, as far as I understand it, it's the same as the module that is provided across the rest of the public health system. The full course is a four-day course that involves both theory and practice on identifying escalating behaviours, techniques of de-escalation and then how to participate in restraint and takedowns of patients where all of the attempts to de-escalate have failed and a decision is made that the person requires restraint.

MS CRAWFORD: Is that what you were saying earlier when you were talking about the sense that you have with the dual role that nurses have with developing a therapeutic relationship with a patient while at the same time being responsible for the management of challenging behaviour which may well involve restraint?

MR HOLMES: That's right. It is frequent one that is experienced, not only in the Forensic Hospital but across the mental health services. I suppose the additional part that is quite difficult is that mental health patients, without complicating factors of personality disorders, probably can come to some level of understanding that the nurse is trying to assist them. But the other roles that the nurses are expected to undertake at the Forensic Hospital include physical searches and activities that some patients, particularly those with some personality disorders, see as very much a policing type approach. That makes it difficult for those nurses, when they are dealing with those particularly complex and difficult patients, to be able to go in and, I suppose, do these both personal searches and searches of their rooms and areas, and have to act like a police or corrective services officer in terms of that particular part of the role. So not only do they have to do restraint, and they often have to --- as I said, they are coming from other wards, there will be the people on the ward and then there's the people coming from other wards so they are rushing into a patient they may or may not know, engaging in a restraint; if everything works as per the policy, engaging in some review post the event. But it is often the case that they are in this dichotomy of having to act in a fairly strong way and then try and re-engage at some stage with that patient on a therapeutic basis and try and maintain that therapeutic trust relationship. And at the same time acknowledging that any seclusion, any restraint, is trauma for the patient and the nurse.

MS CRAWFORD: Would you agree with me, though, that it is not a one-size-fits-all approach in mental health nursing?

MR HOLMES: That's right, and that's why it's a complex role that mental health nurses play in terms of trying to develop those relationships but also then having to deal with the behaviour that sometimes follows from a failure in those therapeutic

relationships.

MS CRAWFORD: Would you agree with me also that perhaps having security staff in an acute mental health facility, whether it is a forensic facility or not, can be de-stabilising to the therapeutic environment as well?

MR HOLMES: Well, there's certainly arguments that that's the case. As I said, my own experience was without security. What has changed, I suppose, is what is the make-up of our workforce in mental health and are there people with sufficient capacity, body mass, strength, to be able to undertake the security part of the role or the restraint part of the role? That is where there is a diversion or a difference of views between nurses themselves and, of course, between the other allied health, psychiatry, psychology staff, about how the particular model is best managed.

MS CRAWFORD: Leading on from that then, is that related to the ageing workforce within mental health nursing and the difficulty of getting junior or nursing graduates into that area of work?

MR HOLMES: Yes. It is both the ageing and I suppose the balance of sexes as well and capacity of people to be able to undertake those roles. In many circumstances, the techniques are designed so that mass and strength should not be the primary choice. But the response from our members about some of the male patients is that in order to be able to properly restrain or safely restrain someone, you do need some level of strength and mass to do that, and obviously that's a view of a number of our members. It may not be a popular view, but if people who are restraining an arm can be thrown against a wall because they simply cannot manage the strength of the patient, then they are at risk, as is everyone else --

MS CRAWFORD: And everyone else involved in that intervention is also at risk?

MR HOLMES: That's right.

MS CRAWFORD: Because the person on the arm can't perform their part of the intervention.

MR HOLMES: That is right. And unless you have been in one of these situations of trying to restrain, then it's sometimes hard to imagine how difficult it is to do everything as per the book, and it requires frequent training, frequent updates, practise of the techniques, in order to make sure that any intervention is done smoothly and safely.

MS CRAWFORD: You said a little while ago that your own background was one of mental health nursing. Would you agree with me that in mental health the general focus is on stabilisation and recovery for patients?

MR HOLMES: Yes. It is about facilitating people to recover and, of course, to resume a normal life, as much as possible. The Forensic Hospital is, of course, one

of those challenging areas where the balance of trying to get them mentally well enough to be able to return to a less restrictive environment, or indeed the community is, I suppose, complicated by the history of the patient and whether the medication and other treatments are capable of assisting that patient's recovery.

MS CRAWFORD: Would you agree with me or disagree that that is not the same model that would be applied to patients with an intellectual disability and complex trauma history?

MR HOLMES: No --

MS CRAWFORD: Sorry, that the model you would employ with those individuals, people who have an intellectual disability or complex trauma history with personality vulnerabilities, is really about positive behaviour support and skill building?

MR HOLMES: Yes. The complicating factor is that there are often people with a disability whose part of their disability has also a mental health component, so they are complex patients. And it is very unfortunate that there are a number of those people who end up in the Forensic Hospital and that model is difficult to always manage in the same way.

MS CRAWFORD: Is it also fair to say that the group of people from whom you may be able to recruit your experienced staff, who have those skills, is a small group?

MR HOLMES: Yes. We do have a shortage of mental health nurses in New South Wales. There is, in my opinion, inadequate attempts to promote the profession of mental health nursing. But at the same time, as a father of a nurse, I would have my heart in my chest if she said that she was going into the Forensic Hospital to do her nursing, as competent as she may be, unless it is --- I can only assume things have improved since the change of management, the change of leadership at the Hospital. But from what I saw in the period from 2016 to 2019, the Forensic Hospital is a very difficult place to work and has a high level of risk and that --- unless that is addressed with appropriate staffing, better skills and there is a lot more consistent support for that, then it is an area where people will go and have a look at, possibly, some will like it and stay because of the environment or the benefits that they may see from working in that area, but it is a very difficult place to recruit to. One of the other cultures that seemed to be there, that I came across which really shocked me, was that there's an understanding or there's an expectation that if you work in forensic health, that you should expect to be injured. That is part and parcel of being a mental health nurse in forensic healthcare, and that's where I suppose the Association certainly holds a different view, where we hold strong that any area of nursing should be safe to undertake and that you should expect to be able to go home without being the subject of severe violence or injury.

MS CRAWFORD: Does that lead on then to the issue that you raised in your statement around enforceable staffing ratios? Is that related to that within the Forensic Hospital structure?

MR HOLMES: There are, as we have said, there is no enforceable ratios at the Forensic Hospital. The Forensic Hospital was sidelined during the discussions in 2011 when we last were able to negotiate staffing levels in the New South Wales public health system. It was put aside as being special, unique and different, and that it should not be considered as part of those negotiations. We have no capacity to enforce a ratio of any kind. We therefore have to rely on management's decisions and the influence that we can have industrially and through their obligations under work health and safety legislation.

MS CRAWFORD: Is that a calculation that is based on a formula related to patient numbers and identified clinical acuity within the unit?

MR HOLMES: In other mental health units where we have ratios, it is based upon the numbers of patients. So we do not have a perfect system that then adds acuity on top of that as part of the enforceable arrangements. The acuity component is the responsibility of local management to determine and therefore add in addition to those nursing hours per patient day or ratios that we have in other mental health units. But at the forensic unit it is entirely at management's behest as to their staffing levels. We engaged with the Forensic Hospital as it was set up, but as per our statement, those arrangements that we first agreed were changed when the introduction of a 12-hour roster component was placed as part of that staffing and we have never been able to go back and engage in a determinative discussion about what the ratios of staff should be at the Forensic Hospital.

MS CRAWFORD: With respect to the use of seclusion and the risk management approach that you take to bringing people out of seclusion, would you agree with me that there is always going to be a component of risk when dealing with the types of individuals that are placed within the Forensic Hospital?

MR HOLMES: Yes. And work health and safety legislation says that you must do everything that you can to minimise that risk, so that you should be taking both the needs of the patient and the safety of the staff into consideration. You have to put the safety of the staff as a high priority and that means that you need systems or processes or ensure that there are adequate numbers of staff available to respond to the unexpected when that patient is taken out of seclusion, particularly if there is concern that that patient hasn't regained their control or that they are a patient who has demonstrated in the past that they are unpredictable in terms of their response when they exit seclusion.

MS CRAWFORD: We have heard descriptions of therapeutic risk taking, because when you have patients who are receiving treatment and developing skills to assist them with their own regulation, that you do have to be prepared to take risks with their therapeutic progress. But would you say that it's still necessary though to ensure that you have the relevant staffing availability to protect not only the patient themselves from the risk of dysregulation but also to protect other patients and staff from those risks that you are prepared to take?

MR HOLMES: Absolutely. And that often means that if you are going to undertake that level of risk, that you have done your risk assessment of that and that you have then put in place all of the controls that you can to minimise that risk. Clearly in this circumstance, that means that you have staff available who are able to respond to the identified risks and in identifying the risks you have got to identify whether there is unpredictability about this particular patient.

MS CRAWFORD: That would involve having staff involved in that planning process but also staff with the relevant skills and experience with the patient involved in that process?

MR HOLMES: Yes. So there needs to be a clinical plan and there needs to be a work health and safety plan, and they should be created so that all of the people involved are aware of both plans and involved in the development of those plans, so that all of the risks are covered that can be, and that the experience for the patient is a smooth one and not the subject of some chaotic response when the unexpected happens.

MS CRAWFORD: You talked about agency staff and graduate nurses and the lack of experienced skilled staff within the Forensic Hospital specifically. But is there a use of other unskilled staff within the unit?

MR HOLMES: Not that I'm aware of. There was a suggestion that they would bring in a number of lesser skilled staff during one of our discussions about the acute shortage. My last understanding was that that did not proceed. But I have not been updated for 12 months about a lot of things that have happened at the Forensic Hospital. I'm hoping that the fact that we have had a reduction in the contact with our members at the Forensic Hospital, that it means that things have improved in that period, or the worst alternative is that those people that were previously willing to speak up are now no longer there or not willing to speak up.

MS CRAWFORD: Are you aware that there are issues around transitioning patients out of the Forensic Hospital, when they are perhaps clinically ready to be transferred, that there are some issues finding a place for them?

MR HOLMES: I'm not specifically aware of that but I'm not at all surprised by that. Our experience in the wider disability area is that of course we have seen the reduction of number of residents in large residentials, and what we have seen is that as the guaranteed two-year period ends, the NGOs get rid of the registered nurses and then rely on disability support workers.

If you have got complex patients, complex residents with disability and mental health and a history of violence, then it is a fairly unique situation. Given that the NGOs ultimately don't want to fund highly qualified nurses, I think there is an ongoing problem in being able to transition a number of patients out of the Forensic Hospital and other disability services.

MS CRAWFORD: You may be able to comment on this, but there is also a difficulty getting patients transferred into the Forensic Hospital from custodial settings because the Forensic Hospital has too few beds available for the demand that is placed upon it.

MR HOLMES: That is understandable. The flow in and out is obviously a major problem there. That is a resourcing issue and a decision, I suppose, taken by government about how much resources they wish to put into forensic mental health and what services. In the wider system, we face difficulties across our mental health services of accessing mental health intensive care units, and where those mental health intensive care units cannot contain or manage their most violent patients. The original expectation would have been that the Forensic Hospital would be a back-up to that, but that is rarely available to be used because of the issue raised about the inadequacy of the number of beds available.

MS CRAWFORD: When you mentioned a moment ago about not having much information from 2020 because you had not been getting out to the hospital much, was that because of the COVID restrictions?

MR HOLMES: Yes. We certainly only made visits into health facilities where there was a serious work health and safety reason to do so. Other contact was then by phone and videoconferencing, as we were concerned about possibly being a vector of carrying COVID into workplaces, and my organisation also has a very high level of respect for work health and safety.

MS CRAWFORD: Looking at the situation in the Forensic Hospital for female patients, for adult women, there is only one of the units there that caters to adult women. That's right, isn't it?

MR HOLMES: That's my understanding. The mixing of acutely unwell with rehabilitating women is very complicated. I think there is an issue around adolescents being involved as well. So in talking to my officers who have been much closer to this and what we have identified in my statement is that that is a problem, that is a resourcing problem that should be addressed. If you are adding someone who is acutely unwell into an area where you have tried to get people well but they are at risk of being agitated, then patients will often spring off each other and get agitated with each other because they are in a confined space. It is not hard to imagine how difficult it is if someone has acute symptoms of mental illness, and that can be quite irritating to other people who are capable of being easily aroused or agitated.

MS CRAWFORD: That would be especially so for patients with intellectual disability or other personality vulnerabilities in that small space?

MR HOLMES: Absolutely.

MS CRAWFORD: Thank you. I have nothing further. Thank you, Mr Holmes. Thank you, Chair.

CHAIR: Thank you, Mr Holmes. I'll ask the Commissioners whether they have any questions, commencing with Commissioner Mason in Brisbane.

QUESTIONS BY THE COMMISSION

COMMISSIONER MASON: Thank you, Chair. I did have a question.

Thank you for your evidence today. I wanted to know about the adolescent forensic unit and if there is a different way of providing nursing and support to those in that area, and that it may be different to the way that those in the areas where men and women are, those forensic units, is there a different model because of them being adolescent, in terms of the things that you have discussed and described this morning, understanding their age and the potential for change?

MR HOLMES: I would not regard myself as being well enough informed about the adolescent model of care that they are using to be able to give you the answer. My main concern would be the mixing of adolescents with adults and the challenging issue around mixing adolescents who are very vulnerable and the challenge of nurses trying to separate vulnerable adolescents from other patients who might be quite assertive or aggressive, particularly around the issue of sex. I can't imagine how challenging that is for our members on a daily basis.

COMMISSIONER MASON: I have made the assumption that adolescents would be confined in separate areas and not necessarily mixing and moving with adults, men and women. What you are saying is that there is that movement?

MR HOLMES: My understanding --- and I would be happy to be corrected --- is that there are some adolescent mixing in the female area. Apart from that, I'm not familiar enough to be able to give evidence on that.

COMMISSIONER MASON: Thank you so much.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: Thank you. I have no questions.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

CHAIR: Do you happen to know the number of your members since the opening of the Forensic Hospital that have been injured in the course of duty as a result of their

interaction with patients?

MR HOLMES: No, I don't have a number in front of me, Commissioner, that I could give you. The number is extraordinarily high, from our experience. It is the case that we don't always get notified as well, unless the nurse or one of their colleagues notifies us then we may not find out about it. In my statement, there were incidences where we were informed by other organisers from other unions. So sometimes it comes to you and sometimes it doesn't. We don't always have branch officials or contacts on duty when things occur.

CHAIR: I understand. I have seen in your statement references to particular cases where nurses were in fact injured in the course of their work.

Are all nurses employed or engaged at the Forensic Hospital members of your Association?

MR HOLMES: No. We have a fairly high density. I would say there is a cohort who don't agree with us and don't join the union. But we certainly have a density of significant numbers, more than 200.

CHAIR: Out of a staff of what?

MR HOLMES: I would be guessing the total staff off the top of my head, Commissioner.

CHAIR: I don't want you to guess. Does the Association have any position on the Forensic Hospital employing non-nursing security personnel to deal with especially dangerous situations?

MR HOLMES: The position of the local Branch was that it did support the introduction of security staff, particularly for those patients that were very violent. That resolution from the members dates back now a couple of years, so that if there were opportunities to have those discussions again, then we would certainly be consulting with our members about that. I have heard that the response from some nurses is that they wouldn't want to work there if there was security. The ballot that was taken --- and that is set out in one of the attachments --- was that there was an overwhelming vote of our members in favour of the introduction of security staff at the time of dealing with a particular issue that seemed to go on for a long period with one of the male patients.

CHAIR: What was the response of the Hospital?

MR HOLMES: The response seemed to say, yes, they would investigate it, and then they walked back from that. As far as I'm aware, it never progressed. I think they thought they had enough of the nursing staff who disagreed with the idea of security. So there was a split, a splitting of staff, around that issue.

CHAIR: Yes. Thank you, Mr Holmes. I'll ask now whether any party represented at the hearing wishes to ask Mr Holmes any question. I'll start perhaps with Ms Furness. Is there anything you wish to ask?

MS FURNESS: No, thank you.

CHAIR: Thank you. Is there any other party, Counsel or legal representative who wishes to ask Mr Holmes any questions?

MS NEEDHAM: No, thank you, Chair.

CHAIR: If not, thank you very much. Thank you, Mr Holmes, for giving evidence. I think the evidence has indicated some of the complexity of the issues that arise that we are looking at over the course of this hearing. So we thank you for your statement and for the helpful evidence you have given today. Thank you.

MR HOLMES: Thank you.

THE WITNESS WITHDREW

CHAIR: Shall we now take an adjournment?

MS CRAWFORD: Yes. The next two witnesses are Ms Seares and Mr Davis and they have arrived in Sydney. Perhaps a 20-minute adjournment and resume at 11 o'clock.

CHAIR: We will resume at 11 o'clock Brisbane time, noon in the other Eastern states.

ADJOURNED **[11.38 AM]**

RESUMED **[12.00 PM]**

CHAIR: Yes, Ms Crawford.

