CHAIR: Good morning everybody, welcome to the third day of our current hearing. I invite Commissioner Mason to give the Acknowledgement of Country this morning.

COMMISSIONER MASON: Thank you, Chair.

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

Ngana<u>n</u>a tjuka<u>r</u>urungku kalku<u>n</u>i A<u>n</u>angu kuwaripa tjara nyinantja tju<u>t</u>a, ngura nyangangka.

We recognise Meeanjin, Brisbane.

Ngana<u>n</u>a 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.

Ngana<u>n</u>a ngurkantananyi karu panya Brisbane River-nya alintjara munu ulpa<u>r</u>ira A<u>n</u>angu nguraritja tju<u>t</u>a 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 are deceased. 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 131 114, Beyond Blue on 1300 224 636, or First Nations viewers, your local Aboriginal Medical Services for social and emotional wellbeing support. Thank you, Chair.

CHAIR: Thank you very much, Commissioner Mason.

Dr Mellifont, yes.

DR MELLIFONT: Good morning. This is the third day of our consideration of the Melanie case study. I call Gary Forrest.

CHAIR: Good morning, Mr Forrest. Thank you very much for coming to the Royal Commission to give evidence. Dr Mellifont, you will tender presumably a statement and then I will ask for the affirmation to be administered. Thank you.

5 DR MELLIFONT: Thank you. You will find Mr Forrest's first written statement at tab 5 of Tender Bundle C. I ask for that statement to be tendered and for it to be --- and for the exhibits to be marked 11.9.1 and 11.9.2 respectively.

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

10

EXHIBIT #11.9.1 - STATEMENT OF MR GARY FORREST

15 **EXHIBITS #11.9.2 - ANNEXURE TO STATEMENT OF MR GARY FORREST**

DR MELLIFONT: Thank you. Now, Mr Forrest, you've provided two statements to

20 the Commission.

CHAIR: Sorry, we better administer the oath or affirmation, as the case may be, to Mr Forrest.

25 DR MELLIFONT: Yes, sorry.

CHAIR: Yes, thank you, Mr Forrest, if you would be good enough to follow the instructions of my Associate, she will administer the affirmation to you.

30

MR GARY FORREST, AFFIRMED

CHAIR: Thank you, Mr Forrest. Just to explain where everybody is because you

35 will probably see people on the screen, Dr Mellifont is in our Brisbane hearing room together with Commissioner Mason. Commissioner Atkinson is joining the hearing remotely. I am in the Sydney hearing room together with Commissioner McEwin. So we are scattered a little but you are, I understand, at a separate location in Sydney so I hope that you will be able to see us all clearly on the screen and hear us. Yes, Dr

40 Mellifont.

EXAMINATION-IN-CHIEF BY DR MELLIFONT

45

DR MELLIFONT: Thank you.

You provided a statement to the Commission dated 8 February 2021 and in fact a second statement of the same date?

MR FORREST: That's correct.

5

DR MELLIFONT: Okay. Now, in respect of both of those statements, are they true and correct to the best of your knowledge and ability?

MR FORREST: Yes, they are.

10

DR MELLIFONT: And are there any things within them that you need to change?

MR FORREST: No, thank you.

15 DR MELLIFONT: Okay. Thank you. Now, Mr Forrest, you are the Chief Executive at Justice Health and Forensic Mental Health Network; is that correct?

MR FORREST: That's correct.

20 DR MELLIFONT: And that is a statutory health corporation established under the *Health Services Act* of 1997?

MR FORREST: That's correct.

25 DR MELLIFONT: Is it part of a broader NSW Health system reporting to the Minister for Health?

MR FORREST: Yes, it is.

30 DR MELLIFONT: Okay. You've held the role of Chief Executive since 2006?

MR FORREST: 2016, yes I have.

DR MELLIFONT: Yes, and you've been with the Network since 2002?

35

MR FORREST: That's correct.

DR MELLIFONT: Amongst your qualifications are a Bachelor of Science in Nursing and a Masters of Applied Management in Health with Distinction; is that
40 correct?

MR FORREST: That's correct.

DR MELLIFONT: And included within your experience is 30 years' experience in
45 nursing, including teaching nursing at colleges and at universities?

MR FORREST: That's correct.

DR MELLIFONT: How long have you actually worked at the Hospital?

MR FORREST: So I don't work in the Hospital. I'm the Chief Executive and I oversee both the adult and young people criminal justice system, and the Forensic Hospital which is part of the forensic mental health system.

DR MELLIFONT: Yes. But in your prior time with the Network before you became Chief Executive and from when you started in 2002, did you spend any time working within the Forensic Hospital itself?

MR FORREST: No. The Forensic Hospital was not part of my portfolio prior to Chief Executive.

DR MELLIFONT: All right, thank you.

CHAIR: You did work at the Long Bay Hospital, I assume?

MR FORREST: That's correct, Commissioner. So the Long Bay Hospital is separate to the Forensic Hospital.

CHAIR: Thank you.

DR MELLIFONT: And is it your understanding that the purpose of the Forensic Hospital, or at least one of them, was to assist patients to move from a custodial environment to a therapeutic environment?

MR FORREST: That's correct.

DR MELLIFONT: I want to get an understanding of data, so far as you are able to assist me, Mr Forrest. Do you keep data as to how many patients with identified disability and/or personality disorder in addition to mental health illness are kept within the Forensic Hospital?

MR FORREST: Yes, we do.

DR MELLIFONT: Okay. And where is that kept?

MR FORREST: The data is kept in our electronic health records system and we are able to extract that data. It is extracted manually so it's not an automated process.

DR MELLIFONT: Okay. And what do you understand are the limits of the way in which it can be disaggregated?

MR FORREST: Sorry, can you ask that question again, Ms Mellifont.

DR MELLIFONT: I will ask it in a different way. If we wanted to, for example, just

find out the number of patients who had an identified cognitive disability, would we be able to do that?

MR FORREST: Patients in the Forensic Hospital, yes we would. It would be a manual process, as I mentioned.

DR MELLIFONT: Okay. Would we be able to find out the number of persons with personality disorder in the Forensic Hospital?

MR FORREST: Yes, we would. Again, manual process.

DR MELLIFONT: Would we be able to find out the number of patients with a mental health illness?

MR FORREST: That's correct, yes.

DR MELLIFONT: Would we be able to find out the numbers of any combination of those?

MR FORREST: Yes, we would.

DR MELLIFONT: Okay.

CHAIR: How long would it take to do that?

MR FORREST: Commissioner, we would be able to do it at a single point of time, so if we were looking at doing it for patients who are in the Forensic Hospital today, it would require some time to get that done manually but we would be able to provide it for that point in time.

CHAIR: When you say some time, what does that mean in day-to-day language?

MR FORREST: Realistically we could provide that data within a day.

CHAIR: Thank you.

DR MELLIFONT: Now, I just want to ask a question that is broader than the Forensic Hospital. Are you aware of any statewide or Commonwealth data that permits us, that is the Royal Commission, to ascertain the numbers of people with cognitive disability who are subject to forensic or mental health orders?

MR FORREST: I'm aware that we are able to provide that data. I'm not aware of whether there's any statewide or federal systems permitting to do that.

DR MELLIFONT: All right. So if I could just clarify that answer. Insofar as New South Wales is concerned, the Network could provide the data for New South Wales?

MR FORREST: That's correct. For the patients that are in the Forensic Hospital, we can provide that data.

5 DR MELLIFONT: What about for patients who are in the community but who have been the subject to forensic or mental health orders. Do you know if that data is kept anywhere?

MR FORREST: We would have high level data, I've seen that, that identifies the
10 distribution of patients, forensic patients across New South Wales. So I've got that high level data but I don't have anything that relates outside of the correction environment apart from that high level data.

DR MELLIFONT: Okay. And when you say "we", that is the Network?

15

MR FORREST: The Network, that's correct.

DR MELLIFONT: When you say high level data, what would that be?

20 MR FORREST: The report I see every month contains purely numbers on locations of forensic patients. It breaks it down by forensic patient, correctional patient and civil patient, and it gives me a record of who is sitting in the correction environment, who is sitting in the Forensic Hospital, who is in the medium secure facilities, in the local health districts, and who is sitting in other locations not covered by those areas.

25

DR MELLIFONT: Okay. Thank you. I want to just move on to another topic. Mr Forrest, have you been listening to the evidence thus far this week?

MR FORREST: I listened to the evidence on Tuesday and Wednesday, yes.

30

DR MELLIFONT: Thank you. So you would be aware one of the issues that has been discussed is the efficiency or otherwise of facilities to step down from the Forensic Hospital and/or move into the community.

35 MR FORREST: Yes.

DR MELLIFONT: And you will have heard already some opinions expressed that really, there is not enough step-down facilities, not enough services or systems in the community. Do you agree with that?

40

MR FORREST: Yes, I do.

DR MELLIFONT: Okay. What would you like to see?

45 MR FORREST: From my perspective I would like to see a better pathway for people with a disability who move through the criminal justice system come into the forensic mental health system and then move out into the community.

DR MELLIFONT: Okay. Well, let's break that down a little bit. If we can accept for the moment that there's not enough facilities for people to go from the Forensic Hospital into as a means of progressing through a pathway, that would indicate to you insufficient opportunities for those patients to therapeutically progress. Would you accept that as a proposition?

MR FORREST: Yes, I would.

DR MELLIFONT: Okay. And that in turn can also lead to frustrations for staff within the Forensic Hospital, that they're not able to assist the patient towards that path out because there's nowhere to go?

MR FORREST: That's my understanding, yes.

DR MELLIFONT: Okay. And if they're not getting out, then at the other end it might be that patients which are in correctional environments which really should be in a more therapeutic environment which is the intention of the Forensic Hospital, may not be able to get a bed. Is that your experience?

MR FORREST: That is correct, yes.

DR MELLIFONT: Okay. So then if we can turn back to the better pathways observation that you made before, what is it that you would like to see in terms of step-down facilities or services in the community so that you've got somewhere for the patients to progress to increase and improve their therapeutic paths?

MR FORREST: I would like to see patients who are sitting in the custodial environment, in the correctional environment being able to move quickly into a health-run facility that's able to provide the appropriate healthcare and rehabilitation. We do have 135 beds in the Forensic Hospital that's available to do that. However, the 135 beds are well occupied, usually about 90 to 92 per cent, and as a result of that we are unable to get patients out of the Forensic Hospital into medium secure beds because we go from 135 down to 75, 76 and then there's virtually no lower secure beds. So we've got our own patient flow issues which is limited by bed capacity. So increasing the amount of medium secure beds and increasing the amount of low secure beds will go a long way to assist patient flow.

DR MELLIFONT: All right. Now, I'll ask you to take that question partially on notice so that if there's anything else you think of after you give evidence today that you would like to see the systems take up in order to improve things, that we can have your thoughts on that, if you don't mind?

MR FORREST: Thank you.

CHAIR: Mr Forrest, can I ask a couple of questions about that. There seem to be two elements and I'm not sure whether you're addressing both. One is people with

cognitive disability who are in the prison system as such and for them there needs to be a pathway to the health system. And then there are people who are in the Forensic Hospital who need to go towards the lower security facility in the community. Were you talking about both of those?

5

MR FORREST: That's correct, Commissioner. Yes.

CHAIR: In terms of the suggestions you have made which, of course, have been the subject of at least references in the evidence, has there been any work, to your
10 knowledge, as to what would be the cost of improving the system in the way in which you have envisaged?

MR FORREST: The previous Minister for Mental Health made a commitment for $700 million worth of mental health infrastructure for a program to build such beds
15 and such facilities, so I'm aware that that announcement was made by the former Minister for Mental Health. I'm also aware that there is currently business cases being developed in order to increase the infrastructure using that $700 million commitment.

20 CHAIR: Is that $700 million exclusively for the kind of programs you've been referring to or does it deal with mental health issues more generally?

MR FORREST: It deals with mental health issues more generally, Commissioner, yes.

25

CHAIR: Are you aware of any component of that $700 million that is notionally, at least, to be directed towards the position of forensic patients or people in prison with cognitive disability who need healthcare?

30 MR FORREST: I can talk about my understanding of that funding allocation. The Network for Justice Health applied for funding to build an additional unit. The Commission would be aware of that, called Freshwater Unit, located within the grounds of the Forensic Hospital, and the funding for that new building is being taken from the $700 million mental health infrastructure program.

35

CHAIR: Is there is a timeline for the completion of that project?

MR FORREST: Yes, there is. The tender has been completed. We're just waiting for the announcement of the successful proponent and once the successful proponent
40 is announced we are hoping to turn soil pretty soon after that, and complete the building in the 21/22 financial year.

CHAIR: And how many additional beds or units will be available through that facility?

45

MR FORREST: It will be one unit and it will consist of five beds.

CHAIR: Thank you very much.

Yes, Dr Mellifont.

5 DR MELLIFONT: Thank you.

Now, I want to move on to the topic of seclusion. And it can be accepted, of course, that by the time you became Chief Executive in 2016, Melanie had already been in seclusion, so-called, for a number of years; correct?

10

MR FORREST: That's correct.

DR MELLIFONT: And so what you came into was a situation which was to some extent entrenched culturally by that stage?

15

MR FORREST: That's correct.

DR MELLIFONT: Okay. It's your view that the use of seclusion is not therapeutic?

20 MR FORREST: That is my view, yes.

DR MELLIFONT: And, more than that, that long-term seclusion is likely to be harmful to the patient?

25 MR FORREST: That's correct.

DR MELLIFONT: In fact, long-term seclusion makes just about everything you're trying to achieve with a patient more difficult, doesn't it?

30 MR FORREST: That's correct.

DR MELLIFONT: So it makes it harder for there to be an adjustment out of seclusion onto the ward, is that correct?

35 MR FORREST: That's correct.

DR MELLIFONT: It makes it harder for staff to engage in a cultural shift that seclusion should not be the norm?

40 MR FORREST: That's correct.

DR MELLIFONT: And it makes it harder for the patient to adjust and to move on down that pathway to therapy towards community?

45 MR FORREST: That's my understanding, yes.

DR MELLIFONT: Okay. So, really, this long-term seclusion has adverse impacts,

psychologically, socially, emotionally for patients?

MR FORREST: That's my understanding, yes.

5 DR MELLIFONT: Okay. And your understanding too is that seclusion is not, does not amount to the provision of evidence-based care to any patient?

MR FORREST: That's correct.

10 DR MELLIFONT: Now, the hospital has at all relevant times for this case study operated under legislation which requires that the restriction on the liberty of the patient be kept at a minimum necessary in the circumstances. That's your understanding as to the legislative regime the hospital is to work under?

15 MR FORREST: If you're referring to the *Mental Health Act* and *Mental Health (Forensic Provisions) Act*, yes, that's my understanding.

DR MELLIFONT: It's referring to section 68(f) of the New South Wales *Mental Health Act* so I think we're in agreement.

20

MR FORREST: Right, thank you.

DR MELLIFONT: Okay. And so it is, therefore, that at relevant times New South Wales has had a mental health seclusion and restraint in NSW Health settings ---
25 different versions over time, but the essence of which speaks to seclusion being used only as a last resort to prevent serious harm? That's your understanding of the policy?

MR FORREST: That's my understanding, yes.

30

DR MELLIFONT: Usually associated with acute severe behavioural disturbance which itself is defined as behaviour that puts the person or others at immediate risk of serious harm. That's your understanding of the interplay?

35 MR FORREST: That's my understanding, yes.

DR MELLIFONT: Okay. And so the policy provides, doesn't it, that there must be the development of a service level action plan to reduce and, where possible, prevent seclusion and restraint? That's to be in collaboration with staff, people accessing
40 services, carers and family. That's your understanding?

MR FORREST: That's my understanding, yes.

DR MELLIFONT: And also the policy requires that it must be ensured that there are
45 adequate staff numbers, peer support, and an appropriate skill mix to maintain a safe workplace for people accessing services, staff and others. That's your understanding of the policy?

MR FORREST: That's correct, that is my understanding.

DR MELLIFONT: And it would also be your understanding that a patient like Melanie has complex needs and requires staff who are appropriately skilled and trained in order to work with her for her benefit?

MR FORREST: That's my understanding, yes.

DR MELLIFONT: Okay. Mr Forrest, I just want to get a sense of how hands-on or direct your knowledge is with respect to Melanie because I do appreciate, of course, that as the Chief Executive of the Network you have 37 correctional centres, 7 police cells, 6 youth justice centres, 37 local and children's courts, 2 transitional centres and 2 hospitals, including the Forensic Hospital, under your area of control, as it were?

MR FORREST: That's correct.

DR MELLIFONT: Okay. So I take it from your statement that you became aware of Melanie's extended seclusion shortly after you became the Chief Executive Officer in 2016?

MR FORREST: That's correct.

DR MELLIFONT: Okay. And insofar as your knowledge at that point in time, was that a matter of being briefed by those within the Network to you as to what the circumstance was?

MR FORREST: I was aware of Melanie's circumstances following a discussion with the then Executive Director, so that's how I became aware of the situation.

DR MELLIFONT: Okay. And so in your statement you speak of barriers, challenges, what's happening with respect to Melanie, et cetera, et cetera. Is that information as via briefings from staff members to you?

MR FORREST: No. I was certainly made aware of Melanie's situation not long after I commenced in 2016 as Chief Executive, but as a result of my concerns about the use of long-term seclusion I commissioned a series of reviews to have a look at what the situation was and what might be possible solutions to move us towards a better situation for Melanie.

DR MELLIFONT: All right. So let me take you to that. Certainly when you started in that role, you thought at that stage that continued and permanent living in seclusion was not acceptable for Melanie? Is that correct?

MR FORREST: Yes, it is.

DR MELLIFONT: Did you go and visit the unit in which she was being held, kept?

MR FORREST: Not specifically to the area where Melanie was kept. I certainly visited the Forensic Hospital and I was able to view a seclusion room but it was not the same one that Melanie was in.

5

DR MELLIFONT: Can I ask you if you've ever gone to inspect the rooms that Melanie has been kept in, in seclusion for all of these years?

MR FORREST: Yes. The first time I visited the rooms where Melanie was being
10 held was with members of the Royal Commission when they came to do a site visit.

DR MELLIFONT: Okay. So I think that was 2020 --- March 2020?

MR FORREST: That's correct.

15

DR MELLIFONT: Approximately. Okay. So that was the first time you'd seen it?

MR FORREST: Seen the actual room, yes. As I mentioned, I had seen the other seclusion rooms.

20

DR MELLIFONT: Okay. Were you surprised by what you saw in that inspection?

MR FORREST: I was not pleased. You know, for somebody to be living in confinement for that period of time, it did cause me great concern.

25

DR MELLIFONT: In terms of what you actually physically saw on that day, that would have caused you a great deal of disappointment and upset, I take it?

MR FORREST: Yes, you're correct. Those seclusion rooms are designed for
30 short-term use. They're not designed for long-term seclusion.

DR MELLIFONT: And in fact what had happened within the Forensic Hospital was that those seclusion rooms were regarded as [Melanie's] rooms, with no actual room on the ward for [Melanie] to go to if she were to come out ---

35

CHAIR: I think the reference should be to Melanie.

DR MELLIFONT: My sincere apologies. I'm so sorry. Hopefully they caught that on the feed.

40

They were regarded culturally as Melanie's rooms, is that right?

MR FORREST: That's my understanding, yes.

45 DR MELLIFONT: With no other room on the ward kept for Melanie for when she comes out of seclusion as her own room. That's your understanding?

MR FORREST: That's my understanding, yes.

DR MELLIFONT: Yes, so the circumstance which was pertaining was not one of Melanie going into seclusion as a means of last resort, but of the default position of her being in seclusion as though it were normal. Is that your understanding of what was going on?

MR FORREST: I agree that the practice of having Melanie in long-term seclusion was treated as normal, and it certainly shouldn't have been.

DR MELLIFONT: No. And in fact I think you accept in your statement that she ought to have been moved out of seclusion earlier than she was; correct?

MR FORREST: That's correct.

DR MELLIFONT: How much earlier, Mr Forrest?

MR FORREST: I can only talk about the time that I've been Chief Executive, so from 2016. There were multiple factors that were complicating the ability to be able to get Melanie out of seclusion, so the idea would have been to do it right at that point in time. But it was a complex situation for both staff culture, as well as staff safety, and all of that needed to be addressed before we could get Melanie out of seclusion.

DR MELLIFONT: Well, let's break that down a little bit. Your view is, coming in in 2016, the situation should never have got to where it was?

MR FORREST: That's correct.

DR MELLIFONT: And your view, coming in in 2016, was it needed to stop?

MR FORREST: Yes.

DR MELLIFONT: And it needed to be stopped as soon as possible?

MR FORREST: That's correct.

DR MELLIFONT: Now I'm going to come back to some of the reasons later, I'm not dismissing what you said, and I'll come back to them, I promise. What I want to do please is take you to paragraph 11 of your statement, so this is STAT.0310.0001.0001 at page 2 of that, so 0002. And I want to take you to paragraph 11, please. Just let me know when you've got that. I see it's coming up on the screen.

MR FORREST: Thanks, Ms Mellifont, I've got that.