MS CRAWFORD: Thank you, Chair. The next witnesses are Helen Seares and Todd Davis, who will give their evidence as a panel. The statement and annexures from Ms Seares' statement are at Tab 2, Tender Bundle B2. I ask to tender this document into evidence and for it to be marked as Exhibit 11.5.1.

CHAIR: Yes, that can be done.

EXHIBIT #11.5.1 - STATEMENT OF MS HELEN SEARES

MS CRAWFORD: You will find a copy of Mr Davis' statement at Tab 3 of Tender Bundle B2. I ask to tender that document into evidence and for it to be marked as Exhibit 11.6.1.

CHAIR: That also can be done. Thank you.

EXHIBIT #11.6.1 - STATEMENT OF MR TODD DAVIS

MS CRAWFORD: Thank you.

CHAIR: Yes. Ms Seares and Mr Davis --- thank you very much for coming to give evidence this morning. Just to explain where we are, you have heard Ms Crawford, who is in the Brisbane hearing room and you can see her on the screen. She is in the Brisbane hearing room, together with Commissioner Mason. Commissioner Atkinson, who you can also see on the screen, is appearing remotely. Commissioner McEwin is in the Sydney hearing room with me. If you would be good enough to listen to the instructions of my Associate, we will administer the affirmation or oath as the case may be.

MS HELEN MARY SEARES, SWORN

MR TODD ROBERT DAVIS, AFFIRMED

CHAIR: Thank you very much. Now Ms Crawford will ask you some questions.

EXAMINATION-IN-CHIEF BY MS CRAWFORD

MS CRAWFORD: Ms Seares, your statement was signed on 14 January 2021?

MS SEARES: That's correct.

MS CRAWFORD: Is there anything in that statement that you wish to amend or correct?

MS SEARES: There were a couple of minor matters. I don't think I have the copy I made the amendments on with me. But where I spoke about my term of office with

the New South Wales Council for Intellectual Disability, it says I was on the Board of Directors between 1997 and 2001 and Chairperson between 1997 and 2001. I was Chairperson between 1998 and 2001.

CHAIR: We were all wondering about that, Ms Seares!

MS SEARES: I believe there was another minor amendment. It might have been a word that I had left out.

CHAIR: Why don't we leave that until later and you can tell us about that.

MS SEARES: Thank you.

MS CRAWFORD: Equally, Mr Davis, your statement is dated 15 January 2021.

MR DAVIS: Yes.

MS CRAWFORD: Is there anything in that statement that you would like to add or amend?

MR DAVIS: No.

MS CRAWFORD: Thank you.

Ms Seares, you have actually worked directly with Melanie?

MS SEARES: Yes, I have.

MS CRAWFORD: Can you tell the Commission in what capacity you worked with Melanie and for how long?

MS SEARES: I worked with Melanie as both a solicitor and for a time as a lay advocate. I first advised her in 2013, when she was being interviewed by police. I advised her in the capacity of solicitor. I then started to represent her regularly as a legal --- as her solicitor, from 2016 to the present time. I did do some social advocacy on and off, when working as a lay advocate with Legal Aid, and that would have been on and off between 2013 and 2016.

MS CRAWFORD: When you say from 2016 that you have represented Melanie, is that with her MHRT hearings, the Mental Health Review Tribunal hearings?

MS SEARES: Yes. With the Mental Health Review Tribunal hearings, with all of them since 2016, and I have represented her before the Guardianship Tribunal on, I believe, two occasions.

MS CRAWFORD: Mr Davis, can you tell the Commission what your involvement has been or what is your knowledge of Melanie?

MR DAVIS: Prior to Helen's involvement in representing Melanie, I represented her on a number of occasions from about 2014 onwards. I have also been in the position of managing that team of solicitors who provide that representation which Helen is a part of.

MS CRAWFORD: With Melanie's transfer from a custodial setting to the Forensic Hospital, perhaps starting with you, Mr Davis, do you have any insights into how that transition was effected?

MR DAVIS: That was consequent to section 53 of the *Mental Health (Forensic Provisions) Act*, that is in the last six months of her limiting term. Her status as a forensic patient ended and she changed over to a civil patient. Maybe I have gone a step ahead. My understanding is first of all she was transferred from a correctional facility to the Forensic Hospital as a forensic patient under her limiting term. During that period of time or during the end of that limiting term, her status under section 53 changed from a forensic patient to a civil patient.

MS CRAWFORD: It is correct, isn't it, that at that time there was no legislative provision for an extension to Melanie's limiting term?

MR DAVIS: Correct.

MS CRAWFORD: But there has subsequently been an amendment permitting extensions to limiting terms in New South Wales?

MR DAVIS: Yes, since December 2013, Schedule 1 was added to the *Mental Health (Forensic Provisions) Act*. The term is extending a person's forensic status.

CHAIR: I wonder if you would mind, for those who are following this who may be in the fortunate position of not having legal qualifications, of just explaining a couple of the terms that you have used, like "limiting term"?

MR DAVIS: A limiting term is the equivalent of a sentence and it is imposed when a person has been found unfit to be tried. They have a special hearing. They don't have the opportunity to plead guilty or not guilty. The special hearing is conducted on the presumption that they are pleading not guilty and if they have been found on the limited evidence available to have committed those offences, then it is open to the court to impose a limiting term.

The difference between a limiting term and a sentence is that there is no non-parole period in relation to a limiting term. That is balanced out by the Act allowing for a person to be discharged, or be released from their status as a forensic patient if they have spent sufficient time in custody and they are no longer an unacceptable risk to the community.

CHAIR: Right. And you referred to Melanie's change of status pursuant to

section 53 of the *Mental Health (Forensic Provisions) Act*. That uses the expression "involuntary patient". Could you just explain to us what that means?

MR DAVIS: An involuntary patient is a person who is deemed to be a mentally ill person, as defined under I think it is section 14 of the *Mental Health Act*, and that is a person who shows symptoms such as hallucinations, delusions, severe disorder of thought form or severe disturbance of mood and, because of one or more of those symptoms, they pose a serious risk of harm to either themselves or others, and there is no less restrictive form of care than the form of care that is imposed, which is detention.

CHAIR: Someone can become an involuntary patient without ever having direct contact with the criminal justice system?

MR DAVIS: Correct. I can add that the majority of people captured by that definition, they have never come across --- they have never intersected with the criminal justice system.

CHAIR: Thank you for those very clear explanations. Yes, Ms Crawford.

MS CRAWFORD: Thank you, Chair.

Mr Davis, since the legislative amendment permitting extensions to limiting terms, can you hypothesise whether or not Melanie's case might have been captured by an extension to her limiting term, had that amendment been able to be applicable to her situation?

MR DAVIS: I would assume it would be, from the knowledge I have got and how the legislation has moved.

MS CRAWFORD: What is the test for an extension to limiting term?

MR DAVIS: A person has to pose an unacceptable risk to the community. There is a two-tiered test, and there is no alternative for them to be a forensic patient. So it is like, but for them being a forensic patient, they would pose an unacceptable risk to the community.

MS CRAWFORD: With the extension to the limiting term, is it correct to say that that then involves the patient being held in a correctional facility and not transferred to a mental health facility?

MR DAVIS: No, it's not.

MS CRAWFORD: Can you explain that to the Commission?

MR DAVIS: When an extension order is made, it means that the person's forensic status continues. The court makes that order, the Supreme Court, but they have no

control over the person's liberty or autonomy. What happens is that the Mental Health Review Tribunal continue with their powers and their control of the patient.

MS CRAWFORD: As a forensic patient?

MR DAVIS: Correct. However, the MHRT does have wide powers, they can detain a person in a mental health facility, a correctional facility, or in another place, such as an aged care facility, or a locked facility, or the person can be released to the community subject to conditions which are determined by the MHRT.

MS CRAWFORD: Coming back to Melanie specifically, she was transferred to the Forensic Hospital at the end of her limiting term in 2012.

MR DAVIS: That's my understanding.

MS CRAWFORD: Ms Seares, is it fair to say that Melanie's problems started much, much before that, that she had longstanding issues since she was a child?

MS SEARES: Absolutely. In fact, since she was born.

MS CRAWFORD: Can you explain to the Commission what you know of her personal history?

MS SEARES: Yes, I can. Melanie was born in a public hospital. She had an Apgar score of 2 and was in intensive care for a week. Now, an Apgar score is a score that is given in hospital to newborn babies and it is to do with their condition and it can also reflect loss of oxygen during the birthing process.

I took the trouble, when I was representing --- first started representing Melanie, to do some research and I actually spoke to a family friend who is a midwife and who runs a baby --- a maternity unit in a hospital. She confirmed that an Apgar of 2 is very serious, could quite possibly indicate brain damage, and that at least today that would lead to a referral to a paediatrician and follow up with a social worker. I have no way of knowing whether any of that happened. But it would appear from her subsequent history that there was little, if any, follow-up of Melanie and her mother after her birth.

Now, the next sort of milestone in her childhood was when she was taken to hospital with a broken elbow and a number of other older injuries were found. When Melanie was five years old she was found to have chlamydia of the throat, which indicates some fairly severe sexual interference, sexual abuse. She was then removed from her mother.

In spite of the fact that it was considered that her mother and her mother's friends had abused Melanie, both physically and sexually, her mother continued to be given access to Melanie and indeed Melanie reported two sexual assaults by her mother when she was given access to Melanie while Melanie was being cared for in a

children's institution.

Melanie had a period of time in two different children's institutions. The first one, [REDACTED], was an institution for children who were basically at that stage in transition between being taken into care and being returned to the community. It is not known from any of the information on the file or anything I could glean from searches whether the institution at [REDACTED] was one with any expertise in caring for children with disability. It seems to be an institution that was there to care for children who were wards of the State. It closed down one year after Melanie was admitted. She was then moved to an institution called [REDACTED].

At that institution, Melanie's mother was given access to her and she was further abused by her mother.

MS CRAWFORD: Can I stop you there for a second. Just to short-circuit some of this, would you agree with me that there were many opportunities in Melanie's childhood before she found herself in the juvenile detention centre where she was not only known to be a child in need of protection, but where the system actually did fail her when she was a child by failing to recognise that she was a child with intellectual disability and other need that were not being addressed?

MS SEARES: That's right.

CHAIR: Don't be inhibited from giving us some more details, though.

MS SEARES: Thank you, Mr Sackville.

Yes. Melanie did report --

MS CRAWFORD: Do you --

CHAIR: Please, if you don't mind, I think Ms Seares wants to add something.

MS SEARES: Melanie did report at [REDACTED] she was punished by being locked up in cupboards and that she was overmedicated. I think the knowledge --- it is well known, it is on her records --- that she had been placed basically in seclusion and she said locked in cupboards, and yet a decision was still made later in jail and at the Forensic Hospital to place Melanie in seclusion.

MS CRAWFORD: Moving forward to the transition from the jail to the Forensic Hospital, she wasn't immediately placed in seclusion when she was transferred; is that correct?

MS SEARES: Yes. She was initially in the women's ward, and I might add that there is only one ward for women at the Forensic Hospital.

MS CRAWFORD: Do you know how many beds are in that ward?

MS SEARES: I think there are about 18, and the unit is divided into two sections, an acute section and a sub-acute section.

MS CRAWFORD: Somewhere between 2013 and 2014, Melanie was moved permanently really into long-term seclusion, wasn't she?

MS SEARES: She was, initially in a seclusion room in the Clovelly Unit, which is a much smaller unit than the one she was eventually moved into permanently, and I did interview her in that room and can describe it if needed.

MS CRAWFORD: Would you describe that for the benefit of the Commissioners? Can you say when that was as well?

MS SEARES: Yes. It was 2013. I don't have the date with me but could supply it if the Commission needed it, at a later date. It was when Melanie was to be interviewed by police about an assault on staff. I was asked --- I was there at the Hospital and I was asked to go and provide her with legal advice. It was a much smaller room than she was later secluded in. I could only see one room at the time, not two. We were told Melanie had to be prepared to be interviewed. While the nursing staff were doing that, a Psychiatric Registrar, Dr Carolyn Stoney, gave the police officer, a social worker and myself, a history of Melanie's earlier background and explained her disabilities to us.

Melanie at that stage was dressed in a safety smock. She had a big lump on her forehead. There was blood on her forehead, which seemed like fresh blood. There was dried blood down the front of her smock. And her room was bare. There was sort of sofa without a back or ottoman that was long, perhaps a little bit longer than this table, maybe a little more narrow, that was covered in a brown vinyl.

The thing that stood out to me the most about that room is that Melanie had graffitied the room with her own blood. The smell of dried blood mixed with body odour and the sight of that graffiti is something that will be with me until the day that I die.

MS CRAWFORD: Ms Seares, that was the first time that you met Melanie; is that right?

MS SEARES: That's right. That is the first time I met Melanie.

MS CRAWFORD: That was also --- you said in your evidence a moment ago that you and the social worker and the police officer were kept outside while staff were preparing Melanie for the interview?

MS SEARES: That's right. She had to be held in holds when we were inside the room, so there was a nurse on either side. Melanie, when she was in holds, had to have her hands like this (demonstrates) and the nurses would thread their arms through her arms.

MS CRAWFORD: When she was in that position, were you able to give her any advice? Was she in a fit state to receive advice from you?

MS SEARES: She was quite calm. She didn't say much. My advice was basically not to make a statement. She was able to indicate by nodding her head that she understood me. But she declined to make a statement. Then I asked her if she wanted me to organise either Legal Aid or the Aboriginal Legal Service to provide representation for her if the matter went to court, and she said yes.

MS CRAWFORD: You said she was in a safety smock. Is that a hospital gown or is it something else?

MS SEARES: I'm not entirely sure. She was wearing a smock. I could assume it was a safety smock. It was a fawn colour. If it was a safety smock, it would be of a sturdy material that she would not be able to tear and use to self-harm with.

MS CRAWFORD: When you met with Melanie on that day, you say that the Registrar spoke to you to prepare you for the interview. Were you given an explanation about why Melanie was in seclusion and in a seclusion wearing a safety smock?

MS SEARES: Yes. I was told that the --- it was because she was a risk of harm to others and to herself.

MS CRAWFORD: You both say in your statements that you are aware that Melanie stayed in long-term seclusion for many years, seven or eight years, it seems --- or at least seven years. With respect to the safety smock, can you say whether or not that was something that you routinely saw her wear and, if so, for how long did that continued?

MS SEARES: It is difficult to bring my mind back to it. Quite possibly the first couple of times that I represented Melanie, I may have seen her in a safety smock when I visited her before hearings, to take her instructions. She was usually allowed to wear ordinary clothes to her Tribunal hearings; that is a requirement of the *Mental Health Act*. And there was a time --- I have my result notes from all the times I have represented her, and I did make a note of when she was allowed to start wearing her own clothes again. I can give you roughly that time, if that's helpful.

MS CRAWFORD: That would be helpful.

MS SEARES: All right.

MS CRAWFORD: While you are doing that, Mr Davis, is it your understanding that when Melanie was transferred to the Forensic Hospital she was transferred for treatment but she was also transferred with an aim that supports in the community would be arranged for her within a short period of time?

MR DAVIS: I have no particular memory, no. But it is something that I have drawn from reflecting on the document that we have got in our file.

MS CRAWFORD: With respect to community supports, were you aware of any particular inquiries that were made about Melanie in the early days of the transfer to the Forensic Hospital?

MR DAVIS: No.

MS CRAWFORD: Ms Seares?

MS SEARES: Yes. At the hearing of 27 July 2017, I have a note that the Tribunal was told Melanie is now permitted to wear her own clothes.

MS CRAWFORD: Up until that time you would infer that she was not allowed to wear her own clothes?

MS SEARES: That is correct.

MS CRAWFORD: There are also notes about Melanie being held in a prone position in order for staff to be able to enter the room.

MS SEARES: Yes.

MS CRAWFORD: Can you describe that for the Commission, please?

MS SEARES: Yes, I can. Food and medication was taken into the seclusion room. This is now in the Dee Why seclusion room where she was kept longer term. Food and medication were taken into her room twice a day. Five nurses were required to conduct that operation. Melanie was required to lie face down on the floor. She was restrained by five staff, one staff member holding each arm and one holding her on the back. Food and medication were left with her and in circumstances where Melanie was dysregulated or circumstances where it was considered that she was --- that it was not safe for staff to enter, she was not provided with food or medication on that occasion. My understanding is that if she was dysregulated for a long period of time, the police were then called and police effected the entry into the seclusion room.

MS CRAWFORD: Is this the period of time before she was moved into the area where there were two seclusion rooms together?

MS SEARES: This continued afterwards. I'm not sure what the arrangements were in the first seclusion room. I only saw her on that one occasion. As I wasn't representing her at the time, I wasn't reading her documents or the reports that were going to the Mental Health Review Tribunal. But it was certainly happening whilst she was in the Dee Why seclusion rooms. She was moved there in about 2013 or

2014, and prone position restraint was continued until --- certainly until 2017, maybe even a little later.