DR MELLIFONT: Thank you. What I want to explore with you, Mr Forrest, are

these words, the second sentence:

5 *Following discussions within the Network, a plan to manage seclusion in a more contemporary setting was prepared, which included consideration of building the Freshwater facility."*

What I read from that is that the plan at that point wasn't to eliminate seclusion, but rather to manage it, but just in a more contemporary setting. Was that in fact the position at that time?

10

MR FORREST: No, that's not the position at the time. "Manage seclusion in a more contemporary setting", what I'd meant by that point was to create an environment where seclusion, restrictive practices were reduced and possibly eliminated, and that's when the concept of Freshwater unit became a point of conversation. The idea
15 behind that unit would be that the seclusion was used as minimally as possible because the design of the facility would permit that.

DR MELLIFONT: And how would the design of the facility permit that?

20 MR FORREST: The unit was built so that patients could be managed in larger areas and be able to interface with staff, that the staff had a safety zone to go to should they need to, without necessarily applying seclusion, allow the patient to self-regulate and hopefully avoid the seclusion incident. If seclusion was needed to be applied, if the situation couldn't be managed by other means, then the facility would allow for
25 seclusion to be applied and the seclusion to be maintained for the minimum amount of time required.

DR MELLIFONT: Okay. And I may have missed something before but Freshwater has been shelved, is that right?

30

MR FORREST: No, that's not correct.

DR MELLIFONT: It's going ahead still?

35 MR FORREST: Yes, that's correct.

DR MELLIFONT: All right.

CHAIR: Just to be clear, Freshwater is the facility where you've talked about where
40 the first sod is about to be turned and going to come into existence some time in 2021/2022?

MR FORREST: That's correct, yes.

45 CHAIR: It does take some time for these ideas to come to fruition, doesn't it?

MR FORREST: Unfortunately, Commissioner, that is the case. We are almost there

and it's very good news.

DR MELLIFONT: So if I can reframe my question. At that point of time Freshwater was being considered as a possibility for Melanie, but now currently, I take it the aim is to get her into the community through NDIS-funded projects together with that governance group and Public Guardian?

MR FORREST: That's correct. In 2016 when I was discussing this idea with the team, the thoughts behind Freshwater unit was that it would be a facility where we could take patients who were subject to long-term seclusion and reduce the duration and occurrences of seclusion use. Over time, that concept has changed and it's changed as a result of progress that Melanie has had within the Forensic Hospital and to essentially regress Melanie's care pathway back to a unit which is no longer fit for purpose for her would be a backward step.

That doesn't mean that, you know, should Melanie require the use of the unit once it's built, that will be a conversation that we have at the time. But the unit now will provide more restriction for Melanie, and that's not where we want to go. As you mentioned, the pathway at this point is to plan to get Melanie into the community.

DR MELLIFONT: Okay. Thank you. I want to take you to a document.

Commissioners, this won't be shown up on screen, it's not redacted but Mr Forrest's legal representatives have been made aware I will be going to this document.

It's a risk assessment, Mr Forrest, and it's dated 23 September 2020. Its document ID number is NSW.0041.0012.0001. Perhaps, Mr Forrest, if those assisting you could give you that document --- take it down, please, off the screen. Take it down, please, off the screen. Thank you.

Can you let me know when you've got that, Mr Forrest.

MR FORREST: Yes. I have the document in front of me, thank you.

DR MELLIFONT: Okay. So I see from the front page it's 23 September 2020 and I note in fairness it's possible that this is a draft because you will see there's a comment box on page 3. Is this a document that you had input into?

MR FORREST: No, it's not.

DR MELLIFONT: Is it a document that you've seen before?

MR FORREST: It is a document that I have seen before. It is a clinical document and it's completed by clinicians rather than myself.

DR MELLIFONT: Okay. I'm going to read a part to you at page 3 in the bottom row. I'm going to ask you if you can help me know what it means and I will be

careful to use Melanie's name. So in the row headed "Team Approach", it has been identified as "Inconsistent approach will increase risk." And then there's an "Agreed Controls" column, and it says:

5 *Implementation of an initial consistent team to assist Melanie with the re-integration process and develop interpersonal skills, with a planned disintegration of the consistent team by February.*

What's a planned disintegration?

10

MR FORREST: Ms Mellifont, I'm not involved in direct patient care so I'm not able to answer that question. I would like to say, though, that the outcome of having an established team to care for Melanie has certainly demonstrated good results, I --- would have kept Melanie out of seclusion since 13 November 2020, and so from my
15 position, I would be hesitant to change something like that without a proper evaluation.

DR MELLIFONT: Okay. And kept Melanie out of seclusion save for a couple of occasions, though? She has been back in seclusion for a couple of occasions of
20 limited duration?

MR FORREST: That's correct. Twice and short durations, that's right.

DR MELLIFONT: Okay. One of 75 minutes, I think the other of about 12 hours. Is
25 that roughly your understanding?

MR FORREST: That is my understanding, yes.

DR MELLIFONT: All right, well, can we take these words in the abstract and from
30 your experience working within the Network, what do you think "planned disintegration of the consistent team" would mean?

MR FORREST: To be honest, I don't know what the team was talking about there. As I mentioned, I'm not a clinician and I am not involved in these levels of
35 discussion. I can certainly say there was a requirement based on all of the changes around safety culture to undertake safety risk assessments, so I'm aware that was happening, but the level of detail in this document I'm not aware of.

DR MELLIFONT: Okay, but that terminology of "planned disintegration of
40 consistent team" is not something you are used to seeing?

MR FORREST: No, that's correct.

DR MELLIFONT: Right. Can I take you back, please, to paragraph 14b of your
45 first statement. I want to clarify the current staffing. At 14b you say the current staffing level for Melanie is three on a morning shift, three on an afternoon shift and two overnight. I want to clarify that. As you set out in the transition plan which

you've also referred to in your statement at page 8, that the three in the morning and the afternoon is actually two people working directly with Melanie and one staff member attending to documentation, medication, et cetera, and available to help manage staff breaks?

5

MR FORREST: That's my understanding. That's correct ---

DR MELLIFONT: Melanie --- I'm sorry, I didn't mean to cut you off. So Melanie is not being specialed by three people all the time, she has got two people with her all
10 the time?

MR FORREST: That's correct. She has two people directly with her, and she's got a third person allocated for her change in staff and documentation, medication.

15 DR MELLIFONT: Thank you. Now, can I take you please to paragraph 18 of your statement. See if you can help me get clarity around that. Paragraph 18, you say that:

.... the Network has developed a positive behaviour support plan ....

20

In consultation with SAL Consulting. Now, SAL Consulting has been around for a while with respect to Melanie's case, is that correct?

MR FORREST: That's correct.

25

DR MELLIFONT: So who is the Network there?

MR FORREST: The Network is Justice Health and Forensic Mental Health Network, so that's the shortened term we refer to for the organisation.

30

DR MELLIFONT: A badly asked question. So is it somebody from the Forensic Hospital?

MR FORREST: So, yes, I was about to explain, that it's referred to as the Network
35 because there are staff from the Forensic Hospital, but there is also a representation from the broader Network on that group.

DR MELLIFONT: From where?

40 MR FORREST: It's our Executive Director (Clinical Operations).

DR MELLIFONT: Okay.

MR FORREST: So that position doesn't sit in the Forensic Hospital, that position
45 has statewide responsibility as well.

DR MELLIFONT: Okay, so it's your ED of Clinical Operations, and then it's staff

within the Forensic Hospital who were working with SAL Consulting for the positive behavioural support plan, is that your understanding?

MR FORREST: That's my understanding, yes.

5

DR MELLIFONT: As to the specifics of who within the Forensic Hospital, am I best to ask that of Dr Ellis?

MR FORREST: Again, that would be a question for somebody else. I'm aware of
10 the high level detail, I'm aware of the engagement with SAL Consulting, I'm aware of this group and the (inaudible) group, I don't have the detail.

DR MELLIFONT: I will come back to it with Dr Ellis, but I will see if I can get a little bit more clarity around a couple of other things whilst I'm on it, though.

15

I just want to get an understanding as to whether it is a complete plan or a partial plan. The reason I want to ask you that is, if you look at the transition plan at paragraph 21 of your statement, it speaks of a partial draft behavioural support plan being completed by SAL and you will see that at page 8 of the statement in the
20 second row. And it says:

Feedback being provided for Forensic Hospital staff.

And the document is currently being adapted to suit Forensic Hospital and
25 environmental needs.

So can you help me with this. Did SAL prepare the draft and the Forensic Hospital providing the feedback? Is that the way it's worked?

30 MR FORREST: Again, I'm sorry, I'm not able to answer that level of detail. That would be best directed to somebody who is sitting on that group or somebody who is working as a clinician in the hospital.

DR MELLIFONT: Okay. And has there been any discussion with you about how
35 that behavioural plan would be adapted to suit the Forensic Hospital staff and environmental needs or environment needs?

MR FORREST: No, there hasn't.

40 CHAIR: Mr Forrest, do you know whether there is a behaviour support plan actually in force as of today?

MR FORREST: The information that I've got, Commissioner, was that the plan was being developed. Again, I don't have the level of detail about whether that plan has
45 been finalised.

CHAIR: So we will need to find out from your colleague as to whether the plan has

in fact been finalised and implemented or is still in the process of development? Is that right?

MR FORREST: Yes, I'm not the best person to answer that question, Commissioner.

CHAIR: No, that's all right. I just wanted to know where we can get the information from.

DR MELLIFONT: Thank you, Chair. We will try with Dr Ellis, although I'm sure Ms Furness will be able to assist me with another person's name. All right. Can I take you then please to paragraph 19 of your statement. Going back a bit now, sorry. Now, we've already discussed the governance group. So to progress Melanie's goals moving into the community, staff from the Network and the Forensic Hospital are members of the Highly Complex Housing Pathway Governance Group; correct?

MR FORREST: That is correct.

DR MELLIFONT: Okay. Now, when you say at paragraph 19 that:

> *While the Forensic Hospital will provide transition of care support for Melanie and it does not provide ongoing care outside the hospital ....*

What do you mean by "the transition of care support"?

MR FORREST: My understanding of this, and again a caveat that I'm not a clinician and I'm not involved in this group, what I've been advised is that in order to assist with integration into the community, there will need to be some handover that occurs and some assistance provided by staff in the Forensic Hospital to wherever Melanie is likely to go and whoever is assuming responsibility for her care, so that there's a period of handover, and so that's what my understanding of that context is meant to be.

DR MELLIFONT: Okay. And so who are you receiving these briefings from about the current position?

MR FORREST: There's a management structure that sits underneath me, so if I may take you to the local managers that sit in the Forensic Hospital, those local managers report up to the two leads. One's a medical lead and one's a clinical lead, and those positions work in the Forensic Hospital. I also have two co-directors. One's a medical co-director and one's a clinical co-director, and they service the Forensic Mental Health Network across Justice Health and Forensic Mental Health Network, so it's much bigger than just the Forensic Hospital. Sitting over the top of that person is the Executive Director (Clinical Operations), and that person reports to me. So communication is up through that management hierarchy.

DR MELLIFONT: Okay, and it's the ED that briefs you ultimately on these things?

MR FORREST: Yes. And I also have monthly meetings with the Executive Director (Clinical Operations) and the Co-Director, Forensic Mental Health (Medical).

5 DR MELLIFONT: Okay. Thank you. All right. Now, can I take you to page 6 of your statement. Again this is referencing the transition plan, under the heading "Connection to Culture and Community".

It sets out that the social worker and Aboriginal Mental Health Assistant --- I might
10 just start that again.

> *[The] Social Worker and the Aboriginal Mental Health Assistant .... are trying to identify Melanie's family and kin cultural connections.*

15 We've heard some evidence earlier this week, both from Dr Riordan, I won't go into the details, and from Ms Osborne about some of that. To your knowledge, when did such cultural work commence?

MR FORREST: The cultural work started when we employed --- so when the
20 Network employed the Aboriginal mental health practitioners. So we currently have 1.8 full-time equivalent funded positions for Aboriginal mental health practitioners. We have two people occupying that 1.8 FTE, and there's a vacancy currently of 0.4 FTE. So those people were employed specifically to provide Aboriginal mental health and cultural support within the Forensic Hospital of which Melanie would
25 have that available to her, and then I'm aware, through advice from others, that the engagement with Melanie around her culture, her Aboriginal heritage has commenced on a more regular basis now that she's out of seclusion.

DR MELLIFONT: Okay. So the 1.8 FTE is for the Forensic Hospital?

30

MR FORREST: Just for --- yes, just for the Forensic Hospital, that's correct.

DR MELLIFONT: Okay. I might just have to get you to slow down a little bit in your answers, Mr Forrest, to assist the interpreters and I will slow my rate of speech
35 as well.

Is it your understanding that the Aboriginal mental health assistant started about just five months ago? Do I have that right?

40 MR FORREST: Yes, that would be correct.

DR MELLIFONT: Okay. And so was there any work done with respect to the family and kin and cultural connections and Melanie's cultural identity prior to her starting?

45

MR FORREST: Unfortunately I'm not able to answer that, again, I think that's a clinical question. I do have oversight of positions within the Forensic Hospital of

which the Aboriginal mental health worker is part of that. But as for the further clinical interactions around culture, Aboriginality, I'm not the best person to ask.

DR MELLIFONT: All right. Thank you. Can I take you though over to the transition plan for the allied health and other therapy supports. Now, are you aware generally that Melanie has a love of animals?

MR FORREST: Yes, I am aware of that.

DR MELLIFONT: And that she has in the past had the opportunity to have some pet therapy?

MR FORREST: Yes, that's correct.

DR MELLIFONT: And that she reportedly responded quite positively to that pet therapy?

MR FORREST: That's my understanding, yes.

DR MELLIFONT: So what we have in this plan, it says that pet therapy was suspended during COVID. Do you know that to be the reason?

MR FORREST: That's my understanding. Prior to coming to the appearance today I did seek some further information. There was suspension of all people coming into secure settings as a result of COVID-19 throughout 2020, the adult, youth justice correctional centres, the Forensic Hospital residential aged care facilities, so Justice Health, the Network, complied with NSW Health's direction on that, and as a result of that, visitors to the Forensic Hospital were ceased for a period of time. That did affect the dog therapy.

I made some further inquiries now that we're into 2021 and we need to get back to business as usual, and unfortunately the person who was coming with the dog has moved interstate, so we are currently trying to source another provider.

DR MELLIFONT: All right. Thank you. Can you help me out with this sentence:

Request for NDIS funding for ongoing therapy when in the community

So under this transition plan, is it the guardian who is going to make that request?

MR FORREST: I'm not able to answer that, I'm sorry. That would be a better question for a clinician.

DR MELLIFONT: All right. But is it your understanding that the Network wouldn't be the people who make the request for NDIS funding for people in the community?

MR FORREST: Yes, that's correct. The Network will fund services in the Forensic

Hospital, so once a patient leaves the Forensic Hospital the responsibility of funding will fall to another body.

DR MELLIFONT: All right, thank you. I'm almost past the transition plan, I just
5 need to check a couple more things.

You see also under that heading of "Allied therapy and other Therapy Supports":

> *Exercise Physiology --- Request for NDIS funding, provided through the public*
10 *hospital system.*
> *Speech pathology --- Request for NDIS funding*

Do you take that to be for when she's in the community?

15 MR FORREST: That would be my understanding. The Network will provide funding for healthcare while Melanie's in the hospital. There are obviously core services that we fund and there might be some bespoke services that we don't fund, and we would need to consider whether we would be able to provide them within our existing budget. Certainly when Melanie goes to the community, the expectation
20 would be that the Network doesn't fund for community services.

DR MELLIFONT: Okay. So it's my understanding from Dr Ellis' statement that you certainly have a physiotherapy --- or physiotherapist or physiotherapists within the staff of the Forensic Hospital?

25

MR FORREST: That's correct.

DR MELLIFONT: So one would expect, in the course of her time at the Forensic Hospital, she would get access to the physiotherapist without having to involve
30 NDIS, is that a correct assumption?

MR FORREST: That's correct, so again it falls into that direct responsibility for healthcare, and that would be paid for by Health, so paid for by the Network.

35 DR MELLIFONT: Now I can't spot a speech pathologist in Dr Ellis' list, you may well have one, but again, is that something you would expect would be but would that be provided within Forensic Health funding without engaging with NDIS?

MR FORREST: The speech pathologist is not part of our core funding. Should we
40 have a patient anywhere within Justice Health and Forensic Mental Health Network who requires access to a speech pathologist, we would make those arrangements with the Local Health District as an external medical appointment. Again, patients in the Forensic Hospital would have access to that. More recently we have some funding under a different budget stream for speech pathology for another part, but it is not
45 with the Forensic Hospital.

DR MELLIFONT: Okay. But you don't need to go to the NDIS to get a speech

pathologist for an in-house patient?

MR FORREST: No, that's correct.

5 DR MELLIFONT: Okay. Thank you. So I want to take you to, please, more recent times. That is, towards the end of last year and this year. So you're aware that Melanie came out of seclusion on the 13 November 2020?

MR FORREST: Yes, I am.

10

DR MELLIFONT: Okay. And so she's on the autism sub-acute ward and has been since that date?

MR FORREST: That's correct.

15

DR MELLIFONT: Okay. And although things haven't been perfect, things are going unexpectedly well with that transition. Would that be a fair description?

MR FORREST: I would agree with you, yes.

20

DR MELLIFONT: Okay. Now, had it not been for the fracture of Melanie's foot on the 8 November 2020, it's fair to say that she probably would still be in seclusion at this juncture, but perhaps with just a little bit more time out, is that correct?

25 MR FORREST: My perspective on that situation is that I believe the fractured foot, while it did play a role, it wasn't one of the most significant factors that contributed to Melanie coming out of seclusion on 13 November 2020.

DR MELLIFONT: Why?

30

MR FORREST: There were several key drivers behind that. The first one was the work that Melanie has done in her recovery journey. I don't think that you can underestimate the amount of effort that she's put in herself to actively rehabilitate. The support that has been provided by the core team that has been established was 35 instrumental in getting Melanie out of seclusion, so I would say that that has been the biggest external contributing factor. And underpinning all of that is the work that has been done around workplace culture and staff safety, and we couldn't have done it without laying those foundations.

40 DR MELLIFONT: I will come back to some of that in a moment, but by that analysis, she really ought to have been out of seclusion, planned to be out of seclusion by November anyway?

MR FORREST: I wouldn't be able to put a date on it. I have mentioned in my 45 statement that it wasn't going to be an overnight fix. We were dealing with quite complicated dynamics in order to get Melanie out, and we needed to address all of those complex dynamics before we were even in a position to be able to have

Melanie out of seclusion.

DR MELLIFONT: Let's explore that just a bit more. Now, you should have with you a document --- and again, please do not display this on the screen, it has not been redacted.

Commissioners, you should probably have a hard copy from your Associates. It's a Seclusion Reduction Plan. I will read the document ID into the record but don't display it. NSW.0041.0011.0001.

Do you have that document, Mr Forrest?

MR FORREST: I do. Yes, thank you.

DR MELLIFONT: Now, it is itself undated but it would appear from its contents that its first iteration was probably earlier than 28 September 2020 because you will see item number 1 and the word "break down" has a start date of that date. And we received some information through the Crown Solicitors that it might be --- this version might be on or about October 2020 and I will be corrected if I'm wrong about that. That's just to orient you in terms of time.

MR FORREST: Yes, I can see that.

DR MELLIFONT: Okay. Is this a document you've had input into?

MR FORREST: No, it's not. The first time I had read the details was in the Tender Bundle.

DR MELLIFONT: Okay. So what I want to show you then, is the second page which is NSW.0041.0011.0003 --- again, keep it off the screen, please --- and you will see that the objectives there, see towards the bottom of the page, the objective in terms of seclusion was to increase Melanie's time out of seclusion by at least 25 per cent by 28 February 2021.

You see that?

MR FORREST: Yes, I can.

DR MELLIFONT: Okay, so you can see what's in contemplation by the authors of this document is that even in two weeks' time she would still be in seclusion albeit hopefully getting time out of at least 25 per cent more? You accept that's a fair reading of the document?

MR FORREST: Yes, I accept that that's the reading of the document.

DR MELLIFONT: Okay.

CHAIR: You mean two weeks from today, not two weeks from the date of the document?

DR MELLIFONT: Yes, I do, I'm sorry if I said it the other way. Okay.

So whatever the cultural changes were --- we will come back to that --- within the Hospital themselves they still didn't believe, as at the date of that document, that she could come out of seclusion and certainly not out of seclusion completely by the end of this month? You agree that's a fair reading so far?

MR FORREST: That would appear so from the document, yes.

DR MELLIFONT: Okay. And so what I want to take you back to is this proposition, that the real reason that Melanie has ended up on the ward is because of the foot fracture. So let me take you through a couple of propositions. I don't want this displayed but I want to read it into the record. A Forensic Hospital Consultation Form dated 11 November 2020, which is NSW.00041.0004.0001, reveals these words:

> *.... recent changes in her physical health and ability to care for self independently have changed her risks and she no longer meets the criteria to be legally nursed in seclusion. Her risks of physical aggression towards others has reduced due to mobility issues.*

Now, having heard that, do you accept that within the Hospital the reason she was moved was because of the foot fracture?