CHAIR: The information you are giving us about the way in which food and medication was delivered to Melanie is based upon your examination of notes, is it?

MS SEARES: On the examination of notes and also speaking to Melanie.

CHAIR: And your understanding, based upon that information, is that this was a standard procedure adopted on each occasion for the delivery of food and medication to Melanie?

MS SEARES: Absolutely. It was the standard approach. I might add that it was contrary to the Department of Health's policy on aggression, seclusion and restraint.

CHAIR: In what respect?

MS SEARES: In the respect that restraint was to be not --

CHAIR: Not --

MS SEARES: --- a standard approach. Also, there were a number of cautions in the policy. A number of criteria that if a patient met those criteria, that caution should be exercised in deciding to operate prone position restraint. There were about 12 of those criteria. Melanie met four of them.

COMMISSIONER ATKINSON: May I ask a question. You said, Ms Seares, that if the nurses decided not to deliver the food for the reasons you gave, then no food would be delivered. Would this go on on more than one sequential occasion so that she was denied food for a longer period of time than just on one occasion?

MS SEARES: I had asked that question and was never given a satisfactory answer. I was told that she wouldn't be left for any period of time without food. But I couldn't actually, either from asking the question at hearings or going through notes, work out how long food would not be available. I would hope that it would not have been very long. Surely, if there were any compassion in the way that regulations or policies and procedures were implemented, that it would not be too long. And certainly staff, particularly the staff who had been given trauma-informed training, would know how to help calm Melanie and how to address her escalating feelings of anxiety.

MS CRAWFORD: Ms Seares, with respect to --

COMMISSIONER McEWIN: May I just ask, did that also apply to the withholding of the medication as well ---

COMMISSIONER ATKINSON: Yes.

COMMISSIONER McEWIN: --- or are we talking just about food and medication?

MS SEARES: Food and medication were taken in at the same time. There were two entries into the room a day, and they were on both occasions to deliver food and medication.

COMMISSIONER McEWIN: So you are saying, just to be clear in my head, that if they withheld food, they were also withholding medication and you were never able to get a complete picture or answer in response to your queries?

MS SEARES: That's right. Yes.

COMMISSIONER McEWIN: Thank you.

CHAIR: Yes, Ms Crawford.

MS CRAWFORD: Thank you, Chair.

Ms Seares, you described Melanie adopting a prone position and being restrained by staff, but did I understand you correctly that the staff didn't put Melanie on the floor, Melanie put herself on the floor in order for them to enter the room?

MS SEARES: That's right. She was required to lie down, and she was cooperative.

MS CRAWFORD: Mr Davis, you have mentioned the policy and you talk in your statement about the NSW legislation being silent on the issue of seclusion. Can you explain to the Commission what your concerns about that are?

MR DAVIS: Because the power to place a person in seclusion is solely in a health policy, there is no power then for the Mental Health Review Tribunal to make any orders or make any directions in relation to how seclusion is being provided; whether it should end, whether it should be ceased for a period of time, who should decide to undertake seclusion and so forth. That puts the Mental Health Review Tribunal in a rather invidious position where it makes orders for people to be detained in a place, knowing that that detention, in this case is a possible example, Melanie's case, knowing that perhaps what is happening there in the form of seclusion doesn't accord with the evidence and the opinion of the Tribunal, but they are confined to making an order that the person is a mentally ill person, therefore they are an involuntary patient and they then continue to be detained in that place.

CHAIR: There is an anterior legal question and that is what the authority to seclude is in the first place.

MR DAVIS: So, in NSW we rely on --- there's a policy, a health policy.

CHAIR: Yes. But a policy, in order to be lawful, has to have some legal

authorisation underpinning it, doesn't it?

MR DAVIS: Correct. And that's why I suggest a possible solution would be to create the power under the *Mental Health Act* and then providing the Tribunal an oversight power in relation to seclusion.

CHAIR: You do refer in your statement, I think, to one case where the Tribunal did make certain orders in relation to seclusion. Was that a special case in some way?

MR DAVIS: It wasn't an order that was directly in relation to seclusion. What happened there, it occurred at the Forensic Hospital, where there was a division between those in the executive arm and a body of nursing staff and some other staff, and the treating psychiatrist and some other nurses and some other staff. The treating psychiatrist wished that person to be released from seclusion. Others did not want the person to be released from seclusion, including the then medical superintendent. Therefore there was a tension there. So the Tribunal made an order that seclusion would be made in accordance with what the treating psychiatrist directed. So it wasn't that the Tribunal was saying this is how seclusion was to be undertaken, it was that seclusion is to be undertaken in accordance with the treating psychiatrist's decision.

CHAIR: How did it get to the Tribunal in the first place?

MR DAVIS: In the first instance it was a review, a normal statutory review under I think it is section 47.

CHAIR: Is that every six months?

MR DAVIS: Correct. During that time that issue came up, I prosecuted an argument that there was some issue there, and that order was fashioned, so it was the order that the person continued to be detained at the Forensic Hospital, and then another aspect of it was that direction in relation to seclusion in accordance with what the treating psychiatrist wanted. The issue then was it came back to the Tribunal within two weeks because there continued to be some tension with the executive arm at the Forensic Hospital. The Medical Superintendent has the power to have the matter be brought back before the Tribunal, that happened two weeks later and it was confirmed, that order.

CHAIR: Has it been authoritatively determined that on a six-month review the Tribunal does not have power to make any order with respect to seclusion that might be continuing?

MR DAVIS: I also made an application in relation to Melanie's matter. I made an application and mounted that argument that the Tribunal had an implied power to do that, for the reasons I have explained, and that was declined by the then-President, President Cogswell.

CHAIR: Thank you.

MS CRAWFORD: Mr Davis, can I step you through that a little bit further. Is that because the issue with seclusion really is based on the moment-by-moment assessment of acute risk, rather than the Tribunal being able to make an order that might extend longer than that and somehow hobble clinical decision-making in the unit?

MR DAVIS: I'm not really sure, what are you asking?

MS CRAWFORD: If you think about whether or not the Tribunal might have a power to, for example, say seclusion should not continue, that would only be effective in that moment, based on the presentation of the patient at that time, because the clinical acuity or the risk that the patient might pose is something that can change from moment to moment. So it would not be a blanket order in any event.

MR DAVIS: I don't disagree with what you are saying. But the tribunal could fashion their orders in relation to the circumstances that are brought before them, because seclusion is not always being provided in accordance just with clinical decisions. I think the issue with Melanie brings that to the Commission today. There is --- I believe there have been witnesses here who are not clinicians that have been involved in giving evidence in relation to Melanie, the patient who was provided seclusion in a State-run hospital. So, in those circumstances, if the Tribunal was given an overarching power just to be used in specific circumstances, given a power then to make directions, knowing that the tribunal is an expert body that is very conservative and --- which should be commended --- very conservative in relation to impinging on clinical decision-making, however, sometimes those decisions are not just confined to clinical considerations; there are, in every aspect, political issues and so forth.

CHAIR: I assume one point you are making is that it is one thing for procedures to be laid down in the manual and it is another for procedures to be laid down either in legislation or enforceable regulations or rules and then subject to supervision or administration by a tribunal?

MR DAVIS: Correct. There needs --- my position is there needs to be a release valve, especially in circumstances where there have been clinicians sitting there asking for a release valve. In the matter I referred to which involved a gentleman where there was a divide between the treating team and the executive --- this was not Melanie, it was a gentleman who was confined to seclusion at the Forensic Hospital for an extended period of time --- they were looking for that, and in that circumstance, yes, there was an order made fashioned to those circumstances. But in most other circumstances, that would not be possible.

MS CRAWFORD: Mr Davis, in your statement, when you talk about the lack of governance, is that really what you are asking for; that there ought be a higher body,

perhaps the MHRT is best placed, to be the agent that will make the decision as to whether or not these particular treatments or the barriers for the long-term seclusion are being appropriately managed in the unit itself?

MR DAVIS: Yes, and that governance from my position should be articulated in legislation, therefore it brings it altogether within that one body, because the tribunal was the body that make the decision in relation to that person --- for the care, treatment and control of the person. When they are making orders at the moment, the orders in relation to Melanie don't --- the orders being made just in relation to her liberty, but the care and treatment are put to the side because in essence the Tribunal are powerless because there is no power there in the legislation.

MS CRAWFORD: If I have understood your statement correctly --- and correct me if I'm wrong --- you are also saying that the patient needs an avenue to apply for those things to be reviewed, and that that's another aspect of that governance provision that you are seeking for legislative amendment in New South Wales?

MR DAVIS: Yes. Knowing that, the Mental Health Advocacy Service of Legal Aid that we work for, we represent 83 per cent of people who go before the civil jurisdiction at the MHRT proceedings, and over 98 per cent of forensic proceedings, so we are there. So most of those decisions would be provided on advice, representation would most likely be afforded, and there could be restraints in relation to the frequency in which a person can make such applications, which is expressed in other aspects of the *Mental Health Act* --- that is, a person can't just infinitely make application after application, the Tribunal can put a restraint on the amount of applications a person makes.

MS CRAWFORD: Also in your statement, just to be clear for those watching, you say that there are other patients at the Forensic Hospital like Melanie who have been held in long-term seclusion situations and it has been incredibly difficult to have them transitioned out of those situations.

MR DAVIS: Yes. Two people in particular come to mind. One is a woman who parallelled Melanie's period in seclusion. That woman spent around about six years in seclusion, the same as Melanie, and in the same sort of process she spent most of her time in seclusion, she didn't have a great deal of time out of seclusion. It was consistent for six years, and it ended around about mid last year, mid-2020.

Secondly, there was the other --- the gentleman that I referred to a moment ago. He is mentioned in the statement. He is the person who was --- he is at paragraph 45 of my statement. He was in seclusion for extended periods of 27 days at a time and then other periods.

MS CRAWFORD: Ms Seares, can you explain to the Commission your observations of Melanie over that period of time and how you were able to interact with her when she was in seclusion, whether you are were able to go in or you had to stay outside, for example?

MS SEARES: When I came to take instructions from Melanie prior to Mental Health Review Tribunal hearings, I had to speak to her through the seclusion room door. She was --- this was the only way I could speak to her privately and without any nurses there. The seclusion room door has a window at head height --- head height for a taller person than me. I would have to stand on tippy toe or sit on a high stool that they had in the outer room and press a button on an intercom-- this window, by the way, had venetians in between two panes of glass. It was difficult for Melanie to stand for any length of time, so she would have to sit on her mattress on the floor when she got tired, and then I would be trying to crane my neck to keep eye contact with her. It was extremely difficult to get meaningful instructions, although Melanie was incredibly patient with the process.

I might also add that, unlike the heavy doors in prisons, there was no hatch in this door. A hatch may have made it easier to administer food and medication and it also would have made it easier to take instructions. When I'm in jail, I can speak through the hatch if a prisoner or a patient is secluded. I asked about that. Apparently there is a safety issue with it.

The alternative, if I wanted to speak to Melanie outside of the seclusion room, even today, would be to have a number of nurses in the room. It has been five nurses. I think that the number may have been reduced by one or two. And that means no confidentiality. My word could very easily be twisted or misunderstood. I did have the situation once where I agreed to take a phone call from Melanie and there was a social worker and five nurses in the room. I wasn't told who was in the room. And Melanie asked me about a recently arrived set of physical restraints that had been imported from Scotland by the hospital, she was worried that she would be put in those restraints. When I told her "No, they weren't bought for you, they were bought for another patient", the phone call was shut down. The next hearing of the Mental Health Review Tribunal, Melanie told me, when I took her instructions, that a nurse had told her that she would be put in restraints whenever she was taken out of the seclusion room. When I asked her psychiatrist about that, he said, "Oh, I was told you told her that." His exact words were, "I was told Legal told her that."

So, as you can see, it is very easy if you don't have complete privacy to take instructions, for misinterpretation, even non-malicious misinterpretation, people hearing things differently, they talk amongst themselves, stories become changed, and it ended up with me being considered by Melanie's clinical team to be some sort of a villain tell her lies about what was to be happening to her.

MS CRAWFORD: Were you ever informed about mechanical restraints being used on Melanie?

MS SEARES: I was informed about mechanical restraints being used on another patient --- the woman patient Mr Davis told the Commission about a minute ago. I have represented that woman once or twice. When the mechanical restraints were imported, I was representing this woman at the time. The Tribunal asked for the

restraints to be brought down during the lunch break so that they could see them and have their use explained to them, I volunteered to be a model for the restraint and was locked in them.

MS CRAWFORD: Can you explain what they were and how they were applied to you?

MS SEARES: If I can. They were soft restraints. They were made from a very dense fabric, probably some sort of a synthetic, with a padding in between layers, the outer layers of the untearable material. There were belts that went around the waist, there were cuffs for the wrists and the ankles and there were chains made of this soft restraint that could be linked so that a person could --- can I stand up and show you?

CHAIR: You can stand up, sure.

MS SEARES: The restraints --- there was a belt, there was the ankles, there was the wrists. Depending on how the restraint was to be used, a number of links could be added. If you had a tall person with a big arm span, you could add more links; short person, there were fewer, and there were enough links to go from the waist down to the ankles without necessarily tripping the person up. I must say, it was a very strange sensation. It was not painful but it was a strange sensation. There was also a loop at the back so that a staff member could securely hold the person by the belt at the back of the waist.

A very strange feeling. It was certainly not a restraint that I would ever like to be seen in if I were a patient or really to be seen in by anyone other than the Mental Health Review Tribunal while I was modelling them.

MS CRAWFORD: Were those the restraints that Melanie asked you about in that conversation?

MS SEARES: Yes, they were.

MS CRAWFORD: With respect to the time that Melanie spent in seclusion, can you describe for the Commission what the physical health effects for Melanie were over the years?

MS SEARES: Melanie gained a great deal of weight. I noticed quite a weight gain from when I first saw her in 2013, where I would have considered her to be chubby but not morbidly obese. She has put on a huge amount of weight. She is very obese. That of course has affected her physical health. She has developed diabetes as a result of her weight gain. Both obesity and diabetes have effects on other parts of the body, particularly the heart. Melanie is concerned about her heart because she has had problems in the past. She was trialled on clozapine at one stage and that had to be abandoned because she developed perimyocarditis, I think it is called. She also has gynaecological problems which can be affected by weight. Not being able to exercise also makes it very difficult to keep weight down and that affects the

metabolism as well. She has scoliosis. I don't know whether the weight will affect the scoliosis.

CHAIR: Maybe we could just leave it at that ---

MS SEARES: I think so.

CHAIR: --- rather than go into the details of Melanie's physical condition. I think we understand the significant effect of weight gain.

MS SEARES: Thank you.

MS CRAWFORD: Ms Seares, with respect to those physical issues, there were also compounding issues with Melanie not being able to get out of seclusion and do the relevant exercise or walking that was expected by the team. You would agree with that, wouldn't you?

MS SEARES: Yes, I would.

MS CRAWFORD: You speak in your statement about one time Melanie not being able to get the time out because she had swollen feet?

MS SEARES: That is correct, Melanie's feet became swollen and her walking shoes did not fit her. There was no mention in the report that went to the Mental Health Review Tribunal that Melanie had been unable to go for a perimeter walk, as they call it, for four weeks before that time. I only found out about it because Melanie mentioned it in passing when I was speaking to her, taking her instructions. I raised that with the Tribunal, and the reason I was given was that there was no one to purchase new shoes for her. Eventually a staff member did volunteer and go and get the shoes. There was discussion at that particular hearing about whose responsibility it was. The CJP, Criminal Justice Program, said they could possibly fund someone to do some shopping for her, but it would have taken four to six weeks for them to organise it.

MS CRAWFORD: That was simply in relation to needing some shoes that were suitable to walk in?

MS SEARES: That's correct.

MS CRAWFORD: When Melanie transitioned into the unit where they had the two seclusion rooms, can you describe to the tribunal what those rooms looked like?

MS SEARES: Yes, I can. From the entrance to the Dee Why unit, there is a door to the right where you enter the area where the seclusion unit is. It is totally separate from the rest of the ward. You walk through the door, on the left-hand side there's a room that can be used for clinical observations, and I believe that also has a door to the outside and one door to the seclusion area. As you walk in, to the left there's the

first room. As I described, the heavy door with the viewing panel at full person's height. You enter the room. There is no natural light. The room is bare and has always been bare, apart from a mattress on the floor, which I think may have been replaced by a taller type of foam bed. For a long while there was a blanket, possibly a pillow. There were no pillowcases for quite some time.

To the right, there is a bathroom with a toilet and a shower and a safety mirror, which is a sheet of metal, I think aluminium, that is polished, so it can't be broken and used for self-harm but it doesn't give a particularly good reflection. So if you are proud of your appearance and want to do your hair, it would be a bit difficult. A window to the outside? There might have been a window high up, I'm not sure. It may have been totally enclosed.