MR FORREST: I'm not going to comment as a clinician. What I would say, and remembering what I said before about what I believed to be the key factors for getting Melanie out of seclusion, with respect to the foot fracture, there is a balance between risk taking, calculated risk taking and making sure that you maintain safety of the patient and the staff. And so I believe that the foot fracture at that point reduced the risk that taking Melanie out of seclusion presented, and it also permitted a much safer environment to do so.

So I accept that that risk versus safety balance was in the right direction related to Melanie's fractured foot, but, as I prefaced, there were a lot of other factors that I would see as being significant contributors.

DR MELLIFONT: Right.

CHAIR: Was one of them the interest of the Royal Commission in Melanie's case?

MR FORREST: Commissioner, I had taken up the cause of, you know, getting Melanie out of long-term seclusion in 2016 and I think that dated --- predated the Commission getting established.

CHAIR: I wanted to ask you about that. Melanie came out of seclusion in November 2020. But she was in seclusion, was she not, from November 2016 to November 2020?

MR FORREST: That's correct.

CHAIR: During that four-year period or thereabouts, did you form the view that this was the least restriction on her liberty, consistent with her human rights and so forth?

MR FORREST: No, Commissioner, I've said in my statement I did not believe having Melanie in long-term seclusion was appropriate and from 2016, certainly through the middle of 2017, I implemented a series of reviews into the restrictive practices in the hospital, the safety culture and also the model of care. And through those reviews it gave me a very clear idea about what the constant themes were that needed to be addressed in order to reach the point where we don't have anybody in long-term seclusion.

CHAIR: But it took in Melanie's case four years for this to happen?

MR FORREST: Yes, Commissioner, I absolutely accept that. And within my statement you will read that there were complicated dynamics, most of which staff were quite fearful of Melanie and also the situation and to address that fear through a culture change and a change in safety practices, that does take a significant amount of time. We did get one of the consultants to come back who completed the review in 2017. That consultant came back and did another review in 2019 and commented quite favourably on the considerable culture shift that had been undertaken within such a short period of time in two years. So the consultant recognised that it was a significant period and we were successful.

CHAIR: For whatever reason, you agree, I take it, on the basis of your evidence, that the restriction and the liberty of Melanie was not kept to the minimum necessary in the circumstances during the four-year period?

MR FORREST: I would agree with that, yes.

CHAIR: I'm not asking you to give a legal opinion but that does raise an issue, does it not, as to whether her seclusion was lawful?

MR FORREST: Sorry, Commissioner, are you asking me for my personal opinion on that?

CHAIR: I'm asking you whether you think there's an issue as to whether it was lawful.

MR FORREST: I do believe, yes --- I believe that the policy which links to legislation was not being applied correctly.

CHAIR: Which leads me to another question --- and I'm sorry, Dr Mellifont, there are some things that I would like to have clarified --- the policy currently in force, as I understand it, is one that is dated 2020 some time. Is that right?

5 MR FORREST: That's my understanding, yes.

CHAIR: It's the Seclusion and Restraint in New South Wales Settings dated 6 March 2020. The previous policy was 2012. Is that your understanding?

10 MR FORREST: Yes. That's correct, Commissioner.

CHAIR: Both policies are expressed to be or were expressed to be mandatory. Is that right?

15 MR FORREST: That's correct.

CHAIR: What's your understanding of "mandatory" in terms of --- mandatory in what sense?

20 MR FORREST: Mandatory means it must be complied with.

CHAIR: As a matter of law?

MR FORREST: I'm not a lawyer.

25

MS FURNESS: I apologise for interrupting. The witness is not a lawyer ---

CHAIR: I understand that but I'm asking his understanding, thank you.

30 In your understanding as a matter of law?

MR FORREST: I wouldn't comment as a matter of law. What I would comment on is the policy compliance perspective, and I would say that policy was not being complied with.

35

CHAIR: Thank you. Both documents require data to be kept on the number of people in seclusion. Was that done, as far as you're aware, from 2016?

MR FORREST: My understanding is that yes it was.

40

CHAIR: And is that material available?

MR FORREST: It hasn't been provided through my statements so I would need to check whether we tendered that into evidence.

45

CHAIR: That would require the same manual calculations as the earlier material to which you referred?

MR FORREST: That's correct, yes.

CHAIR: But you should be able to find out how many people in fact have been in
5 seclusion during the relevant period?

MR FORREST: That's correct.

CHAIR: Do you have any idea of how many were in fact in seclusion at the time
10 you commenced your duties in 2016?

MR FORREST: My understanding at that time is I was advised that we had two females in long-term seclusion, and there was one other male that I'm aware of that was subject to seclusion for multiple days, which I would consider excessive.
15

CHAIR: Thank you very much. Yes, Dr Mellifont.

DR MELLIFONT: Thank you.

20 I want to take you to your observation in respect of the 2019 report, and this is the one referred to in paragraph 37 of your first statement, I take it?

MR FORREST: That's correct, yes. Point 37.

25 DR MELLIFONT: Thank you. You would agree with me that the focus of the 2019 report was about staff satisfaction?

MR FORREST: That wasn't my understanding. That review, which was the third review that I commissioned, was looking at staff culture and safety systems and
30 practices, not staff satisfaction.

DR MELLIFONT: All right. Well, what I'm going to suggest to you is that in contrast to the 2017 Consultation Report which included consultation with a Clinical Director, two NUMs, three medicals, two clinical nurse consultants, eight registered
35 nurses, one mental healthcare worker, three allied health, one security, et cetera, that the 2019 consultation for the report did not involve consultation with frontline staff such as clinical nurse co-ordinators, registered nurses, mental healthcare workers or security. Do you agree with that?

40 MR FORREST: Yes, I do.

DR MELLIFONT: And do you agree that the Clinical Director and the Medical Director apparently didn't participate in that consultation either?

45 MR FORREST: I wasn't aware of that, no.

DR MELLIFONT: So, insofar as reliance upon it as being evidence of significant

cultural change, you would want to exercise a fair degree of caution in forming that view as a manager, given the absence of consultation with frontline staff, wouldn't you?

5 MR FORREST: I would take the 2019 report as being part of a broader picture of organisational or Forensic Hospital staff culture change. It was one aspect that I had the opportunity to review but it wasn't the only thing which was available that would have demonstrated improvements in staff culture.

10 DR MELLIFONT: Okay. So just returning to my question, you would want to be a bit careful about that report in and of itself being used as an indicator of cultural change when it didn't involve frontline staff?

MR FORREST: That's correct, yes.

15

DR MELLIFONT: I take it, Mr Forrest, you would certainly agree that culture of the workplace, culture of the staff, culture of the leadership team is absolutely critical for the proper functioning of a health facility, whether it be a forensic health facility or otherwise?

20

MR FORREST: Yes, I would agree with you.

DR MELLIFONT: Can you just give me a minute. I've managed to secretly hide my notes. Here we go.

25

Now, nobody is suggesting, Mr Forrest, that the circumstances were without complexity at the Forensic Hospital. We've heard evidence from other witnesses of a culture of fear within the staff. We've heard issues about staffing levels, et cetera. So we are not approaching this in a vacuum. But the reality was that for a period of
30 time, even though the consulting psychiatrist was saying that seclusion was not clinically indicated or warranted, Melanie was kept in seclusion. Is that right?

MR FORREST: Yes, I accept that as a true statement.

35 DR MELLIFONT: Okay. And it is also correct to say that there were no specific complaints or statements by the Midwives Association about Melanie specifically? We see that in the statement of Dr Ellis at paragraph 74.

MR FORREST: Not that I'm aware of, no.

40

DR MELLIFONT: Okay. And you've indicated that they were making statements about injuries for the nurses. In your statement we see that.

But even with those things, even with those complexities, when you've got a person
45 who has been in seclusion for that long and things weren't moving, wasn't it incumbent to find a circuit breaker, as perhaps Professor Ogloff suggests, try to find somewhere else for the patient or some other means? Was it incumbent upon the

Hospital and the Network to get that circuit breaker and get it earlier?

MR FORREST: My perspective on this, as you've mentioned, we're dealing with complicated dynamics, and as I put in my statement there's not going to be one single cure, not one single strategy. It is such a complicated dynamic when you're addressing fear and staff safety, which was on the back of staff injury, that I was looking for something that was sustainable in the long-term. And in order to reach that point, it was going to take a period of time in which to put all of those strategies in place. So we've ended up in a situation where hopefully that effort is maintained and we don't have anybody going back into long-term seclusion.

DR MELLIFONT: Was there somewhere else that Melanie could have been sent to for her care?

MR FORREST: From my understanding, no.

DR MELLIFONT: Sitting there now, is there anything you would have done differently?

MR FORREST: As I mentioned, it has been a complicated dynamic. I would have liked to not have significant pressures on getting a solution to hand sooner. There were complicated dynamics with the industrial association, and with SafeWork New South Wales, that I believe that if we'd worked in partnership with those agencies it would have assisted us to get to a position sooner. So I think there's always, you know, things to learn from, you know, the plan that you put in place. There's certainly some things that have been quite successful and I think, you know, continuing to leverage on those and perhaps introducing them earlier than what we did, that might have, you know, shortened the timeframe and been a better way to go.

DR MELLIFONT: Can I ask you if you would like to take that question on notice for further consideration. You may or may not wish to, but there might be some things you think about in the quiet that you would like to share with the Commission about things that you think ought to have been done differently? I'll leave that with you.

MR FORREST: Yes.

DR MELLIFONT: Commissioners, I have no further questions.

CHAIR: Thank you very much, Dr Mellifont.

Mr Forrest, before asking any other Counsel whether they have any questions of you, I will ask the Commissioners whether they have any questions.

First, Commissioner Mason in Brisbane.

COMMISSIONER MASON: No, thank you.

CHAIR: Commissioner Atkinson.

5 **QUESTIONS BY THE COMMISSION**

COMMISSIONER ATKINSON: I do have a question because I find the use of the word "seclusion" misleading. It's similar to solitary confinement?

10

MR FORREST: Commissioner, I wouldn't disagree there could be different interpretations of it. Because I work for health service, the acceptable terminology is "seclusion", but I absolutely accept that viewing it in the terms of perhaps a correctional environment, solitary confinement it is.

15

COMMISSIONER ATKINSON: Is there any difference between what happens in seclusion and solitary confinement?

MR FORREST: Yes, there is. For a person to be in seclusion in a health facility,
20 you need to have direct observation, so we always had somebody outside Melanie's door, and there was a plan on assessment while that person is in seclusion. That doesn't necessarily translate over into solitary confinement in the custodial system. So there are differences because it's applied in a health context.

25 COMMISSIONER ATKINSON: Thank you.

CHAIR: I think Commissioner McEwin has a question.

COMMISSIONER McEWIN: Thank you, Chair.

30

Mr Forrest, in your statement at paragraph 36, you state:

The elimination of long term seclusion for Melanie has been successful ....

35 Et cetera, et cetera. I want to know, when you look at the Seclusion Reduction Plan, was any consideration given to why perhaps it was not called a Seclusion Elimination Plan? As far as you know, what consideration was given to those steps to match what you've said at 36, the elimination of seclusion? Thank you.

40 MR FORREST: Thank you, Commissioner. As I mentioned, I wasn't involved in developing the Seclusion Reduction Plan that is tendered into evidence. My position as Chief Executive is responsible for overseeing compliance with policy, and from all of the information that I have available to me, the overwhelming information suggests that seclusion, if at all possible, should be eliminated. And that's the goal
45 that I've set for the organisation. I know that it's going to be challenging for us to get to that point but I don't think that, you know, setting the bar lower is something that would be acceptable.

COMMISSIONER McEWIN: Thank you.

CHAIR: Mr Forrest, I will now ask Counsel who are appearing for other parties whether they wish to ask you any questions, and I will first ask Ms Furness who appears for the state of New South Wales.

MS FURNESS: Thank you, Chair. I have some questions for the witness.

CHAIR: Yes.

CROSS-EXAMINATION BY MS FURNESS

MS FURNESS: Thank you.

Mr Forrest, can you tell the Royal Commission what the cleaning arrangement was for Melanie's seclusion room in about 2017?

MR FORREST: Yes. Melanie was not expected to do her own cleaning, so that's absolutely not the case. And we do not expect anybody in the acute part of the Forensic Hospital --- so that's both male, female --- to undertake their own cleaning. Usually at that point in time they are acutely mentally unwell and it would not be appropriate for them to clean, and it would not be appropriate to provide them with the implements or the cleaning solutions just purely based on their level of risk at that particular stage.

With Melanie's seclusion room, the cleaning, I would expect that to be done on a daily basis in line with hospital standards. I do accept that there might be some days when that was not possible and that would be because of Melanie's clinical condition at that point in time, but I would also expect that room cleaning be done at the earliest opportunity when Melanie's clinical condition permitted.

MS FURNESS: Thank you. There was a lifeguard present in relation to the pool at the Forensic Hospital at some stage, was there not?

MR FORREST: Yes, that's correct.

MS FURNESS: When did that lifeguard leave?

MR FORREST: The lifeguard left the service in November 2020.

MS FURNESS: Did that person resign or were they sacked?

MR FORREST: I'm not aware of those details, I'm sorry.

MS FURNESS: Has the lifeguard been replaced?

MR FORREST: We're in the process of training staff to obtain their lifeguard certificate. That's looking like it will commence in March due to the availability of those courses. So I'm optimistic that once we get a lifeguard training in place, that we will be able to open the pool again.

MS FURNESS: Mr Forrest, were graduate nurses ever allowed to work with Melanie during their graduate year?

MR FORREST: No, there weren't.

MS FURNESS: Are there any graduate nurses as part of Melanie's core team?

MR FORREST: No, there aren't.

MS FURNESS: What is the orientation for graduate nurses?

MR FORREST: The Forensic Hospital specifically takes an annual intake of 16 full-time equivalent graduate nurses. Their initial orientation to the Forensic Hospital is for 11 weeks, and as part of their 12-month program they have additional classroom face-to-face time, which is not involving in the clinical environment. And so it's a 12-month course, 11-week orientation at the Forensic Hospital, and then approximately 15 face-to-face sessions across the year.

MS FURNESS: Is there any supernumerary arrangement with respect to graduates?

MR FORREST: Yes, there is. The graduates undertake three rotations in the Forensic Hospital so they go to three different wards. The expectation is that they have five supernumerary days at the beginning of their placement when they go into a new facility.

MS FURNESS: Thank you, Dr Forrest.

Chair, I have no further questions.

CHAIR: Thank you very much. Do any other Counsel or legal representatives with leave to appear have any questions they wish to ask?

MS NEEDHAM: No, your Honour, thank you.

CHAIR: Dr Mellifont, is there anything you wish to ask arising out of the questions that Ms Furness put to Mr Forrest?

DR MELLIFONT: No. Thank you, Chair.

CHAIR: Mr Forrest, I have been calling you Mr Forrest. If the correct designation

is Dr Forrest, I apologise.

MR FORREST: No, it's actually Mr Forrest, thank you.

5 CHAIR: Well, thank you very much for coming and giving evidence, and for the statements you've provided to the Royal Commission, and our thanks in advance for the additional information I'm sure you will provide to us shortly. Thank you.

MR FORREST: Thank you very much.

10

THE WITNESS WITHDREW

15 CHAIR: Dr Mellifont, do we take a short break now?

DR MELLIFONT: Yes. Quarter past 11 Queensland time, please.

CHAIR: Thank you, quarter past 11 Brisbane time or quarter past 12 Sydney time.
20 Thank you.

ADJOURNED [11.59 AM]

25

RESUMED [12.16 PM]

CHAIR: Yes. Thank you. Thank you, and yes, Dr Mellifont.

30

DR MELLIFONT: Thank you. The next witness is Dr Andrew Ellis. While he's coming on screen, I observe that you will find a copy of Dr Andrew Ellis' first written statement at Tab 3, and his second written statement at Tab 4 of Tender Bundle C. I ask to tender these statements into evidence and for them to be marked
35 as Exhibits 11.10.1 and 11.10.2 respectively.

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

40 **EXHIBIT #11.10.1 - FIRST STATEMENT OF DR ANDREW ELLIS**

EXHIBIT #11.10.2 - SECOND STATEMENT OF DR ANDREW ELLIS

45

Dr Ellis, thank you for coming to the Royal Commission to give evidence. If you would be good enough, please, to follow the instructions of my Associate and she

will administer the affirmation to you.

DR ELLIS: Thank you.

5

DR ANDREW KENNETH ELLIS, AFFIRMED

CHAIR: Thank you, Dr Ellis. Dr Mellifont will now ask you some questions. Just
10 to explain where everybody is, Dr Mellifont is in the hearing room Brisbane together with Commissioner Mason. Commissioner Atkinson is joining us remotely. Commissioner McEwin is with me in the Sydney hearing room.

Yes, Dr Mellifont.

15

EXAMINATION-IN-CHIEF BY DR MELLIFONT

20 DR MELLIFONT: Thank you.

Good morning, Dr Ellis. Could you state your full name, please.

DR ELLIS: Yes. Dr Andrew Kenneth Ellis.

25

DR MELLIFONT: Right. And you have provided two statements to this Commission; is that correct?

DR ELLIS: Yes.

30

DR MELLIFONT: The first is dated 30 June 2020 and the second is dated 8 February 2021?

DR ELLIS: Yes.

35

DR MELLIFONT: And are those statements true and correct to the best of your knowledge and ability?

DR ELLIS: Yes.

40

DR MELLIFONT: Okay. You are the Clinical Director and the Medical Superintendent for the Forensic Hospital and the Long Bay Hospital; correct?

DR ELLIS: I was the Director of the Long Bay Hospital. I am no longer, but I am
45 of the Forensic Hospital.

DR MELLIFONT: All right. Thank you. And have you been Clinical Director of

the Forensic Hospital since April 2018?

DR ELLIS: Yes.

5 DR MELLIFONT: And that involves being responsible for the clinical care of patients?

DR ELLIS: Yes.

10 DR MELLIFONT: Okay. Now, you have various degrees including a Bachelor of Medicine and Surgery, and you ---

DR ELLIS: Yes.

15 DR MELLIFONT: Thank you. And you are a fellow of the Royal Australian and New Zealand College of Psychiatrists?

DR ELLIS: Yes.

20 DR MELLIFONT: Is that correct?

CHAIR: I'm sorry, I cannot resist asking you, how do you get a Master of Arts from New York Law School and where is New York Law School?

25 DR ELLIS: Okay, it's in Tribeca in New York, and it's --- I studied under Professor Michael Perlin who is the Professor of Law there with a special interest in mental disability law.

CHAIR: Thank you.

30

DR MELLIFONT: Okay. And you hold registration as a Specialist Medical Practitioner Forensic Psychiatrist?

DR ELLIS: Yes.

35

DR MELLIFONT: And you were in fact the treating psychiatrist for Melanie for a period of six months when you were covering a leave of absence by her treating psychiatrist, and that was in 2012?

40 DR ELLIS: Yes, that's correct.

DR MELLIFONT: All right. Now, just can I ask you about the Forensic Hospital, and a question which has arisen in the course of the week is whether adolescents mix with adults. Can you assist the Commission?

45

DR ELLIS: Adolescents don't mix with adults. They are kept in a separate area.

DR MELLIFONT: That is both male adolescents and female adolescents, they are kept separate from adults?

DR ELLIS: Yes.

5

DR MELLIFONT: Okay. Dr Ellis, are you aware as to whether there is a current requirement to provide reports to the Chief Psychiatrist of New South Wales as to seclusions and in particular long-term seclusion?

10 DR ELLIS: Yes.

DR MELLIFONT: There is a requirement?

DR ELLIS: Yes, there is a requirement, and that requirement is performed by the
15 Hospital on a monthly basis.

DR MELLIFONT: And who within the Hospital provides that report?

DR ELLIS: It's collated by one of the after-hours nurse managers, and a report is
20 made and it's submitted to the Ministry.

DR MELLIFONT: All right. I received a note asking you to move to your right a bit so the interpreters can see you better.

25 DR ELLIS: Apologies.

DR MELLIFONT: Thank you. Does that fix the problem, Law in Order? Okay. We will proceed as though it does.

30 Now, were reports to the Chief Psychiatrist, during at least the period of time you've been there, made to the Chief Psychiatrist about Melanie, about her seclusion?

DR ELLIS: Her seclusion was included within those reports, yes.

35 DR MELLIFONT: Okay. And included so as to be able to identify who she was and how long she had been there?

DR ELLIS: There's an aggregate data provided. It doesn't detail individual patients, but because of the special circumstances that there were some patients in long-term
40 seclusion that they were individually notated within that report.

DR MELLIFONT: Okay. And so did those reports note how long Melanie had been held in seclusion for?

45 DR ELLIS: I --- I can't answer that now. They would have indicated the seclusion for that month.

DR MELLIFONT: Okay.

DR ELLIS: I can take that on notice.

5 DR MELLIFONT: Thank you. So those reports are reports that would still be held within the Forensic Hospital which could be obtained and produced to the Commission?

DR ELLIS: Yes, they would be very easily accessible and I would be able to provide
10 them to the Commission.

DR MELLIFONT: Thank you. So too, I take it, would any responses back from the Chief Psychiatrist if there were any?

15 DR ELLIS: I'm not aware of any response back from the Chief Psychiatrist.

DR MELLIFONT: Is that something that can be checked and if there were responses, those responses provided as well?

20 DR ELLIS: Yes, I can undertake to check that.

DR MELLIFONT: Thank you, Dr Ellis. Is it your view, Dr Ellis, that there are insufficient facilities for patients to step down from the Forensic Hospital, both to other places within the hospital system or into the community for people like
25 Melanie with complex needs?

DR ELLIS: Yes. There are a larger number of people with the clinical need for placements in those sort of settings than beds exist.

30 DR MELLIFONT: Okay. And because the Forensic Hospital doesn't have places for the patients to go to, is that creating a problem at the other end, that is that you can't make beds available to people who wish to come into the Forensic Hospital or are clinically indicated to come into the Forensic Hospital, there just aren't enough beds?

35

DR ELLIS: Yes. There's a significant waitlist of people in custody who are clinically appropriate and have appropriate legal orders to move to the Forensic Hospital.

40 DR MELLIFONT: Do you know how long that waitlist is?

DR ELLIS: It's provided to me on a monthly basis. It can be divided in various ways but there would be approximately, at any one time, 80 people, 80 to 100 people who are eligible.

45

DR MELLIFONT: All right. And again those waitlists are documents which could be provided to the Commission?

DR ELLIS: Yes, they could be easily obtained and provided.

DR MELLIFONT: Thank you. Now, I want to take you to some specifics in respect of Melanie.

Is it your view that it was the fracture of Melanie's foot which was the factor which led to her being taken out of seclusion and put into the sub-acute ward in November of 2020?

DR ELLIS: It was one of the factors, yes.

DR MELLIFONT: Okay. Can I ask you if you agree with this proposition, and this comes from a document dated 11 November 2020. I don't want it up on screen, please, but for the record it's NSW.0041.0006.0001, and it's a Forensic Hospital Consultation Form. It's dated 11 November 2020, and to orient you in time, the fracture of the foot was 8 November 2020. The proposition is:

> *.... recent changes in her physical health and ability to care for self independently have changed her risks and she no longer meets the criteria to be legally nursed in seclusion. Her risks of physical aggression towards others has reduced due to mobility issues.*

Do you agree with that statement?

DR ELLIS: At 11 November, that statement was correct, yes.

DR MELLIFONT: Okay. And can I read from a Seclusion Cessation Plan. Again, I don't want it up onscreen but it's NSW.0041.0010.0001 and it records:

> *On 8 November Melanie sustained a fractured ankle due to a fall which resulted in her requiring to wear a moon boot and requiring assistance to attend to ADLs due to her limited mobility. Due to Melanie's physical injury this changes her risk profile, therefore discussions have been held at senior management level of consultation with the consistent team, Austinmer Women's team and HSR's in relation to the cessation of seclusion. Melanie was reviewed by the Medical Superintendent on 11th November who supports a plan to cease seclusion due to the altered risk profile.*

Is it therefore your understanding that the cessation of seclusion as at November was due to the altered risk profile?

DR ELLIS: Yes. The entire risk profile had altered and one of those factors was the fracture of the foot.

DR MELLIFONT: Well, it was actually really a significant factor, wasn't it, because it significantly reduced the physical risk that Melanie presented to staff and, not only

that, in order to get the care she needed, she wasn't able to do that in the seclusion unit? Those things are right, aren't they?

DR ELLIS: Yes, it was a significant factor.

5

DR MELLIFONT: Can you clarify something for me from your second statement at paragraph 8, please. Have you got that there?

DR ELLIS: Yes.

10

DR MELLIFONT: Okay. It says:

> *Melanie was transferred from the Dee Why seclusion room to the Austinmer seclusion room on 7 November ....*

15

DR ELLIS: Yes.

DR MELLIFONT: And then she was moved into the Austinmer sub-acute ward on 13 November?

20

DR ELLIS: Yes.

DR MELLIFONT: Why was she moved from the Dee Why seclusion room to the Austinmer seclusion room?

25

DR ELLIS: So this goes to the overall risk profile, because by this stage a core team of staff had been recruited to and been able to be rostered to work with her, and the envisaged plan was that increasing time out of seclusion and increasing time on the ward was to occur, and she was --- because the Austinmer ward is the women's ward,
30 and so she was being moved, before the foot fracture, into that area so that there would be better access into her transition plan.

DR MELLIFONT: Okay. And so the day after she gets to that Austinmer seclusion room, she fractures her foot on 8 November, is that your understanding?

35

DR ELLIS: That's my understanding, yes.

DR MELLIFONT: And do you know how that came to be?

40 DR ELLIS: I understand she fell.

DR MELLIFONT: Okay. And do I have the chronology correct, then on 9 November 2020 a core team was assembled for Melanie?

45 DR ELLIS: Yes.

DR MELLIFONT: Okay. Up until that point in time the core team had not been put

together; is that correct?

DR ELLIS: It was being put together in the months beforehand, but by that time it was able to be deployed and rostered.

5

DR MELLIFONT: All right. Well, I just want to get an understanding then of the Seclusion Reduction Plan, if you don't mind. And again, I don't want this up on the screen, but it's NSW.0041.0011.0001. Are you familiar with this document?

10 DR ELLIS: Yes.

DR MELLIFONT: Okay. Are you an author or contributor to it?

DR ELLIS: I did not write it but I had--my input was sought about it.

15

DR MELLIFONT: Okay. Sought by who?

DR ELLIS: So the author is the Senior Nurse with responsibility for safety.

20 DR MELLIFONT: Okay. Now, the document itself is undated but if we look at the risk --- sorry, the work break down structure a couple of pages in, it looks like at least the first draft was some time prior to, say, 22 September, presumably?

DR ELLIS: Yes.

25

DR MELLIFONT: Is that your understanding of the timing?

DR ELLIS: Yes. I think this document was some time in development.

30 DR MELLIFONT: Okay. Now, you will see at 2.7 that the plan involves consultation with Public Guardian and other stakeholders.

DR ELLIS: Yes.

35 DR MELLIFONT: And you will see at 6.3 that it says:

Ensure plan is well communicated to Public Guardian, Melanie, relevant workgroups and all stakeholders.

40 Now, the information we have from the Public Guardian via Ms Osborne who, of course, plays a senior role there but there was an appointed guardian as well, is that the Public Guardian was not consulted on the Plan. Is that consistent with your understanding?

45 DR ELLIS: I don't know if the Public Guardian was consulted. The obvious thing from the Plan is that they were meant to be. It would be good clinical practice for the authorised medical officer leading the multidisciplinary team to be in good contact

with a substitute decision-maker, if there's a guardian in place. It is my understanding that the Guardian was invited to the weekly multidisciplinary team meeting. However, I'm not sure if the Guardian had attended all of those meetings.

5 DR MELLIFONT: So you wouldn't be precisely familiar with whether the Public Guardian was actually invited to every meeting, nor of the attendance rate. Correct?

DR ELLIS: No, but I would sometimes attend those meetings and I have been in attendance when the Public Guardian has been there, at least on the telephone.

10

DR MELLIFONT: Right. But you personally are not aware of any circumstance in which the Public Guardian was in fact consulted about this Plan?

DR ELLIS: I haven't seen any written documentation that would prove it.

15

DR MELLIFONT: Okay. But it's certainly your view that the Public Guardian should be consulted about a Plan like this?

DR ELLIS: Yes, it is.

20

DR MELLIFONT: Okay. Thank you. All right. So can I take you back a page in the Seclusion Plan, and you will see under the objectives that the objectives were to have staffing resources identified by 30 October. Is that the core team?

25 DR ELLIS: Yes. I think that's --- I mean, that's fair to say.

DR MELLIFONT: Okay. And this document refers to, by 28 February 2021, the plan was to increase Melanie's time out of seclusion by at least 25 per cent. Is that your understanding as to the stated intention of the Forensic Hospital as at the time of
30 this document?

DR ELLIS: Yes. So, and I think to make that clearer, it says by 4 November there would be a structured timetable. So this was when the core team would be --- so that there would be a substantial increase in time out of seclusion at that point, and then
35 by 2021 February, that be increased by 25 per cent. So obviously slower than what occurred.

DR MELLIFONT: Sorry, I will go back a step. So by 4 November the plan was to, I see, implement a structured timetable for [redacted] --- sorry, for Melanie, outside
40 of the unit, or are you saying that was a structured timetable inside the unit with some time out of seclusion?

DR ELLIS: So the idea was that, and that had been proposed by the treating team, was that the time out of seclusion would be the 8-hour working day, that she would
45 be out all of that time on a structured timetable.

DR MELLIFONT: Is it correct at least as at 9 November 2020 there wasn't such a

timetable in place?

DR ELLIS: No, there wasn't. Because the core team had not been able to be rostered by that stage.

5

DR MELLIFONT: Sorry, not just not rostered but not actually selected. Isn't that right?

DR ELLIS: Yes, that's right, not until 9 November.

10

DR MELLIFONT: Okay. Excuse me for just a minute. Can I take you please, Dr Ellis, to a risk assessment document. Again, I do not want this displayed on screen. And it's NSW.0041.0012.0001. Have you got that document there?

15 DR ELLIS: I do, thank you.

DR MELLIFONT: Okay. Have you seen this document before? Apart from in preparation to giving evidence?

20 DR ELLIS: Only in preparation to giving evidence.

DR MELLIFONT: Okay. Right. Well, we will see what we ask you about it, and it may well be --- you will see a box on page 3. See the comment in the bottom row, "Team Approach", "Agreed Controls", it says:

25

> *Implementation of an initial consistent team to assist [Melanie] with the reintegration process and develop interpersonal skills, with a planned disintegration of the consistent team by February.*

30 Do you know anything of a planned disintegration of the consistent team by February?

DR ELLIS: No, this document --- this is a Work, Health and Safety document as opposed to a clinical document. This would be --- this is an indication that there has
35 been staff consultation about a change in practice that might present a risk to staff. My suspicion is that that word is a typo. When we have formed core teams with other patients that we've been able to successfully exit from seclusion, we have introduced into those core teams other staff from the ward on a gradual basis to upskill those staff members and increase their confidence and ability for working
40 with more challenging patients. It may refer to that. "Disintegration" isn't a word that we would typically use.

DR MELLIFONT: Right. And so is it your intention that the core team which is now in place for Melanie will continue and continue up until such point in time as
45 she is able to go into the community? Is that the intention?

DR ELLIS: Yes, that's the intention that her core team will remain until such time as

she is discharged and successfully handed over to a community provider.

DR MELLIFONT: Okay. Now, with respect to that core team, what's the back-up plan if any of them get crook or resign?

DR ELLIS: Well, it does have a --- again, the core team has --- is more than three individuals because of rostering. So --- and the back-up plan is what I've referred to here is that other people will be rotated into that core team and to work alongside the core team to pick up the skills that are required, increase the confidence, increase the repertoire of people that Melanie can form a positive therapeutic rapport with, and so that the move out of seclusion can be successfully sustained.

DR MELLIFONT: Is that happening now?

DR ELLIS: At this stage I am not aware of that. I think that it is currently the core team members.

DR MELLIFONT: When is the plan to start rostering others in to upskill them and develop that therapeutic alliance with Melanie?

DR ELLIS: I don't know the exact date of that. I can take that on notice and provide that to the Commission.

DR MELLIFONT: Okay. So who is in charge of those decisions?

DR ELLIS: So those decisions will be the Nurse Unit Manager on the ward at the first instance.

DR MELLIFONT: What process is in place to make sure that the nurse unit manager is actively thinking about those things and making decisions so that there is a plan for continuity of care of Melanie?

DR ELLIS: I'm not aware of the exact process. I'm aware that there are regular nursing staffing rostering meetings by the senior nursing staff with the nurse unit managers on the wards, and I would have to ask them for the exact process around that.

DR MELLIFONT: All right. You understand why I'm asking you as the Clinical Director as to what the audit process is of this, given your responsibility for the clinical care of the patients?

DR ELLIS: Yes. Again, I have, you know, the overall responsibility for the care of the patients, and it would be my intention that this exit from seclusion is sustained in order that a discharge to the community can be effected. So ---

DR MELLIFONT: Sorry. I didn't mean to cut you off. Was there something else you wanted to say?

DR ELLIS: So, yes, I will expect that the core team can be supplemented by other staff from the ward as they increase in skill and confidence, and I have regular meetings with the senior nursing staff and can be informed if there are problems developing with that.

DR MELLIFONT: So you will understand that we will want to understand the priority with which Melanie's case is going to be given both in intention and resources? Yes?

DR ELLIS: Yes. I think that ---

DR MELLIFONT: Because you yourself agree that long-term seclusion for a patient is not therapeutic. Agreed?

DR ELLIS: Yes. It's anti-therapeutic.

DR MELLIFONT: Yes. And in that sense can be quite damaging for the patient?

DR ELLIS: Yes.

DR MELLIFONT: And traumatising in varying respects for staff as well?

DR ELLIS: Yes.

DR MELLIFONT: And you agree that all that can be done needs to be done to ensure that any progress which is now made with respect to Melanie is kept on track with carefully planned and audited continuity of care arrangements? Are we agreed?

DR ELLIS: I agree, yes.

DR MELLIFONT: Are there still vacancies across the Forensic Hospital with respect to appropriately skilled and trained staff to deal with complex needs patients?

DR ELLIS: They have very much improved from when I began in the role. The senior nursing staff have done an excellent job in recruiting appropriate staff, and I am informed that as of 1 March there will be no vacancies, and that there are currently a small number of nursing vacancies as well as allied health, a small number of allied health vacancies. There's one consultant psychiatrist vacancy that I am interviewing for in the next fortnight.

DR MELLIFONT: Okay. Can I ask you generally, please, do you struggle recruiting properly skilled staff for complex needs patients and, if so, do you have any thoughts about how things might be improved in that respect?

DR ELLIS: I think that in terms of psychiatry it's certainly the lowest paid and most difficult work to do public mental health work. But there's considerable rewards in

doing that because you can achieve significant outcomes for very disadvantaged people. Recruitment is complex and certainly forensic mental health staff bear with them a pride in their work, and despite criticism from all angles, forensic mental health staff will be criticised by people who think that they're being too easy on people with criminal behaviour and they will be criticised by people who think they are being too tough on people with mental disorders.

So recruitment into this area is difficult but it's also an area where people can thrive and improve their career. And so we want to indicate that it is a positive area in which to work. Many people who enjoy difficult work or a challenge would be well suited for this area of work, and I would encourage them to apply for jobs in the area.

DR MELLIFONT: When you speak about psychiatry being not well paid, are you speaking there of psych nursing, psychiatrists, both, in the public sector?

DR ELLIS: Well, there are --- I think that health jobs in general are well remunerated compared to the general workforce, but there are easier areas of mental health and disability to work in for more pay.

DR MELLIFONT: I want to ask you specifically, what training does the Forensic Hospital provide to its nurses and its mental healthcare workers for dealing with people, helping people with complex needs like Melanie?

DR ELLIS: Yes, there's currently in place what I would consider a comprehensive orientation to working in a forensic environment that includes a number of different areas of specialised practice. There is also then ongoing refresher training in those areas, and there's ongoing options for people to further pursue the specialty up until and including scholarships for Masters level study from nursing staff and allied health.

DR MELLIFONT: Are there incentives for that optional training to be undertaken? Does the Forensic Hospital provide incentives?

DR ELLIS: Well, there's an incentive for the postgraduate training, in that there's scholarships that can be awarded for that. The other, internal and in-house training, is certainly encouraged and but we are bound by our industrial awards, we can't further incentivise and encourage people to attend those trainings.

DR MELLIFONT: I want to ask about the comprehensive orientation. How many days is it?

DR ELLIS: It's more than two weeks.

DR MELLIFONT: All right.

DR ELLIS: Yeah, I ---

DR MELLIFONT: I cut you off.

DR ELLIS: I don't know whether it's one or two days over the two-week cycle, but it's at least two full working weeks with a little extra.

DR MELLIFONT: And who is it delivered by?

DR ELLIS: So that's delivered by our own staff. We have --- there's a training component of our own staff who provide that training, including myself.

DR MELLIFONT: You provide some of the training?

DR ELLIS: Yes.

DR MELLIFONT: How frequent is the ongoing refresher training?

DR ELLIS: Well, there are --- so, it's --- it will depend for the individual different modules of training that are there, but there's also refresher trainings on various things across the calendar year and we can provide the Commission with the calendar of training.

DR MELLIFONT: Is that refresher training mandatory?

DR ELLIS: Some of it is mandatory and some of it is optional.

DR MELLIFONT: Right. Did I cut somebody off then, I'm sorry, one of the Commissioners? No, all right.

What I want to understand is what's your process to ensure that the training you've provided is sticking, is working? What's your auditing process?

DR ELLIS: Yes, so we audit the mandatory training and the voluntary training and that is --- so we have statistics on that provided on a monthly basis.

DR MELLIFONT: Are they statistics that the training has just been done?

DR ELLIS: Yes. But for some of the training, the person has to pass the examiner's requirement that they had met the requirements of the task, not simply attendance.

DR MELLIFONT: Right. And again they're records which are available?

DR ELLIS: Yes, they can be provided.

DR MELLIFONT: Okay. Now, I want to ask a bit more specifically about your personal involvement in the Melanie case, your direct involvement in Melanie's case. Now, you started there in 2018, we've established?

DR ELLIS: Yes.

DR MELLIFONT: And by that time Melanie had been in long-term seclusion for a very, very long time. Agreed?

5

DR ELLIS: Yes.

DR MELLIFONT: And did you form the view at that point in time that she should not have been in long-term seclusion?

10

DR ELLIS: Yes.

DR MELLIFONT: And did you form the view at that point in time that steps must be taken to get her out of seclusion?

15

DR ELLIS: I did.

DR MELLIFONT: Now, I take it that the fact she had been in seclusion for such a long period of time presented challenges to you with the immediacy within which

20 that could occur?

DR ELLIS: Very significant challenges, yes.

DR MELLIFONT: And what were the significant challenges that that length of time

25 of seclusion presented in terms of immediacy of change?

DR ELLIS: The first and greatest that I identified was the significant shortfall in staffing, and that was across all disciplines. And there was a significant shortfall of suitable staff. If you wanted to do something like a core team, you weren't able to

30 roster that because staff were spread thinly covering vacancies. So the kind of management that was able to be done in 2012 --- was not able to be done at that point in time. I think there was some areas of the hospital that needed to have --- the physical environment needed to be improved to expand the capacity of staff to manage patients with complex, emotional and behavioural disturbances. And so that

35 these things needed to be put into place and they weren't able to be rectified immediately.

DR MELLIFONT: All right. What I want to ask you, since the time you've started there, how many times would you have physically gone to the Dee Why seclusion

40 unit to see the unit and to see Melanie?

DR ELLIS: I would see her fairly regularly. I would have to look at the clinical notes to see exactly how many times I went there. But I would say at least every two months I would have seen her face-to-face. I asked that if she was not brought out of

45 seclusion for two days in a row, that I come and personally review her.

DR MELLIFONT: And is that on top of the once every two months or so you were

going anyway, or was that included in the once every two months or so you were going to see her?

DR ELLIS: That would be included within that, because I think that --- and I would see her and interact with her when she was out on the grounds.

DR MELLIFONT: All right. And I'm not being flippant about this question, but you weren't down there regularly checking to see whether Melanie's --- whether the seclusion units were clean or dirty at any given time, I take it?

DR ELLIS: No.

DR MELLIFONT: And I take it Mr Forrest wasn't visiting the Forensic Hospital on a regular basis to check that out for himself either?

DR ELLIS: No.

DR MELLIFONT: Can I just go back a step, and I'm sorry to do this. We spoke before about vacancies being filled. Has there been a reliance, have you had to use new graduates to fill a lot of those vacancies?

DR ELLIS: Not new graduates, because they're a static intake every year.

DR MELLIFONT: You will have to explain that for me, sorry.

DR ELLIS: Sorry. So there's a graduating cohort of nurses who are employed at the Hospital and that is, as I understand, 16. And so the Hospital takes on 16 new graduates every year. I think when I began, there was an over-reliance on agency staff, so staff who weren't regular staff members at the Hospital, or, staff being asked to work overtime to cover those vacancies. I don't think it was an over-reliance on new graduates.

DR MELLIFONT: Right. And so in respect of graduates that do come into the Forensic Hospital, they've had some post-graduate qualification with the university beyond their standard nursing degree. Is that correct?

DR ELLIS: I'm sorry, can you repeat that question? The new graduates, or these are registered nurses who are ---

DR MELLIFONT: Registered Nurses that are coming to the Forensic Hospital to work in a Forensic Hospital, do all of them have the postgraduate qualification in forensic health?

DR ELLIS: No.

DR MELLIFONT: Okay. So what do they have as a basic minimum before you will take them on?