Then the nurse outside can open the door on what has been referred to as being the courtyard, it is really nothing more than a corridor without a roof on it. The floor is a sort of spongy black material like what they put in children's playgrounds. I might add that that is the only soft surface. There is no padding even though this is a seclusion room for people who are meant to be quite unwell and dysregulated.

The outdoor corridor runs between the two seclusion rooms. There is a very, very tall fence, brick fence, you can't see over it, you can't see anything beyond the seclusion rooms. You can see the sky. That's the only nature that's visible.

Then if you go out of that room and you are moving then towards the second room, from the outside there's a gap between the two seclusion rooms where the nurses have a little nurses' station, the desk with Melanie's records. I often sat there when I was examining her records prior to representing her. That area, there's a tall glass window, so staff could supervise Melanie quite well when she is out in the corridor.

Then there is the second seclusion room, similar to before, except there is now a television on the inside, high up, which is a screen, same idea with the bathroom. And I think at different times the rooms had been changed over for their purposes. One has been kept as a sleeping room and the other one has been kept as a living area, a day room. I believe that most recently Melanie was allowed to put a few posters up inside the room.

Outside, in the long outside room, there's a long white wall. Early on in her seclusion, that was pretty much bare. Over time, Melanie was allowed to have pictures up, including pictures of her therapy dog, although at one stage when she became dysregulated and made threats about the dog, all those pictures were taken down and the wall was bare again, and over time she has been allowed now to have more pictures and materials on that wall.

MS CRAWFORD: With respect to the two seclusion rooms that were Melanie's rooms, how did the cleaners get into those rooms?

MS SEARES: I don't know that they did. On 27 July 2017, at the Mental Health

Review Tribunal hearing, the Tribunal had inspected the rooms --- I instituted a practice of inviting the Tribunal to inspect Melanie's rooms before each hearing --- the Tribunal found that the place was not clean. There were questions asked about what the arrangements were for cleaning. The Tribunal was told that "Patients are expected to clean the rooms themselves." Now, Melanie was not allowed access to anything, certainly not a broom, a bucket, a mop, or water and cleaning fluids. There were questions asked about, "How can we organise for a cleaner to come in?" "Well, it would have to happen when she's out of seclusion." There were certain times at that stage that Melanie was out of seclusion, short periods of time. But they weren't regular, they weren't every day. So if Melanie was not considered well enough to come out of the seclusion room, she wouldn't be --- she would be there all day. And we were told it wasn't possible to schedule the cleaners to come in and there was some difficulty expressed in being able to just ring the cleaners or whoever was responsible for the cleaners and say, "Look, can you come down now? She's out for half an hour, can you give it a clean?"

MS CRAWFORD: Can I ask you both if you are familiar with the governance group or the high-level group that is involved in looking at transition options for Melanie?

MS SEARES: Yes.

MS CRAWFORD: What is your understanding of what is happening with the identification of a suitable facility for Melanie?

CHAIR: Mr Davis?

MR DAVIS: It is being chaired by the Public Guardian, Ms Osborne, and at the moment it is moving towards looking at a property and hopefully moving towards getting some supports under the NDIS and looking towards moving Melanie into the community.

MS SEARES: I was an observer at the most recent meeting of the governance group. There hasn't been any commitment to ongoing funding for care, what is called SIL funding, independent living funding. Although a provider was identified who is in the process of building a series of units in the [REDACTED], no definite decision has been able to be made or no commitment has been made to taking on that model, that care provider. So if a decision isn't made promptly, it is conceivable that all the units could be allocated to other people and then they would have to begin again for a service provider and for a building.

MS CRAWFORD: Are you aware, Ms Seares, that Melanie has been moved out of the long-term seclusion area since 13 November last year?

MS SEARES: Yes, she was moved out on --- at 2.00 pm on Friday, 13 November 2020.

MS CRAWFORD: There is the core team of staff working with her in the unit?

MS SEARES: Yes, that's what I understand.

MS CRAWFORD: Are you aware that that's going well or have you heard how that's going?

MS SEARES: Yes. I spoke to the social worker on the ward just afterwards and he said it was going well. I also spoke to Melanie's Public Guardian before she went on leave recently and she said it was going extremely well. She said that Melanie, if she feels overwhelmed by the environment on the ward, asks if she can go to her bedroom, just to withdraw, and that's fine. I understand there were two very brief periods of seclusion, one that she requested herself; another one where she was taken to a seclusion room but left there with the door open. I don't know how long that was for, I haven't seen the seclusion record. Otherwise she is doing very well.

MS CRAWFORD: With respect to facilities in forensic hospitals for women, as I understand it the unit at the Forensic Hospital for women has few beds, I think you said it was 18 or somewhere around there?

MS SEARES: Yes, that is right.

MS CRAWFORD: Is it your opinion that there should be more options for women like Melanie?

MS SEARES: Absolutely. More options for women like Melanie and more options for all women forensic patients. The Forensic Hospital women's unit is the only unit that is able for correctional patients as well as forensic patients and for involuntary civil patients, so the demand for beds far outstrips the supply. It is also the first step in a forensic patient's or involuntary patient's rehabilitation and return to the community. The next step is to go to a medium secure unit, is the step down. There are only three in the state for all people who need a medium secure facility and of those three, only one takes women, so you --

MS CRAWFORD: Do you know how many beds in the one medium secure unit that takes women there are?

MS SEARES: It is the Bunya unit, and I am not sure. I know that a similar unit in Orange has 20 beds. I would imagine that Bunya has a similar number of beds.

MS CRAWFORD: But not all of those beds are allocated to women, is that what you are saying?

MS SEARES: No, that's correct. It's a mixed --- it's the only mixed medium security unit.

MS CRAWFORD: Mr Davis, you said in paragraph 23 of your statement that the prospect of discharge from the Forensic Hospital, with respect to Melanie this is, is

distant because the project remains in the planning stages?

MR DAVIS: Yes, I did.

MS CRAWFORD: Have you come this far before with Melanie and had things fail?

MR DAVIS: There's been --- yes, there's been attempts before, I think it is articulated more precisely in Ms Seares' statement in relation to previous efforts to have Melanie discharged to the community. And they have all failed. What's happened in the past hasn't been under the NDIS, but the current plan is under the NDIS.

MS CRAWFORD: Have you had occasion to see other patients transition out of the Forensic Hospital with NDIS support?

MR DAVIS: Me?

MS CRAWFORD: Yes, you, Mr Davis, or Ms Seares.

MS SEARES: Yes. Well, I know that it happens. I'm just trying to think which of my regular clients might have gone out with NDIS. I know quite a number of them have NDIS packages or have applied for NDIS packages.

MR DAVIS: It is unusual for forensic patients to be discharged from the Forensic Hospital to the community. There is no legal barrier to it, it is just that the normal process is Forensic Hospital to --

MS CRAWFORD: To the medium?

MR DAVIS: To the medium secure facilities. Quite often the NDIS packages come onboard whilst people are at the Forensic Hospital, because it takes a long time, but they are carried over to when they go to the MSU and then they transition into the community.

MS CRAWFORD: When you say the MSU, that is the medium security units?

MR DAVIS: Correct.

MS CRAWFORD: But would it be the same for the civil patients?

MR DAVIS: In most cases. To go back a little bit, the term Forensic Hospital is just a banner, it just means it is the most secure mental health facility, there are over 60 mental health facilities in New South Wales, it is just the most secure one. And civil patients --- the most risky, for want of a better word, civil patients sometimes are detained at the Forensic Hospital, and then they can go on other mental health facilities.

CHAIR: Mr Davis, you tell us in your statement, paragraphs 58 and following, about Long Bay Hospital being a health facility and what happens to people that you say require involuntary mental health care being transferred. Can you just explain to us how that works and who are the people that you are actually talking about in those paragraphs?

MR DAVIS: I'm specifically speaking of people who are imprisoned in the general prison population, either on remand or sentenced. When they fall under the --- when they satisfy the test of being a mentally ill person, as I have described earlier, therefore they need care in a mental health facility. NSW is the only jurisdiction that I'm aware of that, and I refer to an article, footnote 27, that I think supports this, that New South Wales is the only jurisdiction in Australia where there is a mental health facility within a correctional facility, which means that when you are in a mental health facility and you are an involuntary patient, that allows coercive treatment to be provided.

However, if you are not in a mental health facility, that is whilst you are in prison, involuntary treatment, coercive treatment, can't be provided to you. So that means that when the person --- the inmate is in the general prison population, they are deemed to be a mentally ill person, they have to be transferred over, most often, to Long Bay Prison Hospital, which is a gazetted mental health facility. Women sometimes go down to the Forensic Hospital but unfortunately sometimes remain at Long Bay Prison Hospital as well, and adolescents go to the Forensic Hospital.

My position is that there should not be a gazetted mental health facility within a correctional setting because there is no need for it, the studies show the efficacy is not supported, and problems have arisen in the past which was brought out in a recent coronial inquest in relation to David Dungay.

CHAIR: When you say people in the general prison population have been found to require involuntary mental health care because they have a mental illness, who has made that determination?

MR DAVIS: It has to be two medical officers, at least one being a psychiatrist.

CHAIR: This is after conviction?

MR DAVIS: Correct.

CHAIR: The people are in the prison system and there is some manifestation of mental illness?

MR DAVIS: That is correct, and they make the conclusion that person has to go to a mental health facility. They make the decision --- in common language it is being scheduled, so they are scheduled and therefore the process is to go to Long Bay. That creates a lot of problems that I have just described.

Another problem is, because there is only one place where they are going to, quite often delay occurs. It is the same process that applies to us in the community. However, us in the community, if somebody scheduled us, we would be in a mental health facility within the hour, most likely, with the assistance of the police or ambulance, if required. Whereas prisoners quite often wait for six, eight weeks within the prison to get to Long Bay because there is only Long Bay.

CHAIR: When they get to Long Bay, the mental health facility, would that include people with intellectual disability, people with cognitive disability?

MR DAVIS: If they have got a dual diagnosis.

CHAIR: It has to be mental illness plus?

MR DAVIS: Correct. So you would have to fit that. When we say mental illness, mental illness is not --- to be a mentally ill person and being captured under the *Mental Health Act*, it is not based on diagnosis, it is based on the symptomology, risk, and no less restrictive form of care. Banners are avoided because history tells us that using banners in relation to coercive measures is the wrong thing to do. But yes, quite often people have a dual diagnosis and Melanie carries that, she is an example of that.

MS CRAWFORD: That cohort of prisoners that you were just speaking about, that is in addition to the cohort who are approaching the end of their limiting term and might be transitioned into the Forensic Hospital under the Mental Health Review Tribunal provisions?

MR DAVIS: Correct, because I'm talking about people who are not forensic patients. A person who is subject to a limiting term or an extension order is a forensic patient.

MS CRAWFORD: So that's ---

CHAIR: These are people in prison who happen to have a mental illness which is discerned, diagnosed, whatever, after they have been incarcerated?

MR DAVIS: Correct, yes.

CHAIR: Okay.

MS CRAWFORD: That is a number that would be variable, depending on the people in the prisons needing that level of treatment and care, but the number of patients coming to the end of a limiting term and requiring transfer to the Forensic Hospital would be easier to plan for. Would you agree with me about that?

MR DAVIS: Yes, if they need to go to the Forensic Hospital, yes.

MS CRAWFORD: And the demand on the Forensic Hospital beds seems to be very high and getting higher?

MR DAVIS: Yes, absolutely agree with that.

MS CRAWFORD: So there is a body of people who are in custodial settings who need to get into the Forensic Hospital and there are people in the Forensic Hospital, some of whom may be able to transfer to a medium secure unit or to perhaps NDIS-supported accommodation, but there are difficulties in making those transfers happen and so there is a bit of a bottleneck in the Forensic Hospital. Is that right?

MR DAVIS: There is a bottleneck. But might I comment? It's not necessarily the case, I don't see the need that a person who is in prison has to go to the Forensic Hospital for care and treatment in relation to their mental illness. My understanding is in other jurisdictions there's agreements between their respective corrective services and mental health facilities in the community and that they are then cared for in the same space as you and I are --- maybe not every mental health facility, but some have some agreements in relation to the transfer and the relationships between corrective services and the healthcare providers. It just beggars belief why we have to have this delay. It doesn't accord with concepts of equivalence, the Mandela Rules, and so forth, that why should a prisoner who has a mental illness have to wait two, six, eight weeks to get into a mental health facility? If I waited two hours, it would be --- that would be a stretch.

MS CRAWFORD: That would not accord either with perhaps necessary treatment for a physical health condition for a ---

MR DAVIS: Absolutely. If somebody in a prison has a heart attack, they are into an ambulance and down to the local --- tertiary local hospital and they are getting the same care as Kerry Packer in the next bed.

CHAIR: Or maybe not!

MS CRAWFORD: Thank you, Ms Seares and Mr Davis. I have no further question.

Thank you, Chair.

CHAIR: Thank you very much. I'll ask my colleagues whether they have any questions, starting with Commissioner Mason in Brisbane.

COMMISSIONER MASON: No, thank you.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: And Commissioner McEwin.

COMMISSIONER McEWIN: No, thank you.

CHAIR: Does any legal representative wish to ask Ms Seares or Mr Davis any questions?

MS FURNESS: No, thank you, Commissioner.

MS NEEDHAM: No, thank you, Commissioner.

CHAIR: In that case, thank you for coming to the Sydney hearing room to give your evidence. We appreciate your statements and your suggestions for change that we will look at very carefully. We thank you for the assistance you have given to the Royal Commission.

THE WITNESSES WITHDREW

CHAIR: Should we now adjourn?

MS CRAWFORD: Yes, thank you, Chair, until 1.30 pm Queensland time.

CHAIR: Yes, all right, we will adjourn to 1.30 pm Queensland time, 2.30 pm in the eastern states other than Queensland.

ADJOURNED **[1.25 PM]**

RESUMED **[2.30 PM]**

CHAIR: Yes, Ms Crawford.

MS CRAWFORD: Thank you, Chair. The next witness is Dr David Manchester. You will find a copy of Dr Manchester's written statement at tab 1 and his CV at tab 2 of Tender Bundle B1. I ask to tender these documents into evidence and for them to be marked as Exhibit 11.7.1 and Exhibit 11.7.2 respectively.

CHAIR: Yes, that may be done. Thank you.

EXHIBIT #11.7.1 - STATEMENT OF DR DAVID MANCHESTER

EXHIBIT #11.7.2 - CURRICULUM VITAE OF DR DAVID MANCHESTER

CHAIR: Dr Manchester, thank you for coming to give evidence to the Royal Commission. If you would be good enough to follow the instructions of my Associate, she will administer to you the oath. Thank you.

DR DAVID MANCHESTER, SWORN

CHAIR: Thank you very much. Ms Crawford will now ask you some questions.

EXAMINATION-IN-CHIEF BY MS CRAWFORD

MS CRAWFORD: Thank you, Chair.

CHAIR: Just so you are aware, Ms Crawford is in our Brisbane hearing room, together with Commissioner Mason; Commissioner Atkinson is joining us from Oakleigh; Commissioner McEwin is in the Sydney hearing room with me. So we are scattered throughout the country. You are in Sydney, I believe?

DR MANCHESTER: That's right.

CHAIR: In a different part of Sydney.

Yes, Ms Crawford.

MS CRAWFORD: Thank you, Chair.

Dr Manchester, you have provided a statement to the Commission dated 11 September 2020. That's correct, isn't it?

DR MANCHESTER: It is, yes.

MS CRAWFORD: Is there anything in that statement that you wish to amend or add to?

DR MANCHESTER: No, thank you.

MS CRAWFORD: Your background is as a clinical psychologist?

DR MANCHESTER: Yes.

MS CRAWFORD: You have had experience of people in Australia and the United Kingdom as a clinical psychologist for more than 20 years?

DR MANCHESTER: Yes.

MS CRAWFORD: Can you explain to the Commission how you became to be involved with writing a report about Melanie's situation?

DR MANCHESTER: I used to work for ADHC as the practice leader in psychology for ADHC, and during the four years that I was there I also worked with Vince Ponzio, who is the Director of Intellectual Disability Mental Health with the New South Wales Ministry of Health now. And my understanding is that Vince recommended me to the Integrated Service Response as somebody who might be able to assist in the case of Melanie, and I got a request from the Integrated Service Response to prepare my report.

MS CRAWFORD: Your report was prepared in August 2019?

DR MANCHESTER: That's correct.

MS CRAWFORD: In preparing your report, you didn't actually meet with or assess Melanie personally, did you?

DR MANCHESTER: That's correct.

MS CRAWFORD: But you relied on a number of documents that you were provided with and those documents are summarised in the body of your report?