DR ELLIS: If they're not a new graduate, we take on straight out of university. If someone has previous experience working in mental health, they have their nursing degree and then they have their clinical experience. It will depend at what level
5 they're employed at and I may be currently straying out of my expertise here and I have to ask my nursing colleagues for the exact qualifications that we require.

DR MELLIFONT: Okay. So accepting that we might have to ask them or get that information via them, is it your understanding that to work with somebody like
10 Melanie there is going to be a minimum criteria for the staff to be accepted?

DR ELLIS: Yes. There's no graduate nurse working with her. The nurses --- it's also allied health staff who work with her, have significant seniority and experience. They are a very impressive group of people.
15

DR MELLIFONT: Right. Now, I want to go back to your observation before, that you asked to be notified if there had been, is it two or more days where Melanie was not allowed out of seclusion at all? Is that right?

20 DR ELLIS: Yes.

DR MELLIFONT: Okay. And how did that information come to you?

DR ELLIS: The Nurse Unit Manager would provide me with that information and
25 ask me to review.

DR MELLIFONT: And what would she provide you or what would he provide you?

DR ELLIS: They would tell me if she hadn't been out for two days.
30

DR MELLIFONT: A verbal briefing?

DR ELLIS: Yes. Or an email.

35 DR MELLIFONT: Well, then when you got that information and you went to look, what record did you look at when you got there?

DR ELLIS: I would look at the medical records and look at all the clinical entries that had been made. I would speak with the staff who were there at the time, and I
40 would speak with Melanie.

DR MELLIFONT: Okay. So what I want to do is take you to your first statement, please, and I want to take you to page 10.

45 DR ELLIS: Yes.

DR MELLIFONT: Okay. Now, at page 10 and following you set out a table in

response to a question asked of you by the Commission to set out the length of time each day that Melanie had been out of seclusion from 1 December 2019 to the present.

5 DR ELLIS: Yes.

DR MELLIFONT: Okay, so that time period covers a time when you were at the Forensic Hospital in your current role; correct?

10 DR ELLIS: It does, yes.

DR MELLIFONT: Okay. And so in putting together this table, did you or whoever put it together have access to records?

15 DR ELLIS: Yes.

DR MELLIFONT: Okay. So this isn't a cut-and-paste of an existing record, it's a compilation of primary records from elsewhere?

20 DR ELLIS: It is, yes.

DR MELLIFONT: And so we see an example, say, on 5 March 2020 on page 11 that she had no time out of seclusion and the comment was:

25 *No time out due to increased risk to staff*

Now, that wouldn't necessarily have been elevated to you because it was just one day.

30 DR ELLIS: That's correct.

DR MELLIFONT: Is that right?

DR ELLIS: That's correct.

35

DR MELLIFONT: So who, if anybody, who it have been elevated to beyond the a Nurse Unit Manager?

DR ELLIS: It would have been notified to the Consultant Psychiatrist.

40

DR MELLIFONT: Okay. Is that an assumption of yours, expectation of yours, or was there a policy requiring that?

DR ELLIS: There's a policy requiring that, and there would have been first elevated
45 to the junior doctor, the Registrar who is on the ward, because they would review anybody in seclusion every four hours. They would then relay that to the Consultant Psychiatrist.

DR MELLIFONT: By written means? And written records so it's preserved.

DR ELLIS: Yes. There's a seclusion register which is kept, and that is documented.

5

DR MELLIFONT: Right. So can I take you then to page 13.

DR ELLIS: Yes.

10 DR MELLIFONT: And you will see there is an entry on 3 April 20 which says:

No time out of seclusion due to increased risk to staff

You see that there?

15

DR ELLIS: Yes.

DR MELLIFONT: And if we turn over to 3 April on page 21 of your statement. Okay.

20

Now, firstly what we should say about this table which appears from pages 19 and following is that this is a table that you put together to set out the date, time and circumstances of each occasion of self-harm by Melanie?

25 DR ELLIS: Yes.

DR MELLIFONT: And has that come from the clinical records?

DR ELLIS: It does, yes.

30

DR MELLIFONT: So we can see there was an event on 3 April --- I won't go into the specific detail of it but let's call it self-harm and violent behaviour. Not towards others but within the seclusion unit. And I take you back, please, to page 13.

35 DR ELLIS: Yes.

DR MELLIFONT: You see on 4 April:

No time out of seclusion due to increased risk to staff

40

Can I ask you to accept from me there is no correlating clinical record for 4 April?

DR ELLIS: I accept that, yes.

45 DR MELLIFONT: Okay. I'm going to take you to a couple of others and then ask you a couple of questions.

If you go to 6 April on page 13, there's a zero time-out and there's no correlating clinical entry for that date. So how do we know that the reason she wasn't allowed out was because staff were using it as a behavioural management tool, that is, "If you behave you can come out, if you don't you don't get out, that's how we're going to operate it"?

DR ELLIS: If there's no clinical entry that supports the use of the seclusion then you don't know.

DR MELLIFONT: Right. Okay. I'm going to suggest to you that occurs on other occasions within this table. There's no clinical entry on 10 April. There's no clinical entry on 11 April. There's no clinical entry on 13 April. So we simply don't know whether that the non-permission of Melanie to come out of the seclusion room was due to a staff decision as to behavioural management, perhaps punishment for behaviour they didn't like. We just don't know that, do we?

DR ELLIS: Yes. You would have to speculate as to the reason, and that's --- but it's also not acceptable to not make clinical documentation about this.

DR MELLIFONT: And it's particularly problematic from your perspective, isn't it, as the Clinical Director, that you don't have those records that you can look at and feel safe, secure and confident that Melanie was being punished?

DR ELLIS: Yes, that's a problem.

DR MELLIFONT: Chair, I do have another five minutes or so of questions. I could benefit from a chance to look at my notes, if the Commissioners had any questions in the meantime.

CHAIR: I'm sure they'll do their best to fill in the time --

DR MELLIFONT: Thank you.

CHAIR: --- so I will ask whether Commissioner Mason has a question.

COMMISSIONER MASON: No, thank you, Chair.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No, I don't thank you Chair.

DR MELLIFONT: All being very unhelpful!

CHAIR: Commissioner McEwin.

COMMISSIONER McEWIN: Thank you, Chair.

Just a question, Dr Ellis, about, you've said you are responsible for the clinical care of your patient. So what's your observation just when we hear from Mr Forrest who said the nursing staff make the decision, even though you may have provided a clinical decision, say, to reduce or take her out of seclusion? So can you tell me about the tension? I feel there's a tension there. My proposition is that there is a tension there, and what's your view, given that you have clinical overall responsibility?

DR ELLIS: Yes, well the way that seclusion should work, and again it should be used sparingly and only for the management of imminent risk of harm to others, is that it can be initiated by nursing staff, because nursing staff are on the ground and in direct (audio distorted) all the time, whereas the medical staff are not. Medical staff are sometimes on the ground but not as consistently as the nursing staff. But the way it ought work is that nursing staff initiate the seclusion but it can only be maintained by medical staff.

Now, I think the days of doctor says "jump" and the nurse says "how high" are long behind us. We aim to work in a multidisciplinary framework. It's complex, it's not --- I don't see myself as a General of an army issuing edicts from my office to the front. But there should be a constructive discussion between the disciplines about the maintenance of seclusion. Ultimately it does fall to the doctor to maintain that seclusion, but nursing staff are also empowered to cease seclusion. It's not a sole role of doctors.

COMMISSIONER McEWIN: Well, I'm not suggesting --- look, but the proposition is, ultimately, you've said that seclusion is not in the best interests of your patient. It impacts negatively on their, you know, wellbeing. So coming back to my initial question of how do you feel that, you know, you've got clinical responsibility and yet there is an expectation that the nurses should then carry out to the best of their ability what your expectation is?

DR ELLIS: Yes. So we have to also ensure that all the staff are going to be --- to have an appropriate environment in which to manage a patient who has got the potential for aggression, and that they have the appropriate training, and they have the appropriate numbers to manage that situation. And so this was the terrible tension that I was confronted, in 2018, with not having appropriate numbers, not having an appropriate environment and not having appropriate training of the staff. I think that those three factors have been rectified. It's taken my time. I ask myself, could it have been done faster? It should have been done faster, but could it have been without causing further harm to both patients and staff? I think that's the difficult question.

COMMISSIONER McEWIN: Thank you.

CHAIR: Dr Ellis, you've referred to the four-hourly review or check. Can you explain how that works?

DR ELLIS: Yes. So anybody who is placed in seclusion needs to be reviewed in the first hour by a Medical Officer and then at four-hourly intervals by a Medical Officer. And there is a register and documentation kept of that.

5 CHAIR: And would the patient be woken up for that purpose?

DR ELLIS: Not necessarily. If they're asleep and the Medical Officer can ascertain that the person is --- his health is not compromised, then they wouldn't wake them up. Again, if a person is asleep, you question why they need to be in seclusion at all.
10 And there should be a review of that.

CHAIR: You might well have --- (inaudible) ---

DR MELLIFONT: We can't hear you, Chair.
15
CHAIR: Sorry.

DR MELLIFONT: We can't hear Sydney properly, you are cutting out.

20 CHAIR: Can you hear me now?

DR MELLIFONT: Yes, thank you.

CHAIR: Good.
25
Dr Ellis, you were at one stage treating Melanie, weren't you?

DR ELLIS: Yes.

30 CHAIR: When you came to your present position, at least in relation to the Forensic Hospital, you therefore had some knowledge of Melanie's position from some time earlier?

DR ELLIS: I did, yes.
35
CHAIR: Did that lead you to any conclusions at that time as to what could have been done to assist Melanie to transition out of seclusion? I don't mean for you to reveal any confidential information, obviously.

40 DR ELLIS: No. I think the fact that she was able to be managed on the ward before would indicate she was able to again. I was concerned, though, that the staffing levels and the infrastructure of the ward were not at a level where I could do that immediately. But I was confident that we would be able to do this because it had been done before. I had seen other patients with --- I mean, she does present with a
45 clinical risk profile that is highly complex and, you know, in discussions with her treating psychiatrist, we had both worked in other jurisdictions and certainly the risk profile would have challenged most jurisdictions and the ability to manage, but again

I was of the view that it could be done.

CHAIR: Yes. Thank you. Looking at pages 3 and 4 of your first statement, you have provided some information concerning the numbers of people currently held at the Forensic Hospital. You define forensic patients of whom there are 107, and civil patients of whom there are 10 and correctional patients all of whom are adolescents. We've been told, I think, that there is information available about the numbers of people at the Forensic Hospital who have cognitive disability. Are you aware at any given time of what those numbers are?

DR ELLIS: I don't have the specific number to hand at all times. It's usually about a third of patients would have some sort of cognitive disability in addition to or stand alone from mental illness and other psychiatric problems.

CHAIR: And how many of those, to your knowledge, since your arrival in 2018 have been subjected to some kind of seclusion? That is, of those with cognitive disability?

DR ELLIS: I would have to --- I would have to take that information on notice. And again I would also have to look at what definition of cognitive disability is being used, but I could break that down by diagnosis and look at rates of seclusion. That would take a little bit more time than simple data extraction, but it could be --- it would be possible to find out.

CHAIR: So there is not --- I may have misunderstood the earlier evidence --- so there is not a record kept of the numbers of people with cognitive disability at any given time using a definition by the Forensic Hospital itself?

DR ELLIS: No. By one definition, every patient in the Forensic Hospital has a cognitive disability. But other disability advocates may consider that certain people don't have a cognitive disability. People with a diagnosis of personality disorder might be excluded from that group. People with a diagnosis of schizophrenia may be excluded from that group. We don't break down our seclusion data by diagnostic category, and currently our rates of seclusion are very low and lower than the State average, so I would anticipate we could find in recent months that information very easily. Historically in the Forensic Hospital when rates of seclusion were higher, we might have to do some data digging for that.

CHAIR: And just picking up on something you just said, which other patients in New South Wales are subject to seclusion at any time if they are not in the Forensic Hospital?

DR ELLIS: So in New South Wales there are declared mental health facilities, and some of those declared mental health facilities have seclusion rooms, and seclusion can be applied in those declared mental health facilities. The Long Bay Hospital is a declared mental health facility. However, it's also a correctional facility. On paper it looks like no one is secluded. However, they are segregated by correctional rules at

an extremely high rate.

CHAIR: "They" being people with cognitive disability?

5 DR ELLIS: Some of them may have --- and they would be all people who have some sort of psychiatric diagnosis. Again, depending on the extent of the breadth of how you define cognitive disability, many of them would.

CHAIR: Thank you very much.

10

Dr Mellifont, Commissioner McEwin and I have done a fabulous job --

DR MELLIFONT: You have.

15 CHAIR: --- so you should be ready to resume.

DR MELLIFONT: Thank you.

Dr Ellis, is there a written requirement within the Forensic Hospital requiring the
20 proactive advising of a guardian of the use of any restrictive practices including seclusion on patient?

DR ELLIS: I'm not aware of that.

25 DR MELLIFONT: Should there be one, in your view?

DR ELLIS: I think that's a very good suggestion. I will take that onboard and if it does not exist, I will see that it does so.

30 DR MELLIFONT: How long will that take?

DR ELLIS: A couple of weeks.

DR MELLIFONT: Goodo. In the transition plan we've seen in the documents
35 attached to Mr Forrest's statement, there appears to be, really, an absence of Melanie's voice in the plan. Would you agree with that, that there is an absence of her voice in the Transition Plan? Please tell me if you can't comment on it.

DR ELLIS: This is Mr Forrest's statement?

40

DR MELLIFONT: Yes. Have you seen the Transition Plan?

DR ELLIS: Is that the supplementary or the first statement of Mr Forrest?

45 DR MELLIFONT: It's the first statement of Mr Forrest and it appears at about page 6 onwards.

DR ELLIS: Yes. It's a written document and although the guardian who speaks for Melanie is the head of that Governance Group, yes, I would take it --- and I have read this document in preparation --- I would take it that yes, there's no explicit representation of her voice in that plan ---

5

DR MELLIFONT: And are you of the view --- I'm sorry, I cut you off.

DR ELLIS: --- in the written portion of that plan. It may exist in other parts of it, but ....

10

DR MELLIFONT: Are you of the view that in the transition planning it is important to discuss it with Melanie? Of course being careful not to create expectations, but still to have discussions with Melanie about transition?

15 DR ELLIS: It's crucial with any patient, because if the patient is not onboard with the plan, it's likely to fall over.

DR MELLIFONT: Okay. Can I move on to another topic which is, now, that Transition Plan refers to there being a Positive Behaviour Support Plan developed by
20 the Network in consultation with SAL Consulting, and the Transition Plan actually speaks about it in draft. Do you know if there is a completed Behaviour Support Plan in place and being implemented for Melanie?

DR ELLIS: There is behaviour support being currently implemented with Melanie.
25 A Plan will never be complete because it's always going to be modified and adapted according to response. But I suppose in one sense, yes, it's complete. And being enacted by the core team.

DR MELLIFONT: Well, can I take you specifically to what's said at page 8 of Mr
30 Forrest's statement. And this Transition Plan is said to be current as at 30 December 2020 and his statement was done on 8 February 2021, so I'm going to act on this assumption unless you tell me otherwise, that this is the most up-to-date version of the Transition Plan.

35 What it says is it's a partial draft Behavioural Support Plan and is being adapted to Forensic Hospital staff and environment needs. Is that your understanding or do you say one is not just partial but complete, and that whatever adaptation needed to be made has been made?

40 DR ELLIS: Yes ---

DR MELLIFONT: Or do you need to take that on notice?

DR ELLIS: From my observation of what's happening on the ward, and I go down
45 to the ward and see what's occurring there, positive behaviour support is being directly implemented by the core team with Melanie now. I would take it on notice to see if there is a written plan that is being completed. In my view, these plans are

never complete. They require constant monitoring and adaptation to the patient's needs.

DR MELLIFONT: Yes, and you will find no dispute, I think, from anybody here or
5 the Commission that these things must be iterative, they must be dynamic. And what I'm trying to get a feel for, and I think you understand this, this talks about a partial draft. I want to see if there is a current, complete, as at today, document that is in place somewhere. You will have a look for that for me, or get someone to look?

10 DR ELLIS: I am fairly confident that exists given that I see it being implemented.

DR MELLIFONT: Can I take you then to a document which you should have with you --- I don't want it up on the screen --- but, it trials a change from the 12-hour shifts from the current core team. It's NSW.0041.0015.0001. Do you have that with
15 you there, Dr Ellis?

DR ELLIS: Got it, yes.

DR MELLIFONT: What this document does is to seek approval, and it looks like it
20 has been signed off on, moving to 12-hour shift patterns for the core team. Do you see that?

DR ELLIS: Yes.

25 DR MELLIFONT: Okay. And you will see on the page which is NSW.0041.0015.0002 that the request for that is that it will attract some efficiencies is a more consistent approach by reducing the amount of staff working over a 24-hour period. It requires two less FTEs within a 24-hour period. Daily hours of care would reduce from 69 to 60 hours representing a saving, and staff would access
30 a minimum 12-hour break between shifts, additional days off would be available for staff to recuperate.

Now, prior to preparing for giving evidence to the Commission, were you aware of this document?

35
DR ELLIS: I was aware of the proposal but I wasn't aware of the document.

DR MELLIFONT: And you will see there is expected there will be a saving of about $195,000 approximately by doing this. What I want to ask, though, is, what are the
40 downsides of moving from an 8-hour to a 12-hour model in terms of the patient?

DR ELLIS: They are potential downsides, I would suggest. I think this plan was discussed with me by the senior nursing staff and the rostering practices are complex in a large hospital like this. And within our budgetary constraints, anything that
45 helps with that is always looked at favourably. But I think generally, there is some --- I think there are some nurses who prefer this pattern of rostering and it might be sometimes easier to attract certain people into working into those roles.

The potential would be that this rostering practice limits the number of people that Melanie works with. Now, that might be a good thing because it's then a more consistent and stable team that works with her, and that then might deprive her of the challenge of working with a wider range of people and being able to further develop her interpersonal skills and emotional regulation with a wider range of people and to be able to progress into community settings.

But I think that those downsides are theoretical and, again, this is a temporary proposal which is thought to bolster and sustain the current gains. And I think if problems were noted with it, we could revert to the previous.

DR MELLIFONT: Right. So it's planned to do this for six months, we see that?

DR ELLIS: Yes.

DR MELLIFONT: Would you accept that another potential downside is that instead of having regular staff there four or five times there per week, they're only going to be there two to three times per week because they're working the longer shifts; that's a potential downside?

DR ELLIS: Yes, potentially.

DR MELLIFONT: Yes. And the other potential downside is working such a long shift with somebody with complex needs might create additional stressors for the staff? That's another potential downside?

DR ELLIS: Potentially.

DR MELLIFONT: Were those things specifically taken into account in this proposal? Or is that outside what you can tell us?

DR ELLIS: Again, this is my discussions with senior nurses about it. It was felt that, you know, that the positives of this outweighed the negatives. Many staff prefer to work 12-hour shifts. Not all staff, but many staff prefer that rostering arrangement and because they get more rest, because they get greater amounts of time off. So in some ways the fatigue balances out, but it's --- again, I think it's a trial worth doing.

DR MELLIFONT: Just return to my question, though. Do you know specifically whether those two potential downsides were factored into this particular decision? Do you actually know whether they were or whether they weren't?

DR ELLIS: Well, in my conversations with staff considering that, I think that they were considered, yes. But I couldn't point to documentation to support that.

DR MELLIFONT: No, I understand that. Would it be fair to say that's an assumption you made?

DR ELLIS: Yes.

DR MELLIFONT: Right. I see the current plan hopefully is for Melanie continuing to make a therapeutic progress and she will be released in the community. And you're aware of discussions with NDIS and the potential placement in the community. We won't go into the location of that. If that falls through, where else is there for her?

DR ELLIS: This is also one of the questions that I had asked at the start, was there any other facility that she could be managed in. If that falls through we have to try again, I think. I would escalate my concern if this fell through, I would escalate this to the Chief Psychiatrist, and I would escalate it in as many forums as I thought I could.

DR MELLIFONT: Well, let's talk about those forums. Who else apart from the Chief Psychiatrist can you go to?

DR ELLIS: Well, I can --- I would have to go outside --- in my public hospital role I would have to go through my channels of seniority. In my role as a doctor, I can go outside to organisations like the Royal College of Psychiatrists and the Australian Medical Association, make my concerns known to them. If this plan was to fall through, otherwise I would go through my channels of seniority starting with Mr Forrest who is the Chief Executive, but I would go through the people who sit between him and I.

DR MELLIFONT: Okay. Can I ask you whether you accept this statement made by another witness:

> *Melanie's placement in her seclusion was ceased on 20 November 2020. High level focus on seclusion practices within New South Wales and subsequent policy change as well as high level meetings such as the Highly Complex Housing Pathway Governance Group and scrutiny by the Royal Commission galvanised buy in to overcome barriers to more closely align with Melanie's treatment and risk needs and provide a pathway out of seclusion in the Forensic Hospital.*

Do you agree with that?

DR ELLIS: Yes, I would agree with that statement.

DR MELLIFONT: How did scrutiny by the Royal Commission galvanise buy in to overcome barriers?

DR ELLIS: Well, I think all healthcare workers want to be seen as doing the right thing, and when it's made abundantly clear by organisations such as Royal Commissions, or the Chief Psychiatrist's Office, or other agencies, that the right

thing is to move people out of seclusion, that that forms part of the motivation of healthcare workers and I would include myself in that.

DR MELLIFONT: Do you regret Melanie not having been moved out of seclusion earlier than 13 November 2020?

DR ELLIS: I do.

DR MELLIFONT: What else would you do differently now in hindsight to make that happen earlier?

DR ELLIS: I would do --- I defer because I can hear your microphone, sorry.

DR MELLIFONT: My apologies. Go ahead.

DR ELLIS: It gave me time to think, so it's of use. No, this is something that has weighed particularly upon my mind in the role I undertook. I would have done everything I did, but faster. I am confident that this move out of seclusion will be sustained. I think that if I had done things on the day I started the job, if I had come in waving a pen and telling everybody what to do, we might be in a much more difficult situation than we are now.

DR MELLIFONT: Why do you say that, Dr Ellis?

DR ELLIS: I think that given the levels of staffing and levels of experienced staff, that there was a potential for an adverse outcome such as violent outcome, and that would have potentially set back what progress had to make. I think also it would have been --- it would have been somewhat presumptuous of me on the first day in a job, coming in overturning practice of some years without understanding it fully. I did need time to understand what was going on in the Hospital, and to --- then I needed time to, you know, ensure that recruitment was sufficient, and to address all the issues so that they could be addressed in a sustained manner. I don't think there was a quick fix here.

DR MELLIFONT: I'm going to ask you one more question but just with respect to the question I've just asked you, which is reflections about what you might have done differently. If there are further thoughts that you have, are you content to take them on notice and provide them later?

DR ELLIS: I am, yes.

DR MELLIFONT: Thank you. Now, you said that you hold some optimism in terms of Melanie and being out of seclusion, and that will continue. What measures have you put in place to be confident that she's not going to be returned to that seclusion, extended seclusion arrangement?

DR ELLIS: So we have a new seclusion policy that falls in line with the NSW

Health Seclusion Policy. The term "long-term seclusion" no longer exists. If she was in seclusion for longer than a day, I would be doing everything possible to overturn that.

5 DR MELLIFONT: And what about some actual written procedures around detecting, triggering, reporting of times in seclusion up to you, auditing and processing through to make sure things are followed up on. Is that going to be part of the plan?

10 DR ELLIS: Yes, that's part of it --- there's significant documentation around seclusion. It is also going to be made a key performance indicator for the Hospital.

DR MELLIFONT: Thank you, Dr Ellis.

15 Chair, I understand that Ms Needham does have some questions of Dr Ellis and I'm not sure who else might as well.

CHAIR: Yes, all right. Just before we do that.

20 When you take into account, Dr Ellis, the question that Dr Mellifont has just asked, mainly what might have been done differently, would you be good enough to take into account the existence of the several reports that Mr Forrest had organised upon his arrival in 2016 and I think were in existence by 2018?

25 DR ELLIS: Yes. Those reports were provided to me when I started. I had those available to me when I started in the role.

CHAIR: All right. Thank you.

30 Ms Needham, you wanted to ask some questions?

MS NEEDHAM: Yes. Thank you, Chair. I have some questions for Dr Ellis about paragraphs 57 and 58 of his first statement.

35 CHAIR: Just so you understand Dr Ellis, Ms Needham represents the Public Guardian.

DR ELLIS: Thank you, yes.

40

CROSS-EXAMINATION BY MS NEEDHAM

MS NEEDHAM: Thank you, Chair.

45

Dr Ellis, do you have that statement in front of you?

DR ELLIS: Yes, I've got those.

MS NEEDHAM: Those paragraphs are on pages 16 and 17.

5 DR ELLIS: Yes.

MS NEEDHAM: Now, looking at paragraph 57, that's a list of services and activities available to Melanie while she was in her rooms. That's correct?

10 DR ELLIS: That's correct.

MS NEEDHAM: And during the time that she was in seclusion, understanding that this is no longer the case, she was in her room for up to 22 hours --- sorry, for at least 22 hours a day. Is that correct?

15

DR ELLIS: Yes.

MS NEEDHAM: And the activities that you've listed there which are available to her whilst she was in her rooms are activities which were dependent, to a great

20 extent, leaving aside the clinical reviews, upon the staff providing those activities for her; would you agree with that?

DR ELLIS: Absolutely. She was in seclusion and reliant entirely on staff to provide those.

25

MS NEEDHAM: And, for example, the music that she was able to listen to had to be provided for her by staff for her to be able to listen to music?

DR ELLIS: Yes.

30

MS NEEDHAM: And for television programs, she had to request those programs and the staff had to approve them and turn the TV on?

DR ELLIS: That's correct.

35

MS NEEDHAM: Again, her magazine reading was provided to her by each individual page of a magazine being ripped off and passed under the door?

DR ELLIS: That's correct.

40

MS NEEDHAM: And those magazines were determined as being suitable by the staff and not by Melanie's choice; is that right?

DR ELLIS: That's correct.

45

MS NEEDHAM: And it's the case, isn't it, that spending time in her courtyard was really something that happened more when she was being moved from one room to

another?

DR ELLIS: That was sometimes --- she did sometimes spend time in the courtyard by her decision but it was primarily a means of moving between one room and the other.

MS NEEDHAM: And it's the case, isn't it, that these were activities that --- sorry, the games that were played with her were through, as we've heard, a heavy unbreakable glass panel at head height in a very heavy door to the seclusion room?

DR ELLIS: Yes.

MS NEEDHAM: So when she played, for example, I Spy or Hangman, there was a physical barrier between the person playing with her and Melanie?

DR ELLIS: Yes, there was.

MS NEEDHAM: Now, moving to the list of activities which you have when she was out of her room, again this is a list of items which include some clinical or therapeutic sessions. For example, pet therapy, psychology sessions, occupational therapy. Do you agree?

DR ELLIS: Yes.

MS NEEDHAM: And some of those activities were actually part of --- sorry, I will withdraw that. They weren't recreational per se, they were part of her therapy. For example, the cooking sessions were part of the occupational therapy sessions; is that correct?

DR ELLIS: Yes. Some of them are skill-building sessions and have a therapeutic bent rather than something that's completely guided by the person.

MS NEEDHAM: Now, the list which is available there is not a list of what was available for her each day. It was a list of activities which had been available to her at some point during the years when she had been in seclusion. Would you agree with that?

DR ELLIS: Yes. She certainly didn't do all those things every day.

MS NEEDHAM: And she didn't have the choice of each of those things every day, did she?

DR ELLIS: No. That would have been largely dependent on factors outside of her control.

MS NEEDHAM: Yes. So if she was having a psychology session, there wouldn't be much time left for walking or swimming or pet therapy?

DR ELLIS: Yes. And again I think we've heard evidence about the pet therapy, that that was from an external provider and so that's not available at the time.

5 MS NEEDHAM: Yes. And the swimming hasn't been available for some time, has it?

DR ELLIS: No, it hasn't.

10 MS NEEDHAM: And that was something she particularly enjoyed?

DR ELLIS: Yes.

MS NEEDHAM: And generally speaking the activity available to Melanie, which
15 was offered to her as a recreational activity, was going for a walk?

DR ELLIS: Sometimes, yes.

MS NEEDHAM: And the sensory rooms weren't actually available for her, they
20 were located on a different ward?

DR ELLIS: Yes. The sensory rooms and also are a relatively new addition.

MS NEEDHAM: Yes. Just excuse me one second. So it's fair to say that even
25 though there is a long list of activities which were available to her when she was outside the ward, it was the case that she didn't have access to these activities on a frequent or even a regular basis for various reasons?

DR ELLIS: That's correct.

30

MS NEEDHAM: Thank you. Thank you, Chair, there is no.
Further questions.

CHAIR: Thank you very much. There was one thing actually I meant to ask. To
35 your knowledge Melanie does not have difficulty reading and writing, does she?

DR ELLIS: She can read and she can write. In fact the other day she showed me some tasks that she would been doing with the psychologist that she was particularly proud of and she requires assistance in those areas but she's certainly capable of
40 reading and writing.

CHAIR: Good. Thank you. Does anybody --- any other party have questions, particularly Ms Furness, is there anything you wish to ask?

45 MS FURNESS: No thank you, Chair.

CHAIR: Is there any other counsel or legal representative that wishes to ask

questions of Dr Ellis? If not, Dr Mellifont, is there anything that arises out of the questions that have been asked?

DR MELLIFONT: No. But can I ask two more quick questions, please?

5

CHAIR: Of course you can.

DR MELLIFONT: Thank you. Dr Ellis, when did cultural work that is connected with her First Nations identity start with Melanie?

10

DR ELLIS: I understand that this has started relatively recently due to the fact that we didn't have Indigenous health workers in the hospital before. Other than the generic interventions that we would have available to any Indigenous patient so that it's only a relatively recent introduction.

15

DR MELLIFONT: So by generic interventions you mean NAIDOC Week, for example?

DR ELLIS: Things like that, yes. We have some cultural resources but the majority
20 that --- we have very few Indigenous employees.

DR MELLIFONT: Okay. Now, the last thing I want to ask you is this. We know that the Adult Guardian is doing the work trying to get the NDIS package for Melanie in the community, both STA funding and SIL funding. Who does that for
25 patients who are transitioning into the community who don't have a guardian? Does the Forensic Hospital take it on for them?

DR ELLIS: Yes, we do. So we have our staff apply for NDIS packages and we've been able to move some, a very small number, but some patients out of the Forensic
30 Hospital into appropriate care supported by the NDIS. It is a somewhat cumbersome process but our staff can do that and we have --- Justice Health has a dedicated position for assisting with dealing with the NDIS.

DR MELLIFONT: Thank you. Thank you, Chair.

35

CHAIR: Thank you. Thank you very much, Dr Ellis, for giving evidence. We appreciate the assistance you've given to the Royal Commission and thank you for agreeing to provide the additional information that has been referred to during your evidence. Thank you.

40

DR ELLIS: Thank you Commissioners.

THE WITNESS WITHDREW

45

CHAIR: Dr Mellifont, we should now adjourn until when?

DR MELLIFONT: Well, we are running a smidge behind. We had planned on coming back at 1.30 Brisbane time, 2.30 Sydney time, but that's too short a period for lunch. So can we make it 20 to? Is that too short a time?

CHAIR: We will compromise and make it 1.45 your time and 2.45 our time.

MS NEEDHAM: Chair, can I say that's the end of the involvement of the Public Guardian of New South Wales in the case study, as I understand it.

CHAIR: Yes. Thank you.

MS NEEDHAM: So I seek to be excused.

CHAIR: Yes. By all means. Thank you, Ms Needham.

MS NEEDHAM: Thank you Chair, Commissioners.

ADJOURNED **[1.53 PM]**

RESUMED **[2.46 PM]**

CHAIR: Yes, thank you. Mr Power, yes.

MR POWER: Thank you, Chair, I call Dr Piers Gooding.

CHAIR: Yes. Thank you. We will wait for Dr Gooding to come up on screen. I'm told five seconds. There we are.

Good afternoon, Dr Gooding. You can hear us apparently but we can't hear you which probably means you've to unmute yourself.

DR GOODING: Afternoon, Chair. Thank you so much for having me.

CHAIR: Thank you for coming to give evidence. First I'll ask Mr Power to attend to one or two formalities and then we will have you sworn or affirmed as the case may be.

DR GOODING: Thank you.

MR POWER: Commissioners, you will find Dr Piers Gooding's written statement at tab 5 and his curriculum vitae at tab 6 of Tender Bundle B1. I ask to tender these documents into evidence and have them marked as 11.11.1 and 11.11.2 respectively.

CHAIR: Yes. Thank you. That can be done. Thank you very much.

EXHIBIT #11.11.1 - STATEMENT OF DR PIERS GOODING

EXHIBIT #11.11.2 - CURRICULUM VITAE OF DR PIERS GOODING

MR POWER: There are attachments to Dr Gooding's statement. They are at tabs 3 to 5 of Tender Bundle D1. I asked they be tendered into evidence and marked 11.11.3 to 11.11.5, and then further, at tabs 33 to 35 of Tender Bundle D1 are a chart and two articles that will be referred to in evidence and they are --- I ask that they be tendered and marked as exhibits 11.11.6 to 11.11.8.

CHAIR: Yes, all of those documents will be admitted into evidence and given the markings indicated by Mr Power.

EXHIBITS #11.11.3 TO #11.11.8 - ANNEXURES TO STATEMENT OF DR PIERS GOODING

Dr Gooding, if you would be good enough to follow the instructions of my Associate and she will administer the affirmation.

DR PIERS GOODING, AFFIRMED

CHAIR: Thank you, Dr Gooding. Just to explain where everybody is, Mr Power is in our Brisbane room together with other Counsel Assisting the Royal Commission. Commissioner Mason is also in the Brisbane hearing room. Commissioner Atkinson who is onscreen is joining us remotely, and Commissioner McEwin and I are in the Sydney hearing room.

Now Mr Power will ask you some questions.

EXAMINATION-IN-CHIEF BY MR POWER

MR POWER: Thank you, Chair.

Dr Gooding, could you tell the Commission your full name and your occupation.

DR GOODING: Dr Piers Gooding. I'm a Research Fellow with the Melbourne

Social Equity Research Institute and Melbourne Law School.

MR POWER: Is the statement that has just been tendered into evidence dated 5 November 2020 correct to the best of your knowledge?

DR GOODING: Yes.

MR POWER: Now, at paragraphs 33 to 43 of your statement you discuss the different legal frameworks that exist across Australian jurisdictions for fitness for trial and the consequences of such a legal finding. Could you describe, by way of overview, the different approaches between the jurisdictions with regard to the question of fitness for trial, how that's determined, and the consequences of that finding?

DR GOODING: Sure. As I noted in my testimony, the legal test of a person's unfitness to stand trial is effectively the same throughout Australia, and it's drawn from the Victorian case of *R v Presser*. I won't read the criteria here which I've included in the statement, but crudely a person must be able to understand what's happening in court proceedings, follow along, contribute, raise a defence and so on. Now, that's a crude summary but that's essentially what's happening.

Although the test is broadly the same across the board, the outcomes of a finding of unfitness to stand trial and what happens in that determination is substantially different, and there are two main differences. First, the testing of the evidence against the person and second, the disposition of the accused or what the court decides should happen to that person at the end of the proceedings.

Outcomes can include acquittal, indefinite detention in prisons with no judicial scrutiny of facts, special hearings that could lead to non-custodial supervision orders in the community or in other settings, or detention for a fixed term in a forensic facility.

Some jurisdictions have special hearings which are essentially modified or shortened trials designed to ensure that an individual's liberty isn't restricted without some proper basis, and in all jurisdictions with a special hearing the Crown must prove the physical elements of the offence to the criminal standard.

At the Commonwealth level there is no provision for a special hearing although the prosecution must establish a prima facie case against the accused.

In Western Australia and Queensland there is no provision for special hearings or, as I understand it, an alternative means of putting the Crown to proof. So after a person is found unfit to stand trial, most jurisdictions permit a court or a tribunal to elect between a custodial order and a community-based supervision order. Supervision orders are typically for less serious offences and involve ordering a person to reside in a secure setting or a highly restrictive setting within the community.

Forms of custodial order, on the other hand, differ considerably between jurisdictions. If the same person was found unfit in Western Australian law, that individual would be subject to a custodial order at the Governor's pleasure. In Queensland and Tasmania that same discretionary power is granted. Whereas in other jurisdictions, that person would face a custodial order that operates essentially like a sentence imposed after a conviction that expires on a pre-determined date.

So this means, in short, that there are four unfitness detention models in Australia. The first is the Governor's pleasure detention, again in Western Australia and Tasmania, there is effectively this model. Disposition is discretionary in the sense of the courts, or in the case of Queensland, the Mental Health Tribunal can decide whether to make a custodial order or release a person. But if a court or tribunal decides to proceed with a custodial order, that order is indefinite.

MR POWER: Sorry, Dr Gooding, can I ask you to slow down slightly to ensure that we catch everything and the Auslan interpreters can do so.

DR GOODING: Excuse me. Yes.

The second is a nominal term approach which you see in the Northern Territory and Victoria. Under this approach, after a person is found unfit and it's determined that they should be not released unconditionally, a nominal term is set. These dispositions essentially still amount to indefinite detention. However, at the end of the nominal term, the court must conduct what is called as a major review. This term is designed to safeguard against arbitrary detention and requires the court to ensure that the person isn't lost in the system.

But ultimately, again, the term remains indefinite and can lead to a sentence that is longer than would otherwise be imposed in a typical trial.

MR POWER: All right. Now, just to draw out from that, firstly in some jurisdictions the detention can be in a prison itself, that is a correctional institution. Is that correct?

DR GOODING: Indeed.

MR POWER: Yes. The second aspect of that is that even in jurisdictions that have nominal terms or limiting terms, depending on the terminology, they are not truly limiting in that they can be extended upon application?

DR GOODING: Yes. A limiting term, just to provide a little context, is operative in South Australia and New South Wales and it essentially imposes the best estimate of the sentence that the court could have considered appropriate if the person was tried and convicted in typical proceedings. The individual would then cease to be a forensic patient and then be released.

However, health authorities may apply for extensions to custodial orders and so

arguably that could result in an indefinite detention if that order was reimposed. And that would be determined by, again, health professionals who would consider the risk that a person poses.

5 CHAIR: Dr Gooding, what is the difference between a nominal term and a limiting term?

DR GOODING: Again, with the nominal term there is a period of review --- sorry, there's a period of detention after which a review takes place by the court. And then
10 that is imposed based on, as I understand it, often the maximum period of detention that's possible. Whereas with a limiting term there is a requirement to make the best estimate of the sentence that the court would otherwise have imposed should the person have been tried in typical court proceedings.

15 CHAIR: A nominal term, in other words, has nothing to do with the severity of the offence or the punishment that would have been imposed had the person been fit to plead and found guilty, it's to do with the process of reviewing the custody of the person?

20 DR GOODING: Indeed. Yes, thank you, Chair.

MR POWER: Now, the other main option is where, by virtue of the finding of unfitness being permanent, a court orders that a person be either placed on an order or not placed on an order, but, if placed on an order that exists indefinitely, subject to
25 in some jurisdictions review by mental health tribunals and ultimately in Queensland at least by a mental health court.

Now, has there been, or is there available any empirical data showing whether persons with disability who are found unfit in those two different types of system
30 spend more or less time in detention-type custody, whether in a mental health hospital or in a prison as between those two different systems?

DR GOODING: I'm afraid not. This information is simply not easily and publicly accessible. If it is available, I'm not aware of how to access it and I'm certainly not
35 aware of any empirical research that has been conducted to verify whether people are detained in excess of what they would have received, at least systematically. But we certainly know that there are cases, in some instances quite notorious cases in which people have been detained well in excess what they would have received in a typical trial.

40

And it's really important to try to access that data because without it, it becomes much harder to monitor against these kinds of indefinite detention periods that far outlast a typical sentencing approach. And that really makes it difficult for Australia to meet its obligations under various, well, international human rights law
45 instruments such as the optional protocol for the *Convention against Torture* but also under the *Convention on the Rights of Persons With Disabilities*. So without that data there is a gap in monitoring an accountability effort.

MR POWER: And in a practical sense does it also make it difficult to work out what is the best legislative model as measured by actual outcomes within a --- as between jurisdictions?

5

DR GOODING: I think that's almost certainly true. It makes it far more difficult to see how the law is working in practice because it's one thing to analyse the legislative text but it's another to see whether people are being treated in accordance with those laws and where they may be going terribly wrong or where they may be working as
10 intended.

MR POWER: Now, as has been referred to just a short time ago, the imposition of a limiting term, at least in New South Wales, involves a determination of the penalty that would be appropriate for a person who had committed the alleged offence. Do
15 you consider that there is a tension between that quasi-sentencing exercise and the fact that the person who is subject to that exercise having been found unfit to stand trial has not been found guilty of any criminal offence?

DR GOODING: Well, yes, there is certainly a tension, and that tension goes to the
20 heart of the debate about the appropriateness of unfitness to stand trial laws. And this tension is playing out in other areas of contemporary life relating to disability, and that essentially boils down to how you achieve equality. So in the example of schools, special schools, for example, you know, there's a question of whether they should be closed down and integrated with mainstream schools. Well, there's a
25 question here about whether it's appropriate to impose a detention period that is linked to a criminal trial when in fact a person hasn't been convicted of a crime.

On the one side you've, I suppose, a therapeutic and protectionist or welfare approach which suggests that prisons are fundamentally the wrong place for people with
30 certain cognitive disabilities, so therefore they must be diverted to forensic services for the purposes of healing and treatment. And, indeed, the Victorian Law Reform Commission rejected the call for limiting terms for this very reason, suggesting that it would be inappropriate to link to the typical penalty.

35 But on the other side you've a call under legal instruments like the *Convention on the Rights of Persons with Disabilities* for a more transformative approach to equality that says, well, we can no longer design public institutions that treat disability as an exception that requires separate and special treatment, and that instead those very public institutions must be transformed to duly acknowledge the fact that disability is
40 a core part of human diversity.