DR MANCHESTER: I did. And in addition to that I relied on interviews with treating staff members.

MS CRAWFORD: Did you have any occasion to actually visit the Forensic Hospital that Melanie was being held in, in the preparation of your report?

DR MANCHESTER: I did. I went out to visit the ward where she was being held and I was escorted around that environment by Dr Riordan, the treating psychiatrist and also Mr Andrew Kaw, the senior clinical psychologist there at the hospital.

MS CRAWFORD: In preparing your report, you considered Melanie's personal history as well as her forensic history?

DR MANCHESTER: I did.

MS CRAWFORD: You were aware, weren't you, that she had been a child who was identified at a very young age as being a child in need of protection?

DR MANCHESTER: Yes.

MS CRAWFORD: You had also been made aware, with respect to the documents

that you had access to, of her particular placement issues and forensic issues, including the offences of which she had been subject to the limiting term?

DR MANCHESTER: I was, yes.

MS CRAWFORD: In the course of looking at the documents that you were provided with, it became apparent to you that Melanie had complex diagnostic profile; is that fair to say?

DR MANCHESTER: It is.

MS CRAWFORD: And within that profile she had an intellectual disability?

DR MANCHESTER: Yes.

MS CRAWFORD: As well as personality vulnerabilities?

DR MANCHESTER: Yes.

MS CRAWFORD: The personality vulnerabilities, those are developmental type issues; is that right?

DR MANCHESTER: Not especially so. You don't have to have an intellectual disability to have the personality disorder diagnoses that Melanie has.

CHAIR: Dr Manchester, can we just go back a step, please. How did you come to prepare this report?

DR MANCHESTER: I was approached by the Integrated Service Response at the Ministry of Health, and I was asked to prepare the report on Melanie.

CHAIR: For what purpose?

DR MANCHESTER: The purpose was to provide an opinion on to what might be helpful in terms of going forward with treatment and support for Melanie, that might reduce the use of restrictive practices currently for her at that time that were in place.

CHAIR: Why were you brought in to do that? Why was it, on your understanding, necessary for someone outside the treating group to do this?

DR MANCHESTER: I believe there was a sense of a --- of an impasse being reached, really. There was a great amount of information that had been gathered in other assessments and I felt people were a little bit stuck on what might be the way to move forward. I think in particular, and I mentioned this at the beginning of my report, I was asked to address the recommendations by Emma Rudman in the SAL report, which was a very comprehensive earlier report, and the Ministry of Health felt there was a good sense of what was needed but they wanted a bit more

clarification about how that might be achieved, so what the next steps might be.

CHAIR: When you say "they", you mean who?

DR MANCHESTER: The Ministry of Health and the Integrated Service Response, and the stakeholders with whom they were liaising.

CHAIR: Is that Elizabeth Hewitt, or was it Elizabeth Hewitt?

DR MANCHESTER: It was, yes.

CHAIR: What was her role?

DR MANCHESTER: She was Principal Policy Officer with the Integrated Service Response.

CHAIR: I noticed, and you have already said, you did not see Melanie herself. I judge from your report that that had something to do with what you were told about her behaviour. But is it difficult to do a report on somebody such as Melanie without actually seeing her in the environment in which she is being placed and the way in which she is being dealt with in that environment?

DR MANCHESTER: It is possible to do a report without actually interviewing the person, and I have done desktop reports previously where --- the majority of the evidence that is helpful comes from the behavioural evidence that is amassed, in this case over many years, in the reports of other people, and of course because many of those reports are by treating clinicians, one gets a very good sense of what Melanie's personal goals are and also what her frustrations are. That's a long answer to your question. The short answer is, yes, I think it is possible to do a report without seeing the patient, in a circumstance like this.

CHAIR: Would it be possible to do a better report if one had seen Melanie and understood from her what her goals were?

DR MANCHESTER: I don't know that it would have added too much because I feel Melanie would not have been privy to the information that I feel is important to know in cases like this to unlock the impasse that I mentioned and to move forward. A lot of the issues are at a systemic level, as I think I point out in my report where I reach a conclusion, and that would be something that I would not feel Melanie would be across or that I would expect her to be across.

CHAIR: But she would be across her own expectations and hopes, wouldn't she?

DR MANCHESTER: She would, yes, and I was satisfied that I had a reasonable understanding of what they were from the reports of from other clinicians who had spoken with her and who had asked her those questions and she had been answered them.

CHAIR: That might have been the clinician's perception of what Melanie hoped for.

DR MANCHESTER: Yes, it would have been.

CHAIR: Thank you. Yes, Ms Crawford.

MS CRAWFORD: Dr Manchester, you were specifically brought in because by the time in 2019 that you did your report, Melanie had been in long-term seclusion for six years. Is that correct?

DR MANCHESTER: That's my understanding, yes.

MS CRAWFORD: In fact, that long-term seclusion was creating some tensions within the unit between the staff? Do you agree?

DR MANCHESTER: Again, that's my --- yes.

MS CRAWFORD: There were differences of opinion as to whether or not continuing with seclusion, as it was, was clinically indicated, or whether in fact Melanie should be managed in the open ward or the sub-acute area of the ward, rather than being held in seclusion on that ongoing basis. Do you agree?

DR MANCHESTER: Yes, I do.

MS CRAWFORD: You have spoken in your statement about restrictive practices being a behaviour management strategy.

DR MANCHESTER: Mm-hmm.

MS CRAWFORD: Can you explain to the Commission why restrictive practices being implemented as a behaviour management strategy don't address therapeutic goals?

DR MANCHESTER: I can, yes. I think the first thing I would say is in my report I don't describe it as a behaviour management strategy, I think I describe it as a reactive management strategy. What I mean by that is that they typically --- although not invariably, not in all cases, but they typically come into play in reaction to aggression. So somebody is reacting, aggressive, and a restrictive practice is put in place. The aim of course is to reduce risk. There is less indication that it has a therapeutic effect, and that's what I had meant by it is more a reactive strategy than a therapeutic strategy.

MS CRAWFORD: You have just said there is no indication that they reduce risk? Is that what you just said? I was having a bit of trouble hearing you.

DR MANCHESTER: My apologies. What I said was that reactive strategies are ---

they are --- usually they are short-term strategies that are to contain risk, to reduce risk. They are not typically thought of as therapeutic endeavours that would be akin to treatment that help a person to cope better in the future.

MS CRAWFORD: Can you explain why then seclusion might appear to be an effective tool in an environment like the Forensic Hospital for a patient like Melanie?

DR MANCHESTER: I think what it does is it does reduce risk because, of course, you reduce the opportunity for somebody to be in physical contact with another person that they might hurt. So it can appear to do exactly what it's meant to do, and that is, yes, it does reduce risk. And that could be reinforcing for staff, it could be reinforcing for a system because it keeps people safer. And once you're in that mode of responding, it can be more difficult to, if you like, withdraw from it or to retreat from it or to use it less, because it has its own advantages, as people are reassured that they are safer in the workplace.

MS CRAWFORD: What is the impact on the patient? Notwithstanding that the people outside the seclusion room might feel safer but what about the patient's response to the seclusion?

DR MANCHESTER: Well, typically when patients have been asked about their experience of seclusion, of course, to get somebody to go to seclusion often requires physical restraint and a patient's response to being physically restrained is the response that you would expect of anybody, of you or I to be restrained against our will, and it is distressing. I would add to this, that one of the extra difficulties that you come across when using physical restraint and seclusion with individuals with cognitive impairment is they have less ability to control the outcome in the future. What I mean by that is that if the contingencies are such that you will go into seclusion if you are aggressive in the future and you have less ability through your cognitive impairment to learn adaptive behaviour, to replace your aggression, then you are powerless to reduce the likelihood of being physically restrained and secluded in the future.

MS CRAWFORD: Being in seclusion then, it's a very difficult thing to bring that to an end with a person who has an intellectual impairment because being in seclusion is not assisting them to deal with whatever it is that might trigger a behavioural response outside the seclusion?

DR MANCHESTER: In and of itself, seclusion won't teach the person any new skills, and that's the dilemma that seclusion in the absence of any therapeutic endeavour to teach alternative behaviours, to help the person cope in a different way, that's the dilemma that the system has as soon as it introduces seclusion.

MS CRAWFORD: That's where you talk about being stuck in the cycle of the restrictive practice and the lack of other options being able to be tried; is that correct?

DR MANCHESTER: That is certainly a part of it. What tends to happen is if you

introduce seclusion and the physical restraint to take somebody into seclusion, because it is very distressing and the person reacts to that, they escalate in their aggression. They essentially escalate in one of the very few ways they are able to do. When that happens, that can lead a service to think, well, we need to increase or escalate our use of seclusion; because clearly we are not secluding the person long enough or often enough." And so it increases. Once that happens, then the patient escalates also, and so you're caught in a cycle of escalation, which in my experience typically ends with very high levels of seclusion, very high levels of restrictive practice and somebody in a bare isolated room, sometimes not in their own clothes even, and sometimes those clothes will be taken off them and they are in a gown that they can't rip and they stay there for a very long time.

MS CRAWFORD: Then with respect to bringing the patient out of seclusion, with Melanie there was the use of a traffic light system. Can you explain to the Commissioners how that was expected to work for a patient like Melanie?

DR MANCHESTER: I didn't speak to the person who made that system. I did speak to the staff members who had to operate with that system. My understanding of the expectation was that Melanie needed to meet particular criteria so there was an expectation that she wouldn't engage in a number of behaviours that were listed, and there may have been some behaviours that she was expected to engage in also. And then if she was to do that for a sustained period of time, which I think was for an entire shift, then she would --- ostensibly she would have earned some time out of seclusion. I can go on to say what I think the difficulty with that system was, if that's helpful, or I can --

MS CRAWFORD: I would like you to elaborate on that if you can, please.

DR MANCHESTER: Yes, so the difficulty with the system is if you are going to have a behavioural system where --- essentially what you are hoping to do through a system like that is you are hoping to reinforce alternative behaviour. So you are hoping to strengthen the likelihood that more pro-social behaviour will occur. That's a perfectly reasonable behavioural technology to use. The difficulty is that it is a sophisticated technology to use in a way that is helpful.

What occurred, I think, in the behaviour management system that used this traffic light approach was the bar was set simply far too high, so Melanie was being expected to achieve a level of behavioural control that was unrealistic, given her cognitive impairments, so that's the first thing. The bar was too high.

The next thing which was a difficulty was to assist her to get anywhere near that level of behavioural control, she would need to be supported to learn skills that would assist her --- that essentially would support her to do that. And the technology to teach those kinds of behavioural skills with somebody with an intellectual disability, that technology is there, but it was not being used in this instance.

The only other thing I would say about this system is it was particularly problematic,

is, given Melanie's history of sustained abuse over many years by significant others, that understandably there's been a severe disruption in attachments, and she is, I think, perfectly reasonably very suspicious of people, it is difficult for her to trust others, and the behavioural management guidelines stipulated that if she were to achieve this level of control she would come out. The guidelines were such that to come out of seclusion and spend time beyond the confines of the rooms where she was most of the time, required five staff trained in physical restraint. So the upshot of this was that on occasion, Melanie actually had earnt that right to be out and the system didn't support her, didn't meet their side of that contract, if you like, and said, "We don't have enough staff." That's incredibly problematic because it further disrupts any sense of a therapeutic relationship and a belief that staff can be trusted. It's not a criticism of staff; I totally understand it is very difficult to operate within that system. However, these are some of the difficulties of the primary therapeutic approach or a primary therapeutic approach that was being used.

MS CRAWFORD: At paragraph 15 of your statement you talk about you being of the view that Melanie has experienced shaping at the Forensic Hospital. Can you explain to the Commission what shaping is?

DR MANCHESTER: Shaping is a behavioural term that refers to an approach to eliciting a behaviour that you don't already have in your repertoire. What I mean by that is that if you want to teach somebody something they have never done before, you can't wait for them to do it and then reinforce that behaviour because they don't have that behaviour in their repertoire. What you would normally do instead is you would break that behaviour down into steps, and you would start off with a very small step at the very beginning, and reinforce that step, and when that was being elicited reliably, you would then add on the next step in that behavioural chain, and you would reinforce that.

You would carry on doing that until you'd reached the terminal behaviour. A positive, very concrete example of that, would be if you were teaching somebody to cook a meal and they had never cooked before, you would break that task down to its component parts and you would start with perhaps the first thing is you arrange the ingredients for them, you teach them how to take a lid off a jar.

Now, that is a positive example. An example of more negative shaping, and this is what I'm alluding to in my report, is when you come across individuals who are in very high levels of seclusion, very high levels of restraint, it is absolutely the case that they very often exhibit extremely aggressive behaviour --- frequently, when given the opportunity. When you look back through their record, they weren't always exhibiting that level of aggressive behaviour. They often started off at a much lower level, and what has happened is --- typically, what has happened is that something in their environment has upset them, maybe they didn't get what they wanted from a particular staff member and they have become upset by that and they have reacted to that. Then the staff or the system had responded to that and then sometimes --- and you will hear this sometimes in staff discussing how to manage behaviour --- "Oh, that's attention-seeking behaviour, so we are going to downplay

that" or "We're going to ignore that." It is problematic when you hear that, for a number of reasons. But one is, if you attempt to downplay it or ignore it or erase it through punishment, the person escalates, and they escalate sometimes to a behaviour they hadn't exhibited before but it is a higher level of aggression. Then the system again responds in a way that may be reinforcing for the person, and then the person, through shaping, they have now arrived at this higher level of aggressive behaviour to exhibit when they are frustrated.

Similarly, and it is really just repeating the same process, at some point the service will try to extinguish that behaviour through ignoring it or downplaying it or punishing it or taking away a particular valued activity, and the person escalates again. And then so does the system. So that's really an example of negative shaping, I suppose.

I can give you a concrete example just from my own clinical practice. I assessed somebody several years ago who had very high levels of restrictive practice, they were in seclusion a great deal of time and when they were out of seclusion they were being supported during the day by four to one. From memory, there were cameras in every room. When they were in seclusion, their clothes were taken from them because they had started to rip their clothes and tie clothes in a ligament around their neck to strangle themselves, and they were placed in a gown that they weren't able to destroy. Those weren't the behaviours they started their challenging behaviour career with. When you went back through the records, they first came to the notice of services because they were making nuisance phone calls to emergency services. What you see is you see this progression through shaping.

MS CRAWFORD: In your opinion, is that what's happened with Melanie?

DR MANCHESTER: I think that's certainly part of it, yes, in my opinion.

MS CRAWFORD: With respect to the model of care, you have opinioned in your statement that there needs to be a psychology-oriented model of care. Can you just explain what that would look like for Melanie?

DR MANCHESTER: The model of care that I think would be helpful is a model of care that focuses on her --- her primary impairment has been one of behaviour. It's her behaviour that causes her to be in seclusion. When I have worked with clients who are subject to these levels of seclusion and restraint, they often have a number of diagnoses, mental health diagnoses that are often very similar, schizophrenia or bipolar disorder or anti-social personality disorder or borderline personality disorder, as well as intellectual disability. You can have all of those diagnoses and you can still live a life free of restraint and seclusion if your behaviour is appropriate to the situation and does not put you or others in danger.

My feeling is that, leaving all the diagnoses to one side, the primary focus of treatment and support is on behaviour, in particular, taking a neuro-behavioural approach. And that prefix "neuro" is to recognise that Melanie has very significant

cognitive difficulties that will affect how quickly she is able to learn alternative behaviours and will affect the degree of structure and support she requires in breaking behaviours down for her and teaching her, sometimes through the method I have just mentioned of shaping, teaching her how to learn new behaviours. So that's what I mean by a psychology approach, and I really just use the term "psychology" as an umbrella term because it is psychology's emphasis upon the importance of behaviour and functional activity.

MS CRAWFORD: With Melanie's situation in the Forensic Hospital, there appeared to be a degree of notoriety around her dangerousness. Can you speak to those tensions within the staff at that time when they were looking after her and why those opinions become quite entrenched?

DR MANCHESTER: I can only speak in more general terms about why that happens when I work clinically with individuals who can engage in extreme behaviour. It is --- I think it is a perfectly natural tendency for people to be frightened by, firstly, what can be difficult to understand; secondly, what can be perceived as difficult to predict; and it is the flow-on from the perceived difficulty of prediction and that is your ability to protect yourself or to manage that risk. I think as soon as somebody gains a reputation for being frightening, dangerous, unpredictable, then that's a reputation that can understandably spread.

MS CRAWFORD: What is the impact on the patient of being labelled in that way?

DR MANCHESTER: I think it can be a double --- it can be double edged, really. The practical impact on the patient is that people can become frightened to work with the person. The other impact on the patient --- and this is critical for working therapeutically with a person with Melanie's difficulty --- the other impact is on the mindset of staff. By mindset, what I mean is it is of absolute fundamental importance that staff are able to understand the degree of control that Melanie has over her dangerous behaviour is adversely affected by her cognitive impairment, is adversely affected by her trauma history, and it means that she has really very minimal control over her behaviour.