And so that would require more clearly linking the process to the criminal trial. So I hope that explains what I think is almost a philosophical tension but it's certainly a tension that's playing out in the policy and legal questions around
45 unfitness-to-stand-trial laws.

MR POWER: And in your statement you refer to that position, sometimes called the

abolitionist position, and at paragraphs 31 and 44 of your statement you indicate that at least some advocates and academics consider that a person with a disability being declared unfit to plead and as a consequence being detained in any form is incompatible with articles 12 and 14 of the United Nations *Convention on the Rights of Persons With Disabilities*. Now, is that a universal view or are there academics who hold a contrary view to that abolitionist position?

DR GOODING: It's not a universally held view but I think it's safe to say that Australia's unfitness to plead regimes are quite clearly in violation of the Convention Against Torture --- sorry, *Convention on the Rights of Persons with Disabilities* and particularly articles 12 and 14 but also, I would say, article 13 is engaged here. Article 12 essentially requires respect for a person's legal capacity on an equal basis with others, and a requirement that the person receive support to exercise his or her legal capacity. Article 13 then concerns access to justice and requires the State to provide procedural accommodation to ensure equal access for persons with disabilities, and article 14 effectively prohibits detention on the basis of disabilities.

So if a person is deemed unfit to stand trial without there being a requirement in law to ensure maximal support for that person to participate, then it is hard to see how article 12 is being respected. And, indeed, the eminent law professor Ron McCallum, I note, in his report for the Royal Commission, writes that the doctrine of unfitness to plead goes against the ethos of article 12 by not enabling persons with severe cognitive disabilities to defend themselves. Then article 13 and 14, he goes on to say, are violated by these laws because the inability to access justice and be deprived of liberty on grounds of disability often go hand in hand.

So to elaborate, and forgive my long answer here, if a person is detained even though they haven't received a criminal conviction and haven't had the evidence against them fully tested, then it's hard to see how such an individual is not being detained on the basis of their disability. But the question is how far do you go, and that's where I think you will find the debate amongst people. Do you fundamentally re-think the nature of responsibility in criminal law to better accommodate people with disability, or this would require effectively that there is no designation that a person is unfit? And instead, various supports would need to be provided to ensure a facilitated trial in which all evidence could be tested. But this has been vigorously refuted by some.

For example, US law professor Michael Perlin has argued that abolishing these kind of special defences would actually result in severe disadvantage that would ultimately violate the Convention and violate people's rights to a fair trial. It would also, he argued, end up with more people with cognitive disabilities in prisons which would arguably compromise their right to freedom inhuman and degrading treatment. But I just provide that debate for context because it's really what we need to grapple with.

But there is strong overlap between these positions, and where I think there's a lot of productive room to move in a practical sense is ensuring supports in court

proceedings.

MR POWER: I want to turn to that aspect of your evidence in a moment but just so we can complete that, you've referred to the position of Professor Michael Perlin of the New York University Law School and I note, Chair, that's the person who Dr Ellis studied with.

CHAIR: I'm not sure that's right, is it? New York University is not New York Law School.

MR POWER: I think Dr Ellis referred to it as New York Law School but Professor Michael Perlin is New York University Law School.

CHAIR: In that case, New York University Law School which I have attended as a visitor was misplaced. It is in Washington Square, I can promise you.

MR POWER: Yes. Yes. So the article that's referred to, and it's in the Tender Bundle, and that is DRC.9999.0023.0022 and on page 495 of that article, which is DRC.9999.0023.0041, Professor Perlin notes that:

> *The trial of a person who cannot comprehend what is going on or who cannot cooperate with her counsel cannot be a fair trial.*

And he also makes the point that it is something where the preservation of this system, as you've indicated, in a practical sense is required for as long as the system that we presently have exists.

So if I can then turn to the issue of making accommodations to our system of trial for persons with disability, and if I can just ask you this. Has the research you've conducted been directed solely to people who would otherwise have been unfit or is it broader than that, that is, people with disability who would be found fit but nonetheless would suffer from disadvantage under our present system?

DR GOODING: My research which I conducted as a post-doctoral researcher for a group of researchers based here at the University of Melbourne and the University of New South Wales involved looking at all of those categories. That research was led by Professor Bernadette McSherry and chief investigators included Associate Professor Anna Arstein-Kerslake, Professor Eileen Baldry and Professor Kerry Arabena.

We looked at all three categories and we argued that it was useful to consider them together by focusing simply on those who are manifestly unfit to stand trial under current laws. There are limits on the type of (inaudible) that can be provided. We were quite interested in those who were in the grey zone between fit and unfit, and our work was premised on the view, which is supported by various Law Reform Commissions, that certain people could be assisted to optimise their fitness to stand trial under current laws.

However, in the process of providing assistance in community legal services to accused persons with cognitive disabilities, it became apparent there are a great number of people who fit that category who are manifestly fit to stand trial, but who nevertheless face considerable disadvantage in their encounters with the criminal justice system. That could be at the point of police interview right through to engagement with lawyers and in the court proceedings themselves.

And so we viewed the type of assistance that was being provided through our research as valuable to all three groups, because the type of support that is likely to be of use to someone who is in the grey zone of fitness and unfitness, is also likely to be of use to persons with cognitive disabilities more broadly. And indeed potentially those who are manifestly unfit, and that could take various forms.

MR POWER: To break that into two parts, the first part of it is assistance within the courtroom itself or adjacent to the courtroom itself. The second part is assistance in the criminal justice system more broadly. But I want to start with that first part. At paragraph 49 of your statement you refer to a 2016 report of the Law Commission of England and Wales, and in that report reference is made to an English case The Queen v Sevenoaks Youth Court [2010] 1ER 375 which discussed the power of a court to appoint an intermediary for a person with a cognitive disability and to make other accommodations in the manner of the trial.

Now, the English Court of Appeal held that that was inherent in the common law powers of the court and that such adjustments needed to be considered. Are you aware of whether those powers have been discussed in Australian cases?

DR GOODING: I am certainly aware of Australian cases which have made use of the jurisdiction of the courts to provide for reasonable adjustments to the trial of an accused person with a cognitive impairment. I'm both aware of individual cases that have made use of evidence law to allow adjustments in courts, as well as concerted programs that have emerged in recent years to embed a communication intermediary in a court, and just to elaborate on what an intermediary is, in the formal sense of a court intermediary or a communication assistant that is appointed by the court, they are considered to be an officer of the court who is a neutral communications specialist. And that was slightly different from the type of support we provided throughout our project, but I'll elaborate on that later.

But to give you an example of an Australian case where that kind of support was provided, in GAE v Western Australia, the expert witnesses submitted that the accused had a poorly defined cognitive impairment, and mental impairment, and the court in that case allowed for the use of regular breaks, a closed circuit television room so the person could provide a statement, and the assistance of a family member to assist in communication, following a special witness declaration.

And these supports were considered appropriate safeguards that enabled the defendant to participate in proceedings. And as a result of that, the accused was

found fit to stand trial. I have other examples. I don't know if you want me to go into them but I can elaborate.

MR POWER: No. Thank you. And they are referred to, with the footnotes for them in a paper which forms part of the Tender Bundle. And just to note, you've referred to the Victorian Equal Treatment Bench Book, and I note that the Queensland Supreme Court Equal Treatment Bench Book has the provision for something similar to what you've described, in that a person with intellectual disability can give evidence by way of pre-recorded evidence by videolink and:

> *.... and to have a carer interpret the witness' evidence.*

The Bench Book notes:

> *Whether such an application is accepted is a matter for the trial judge.*

In the review of the cases you've done ---

COMMISSIONER ATKINSON: Mr Power, I think I better at this point declare that I was the co-editor of that particular publication.

MR POWER: Thank you, Justice Atkinson.

The reason for my referring to that is that although there is reference to that in the Bench Book, is it correct, from your review of the cases, it's very rare, although it has been done, to see that reflected in at least reported decisions?

DR GOODING: I'm not sure whether I can say that it's very rare, but our research which sought to summarise and seek examples from case law of the invocation of these types of supports, we came to the conclusion that the measures appeared to be applied in a rather ad hoc way and were used somewhat inconsistently. So I don't know that we can say that they are used rarely, but we certainly cannot say that they are used in a systematic manner across various courts in order to ensure the participation of persons with disabilities in proceedings.

So I would say there's sufficient evidence to say that they are under-utilised.

MR POWER: All right. So we will turn now to the other --- well, an aspect that you've also studied and that is the assistance of a disability justice support person. Could you explain briefly what the research was and what the findings of that research were?

DR GOODING: Sure. That was a two-year project that was funded by the National Disability Research and Development Grant to examining unfitness-to-plead laws, and the aim was to experiment and identify effective supports for people who were at risk of being found unfit to stand trial and detained indefinitely.

As part of that research, four disability justice support persons, as we described them, were embedded within three community legal services, two of them were Aboriginal-controlled legal services, and they spent six months assisting accused persons with various intellectual, cognitive and psychosocial disabilities in their proceedings. And the aim was to particularly try to identify those who were in the grey zone of being fit and unfit, but also to attempt to provide support to people in various ways.

The support ranged from communication assistance to gathering essential files relating to that individual, approaching various services, engaging with courts to discuss and agree upon reasonable adjustments and so on. And in that six-month period we found a myriad of ways in which such advocates could provide effective support to people, including optimising a person's fitness to stand trial.

We also did a cost-benefit analysis and various other inquiries into how that program played out.

MR POWER: I was going to come to the cost-benefit analysis in just a moment. But at paragraph 56 of your statement you go through the range of matters that the support people provided and at paragraph 56. I won't read them all out but they can be seen there listed from (a) through to (j). But is it correct that this was about a person with disability gaining autonomy, being able to be assisted to make decisions affecting themselves in the criminal justice system right from the start of the case?

DR GOODING: Indeed. That was the intention. The aim was to provide supported decision-making to a person as they engaged with their defence counsel and engage with the court processes. But what we found was that the assistance provided went beyond just the decision-making of the individual. I can give you one quick example to show how that played out.

MR POWER: Yes.

DR GOODING: There was a person who was charged with an assault in a group home, and that person was --- their file had come to the community legal service. As they were preparing for the trial, the assistant or the disability justice support worker identified that the Disability Service itself had not been following its own guidelines on reducing conflict. And so, pointing that out, the police prosecution withdrew the charge. And so that was an example where the disability justice support person never interacted with the accused person but had a profound impact on their case.

So the support went beyond supported decision-making to include various forms of advocacy to address disability disadvantage.

MR POWER: And you note, you've said that these disability support persons were housed within community legal centres, one in Northern Territory, one in Victoria, and then the Intellectual Disability Rights Service in Sydney. And is it the case that the support people were able to gain support from that structure, but also that

community service could use those people across quite a large number of clients where they averaged 15 to 20 people with disability who were assisted by those workers?

5 DR GOODING: That's correct. And another example of the ways that the disability justice support workers were assisted by the host organisations is in the two Aboriginal-controlled legal services which provided cultural competency training to the non-Indigenous support people, and that was essential for the type of clients that were being assisted as part of their work.

10

And indeed I would just like to notice the Intellectual Disability Rights Service drew from their work with the Justice Criminal Support Network which I understand has now evolved to the Justice Advocacy Service, which provides a very similar and I would say vital form of individual and, in some ways, systemic advocacy for persons

15 with cognitive disabilities within the justice system.

CHAIR: Dr Gooding, I can readily understand the benefits of the kind of supports to which you referring, people with cognitive disability in the justice system and not only in relation to fitness to plead. It's obviously a general issue about access to

20 justice supports for people so that they can understand and participate in the system. What I'm not entirely clear about is why it would necessarily be to the advantage of somebody to go through the orthodox criminal justice system rather than be found unfit to plead and be dealt with in another way if, following such a determination to plead, there were very different systems for review and so forth. I can understand

25 why Professor Perlin --- who by the way is at New York Law School and not New York University --- I can readily understand why he says that there are dangers in the American legal system, three strikes and you're out and all sorts of things, you can end up in jail for life for relatively minor offences. Australia fortunately is not that draconic, but I'm just wondering if there is another way of approaching this that

30 doesn't necessarily revolve around having a greater participation in the fitness-to-plead part of the exercise.

DR GOODING: Thank you, Chair. It's an excellent question. I refer to the Law Commission of England and Wales finding or recommendation that the typical

35 criminal trial is ideal for several reasons, for the victims, for the community to ask people to account for their crime, and for the person to be able to defend themselves.

Speaking to the particular context of Australia, well, what we identified was that there were risks, and these are well identified in various reports, that people who are

40 found unfit to stand trial would face extreme and deleterious consequences for that finding, including being indefinitely being detained far in excess of what they would have got in a typical trial. Interestingly, Professor Michael Perlin notes the case of Mr Marlon Noble in Western Australia in --- which I've included in my witness statement so I won't go into detail, but I think he misunderstood that the precise

45 outcome he was concerned about, the incarceration of a person in the prison system, occurred after the man was found unfit to stand trial. So the risks in certain jurisdictions are very clear such that we had reports from defence counsel who would

consider the ethical dilemma of potentially wishing to enter someone in a plea even when there was a question about their unfitness because they knew the person would be released after their sentence, whereas an unfitness to plead finding would lead to detention far in excess, so there's a --- sorry, Commissioner, go ahead.

COMMISSIONER ATKINSON: Sorry, I should let you finish.

DR GOODING: No, that's okay.

COMMISSIONER ATKINSON: I think the problem with your logic is this. There are two issues here. One is the right of a person to understand their criminal trial, and as a former judge I can tell you I would be very uncomfortable having a criminal trial if I thought that the person who was in the dock understood nothing of what was going on. And I'm certainly someone who would use every effort to try and get them assistance to understand what was going on. But then it seems to me the quality of treatment does not involve treating unlike like, and if someone cannot understand their criminal trial then it is grossly unfair to them, indeed cruel to make them stand trial, and in fact I think that might well lead to the criminalisation of disability because if the reason for the offending was the disability or the reason why they had been arrested for that offending was because of their disability, it seems to me to be grossly unfair. That's just my opinion.

But the second thing is the consequence of it. Now, if we look at cruel and unfair consequences of not being able to understand the trial and therefore never having been found guilty, now obviously a person should not undergo cruel and unusual and essentially harsher penalties if they haven't been found guilty, and that's one of the problems I have with the idea of a limiting term.

The judge imposes a sentence of imprisonment not just for the offence and not just for the effect on the victim, but for the liability, the criminal responsibility of the offender. If the offender has none, how could you do that? That's intellectually void. It's just not possible to do it. So I think you've got to separate out the two things: the right of a person who is accused of a crime and has to undergo a trial to understand what is happening to them. And even with all the supports that can be possibly provided they cannot, it seems to me and I'm open to hear argument, that that is cruel and unfair and marginalising them and punishing them because of their disability.

But the second point, and we shouldn't confuse the two, is the consequences that flow from someone not having been found guilty because they are incapable of understanding a trial, incapable of entering a plea of guilty or not guilty, and if they can't enter a plea, then they are taken to a plea of not guilty. If they have never found guilty, then obviously the fact they would be in effect punished is grossly unfair.

But I suppose in my longwinded way I'm trying to say we need not to conflate the two issues. It's very important not to conflate the two issues.

DR GOODING: Commissioner, I think that's an excellent point and it summarises

really the logic for having unfitness to stand trial laws themselves. So I suppose it can be unhelpful to focus on this question of whether unfitness to stand trial laws should be abolished or not, and it's more productive in --- our research indicates, more room for practical, political reform to focus on what it means to, I suppose, incorporate inclusive design principles to inform an equality-based approach. And at minimum we argue that this would require the same standard of proof and probative value of prosecution evidence as typical trials, the same presumption of innocence with associated requirement of proof of all elements, and the availability of all defences and so on.

So as well as proceedings to be based on the rights, wishes and preferences of the person --- perhaps rather than a best interest approach. And two very pre-eminent legal scholars, Professor Anna Lawson at Leeds University and Ms Rosemary Kayess, a legal scholar known to many people here, have argued a trial of the facts or special proceedings could well constitute a reasonable accommodation and an accessibility measure for persons who are manifestly found unfit to stand trial under current laws.

We were certainly not advocating for the trial of people who are manifestly unfit under current criminal laws. That would be an egregious situation. But we were, I suppose, probing what it would mean to bring that inclusive design and to perhaps shift the focus somewhat away from a protectionist and therapeutic approach to ensuring equal recognition before the law. I realise there is not a neat distinction between the two, but as with the case of individuals like Mr Marlon Noble, we can see where those approaches can go terribly wrong.

CHAIR: I don't know whether you are familiar with Melanie's case that we've been discussing, but Melanie was ultimately sentenced to a limiting term --- sentencing, I mean, of 10 years based on what was said to be manslaughter. Reading the judgment I had the greatest intellectual difficulty in understanding how one goes about a sentencing process in relation to someone who has been found unfit to plead. It seems to me an exercise of not just complexity but there are inconsistencies in many ways, and I'm just wondering if this focus on the criminal law is somewhat misconceived, in the sense that, of course you've got to determine I think whether someone is fit to plead for the reasons that Commissioner Atkinson has given --- you can't have a criminal trial unless the person who is being tried understands what is going on. That would have been, I would have thought, a monumental affront to justice in a variety of ways. But once that happens, isn't the issue about the safety to the community and whether there's a risk and that is true regardless of whether anybody has been charged with an offence. In other words, exactly the same issues arise if someone has acted in a way that demonstrate that they are for the moment at risk of a serious harm to themselves or the community. It's in the same position, relevantly, as somebody else whose conduct demonstrates that risk of harm but have never come close to being charged with an offence. I'm not sure why the criminal law has got anything to do with it once they have found someone is unfit to plead. I might be overlooking a vast number of things and it might be totally misconceived, but it just seems to me, brings into a whole range of confused thinking about what

we're trying to achieve here.

DR GOODING: Thank you, Chair, for those observations and I think they're excellent points. I suppose these are live policy questions, as evident in the different approach that Law Reform Commissions and indeed jurisdictions have taken to these questions, but an example of where I suppose the lack of due process safeguards that accompany a criminal court proceeding not being applied and having an extreme and deleterious effect was in the case of Mr Marlon Noble, in which the evidence surrounding the original charges could never be tested in a court because the reason for detention was precisely the reasons you've described, concerns over community safety. But those concerns over community safety stemmed from the original accusations which had never had an opportunity to be fully tested.

So I suppose we are perhaps conflating to issues here as Commissioner Atkinson has pointed out, the process of testing the evidence in the first place and the disposition afterward. But I suppose my point is that there are due process safeguards associated with the criminal court proceedings that are essential here as well as, I suppose, rights concerns about equal recognition before the law. And it's not merely a formal equality that involves treating unalike alike but rather a question of what it requires to ensure that that person enjoys their right to equal treatment before the law on an equal basis with others.

CHAIR: Whatever that means. And there is lots of argument about what that means, as I'm sure you know. But there are many ways in which due process, as you describe it in the customary North American way, can be adhered to. It doesn't have to be through a criminal trial. If the issue is, is this person a threat to himself or herself or to the community, of course you would have thought you can have a process that is fair, that ensures a person is properly represented, and to the extent appropriate, supported, to address that issue, which is really the issue that is relevant once you are trying to decide whether somebody needs to be, as awful as it is, to be in some kind of institution as a measure of safety to that person and the community.

DR GOODING: Thank you, Chair. I think those are excellent points.

CHAIR: Anyway, that is probably something that has been addressed in the vast numbers of reports that I haven't read.

COMMISSIONER ATKINSON: Sorry, Mr Power, the Chair makes me want to say something else.

But, Dr Gooding, you said not a therapeutic approach. But if someone has committed what would otherwise be a crime for which they're not criminally responsible but which makes, on any rational view, them a danger to themselves and the community, then surely a therapeutic approach is the best approach? That is, to adopt an approach by which that person can be assisted to become well, and rehabilitated, and rejoin society, rather than a punitive approach which is essentially what punishment in the criminal justice system is, although there is also a view of

rehabilitation. One of the purposes of sentencing is explicitly punishment and community denunciation, which seems to me to be entirely inappropriate for someone who hasn't been found guilty, where rehabilitation and a therapeutic approach would seem to be a rational response to that person's situation. Surely they
5 shouldn't be punished?

DR GOODING: Thank you, Commissioner Atkinson. I should clarify that when I use the term "therapeutic", I don't mean to suggest that there is no role for a therapeutic approach in assisting people with impairments because that's manifestly
10 not true, and it's rather an overarching approach to (inaudible - coughing) law and policy that has adopted a concern with the best interests of the individual, does not necessarily lead to outcomes that would provide for the same assurances that the person has with the various safeguards in place that you would hope exist in a criminal law context. And I suppose focusing on the rehabilitative aspects of the
15 criminal law response could provide then an approach which provides greater consideration for responding in those cases.

But I think these kinds of, perhaps you could call them philosophical questions, perhaps detract from just the kinds of interventions that could assist in the vast
20 majority of cases.

COMMISSIONER ATKINSON: Sure.