One of the difficulties you have with this perception of dangerous people in these instances is there can be a very understandable belief on the part of staff that the person can control their behaviour more than they really can. In psychology, this is a very well known --- it is probably one of psychology's more robust findings --- it is a very well known thinking area, it's called the fundamental attribution error.

Janice, with respect to you, you will have this just as much as I will and anybody else in the Commission. The fundamental attribution error simply refers to our tendency to attribute unpleasant behaviour in others to their personality and less to external factors or ameliorating factors. The reverse of that is true as well, that if we do something that is particularly good, we will tend to think that was entirely us and nothing to do with environments. If you and I do something that is extremely dangerous, we tend to attribute it more to the environment and the stress we were

under rather than our personality.

I mentioned there was a double side, so that's one side, the effect it has upon staff and their mindset.

The other effect it can have, and I think you will read this in other reports, is if Melanie has a very low sense of self-worth, and this is an important part of treatment, giving somebody a sense of self-worth through giving them achievements, if she has a low sense of self-worth, if your only sense of self-worth comes through how frightening you are and your reputation, it can be reinforcing for you. It becomes your only way of getting esteem.

MS CRAWFORD: Looking at Melanie's situation, you recommended a core team be put in place to really break that cycle, didn't you?

DR MANCHESTER: Yes.

MS CRAWFORD: And that has happened in the unit over the past three months or so. But the team that you were recommending, not only was that to be a treatment that was recruited internally but perhaps also externally, and it was more important, if I have understood your evidence in your statement correctly, that these are people who are willing to work with Melanie and have particular attributes themselves, perhaps not only professional attributes but also personal attributes?

DR MANCHESTER: Yes.

MS CRAWFORD: That staffing model with the core team requires supports for the team, doesn't it?

DR MANCHESTER: It does.

MS CRAWFORD: And those supports --- the supports that have been put in place are that the core team have regular meetings together.

DR MANCHESTER: Yes.

MS CRAWFORD: And they have had planning days as well, that they also have external group supervision and there is also external individual supervision, I'm not sure for how many of them at this point but that seems to be in the plan as well. And there is also easy access to senior clinicians for the core team with respect to any advice they might need to a moment-by-moment basis. Is that enough or is there anything else that might be implemented to support the core team?

DR MANCHESTER: I think the first thing to say is that I think it's very impressive, and I think I made clear in my report that the treating --- the primary treating clinicians at the hospital I think are very impressive, and the difficulty is not in their clinical opinion. All the changes that you have just described, I expect are driven by

those clinicians and they are very positive. With regard to is it enough, they are the treating clinicians, I have respect for them, if they say that is enough, then I would defer to that. If I was asked, from my own experience, what can be especially helpful, I --- in addition to what you have described, I can certainly answer that. With your permission, I will do that now.

MS CRAWFORD: Please do.

DR MANCHESTER: What can also be helpful is the core team are incredibly important and the stability of the core team is incredibly important because most of Melanie's aggression will be creative and it will be reactive to people, it will be how she perceives she is being spoken to or whether or not she perceives somebody has broken a particular agreement that she had with them. It can be the smallest thing that over time has become a trigger for her. But essentially, this is the first thing: when you think about change architecture, in cases like this, yes, the building is important, what's incredibly important though is who is in front of her physically talking to her and giving Melanie feedback, guidance and instruction.

So you get the kind of empathy and kindness and support and consistency across those variables that you need, you can have a core team of staff, and they are supported by a very clear treatment philosophy. One of the best treatment philosophies we have, for instance, is extreme violence in intellectual disability is positive behaviour support, and that is a philosophy that is still evolving in some ways but it was based, at its best, on applied behavioural analysis but within a human rights framework that looks at person-centred practice, looks at improving quality of life, all those things that I think her clinicians are trying to do at the Forensic Hospital, and you have just mentioned the advances you are making. What I think is especially helpful, in my experience, you need somebody who is absolutely across every variable that I have just mentioned there, who is on the floor every day or nearly every day, catching the staff doing it right and reinforcing their behaviour and shaping their behaviour and modelling and explain the philosophy. "You know, this is why we respond this way when Melanie says that" and "This is why we don't use seclusion when she does this."

If you have that, it is incredibly powerful because it is essentially an apprentice/master person model. Your core staff, and that is the people who have the one-to-one day in day out, they are hugely important. If they get that support, they get highly effective modelling, they get immediate feedback and they get really good really quickly.

MS CRAWFORD: With that approach being taken now with Melanie, and she has been transferred on to the sub-acute ward with that team of staff around her, given her long-term institutionalisation and her cognitive difficulties, this is going to be a gradual process, isn't it?

DR MANCHESTER: It is, yes.

MS CRAWFORD: Is there any way to know what that timeline looks like or is it just something that has to be worked out along the way, driven really by Melanie's response to it?

DR MANCHESTER: It is driven by Melanie's response to it. When I say "it", what I mean, just on that a little, is appropriate treatments in the right environment at the required level. It is that response that will give you behavioural data, and that is the evidence that you use for all decision-making going forward.

MS CRAWFORD: But again, I expect that you would defer to the core team to make any progressive changes around what they are doing with Melanie, based on what they see as being effective and Melanie's tolerance and ability to regulate herself in given situations?

DR MANCHESTER: Yes, within the parameters of the treatment approach that I have just described.

CHAIR: Dr Manchester, I have read your report. If I may say so, it seems very sensible. In the course of the report you refer to five previous reports and you summarise them or quote from them. Why did it take so long to get to an approach that seems to be perfectly sensible?

DR MANCHESTER: It's a fundamental --

CHAIR: It's a good question, isn't it?

DR MANCHESTER: It's a great question, and it's a question that I have never really understood the complete answer to, and I think if you were to speak to her treating clinicians, they have a similar view about it.

What I would say in response to the question is, it's the same question in response to the same behaviour --- (videolink disconnected).

CHAIR: I think we have lost Dr Manchester.

MS CRAWFORD: It looks that way, Chair. We will try to get that link back.

CHAIR: We were just getting to the critical point and we lost him.

MS CRAWFORD: We are texting Dr Manchester to make sure he is aware that the link has been broken.

CHAIR: Yes.

MS CRAWFORD: Chair, perhaps we might adjourn for five minutes and we should be good to go when we get back.

CHAIR: We will adjourn for five minutes, in the hope that we will be good to go.

ADJOURNED **[3.10 PM]**

RESUMED **[3.14 PM]**

CHAIR: I'm sorry for the interruption, Dr Manchester. If you wouldn't mind resuming from where you left off.

DR MANCHESTER: I will try. I think what I was saying was that it is the same question, in terms of why does it take so long to do what everybody agrees needs to be done or what a lot of people agree needs to be done? It's the same question that I have been hearing for --- I don't know --- 15, 20 years, in response to the same behaviours, the same extreme behaviours in individuals with cognitive impairment.

The answer, which we have just been talking a little bit about, which is about coordinated integrated care that understands applied behavioural analysis now within the evolving positive behaviour support framework, why does it take so long? It seems to take so long because there is a lack of will, a high level of statutory service --- and especially now in the era of NDIS --- to support the kind of funding and model that is most effective.

So what varies over those years, I have noticed, is the commitment of the true decision-makers to do what their clinicians and patients and significant others are asking them to do, which is provide the right treatment in the right setting at the required intensity. I will give you, if I may, just an example of this. When I was with Aging, Disability and Home Care, as I say, I was the practice leader in psychology, I was in the clinical innovation and governance branch, and colleagues within that branch prepared a high level report on examining this question of what to do with people who have extreme behaviour and cognitive impairment and severe mental health disorders.

It was an excellent report, it recommended a specialist secure unit be developed by the state for people with cognitive impairment and severe mental disorders, where you could populate it with the kind of expertise that I have been talking about and where you could do the kind of work that I have been talking about that would allow somebody to be transitioned out to less restrictive environments over time.

To the best of my knowledge, that report proceeded nowhere because, of course, the political landscape changed. NDIS came in, there was a move to have the private sector step into this space. There will be a range of opinions on the willingness of the private sector to work with clients who present the way Melanie does. So my own feeling is that the answer to your question is, there has been variable motivation and commitment to do what most people who have experience in this area say needs

to be done.

CHAIR: Is it fair to say that the report you prepared for Melanie is really from your perspective a template for how people in institutions like Melanie should be treated?

DR MANCHESTER: I think that is reasonable to say, that there are so many commonalities across these individual presentations, and the dynamics are very similar, at a systemic level, at a patient level, at a staff interpersonal level. But yes, I think there are so many commonalities that it is reasonable to say it is almost a template of a way forward.

CHAIR: And if we take a hypothetical of someone like Melanie coming into the system with her history as at 1999, that is after the second "offence" that she had committed, how should such a person be dealt with now in New South Wales or, for that matter, in Australia?

DR MANCHESTER: I think again it goes to saying, well, what's the most appropriate treatment? I think I have talked a little bit about what my feeling is as much as I can within my area of expertise. So where can you provide that and how do you provide that? It's not in the system you have at the moment. I think what you have at the Forensic Hospital, as Janice has just described it to me, and this is my experience at the Forensic Hospital, you have some exceptionally committed staff who are doing the very best they can in an inappropriate setting with inadequate resources.

CHAIR: What do you do to overcome that?

DR MANCHESTER: I think you listen to your staff and you go to the literature. I talked about this a little while ago when somebody was asking me, well, how do you skill up people, how do you build capacity in what is a very narrow area, a very extreme area of behaviour? The evidence is there. If you go to the literature, the evidence is there, one of the best ways you can do it is just get yourself in front of somebody who has done it. Ask them and follow them. I think Emma Rudman talked about de Boer and his work in New Zealand in a particular service that sounded to be doing excellent work.

Again, I do not think it is a difficult question, or not as difficult a question as you might imagine to answer, what ought we to do? The difficulty is how do we get people to do it once we have agreed what ought to be done? As I say, even when you get to the level of --- I forget entirely who was on the advisory panel for the report I just mentioned from Rudman, but it was certainly a range of people with a great deal of expertise. So when you get to that level, preparing high level reports for government and the executive, saying, "Here is what to do" and it goes nowhere, and I can understand why it went nowhere, the political scene changed. However, that's what I think you need to do. You need to question less about "What is it we ought to be doing", it's more about, "We know what we ought to be doing, how do we get there?"

CHAIR: I think Commissioner Atkinson had a question.

COMMISSIONER ATKINSON: I did. Can I put it in context. We are talking about people who, if they are don't receive appropriate treatment, are a danger to themselves and a danger to others. So we are talking about the human rights of the person with intellectual disability and mental illness, but we are also talking about the human rights of other people as well, aren't we?

DR MANCHESTER: Yes.

COMMISSIONER ATKINSON: Would it be fair to say that this is not about individual failings, this is the system's failing?

DR MANCHESTER: Yes.

COMMISSIONER ATKINSON: Would it also be fair to say that as far as you can tell Melanie has been subject to system failings her whole life?

DR MANCHESTER: I think it could have been done a lot better, yes.

COMMISSIONER ATKINSON: Thank you.

COMMISSIONER McEWIN: Dr Manchester, when you were talking about your ideal for the change advocate, your word, you prefaced it with references to concepts like kindness and empathy. Are you suggesting that it doesn't take a particular skill set to be part of staff to support Melanie in the way that you have described, or does it really take a particular skill set to be part of that team?

DR MANCHESTER: It does take a particular skill set, and the person who has that skill set is important, though. So you can be a psychologist trained with a particular skill set, for example cognitive behaviour therapy, but if you are a prickly individual, you are probably not going to help a lot of persons because they are going to react to your prickly personality. So when you are recruiting staff into this space, and as I say, this one-to-one, the people who are doing the eight hour shifts one-to-one, critically important team members, when you are recruiting into that space, I am less concerned with their degree at that point than I am with their ability to be kind, empathic and to have a flexible attributional style for why this person might be behaving the way they do. That's the foundation skill set I want them to have, and I want them to have that because it is very difficult to teach that, it is very difficult to teach people to be kind. When you ask patients who their favourite therapists are, and a lot of work has been done, a lot of patient will use this word to describe their favourite therapist, and they will say "They were warm", and they will also say, "They will listen to me." It is very difficult to teach someone to be warm, yet we have all been in a room with somebody who is cold.

So I want a warm, empathic person to begin with, who has a flexible attribution

style, and that is the raw material --- and it is a very important raw material --- that you build the skill set on. The skill set, there are a lot of skills, but they are understanding how to do --- behavioural shaping would be one, how to downplay rather than to get --- feed-in or reinforce inappropriate behaviours.

I talk about, in my report, motivational interviewing. I do a lot of work in motivational interviewing and I like that as a therapeutic style because it teaches you to listen better to someone and not get into arguments with them. It is difficult because you have to be taught that skill, supported in it. So yes, there is a range of things, my colleagues will talk about additional ones too, but to answer your question, you start off with those human factors that are engaging.

COMMISSIONER McEWIN: Thank you.

CHAIR: Ms Crawford, you are on again.

MS CRAWFORD: Dr Manchester, you mentioned the unit for people with cognitive impairment. Would that be a smaller unit than the Forensic Hospital unit or do you have a vision for what that unit might look like?

DR MANCHESTER: I think it would be a smaller unit. It is quite a few years now since that report was prepared, and they would have done an audit on who were the more extreme case studies or instances they were hearing out that would require this. I think it would be a fairly small unit. If you are asking me what would be the exact number, I really couldn't tell you that. What else would I say about that unit in terms of numbers? I think I would only add that it's not just for individuals who are in the Forensic Hospital, that they are, as we know, cognitive impairment is overrepresented in prisons, and people aren't in prison because of their cognitive impairment because they have memory problems. You don't go to prison because you have a memory problem, you go to prison because you have impaired executive functions. What I mean by that is the executive functions are higher order skills, Melanie has gross impairment of her executive functions, and those higher order skills are to do with planning, organising behaviour, problem solving, and the main one, impulse control.

After I prepared the report for the Integrated Service Response, I went to work for the Integrated Service Response for nine months before funding was wrapped up and that service was dissolved, a few months ago. However, I was able to see that a lot of the behavioural difficulties, these extreme behaviours that you see in this small cohort of cognitively impaired individuals with these significant histories of traumas, there is an expectation that there's support from the community after they come out of prison, and it is wholly unrealistic. Communities struggle, NGOs struggle, wonderful providers working very hard struggle, significant others struggle. The type of service that I describe, I think that would be a wonderful service for individuals who were, if not in the forensic system, the prison system to exit into, to be given the chance for appropriate support, skill-building and treatment and successful transitioning out.

MS CRAWFORD: Thank you. Thank you, Dr Manchester. Chair, I don't have any further questions for Dr Manchester.

CHAIR: Thank you very much. I will just ask the Commissioners again whether they have any further questions.

Commissioner Mason, do you have any questions of Dr Manchester?

COMMISSIONER MASON: No, thank you.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No, I don't, Dr Manchester, I just wanted to note that you describe so many of the people who came before me for sentencing when I was a judge, that it's almost eerie how accurate it is. Thank you.

DR MANCHESTER: Thank you, and thank you for the opportunity to come and discuss this.

CHAIR: Dr Manchester, I am being reminded I should ask whether any counsel or legal representatives have any questions of Dr Manchester.

MS FURNESS: No, thank you.

MS NEEDHAM: No, thank you very much.

CHAIR: Dr Manchester, thank you very much for your evidence, which has been very helpful, and for the statement you provided, and we have of course the report that you have had prepared, which is part of the evidence before the Royal Commission. Thank you very much.

DR MANCHESTER: Thank you. Bye now.

THE WITNESS WITHDREW

CHAIR: Ms Crawford, what should we do now?

MS CRAWFORD: I understand that Professor Ogloff is ready to go. He is the last witness for the day.

CHAIR: We can proceed directly to Professor Ogloff. Do you wish to tender his statement?

MS CRAWFORD: I do, thank you, Chair. Professor Ogloff's written statement is at

Tab 3 and his CV is at Tab 4 of Tender Bundle E1. I seek to tender those documents into evidence and for them to be marked as Exhibits 11.8.1 and Exhibit 11.8.2 respectively.

CHAIR: Yes, thank you, that can be done.

EXHIBIT #11.8.1 - STATEMENT OF PROFESSOR JAMES R P OGLOFF

EXHIBIT #11.8.2 - CURRICULUM VITAE OF PROFESSOR JAMES R P OGLOFF

MS CRAWFORD: There is an attachment to Professor Ogloff's statement at Tender Bundle D1. I ask to tender that document into evidence and for it to be marked as Exhibit 11.8.3.

CHAIR: That also can be done. Thank you.

EXHIBIT #11.8.3 - ANNEXURE TO STATEMENT OF PROFESSOR JAMES R P OGLOFF

CHAIR: Professor Ogloff, thank you very much for coming to the Royal Commission to give evidence. Just to explain where everybody is, because it can be a little confusing.

Ms Crawford, will it be you or Dr Mellifont asking questions?

MS CRAWFORD: It will be me, thank you, Chair.

CHAIR: Yes, okay. We have in our Brisbane hearing room Commissioner Mason and we also have Ms Crawford of Counsel, who will be asking you some questions very shortly. Commissioner Atkinson is joining the hearing remotely, Commissioner McEwin is in the same hearing room in Sydney with me. So that is where we are. I shall now ask you to follow the instructions of my Associate, who is in the Sydney hearing room, to take the affirmation. Thank you very much.

PROFESSOR JAMES R P OGLOFF, AFFIRMED

CHAIR: Thank you, Professor Ogloff. Now Ms Crawford will ask you some questions.

EXAMINATION-IN-CHIEF BY MS CRAWFORD

MS CRAWFORD: Thank you, Chair.

Professor Ogloff, can you hear me and see me clearly?

PROFESSOR OGLOFF: Yes, I can, thank you.

MS CRAWFORD: You provided a statement to the Commission dated 8 February 2021?

PROFESSOR OGLOFF: That's correct.

MS CRAWFORD: Is there anything in that statement you wish to amend or anything you want to add to it?

PROFESSOR OGLOFF: No, there's not.

MS CRAWFORD: Professor Ogloff, you are well credentialled in providing reports for forensic disability services and mental health services, nationally and internationally?

PROFESSOR OGLOFF: Yes, that's correct.

MS CRAWFORD: You were involved in 2018 in authoring a report specifically looking at the Queensland Forensic Disability Service system?

PROFESSOR OGLOFF: That's true, yes.

MS CRAWFORD: In Queensland there is a Forensic Disability Unit which is specifically designed for individuals with cognitive impairment and complex forensic needs, if I can put it that way?

PROFESSOR OGLOFF: Yes, that's true, who are on forensic orders.

MS CRAWFORD: Would you agree that a forensic disability service is a necessary type of facility for managing forensic disability patients with complex needs or can they or should they be managed within forensic mental health facilities?

PROFESSOR OGLOFF: I think that's a very difficult question to answer simply. The reality is that there's a difference in expertise between managing and supporting people with forensic disability versus those with forensic mental health, and I think one of the problems we faced in Australia traditionally was that people with disability in forensic systems were often caught up in the forensic mental health systems which were largely designed for people who are mental illness, which is

generally remediable through medication, rather than people who had expertise in disability. Obviously the people with disability are often much smaller in number, so this led to a number of difficulties.

As a result, for example, in Queensland there was a report referred to as the Carter Report from 2006, where Justice Carter made recommendations about the need to identify specific expertise and develop services that meet the needs of people with forensic orders who are disabled.

So the answer to the question is that people with forensic disability require services that are tailored to their specific needs, but that's a separate question from whether forensic disability services could be part of a larger forensic mental health system, and that could vary across jurisdictions. But the salient point is that whatever service system exists, it requires staff to have a level of expertise in assisting people with disability, not just mental health because they are very different conditions.

MS CRAWFORD: I was going to ask you to explain to the Commission what you think the differences are between the skills for, for instance, that someone who has mental health professional qualifications would be, as to those who deal with patients with cognitive disability in particular, and what the difference is between those two skill sets?

PROFESSOR OGLOFF: Yes, I think in brief I could say traditionally these overlap dramatically. So for example, even at the beginning of my life, my professional life in the early 1980s, it was still often the case that there were large institutions and these groups were combined, they may be on different units but they're essentially managed by the same staff. Over the time, though, the reality is that we have understood probably much more about mental health and the remediation of symptoms in mental health, so we have seen, for example n Australia since that time a de-institutionalisation of mental health services, largely as a result of the advanced ability to manage people with mental illness in community, largely by psychiatric medication. So the vast majority of people with mental health problems, even significant psychiatric disorders, are able to be treated effectively with medication and a range of other modalities. Of course, the difficulty with people who have disability in the main, not all people but the majority, certainly people with intellectual disability, for example, is that their condition, the disability condition, is not remediable, so it is a lifelong disability which they will endure. So the efforts to work with people with disability is a very different focus than those with mental illness. It is largely on rehabilitation and also a much more basic level of behavioural modification and behavioural support. So obviously the majority of people with mental illness do not have a disability, an intellectual disability or a cognitive disability, so they are able to communicate, they have an executive functioning capacity that's at least average, and therefore modalities such as cognitive behavioural therapy, for example, have flourished over the last three decades as an adjunct to medication. The difficulty with people with disability, by definition, is they will have a level of dysfunction in self-management often in care, in the ability to care for themselves, and they have limited capacity for

decision-making and executive functioning.

So the support and management and remediation of challenging behaviour, for example, requires a very different skill set among people who work with disability, as compared to those who work, say, exclusively with people with mental illness.

CHAIR: Professor Ogloff, I am sorry, I have been asked --- I think you did slow down a little in your presentation, just after I was asked to ask you if you wouldn't mind slowing down a little in your presentation. Thank you, because we have to translate through our Auslan interpreters and also for the realtime transcript. Thank you.

PROFESSOR OGLOFF: Thank you, Chair, I will.

MS CRAWFORD: Professor Ogloff, with respect to restrictive practices, the case study that the Commission is currently examining is a case study of a woman by the pseudonym Melanie, who was held in a long-term seclusion environment for a number of years. Can you comment on the use of seclusion with respect to patients with cognitive impairment and what that might achieve by way of behavioural support, if anything?

PROFESSOR OGLOFF: Yes. I think most people would agree that seclusion has a place, both in forensic disability and forensic mental health, but it should be extremely limited because what we know, given what I have already mentioned about limited capacity of people with disability, is that their ability to abstract reason and to gain from restrictive practices is incredibly limited. More often than not, people who are subject to ongoing or chronic restrictive practices, including seclusion, simply acquiesce or adapt to those, and the experience I have had is that rather than having a long-term benefit in, for example, reducing challenging behaviour, it in fact often has a crippling effect which can in fact exacerbate that behaviour over time. I have seen this in many cases. I have never seen Melanie but I have seen many other people in those circumstances.

MS CRAWFORD: With respect to long-term seclusion for patients or a patient with a cognitive impairment being expected to earn their way out of seclusion by way of a traffic light system, have you got experience of the traffic light system with respect to patients with a cognitive impairment?

PROFESSOR OGLOFF: I do. Sorry, you were going to ask a question?

MS CRAWFORD: I was going to ask you if that's a reasonable expectation, that a patient with a cognitive impairment would be able to control their own behaviour to the extent required in order to meet the traffic light system and earn their way out. Do you have any comment to make about that?

PROFESSOR OGLOFF: Yes. Again, traffic light systems can be effective. They need to be --- again, because of the lack of ability for abstract reasoning --- they need

to be very, very concrete, and any sort of expectations need to be within the capacity of the individual. So where these systems fail is when the expectations extend beyond the capacity of the individual. So, just to give you an example, if someone is expected to refrain from a particular behaviour for a period of time, then the period of time needs to be, at the beginning, very, very brief so that the person can gain mastery over that behaviour. But sometimes what happens is people are put in situations where expectations exceed their ability, and very quickly they devolve into a learned helplessness and the behaviour can sometimes actually exacerbate rather than remediate.

MS CRAWFORD: They could become more aggressive rather than less aggressive in certain situations?

PROFESSOR OGLOFF: Yes, absolutely. More aggressive. I have seen this in a number of examples across the country, in work I've done. It's, I think, counterintuitive to people but the individuals in those circumstances, as a result of a variety of things, including again sometimes their historical experiences, experiences with trauma, and the way they react to people in authority, their own view of themselves, their own experience, we can sometimes see these effects backfiring, and we can see people becoming deeper and deeper sort of pushed into a rut. Often when I work in those cases, we are looking for some kind of circuit breaker to try to change that cycle because for the individual in the midst of that --- and often the staff who are there to support them --- there is this collective learned helplessness.

MS CRAWFORD: That would only exacerbate itself over time, the longer that situation has been going on, the more helpless the staff and the patient would feel in that space?

PROFESSOR OGLOFF: That's correct, and I think sometimes in some cases I've seen, for example I have seen individuals who have been confined for extraordinary periods of time, sometimes years, in a room by themselves, and sometimes they become deteriorated to the point, for example, where they no longer wish to go outside, so if they are offered an opportunity to go outside, they just decide not to. Sometimes, when I have been able to speak to these people, after those periods of time, they can reflect that for them, the pain of going back into the sort of seclusion area was so great that they chose not to even leave it and they feel like there's no purpose in leaving. So, again, without a continuing movement towards trying to reduce the restriction through a variety of different means, the individual --- they may look like they are subdued and it may appear that they are being managed in a way that is assisting, but it is certainly not assisting over the longer term. It is not helping towards a solution to restrict those practices.

MS CRAWFORD: The Commission has heard that often the reason for the continuing seclusion for a long-term period of time is because there is this tension between workplace health and safety issues with safety of the staff and other patients rubbing against the individual rights of the patient who is detained in the seclusion area, because they are perceived to be so dangerous.

PROFESSOR OGLOFF: That's absolutely correct.

MS CRAWFORD: So you talk about the circuit breaker. When you get to a point like that, is that when you need to bring in someone external or start doing things in a very different way with a core team, for example, to move things along?

PROFESSOR OGLOFF: I think the starting point --- the short answer is yes. But the starting point is that it should as much as possible never get to that point because, like all other behaviours for people, once a behaviour becomes entrenched, it is all the more difficult to undo that. And so steps need to be taken right from the beginning to reduce the practices, and so in facilities in which I have worked or reviewed, that's where we see things start to become positive where there's positive behavioural support or other sorts of interventions, right from the beginning. So to answer your question directly, once people are in this entrenched pattern, my experience is it's very, very difficult to change that, and particularly when we have limited opportunities for something truly different. So one of the points I make in my statement is that because of our State system in Australia, we have very limited facilities or capacity to manage people with particularly challenging behaviour, and so what happens in reality is it's a fixed group of staff and an individual in the same sort of general setting, trying to do things differently. That is not often an adequate circuit breaker. The circuit breaker that I have seen would be a significant change in environment and staff with them. That benefits the staff who often understandably can become fearful, they can become burnt out and they can themselves become hopeless. So in a country, for example, like the UK, they have an ability to move people, because there's a national system, from one place to the next, and there's different levels, for example, of security and safety. In our states, even in large states, we typically have one sort of facility or sometimes no facility, so it becomes incredibly difficult to change the context and the mechanisms used to work with the person to an extent to effect change.

MS CRAWFORD: Are you suggesting that there should be cooperation across state borders in order to facilitate some of those circuit breakers that you are talking about in those most difficult cases?

PROFESSOR OGLOFF: I think both across states but even within states. One of the facts we see in Australia is when an individual is in a high secure setting, whatever that is --- it could be prison, it could be a facility such as Queensland FDUs --- it becomes very difficult to step them down. Sometimes that actually could be very successful, but it becomes more and more difficult to do that.

One of the principles, again, of behaviour that we see is that when an individual client is in a circumstance such as we are describing and one tries to begin to change behaviour, there's usually an increase in the challenging behaviour before there's a reduction in it. So this is a very common principle of human behaviour, that when you are trying to change behaviour, sometimes the challenging behaviour actually increases before it will start to reduce. There are a variety of reasons for that but that

is a principle that we often see.

If we translate that into what it means, is that when we try to, for example, have some sort of circuit breaker for an individual, we might see an increase in challenging behaviour for a period of time, and usually what happens is the response is to put the person right back into the same environment, the same circumstance in which they found themselves, and as a result that further sets them back.

MS CRAWFORD: That really brings in the issue of the staff skill and the ability to not get to that point in the first place, but when you are in that situation, how do you communicate with anyone else within the system in order it make things change? What needs to be done then?

PROFESSOR OGLOFF: In my statement, I make a few observations and potential solutions. You have touched on staff training. I think that is a very important point. As I mentioned at the outset, the skill set is very different. You could have similar education; for example, a person could be trained as a clinical psychologist or as a psychiatrist, have essentially the same university education but over their professional experience develop expertise in working with one population or the other. So often in my experience in disability and forensic disability, it has been very difficult to recruit staff who have a high level of expertise to work with a particular population, especially those who have challenging behaviour. So I think the staff training and experience certainly is one important aspect of that.

MS CRAWFORD: The multidisciplinary team approach is in your statement at paragraph 87, where you talk about that as being important as the best way to run a forensic disability service. What does the multidisciplinary team look like for people who have a cognitive impairment and who might need that level of positive behaviour support?

PROFESSOR OGLOFF: I talk about positive behavioural support. I know through other witness statements also, there's also --- neuro-behavioural limitation is often mentioned. These modalities require individuals who comprise the team with different skills and abilities. So, because the individuals who have challenging behaviour doubtless have a host of problems, then you need members of the team who have different and complementary areas of expertise. So they separate variously but typically they will include someone who has medical expertise and a background typically in psychiatry, someone who has expertise in typically neuropsychology or less commonly neuropsychology, who understands the brain behaviour interaction; you have to have some frontline clinical people, these would be people who could have various professional backgrounds but have expertise in working with people with disability to understand how to work and what skill set is required. Then there are a host of so-called allied health staff, such as occupational therapists or rehabilitation therapists to work with the individual as well.

So it is really a combination of people with different skill sets who are able to work

with individuals. In my experience, very often we will see a dearth of those sort of people or, if you do have someone who is particularly qualified, they will have a much less hands-on opportunity with the individual, and then the day-to-day work is left to staff who are typically less experienced or less skilled and obviously they are the ones who are going to experience and face the greatest challenge.

MS CRAWFORD: You talked in your statement about high staff turnover. Would you expect, if you had a team with the relevant skill set involved, that the turnover would be reduced?

PROFESSOR OGLOFF: That's been the experience. The experience on which I draw really comes from the development of forensic mental health services, which is my day-to-day work. When I came to Australia, it was really to assist in the development of the Victorian statewide forensic mental health service. At the beginning of the time when I arrived, there were very few people across disciplines who had expertise in forensic mental health. As a result, in the state prior to the establishment of the Victorian Institute of Forensic Mental Health, or Forensicare, there was a typically high staff turnover and it was seen as very unsatisfactory work. Over many years and development, it has ebbed and flowed, but the staff retention is often comparable to other areas of mental health. So that the area which is often seen as most challenging can still be a safe and satisfying workforce.

So although it is a long process, it is the case that by changing the model where people work and deliver services, can assist in creating a more satisfactory employment set, because you touched on the fact that there certainly are occupational health and safety issues, and it is the case with many of the people with these challenging behaviours, they have caused physical harm to others, including staff. So you mustn't underestimate how challenging it is, but it is meeting the needs of these individuals. Maybe I will just close that bit by saying that this is why one of the concerns I touch on early in the statement is that, although I can't be definitive, it is likely the case around Australia that we have too many individuals in some of the higher secure sort of facilities and certainly in prison than we would really need to if we had service systems that were more tailored to the needs of the individual.

MS CRAWFORD: In mental health, there are a range of facilities and a range of opportunities for care and treatment in the community, working through into acute services, medium secure, high secure, et cetera.

PROFESSOR OGLOFF: Correct.

MS CRAWFORD: Do you say that there is a similar need in the disability sector?

PROFESSOR OGLOFF: I think there is. I think that certainly, both in mental health but more in disability, I think there is less need for the institutions. We used to be very dependent on institutional care. We have thankfully moved away from that, but sometimes at the expense of the reality that there needs to be what we would call inpatient care for a small number of people. That, for example, is my experience in

all the states in which I have worked or done reviews, is that, for example, if we use Queensland as an example, there is a small Forensic Disability Service which is high secure, and actually purpose-built and from a physical structure, actually quite a good facility. But the difficulty is, as I mentioned earlier, it is almost impossible to transition people away from that facility, and so there's a lack of adequate step-down places. So in Queensland I have seen, for example, people who are on forensic disability orders being managed in, for example, acute psychiatric units with patients who are acutely psychotic, which you have somebody who has got a cognitive impairment, lack of ability around executive functioning, and they are living with people who are acutely unwell. So while there's a justifiable focus on community, because of the small number of people with disability, we don't have an economy of scale to see the sort of graded care levels to which you refer.

MS CRAWFORD: When you spoke a moment ago about the difficulty in transitioning with patients from the Forensic Disability Service in Queensland, is that limited to the time that you had spent during your report with interest in that particular facility or do you have knowledge of that currently? Is that limited to 2018 or is it current?

PROFESSOR OGLOFF: No, I think it's current. My official role at the time was to do a review, which took a long time, obviously. We finished in 2018. I then had a role as an authorised officer under the *Forensic Disability Act* and did further work there. But even looking at the recent annual report and speaking to staff, they are having more success, but it is still a challenge in every single case. That would be exactly the same in New South Wales, the same in Victoria, the same in our other States and Territories.

MS CRAWFORD: Can you comment on how many patients across the country would be in similar circumstances to those within the Queensland Forensic Disability Service or Melanie's situation? What's the number? You say there's no economy of scale but what is the number, do you know?

PROFESSOR OGLOFF: If I could just start, the people with the most extreme challenging behaviour, like Melanie, thankfully there are very few. Most services will have one or two people who are in that category but typically no more.

The problem is we don't really know the number because, as I mention again in my statement, in forensic mental health most people, though not in all states but in most of the states, people who are either unfit to stand trial or not guilty by reason of mental illness or however it is referred to in the State legislation, they are now detained in forensic mental health facilities, such as the Forensic Hospital in Sydney or the Thomas Embling Hospital in Melbourne. With forensic disability, though it is still very common for people to be detained in prison, so their behaviours are managed by a custodial approach, not a disability approach. So the difficulty is it is difficult to estimate the exact numbers because if we look at the number of people on the forensic orders, they would be quite large, but then within that group, separating out who requires a custodial order versus a community order, and then again within

the custodial group, who can be managed in either custodial environments or hopefully better less secure environments.

So, for example, in Victoria the majority of people on forensic orders are managed either by --- there's a statewide Forensic Disability Service, or, are still in prison. So the problem is the numbers are relatively small, especially as you look at the more and more challenging, the number gets smaller. I think what happens is the services, including Queensland and New South Wales and elsewhere, they develop a way to manage the small number of people that I think we would uniformly agree would be not ideal, in fact probably sometimes terrible, but because it is the only way they can get it to work --- and by work I mean reduce staff damage and save the welfare of the individual being detained, their physical safety --- that we allow that to continue. So in the cases I have seen, it's not like people are happy and they don't worry about this, because just they can't see any way forward.

MS CRAWFORD: Do you have any particular solutions that might be able to be adopted?

PROFESSOR OGLOFF: Yes. I should say, some of the solutions that have helped --- again, unfortunately, I'm less positive about people who are entrenched in these very difficult circumstances because, as I mentioned earlier, the longer one is in the circumstance, the more difficult it is to change that behaviour. But the experience in Queensland, just for example, has been there are still problems, everybody would acknowledge it, but it has in fact improved fairly dramatically. So the Forensic Disability Service in Queensland for the first, I believe, five years of operation could discharge no one, so it filled immediately and no one was transitioned, and it contained stagnant (audio distorted) patients, efforts were essentially dysfunctional, so there was a lot of work done internally to transition; right from the beginning, when someone is admitted, to begin the transition planning, and to truly adopt the least restrictive environment approach.

So the fairly straightforward principles are obviously a very comprehensive assessment to be very clear about the individual's deficits and their strengths, and also the factors that contribute to challenging behaviour. And then to establish on an individual basis something such as a positive behavioural support plan or neuro-behavioural rehabilitation principles often combined, to begin to address those needs in a preventative way. One of the reasons we move people to secure environments is because within a secure environment you can typically afford people a greater degree of liberty and that can assist them in developing behaviour. The assessment is the first component, then the tailored rehabilitation, and always with the eye on transition and moving the person through. So this keeps the individual hopeful and the staff hopeful. So even if there are setbacks, which will be inevitable, the setbacks aren't seen as taking that person right back to square one but rather a period of time where there needs to be a step back and then moving back forward.

Certainly, as the FDS service has shown, the majority of people have transitioned through, and the ones who have transitioned, if they can find suitable

accommodation, have generally done quite well. So it is having the very high level of expertise in assessing and intervening, and then a sensible support system and transition system.

CHAIR: Professor Ogloff, do you have the report that you prepared handy?

PROFESSOR OGLOFF: I don't have it. I have it electronically but not --- it is on my screen, I can refer to it.

CHAIR: I just wondered whether we might make some of your observations about numbers a little more specific by reference to your report, and then you can tell us what has happened since.

At page 19 of that report you say that in 2017 --- in Queensland we are talking about ---

PROFESSOR OGLOFF: Yes.

CHAIR: --- there were 32 new forensic orders (disability), and that was an increase, and there had only been 14 revoked since 2011. The result as at 1 December 2017 was that 97 people were on forensic orders (disability), 86 per cent of whom were male and 14 per cent of whom were female. What does that mean, 97 people were on forensic orders (disability), and you tell us that six people were detained to the FDS and a further 64 with co-occurring mental illness and intellectual disability or cognitive impairment were managed by Authorised Mental Health Services. Can you pull that in and explain what those figures mean?

PROFESSOR OGLOFF: Yes. I think the confusion speaks to the complexity and difficulty of the system. Individuals who are on --- in Queensland, and it is unique in the way they call the order, they have a forensic order (disability) versus a forensic order, which essentially is mental health. As I mentioned, there is a much larger population of people who are forensic orders mental health but the smaller group has a forensic order (disability). To even complicate matters further, within that group of people, a number of them, not surprisingly, will have a co-occurring disability and mental health.

So within the group of people who have a forensic order (disability), as the report makes clear, it is really just a minority of them and in fact six people who were in the FDS during the period. The rest of the people are managed around Queensland, and again the system there is unusual because only when the individuals are in the forensic disability service, which is this small facility in Brisbane, are they managed by forensic disability. If they are managed outside of that service then they are managed by the area mental health services around the state.

CHAIR: Yes, you have got a table that shows us where the people on forensic orders (disability) are located in Queensland, different places.

PROFESSOR OGLOFF: That is exactly right.

CHAIR: How are they dealt with, how are they treated, how are they managed?

PROFESSOR OGLOFF: Again, that's the concern I have at the beginning, is they are managed with people with psychiatric illness, and they are managed at a level of security that's dependent on their behaviour. The problem is that for example, in mental health services, the higher secure facilities are more acute. But what that means is there are locked-in patient facilities where people have acute psychiatric illness, and typically what that means is they have delusions or hallucinations or very extreme mood disorders, such as bipolar disorder or very serious depression.

CHAIR: I was prompted to ask the question by your observation that Melanie's case is at the extreme end and that the number of cases like that was relatively small. I'm trying to get a feel for the 97 cases that existed that had the forensic orders (disability) as at 2017. I appreciate that only six were detained at the FDS, but the other 91 were also detained, weren't they, in different parts of Queensland?

PROFESSOR OGLOFF: Yes, that's right. Thank you for the opportunity to clarify. When I was asked the question, I really thought the question was around the people who required these high level of staff in a secure environment. So the reality is that of that 97, quite a few are living in much less secure mental health facilities, including, for example, some I saw living in essentially cottages in a community which has people who are not acutely unwell but are in mental health rehabilitation and so they would have their own accommodation, they do their own laundry, these sorts of things.

So the range is quite significant from the small number of people at the FDS requiring what I would call high secure containment to the larger number of people who still require accommodation but who are able to be in much less restrictive environments.

So just to give the Chair and the others the comparison in a mental health system, in a hospital such as the Forensic Hospital in Sydney or the Thomas Embling Hospital in Melbourne, there are a range of levels of security within the hospital. You have restrictive units; for example, the Thomas Embling Hospital has a very small seven-bed highly restrictive unit with a very high staff ratio for people who require the highest levels of security. They do not have access to the broader hospital, they have access to --- outside there are courtyards within the unit. At the other extreme of the units at the Thomas Embling Hospital, there is a low secure unit which simply has a wire fence around it and people live in their own accommodation, they do all their own cooking and cleaning, they go shopping, they do return to the facility and they are locked there overnight. And then of course there would be people who move to less secure community arrangements.

The point I make is that the challenge around the country is, in disability we typically have very small capacity for the most challenged and then almost no transition or

very limited opportunities for appropriate transition.

CHAIR: Of the 97, your table tells us, for example, there were 14 at the West Moreton network. I'm choosing that at random. What sort of security or conditions would those people have been held under, do you know?

PROFESSOR OGLOFF: Yes. In each of the regions, they have the differing levels of treatment. This is, of course, the model of mental health around the country. West Moreton would have an inpatient unit and they would also have a secure standard care unit, and they would have less secure units. So the individual on a disability order would be placed in the unit that could best manage or contain their behaviour. But of course the difficulty is that their disability needs are not really being taken into account or addressed.

CHAIR: I understand that. But it may be the case then that of the 14, some would have been in quite secure accommodation or detention, however you want to describe it.

PROFESSOR OGLOFF: That's correct. Again, Chair, that would be people in what we call in the inpatient unit, the acute inpatient unit. I don't have the numbers to hand, but of the 97, my experience is that would be a fairly small number, probably a fifth to a third of them, at any given time would require that. So in a state like Queensland, what that means is, if we start to think about it, 7 to 10 people in high secure, such as the FDS; something like 20 to 30 people in a still secure but less secure environment; and then others would be even less secure. So in the forensic systems across the country --- and really the best examples are Victoria and New South Wales --- these gradations of security and care are in one large hospital, which has, for example, swimming pools, physical --- at the Thomas Embling Hospital there is a TAFE, there is kiosks. Some individuals there are not locked at all in their rooms and they have access 24 hours in the perimeter of the hospital.

In disability, again, we unfortunately don't have that. So we see this misfit between trying to meet the needs of the individual, alongside people for whom the services have been built who have very different needs.

CHAIR: In that report, at page 19, you say there were a further 64 beyond the 97 who had both a mental illness and an intellectual disability or cognitive impairment and they were managed by the Authorised Mental Health Services on a forensic order (mental health). That means, as I follow it, that some of those people, although they had a mental health issue, also had a cognitive disability. What does it mean that they were managed by authorised mental health services? How were they managed?

PROFESSOR OGLOFF: The way it works in Queensland, and it is similar in New South Wales, is if an individual has a co-occurring mental illness and disability, they are managed like anybody else with a mental illness. They would be in similar facilities, as we just talked about, to remediate the mental health symptoms but at the

same time they will have a disability. From a disability perspective they are not dissimilar, it is just that that group of people would have, in addition to an intellectual disability, maybe a disorder like schizophrenia.

CHAIR: Would some of these be held in secure facilities as well?

PROFESSOR OGLOFF: They certainly are but they would be secure mental health. Certainly that would be the case in a forensic hospital in Melbourne or Sydney, so that is exactly right.

CHAIR: I'm not implying any criticism, I'm just trying to get a feel for what kind of numbers we are talking about. The numbers, from what you are describing now, although they may appear relatively small in absolute terms, are not insignificant numbers of people, people with cognitive disability subject to, in some cases, high levels of security.

PROFESSOR OGLOFF: You are exactly correct. Again, in the report, they are the recommendations we make. The problem that we saw is that the authority of the Director of Forensic Disability is limited and there was an example from a Mental Health Review Tribunal case that I used as a quotation, that that shows that --- you have a director who has expertise in disability, but only has control really over the clients of the disability service. So that when the individuals are not in that service, and of course the vast majority aren't, then they are managed by mental health services, where the individual clinicians may or may not have that expertise. And similarly the Mental Health Review Tribunal who deals with them, as we have identified, similarly struggle to understand disability. What you certainly appreciate in your Commission is the fact that there's a range of people with disability, some of whom can be very, very complex, but their needs are very different from people with mental illness. I think what I'm trying to demonstrate in a less than articulate way is that those with forensic disability orders are at significant disadvantage in Australia, compared to people with forensic mental health orders, for whom there is a much broader array of services, but also the services are purpose-built and designed and targeted at their needs, whereas those on disability orders are typically moved into the Mental Health Services to contain them, that is, to meet their security needs, but the extent to which they are meeting their rehabilitation and disability needs would be I think woeful.

CHAIR: Thank you.

MS CRAWFORD: Thank you, Chair.

Professor Ogloff, the numbers at the FDS-type secure facility requirement are quite small. But if I have understood the conversation and the questioning by the Chair and the answers that you have given, it would seem that the data that is available is quite difficult to drill down into, to tease out where those needs really are for people with cognitive disability with direct numbers that can support that type of inquiry.

PROFESSOR OGLOFF: Yes. It varies across the country. But in the main that's true. It was very difficult to get the data we got, and we were very fortunate to have a period of time to do that. But they weren't available very easily; similarly, the excellent question the Chair asked about, say, West Moreton, we had no way to know, even on a snapshot, where exactly people were within West Moreton. We knew they were in this area of Mental Health Service, which has a very large catchment area and a large number of patients, but we wouldn't know within the Service exactly where they were.

So I guess the point is, moving forward, there would need to be considerable effort around identifying the numbers as step 1 in planning.

MS CRAWFORD: With the issue of transitioning out of those longer term facilities when a patient perhaps is ready for a change to a step-down facility or some other type of accommodation, has that been complicated by the NDIS?

PROFESSOR OGLOFF: I'm afraid it has. The experiences I think across the country have been that, potentially not surprisingly, people who are more challenging and more difficult to manage, it's been much more difficult for them to find suitable accommodation. I think that's certainly understandable. The Act, the *NDIS Act*, makes reference to a provider of last resort, typically being the state, and the fact is that there has been some effort in some states to establish forensic disability services through the NDIS, but that has been very difficult. I must say, I'm not across the intricacies, but I know some of the issues we did canvas at the time of the Queensland review and I have seen consequently, the NDIA now will question what services they should provide, and obviously they see themselves understandably as providing disability services but monitoring and what we would call forensic services are things that they might not thinking she should provide under their remit. So there is a question of where does responsibility fall for the care for the individual? Because obviously the individuals who we are talking about have a mixture of disability issues but also other forensic issues --- and by forensic I mean issues that contribute to challenging behaviour and offending, which would extend beyond mere disability.

MS CRAWFORD: Thank you. I have nothing further. Thank you, Chair.

CHAIR: Thank you very much.

I shall ask Commissioner Mason, do you have any questions of Professor Ogloff?

COMMISSIONER MASON: No, thank you.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No questions, thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

QUESTIONS BY THE COMMISSION

CHAIR: Professor Ogloff, this perhaps might be regarded as a thought bubble, but Dr Manchester commented earlier this afternoon --- I don't know whether you were observing his evidence --- that the difficulty with the NDIS in terms of people of the kind that we are talking about, who are to transition or hopefully to transition into the community, is that the NDIS uses a private provider model and private providers are not well adapted to dealing with the extraordinarily complex and difficult issues that you and he have described, and indeed others have described. I'm wondering whether a possible approach to that kind of issue is for NDIS funds to be used in a rather different way, for people of the kind we are talking about to transition into the broader community, and that is perhaps for them --- whatever the position for others might be --- to carve out a separate model, so that any funds that are available are actually directed in an appropriate way to their particular situation.

PROFESSOR OGLOFF: I think that's an excellent idea. Again, if we just draw a parallel to the Forensic Mental Health Services, although there is obviously a Commonwealth Medicare model, people in Forensic Mental Health are not funded through that model, but they are still funded, so in a secure hospital such as I have mentioned and in the transition from that, all of the care of the individual is paid for and responsible by public funding, not just treating mental health, so for example, in the Thomas Embling Hospital, the people are not dissimilar from people with disability, they have a mental illness but they would also have a host of problems: substance abuse, potentially personality problems, anger management, a range of things which are not strictly speaking mental health, but no one ever tries to separate out, wait, what is mental health responsible for, versus some other entity. Instead, the individual is treated collectively.

I think in the NDIS, similarly, if in the transition the range of needs the individual has are identified and those funds were used to fund that rather than trying to tease out --- like the examples I had --- and again this is in different cases --- sometimes you would have an individual who would be on a very large package prior to the NDIS --- and by large I mean in the hundreds of thousands of dollars --- who would then get an allotment of, say, $35,000 because that was the amount seen to manage their disability or to provide disability support.

So it sort of goes back to the principle of assessment: identify the range of needs the person has and meet the needs. Because, particularly, people on forensic orders, from a legal perspective, they are being detained on those orders, or managed on orders, not just because of their particular disability but because of the ongoing risk they pose to society. So there's an obligation to provide them with mechanisms to reduce that level of risk and ultimately come off those orders.

CHAIR: Thank you very much. Do any counsel or representatives wish to ask Professor Ogloff any questions?

MS FURNESS: No, thank you.

MS NEEDHAM: No, thank you, Chair.

CHAIR: In that case, thank you very much, Professor Ogloff, for coming to give evidence and for the report, the statement you have provided and also the documents that are attached to that statement. We are grateful for your assistance, thank you very much.

PROFESSOR OGLOFF: Thank you, good afternoon.

THE WITNESS WITHDREW

CHAIR: Yes, shall we adjourn until 9.30 am Queensland time/10.30 New South Wales and Victorian and Tasmania and no doubt offshore islands time?

MS CRAWFORD: Thank you, Chair.

CHAIR: Very good. Thank you.

HEARING ADJOURNED AT 4.25 PM UNTIL 10.30 AM ON THURSDAY, 18 FEBRUARY 2021

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