DR GOODING: And certainly I think the lack of community-based alternatives of
25 support for people, certainly in jurisdictions such as the Northern Territory, is the key to addressing the negative outcomes that we see regardless of what philosophical approach, I suppose, for want of a better way of describing it, is taken. I certainly wouldn't want that to detract from those very practical interventions, the front end of a person's engagement with the criminal justice system.
30
COMMISSIONER ATKINSON: And to prevent what Professor Baldry correctly calls the criminalisation of disability.

DR GOODING: Indeed.
35
COMMISSIONER ATKINSON: We agree on that.

MR POWER: Perhaps to unite some of those issues, can I ask that the graphic which has been prepared in relation to a case study of "David" be placed on the screen. It's
40 DRC.9999.0023.0001. That will come up in a moment. Is it correct that the pseudonym "David" was used for a person within --- a case study you were involved with, and David was the person who had a cognitive impairment, his lawyers and those supporting him faced a quandary because he was on bail and there was a report saying he was unfit, and that as a result of a criminal justice support person, their
45 expertise, their linking together options, a suitable place was found for David in supported housing. And what this graph shows the vast differential in cost, with the point at the top being the cost allocated to the justice support person, and the other

potential pathways which were very real in this case because he was involved in the criminal justice system being tracked out with potentially a $390,000 difference between them.

5 And as a result of that support, the prosecution were persuaded to drop the charge because they considered that that diversion was open because of the support that was present in the community.

Sorry for that longwinded description but does that describe what this graph,
10 graphically imparts and your statement sets out in much greater detail?

DR GOODING: That's an excellent summary, and this work was undertaken, indeed led by Dr Ruth McCausland and Dr Rebecca Reeve in a paper of which I was a co-author. That graphic was an effort by us to identify the cost-benefit savings
15 associated with strategic intervention at an early stage in a person's encounter with criminal justice service assistance, to provide assistance for disability-related support needs.

I can elaborate on the case, but I think the graph speaks for itself and the additional
20 detail is there for anyone who wishes to read it. But we would argue this is indicative of the kinds of cost-savings that are possible with a program like the Disability Justice Support Program or indeed other equivalent types of programs such as the Justice Advocacy Service in New South Wales.

25 CHAIR: Dr Gooding, just so I can understand this, what are the assumptions that underpin the cost of "Charge withdrawn with support" and the cost associated with "Forensic Unit"? What are we comparing here?

DR GOODING: Thank you, Chair. The assumptions underlying the "Charge
30 withdrawn with support" are that these are the criminal justice system associated costs.

The support worker engaged with the individual and his family as well as associated disability services and came up with a plan to house this individual in a male-only
35 housing unit, with additional support such as relationships and a sexual education support.

CHAIR: Who was going to pay for that?

40 DR GOODING: The payments would have come, I suppose then, from the Department of Health and Human Services in the Victorian context. As I said, these are criminal justice system related costs that are underlying this ---

CHAIR: With all due respect, you are not really comparing like-for-like, are you?

45

DR GOODING: Indeed.

CHAIR: Because in order to compare the first item "Charged withdrawn with support", you've limited it to the criminal justice proceedings, but in the "Forensic Unit" you've lumped together the cost of looking after this person for presumably a significant period of time?

DR GOODING: Indeed, and I suppose a more robust cost-benefit analysis would incorporate all of those. I mean, we had to constrain the scope for pragmatic reasons to do with time and scale of the research project, and it was meant as an indicative approach to assessing these related costs. But we would, in the fullness of time and with sufficient resources, ideally undertake a larger scale cost-benefit analysis, which I understand is occurring in relation to the Justice Advocacy Service that I previously mentioned.

CHAIR: Yes. I'm not being critical of the particular study, but I do bear in mind that if a Royal Commission was to make a comparison of costs, we would have to be very careful to ensure that we are comparing like-for-like as far as possible.

DR GOODING: Thank you, Chair. It's a very important clarification.

MR POWER: Just on that point, David in this instance was in supported accommodation previously. So to the extent that it's not accounted for, which as the Chair says it's not, it was a pre-existing cost for David prior to this incident, and it was finding an alternative, perhaps slightly more supported and slightly differently populated, support housing for David after this event?

DR GOODING: Indeed, and if I can add one additional caveat, the projections of cost were based on the 12 months following the incident, and we indicated in our fuller study of this that ideally we could look at long-term costs, and my colleagues made the point that additional involvement with criminal justice system does tend to, for young men like David with cognitive disabilities, result in a snowballing effect of continuous engagement with criminal justice services. So a fuller examination would try to take into consideration those long-term costs.

COMMISSIONER ATKINSON: And I think, if you were doing a sophisticated examination, you would have to consider also who the victim was. You talked obviously ---

DR GOODING: Indeed.

COMMISSIONER ATKINSON: You are talking about some sexual offending in a group home. If the victim is another resident of the group home, then you're talking about a person with disability who is a victim of crime, and we often know that they are not treated equally as victims in the criminal justice system, and a person will not be tried based on their evidence. So that's a systems failure because an unsuitable group home was created which created the circumstance in which that crime would occur --- on which that offence or whatever it is, would occur.

So there are larger questions than just whether or not that person should be tried.

Often a victim in that circumstance would feel as if they had been let down by the criminal justice system because their victimhood was not taken as seriously as if the victim had not had a cognitive disability.

SO there are many ways of looking at it and, as the Chair says, other ways to fix things than through the criminal justice system.

DR GOODING: Thank you, Commissioner. That's an extremely important point. We did make that point in our article and I had it in the notes to discuss here, but as with all things there are complexities that don't make it straightforward and we probed this question, how would the alleged victim fare in this situation. And indeed, as you point out, there was no opportunity to, in a way, interrogate the service arrangement to make assurances that arrangement was rectified, and so that original service provider was doing something to address that at a more systemic level, I suppose. And there was no opportunity to assess whether they were doing something potentially negligent in the first instance. So those are certainly considered in more detail in our paper.

MR POWER: Thank you, Chair. That concludes the examination of Dr Gooding.

CHAIR: Thank you very much. I will assume that neither Commissioner Atkinson nor I have any further questions.

Commissioner Mason, do you have any further questions?

COMMISSIONER MASON: No thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No.

CHAIR: Commissioner Atkinson, if you really want to.

QUESTIONS BY THE COMMISSION

COMMISSIONER ATKINSON: Yes. Just one thing that I wanted to ask you because you did mention it, it's on a completely different topic.

Community legal services, as no doubt you know, and I certainly know, run on the smell of an oily rag. They have very little funding, they often do a lot of work to help vulnerable clients --- in fact that's essentially what they do across Australia --- the funding for this particular position --- that three positions I think you said in three organisations, where did that funding come from? Because the Commonwealth is

very limited in the funding it gives to community legal services.

DR GOODING: That's a very important question, Commissioner Atkinson. The funding came as part of the research funding, so given that was a trial that was six months long, it was an effort to introduce that program for a six-month period and then assess the outcomes. It's a live policy question as to where the funding like that would arise from in a more long-term way, and ---

COMMISSIONER ATKINSON: If your research showed that it was a good idea and it worked, then obviously if we were going to make a recommendation based on that, it would have to be on the basis that there was some funding for such a position, and where would the best fund --- who would the best funder be, and how would you ensure that was long-term, and what organisation should it be given to.

DR GOODING: Thank you, Commissioner.

COMMISSIONER ATKINSON: If you want to give some more thought to that, and perhaps provide us with your thoughts on that, that would be useful, thank you.

Sorry, Chair, I did have more to say. If you give me the rest of the day I probably would have a lot more to say. Thank you.

CHAIR: Thank you very much. I will just ask whether any of the counsel or legal representatives wish to ask Dr Gooding a question.

MS FURNESS: No, thank you, Chair.

CHAIR: Thank you very much.

In that case, Dr Gooding, thank you very much for providing your statement and giving us a very stimulating afternoon of discussion. You remind me next month will be 61 years since I entered the University of Melbourne Law School as a student. Time does pass very quickly, Dr Gooding. Thank you very much for your attendance.

DR GOODING: Thank you so much, Chair.

Thank you, Commissioners.

THE WITNESS WITHDREW

MR POWER: Thank you, Chair.

DR MELLIFONT: The next witness is Professor Eileen Baldry who should be with you there in the Sydney hearing room. May I just ask if she's there or we need to

have a couple of minutes' break to set up?

CHAIR: We better have a couple of minutes' break because Professor Baldry is not in fact here. I did see her earlier just coming out of the lift so I assume she is in the building. We will track her down and we will resume in five minutes.

DR MELLIFONT: Thank you.

ADJOURNED [3.54 PM]

RESUMED [3.58 PM]

CHAIR: Dr Mellifont, we do in fact have Professor Baldry in the Sydney hearing room so please take it from here.

DR MELLIFONT: Thank you. You will find Professor Baldry's written statement at Tab 7, the curriculum vitae at Tab 8 of Tender Bundle B.1. I ask to tender these documents into evidence and for them to be marked 11.2.1 and .2 respectively. Attachments to Professor Baldry's statement are at tabs 6 to 14 of D.1. I ask they be tendered into evidence, marked 11.2.3 through to .11.

CHAIR: Yes ---

DR MELLIFONT: A PowerPoint presentation --- there is one more, a PowerPoint presentation which we will be displaying in the course of Professor Baldry's evidence is Tab 36, Tender Bundle D1. I ask for it to be tendered into evidence and marked as 11.2.12. There is a couple of typos in it and we will correct them as we go and provide a corrected copy for the public record.

CHAIR: Very good. All of those documents can be admitted into evidence and given that designation. Thank you.

EXHIBIT #11.2.1 - STATEMENT OF PROFESSOR EILEEN BALDRY

EXHIBIT #11.2.2 - CURRICULUM VITAE OF PROFESSOR EILEEN BALDRY

EXHIBITS #11.2.3 TO #11.2.11 - ANNEXURES TO STATEMENT OF PROFESSOR EILEEN BALDRY

EXHIBIT #11.2.12 - POWERPOINT PRESENTATION BY PROFESSOR EILEEN BALDRY

5 Professor Baldry, thank you very much coming to the Royal Commission to give evidence. On behalf of the Commissioners, I'm sure they join me in congratulating you on being made an Officer of the Order of Australia in the recent Honours list. I would ask you, if you don't mind, to pay attention to my associate who will read you the affirmation.

10

PROFESSOR EILEEN BALDRY, AFFIRMED

15 CHAIR: Thank you, Professor Baldry. Dr Mellifont will now ask you some questions. Just to explain the setup, Dr Mellifont is in the Brisbane hearing room with Commissioner Mason. Commissioner Atkinson is joining the hearing remotely, and as you can see Commissioner McEwin and I are in the same Sydney hearing room as you are.

20

EXAMINATION-IN-CHIEF BY DR MELLIFONT

25 DR MELLIFONT: Thank you, Chair. Can I ask that the PowerPoint be brought up DRC.9999.0024.0004.

While that is happening, Professor, good afternoon.

30 PROFESSOR BALDRY: Good afternoon.

DR MELLIFONT: You provided a statement to the Royal Commission?

PROFESSOR BALDRY: I did.

35

DR MELLIFONT: The contents of that statement are true and correct to the best of your knowledge? You are the Vice-Chancellor, Equity, Diversity and Inclusion and a Professor of Criminology at NSW, correct?

40 PROFESSOR BALDRY: Correct.

DR MELLIFONT: You are a Director on the Board of the Public Interest Advocacy Centre and Deputy Chair of the New South Wales Disability Council?

45 PROFESSOR BALDRY: I left that post at the end of last year so, that was the previous position as Deputy Chair of the New South Wales Disability Council. I am now Chair of the New South Wales Aging and Disability Commission Advisory

Board.

DR MELLIFONT: Yes. Thank you for that correction. Now, your CV is an exhibit and it's lengthy. We won't go through it, it's part of the Tender Bundle. Is it correct to say that in your research you've had a focus on social justice, including mental health and cognitive disability in the criminal justice system?

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: Okay. Can we go, please, to the next slide, DRC.9999.0024.0005. What does "criminalisation of disability" mean?

PROFESSOR BALDRY: Criminalisation in general means that legislation, the law makes something illegal or a criminal offence. And when a law or when the practice of the law focuses on particular groups or individuals with particular facets, then that can be said to criminalise them. So I'll give you a couple of examples. For people with disability, particularly people with mental health disorder and/or cognitive disability, the fact that police, for example, are those who are called to take someone who has a mental health episode, to pick them up and take them to a psychiatric unit, for example, is not in itself criminalising, but what it does is put that person in the purview of the criminal justice system because the police are agents of the criminal justice system.

But very more particularly, many of the ways in which people with cognitive disability, for example those who have very poor impulse control, behave, when perhaps confronted by someone, they may lash out, they may run away, that behaviour can easily be criminalised by the police because the police then arrest that person. That person hasn't necessarily done anything wrong or they may not at that point have done anything wrong.

So criminalisation of disability is talking about bringing some of the behaviours of people with disability into the remit and the purview of the criminal justice system, largely by the police but not entirely.

DR MELLIFONT: Thank you. In the course of your research, did you form the view that there was a general acceptance by people involved in the administration of criminal justice that high rates of people with disability in the prison population was normal?

PROFESSOR BALDRY: Yes, indeed. And I have observed that for decades.

DR MELLIFONT: And what's the impact of that?

PROFESSOR BALDRY: So the impact is that it is just seen as normal. It is normalised that kids and adults --- but, you know, it is particularly observable amongst children that children with disability who behave in challenging ways are offending, and that this is the way it is. And we see this increasingly and particularly

amongst First Nations communities and children. But it is, in general, very particularly the case in disadvantaged poor communities, where parents don't have the means necessarily by which to support their kids or their family member. Where the community as a whole doesn't have the resources to support people who may behaviour in ways that are a bit difficult. And they become managed --- and we will talk about this a bit later perhaps --- managed by the police. And once someone becomes managed by the police, that is a criminalising experience, and it means that it's just taken as given that those people are more likely to offend.

And this is not something which is recent. This goes back centuries --- and millennia, in fact --- that people, particularly people who have cognitive disability, intellectual disability, were seen as behaving in ways that were not appropriate in the community and therefore they were sequestered either in an institution. But that saying, you know, "mad, bad or sad", is kind of a relic, I think, of the past. And that indicates that it has long been just accepted that, yes, that prisons and our criminal justice systems, particularly our magistrates courts, will have lots and lots of people who have disability in them.

DR MELLIFONT: Good. Thank you. Can we go to the next slide please, DRC.9999.0024.0006. And we will speak in a little more detail later about appropriate supports, but in short form for the time being, did your research disclose evidence about how the availability and provision of robust disability appropriate support options available to families with a child or children exhibiting difficult behaviours?

PROFESSOR BALDRY: This has turned up many times over the last two or three decades in my research. For example, I did some research with a disability organisation around intensive support for families and children with a disability where there was a risk of the child being removed or a risk of the child offending or being violent. And the intention of that was to provide a brief intensive support which then could be picked up later. That was extraordinarily successful so that the parents who were involved in that research and that trial with that organisation, there was almost no calling of the police. Whereas, prior to this intervention, those families, not necessarily those particular families, but the history that we could see in previous families, was that those children would often either be given up to the State because they could not be supported safely in the family, or that the police would be called to help manage what was going on in the family.

So that is an example of robust intensive appropriate disability support given at the right time, which then prevented further deterioration in that situation and prevented involvement in criminal justice. And, as you say, we can look at some more examples of that once we talk a little more about the data cohort.

DR MELLIFONT: Thank you. Next slide please, DRC.9999.0024.0007. Did your research show a connection between people with disability first being a victim and then later an offender?

PROFESSOR BALDRY: Yes, indeed. That shows up consistently, both in my research, my team's research and other people's research, that people with disability, particularly those with cognitive disability, are more often, but --- not only, but in the cohorts that we're talking about at the moment --- they are very likely to have been victims in some way, usually as children or teenagers, which then usually continued into their later lives. And the range of victimisation or the ways in which they were subject to abuse, neglect or whatever were things like violence, sexual assault, being a witness as a child, being in a household with violence, in a household with high use of alcohol and drugs and they were introduced to alcohol and drugs as children. And that is evidenced by the high proportion of people in our data set who, as --- when they were children, were reported to Child Safety in some way.

DR MELLIFONT: And is it that feature, that is that connection between victim first, then offender, and the issue we spoke about moments ago, that is the provision of support may have changed the trajectory that led you to want to explore how the experience of people with disability in the criminal justice system involved violation of their rights, and to seek to fill the gap about people with disability in the criminal justice system. Is that correct?

PROFESSOR BALDRY: Yes, indeed, it was a very strong motivating factor for me to see that these people who had been victims did not have their rights upheld, but in fact became enmeshed in the criminal justice system as offenders, and that was --- I mean, that's so unjust. And I felt it was really important for us to all understand how that happened, why that happened or why it happens and to do something about it.

DR MELLIFONT: Thank you. Can we move to the next slide please, DRC.9999.0024.0008. So that led to the Mental Health Disorders and Cognitive Disability in the CJS, in the criminal justice system, a New South Wales study. That's correct?

PROFESSOR BALDRY: That's correct. It was an ARC linkage study that I was an investigator for. Yes.

DR MELLIFONT: Thank you. I will lead you through a couple of pieces of the detail here and then just conclude the discussion a little bit later, but in short you were the Lead Chief Investigator together with chief investigators Leanne Dowse and Ian Webster and one of the partner investigators included Mr Jim Simpson.

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: It developed a data set from a lifelong human services and criminal justice involvement of 2,731 offenders in prison between 2000 and 2008, most of whom had a mental health disorder and/or a cognitive disability.

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: And it involved linking and merging disparate data sets from

different agencies and departments; correct?

PROFESSOR BALDRY: That's correct.

5 DR MELLIFONT: Okay. Now, you've observed in your statement some limitations in that data set, but nonetheless it's fair to say that the data set is informative in providing for the first time a chronology and narrative of individual experiences of multiple system involvement which would be difficult, if not impossible, to obtain from anyone agency or individual alone. Is that correct?

10

PROFESSOR BALDRY: That's correct.

DR MELLIFONT: So by being able to link these data sets together, it opened new ways of understanding people's pathways into the criminal justice system?

15

PROFESSOR BALDRY: Yes, that's right. For the first time we were able to see the breadth of institutional administrative government service interactions and events for this group of people, from the first time we see them in the data until the day the data was drawn. So for some people in the data set, that spans 40, 50 years, and for others
20 it's shorter, of course, because they were younger when the data was drawn.

DR MELLIFONT: Thank you. Can we go to the next slide, please, DRC.9999.0024.0009, and this led into a related study, the Indigenous Australians with Mental Health Disorders and Cognitive Disability study and the acronym should
25 have "IA" in front of "M", is that correct?

PROFESSOR BALDRY: That's correct, and it wasn't 2007. That was started in 2011.

30 DR MELLIFONT: Yes, I'm sorry. Thank you. And we've got a pie chart there. That indicates that of the MHDCD cohort of 2,731 offenders, 25 per cent were First Nations people. Is that right?

PROFESSOR BALDRY: That's correct.

35

DR MELLIFONT: And in respect of this Indigenous Australian study, you were the Lead Chief Investigator with Chief Investigators Leanne Dowse, Julian Trollor and Patrick Dodson?

40 PROFESSOR BALDRY: Correct.

DR MELLIFONT: Next slide, please, DRC.9999.0024.0010. Again we will correct the entry under paragraph 34. So of the 25 per cent of First Nations people who are part of the cohort, 91 per cent identified having a cognitive disability or a mental
45 health diagnosis, most of whom had complex needs. Is that right?

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: Okay. And of those who had a mental health diagnosis, 77 per cent of them reported an alcohol or drug use history, and 36 per cent also had a cognitive disability?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: Okay. That's correct?

PROFESSOR BALDRY: Yes, that's right.

DR MELLIFONT: Okay. Now, if we can go then to the next slide, DRC.9999.0024.0011. In your own words, could you describe the objectives of the Indigenous study?

PROFESSOR BALDRY: The Indigenous study was intended to draw out in far more detail and depth what we saw in the initial Mental Health and Cognitive Disability Research 2007. What we saw, we didn't have either the money or the time to look in-depth at the Indigenous cohort. But what was clear at a surface level was that the First Nations people in our data looked as if they were significantly more both at risk, and to have experienced all the negative things that the people in this cohort were experiencing, from early police involvement to being in out-of-home care, to being homeless, to significantly more arrests and times in prison and so on. So we felt we needed to, one, have the time and money to investigate our data more thoroughly.

But, two, and very importantly, because all research that involves First Nations people must be led by First Nations people, and therefore we went to four communities, three in New South Wales and one in the Northern Territory, and those communities said they would really like to be involved in this, and so they led the work in their communities about the nature of an Aboriginal person having complex support needs, cognitive disability, mental health disorder or other, for example, hearing impairment which was quite common in the Northern Territory.

So they led the work of enabling people in their communities to talk with us and our Aboriginal researchers about what that meant and about the experience that that was for the families, the communities and the individuals, and we also interviewed significant numbers of people in the criminal justice systems, from police to the courts to law, lawyers, to try and understand what we were both seeing in the data, in the quantitative data or the data set and what we were hearing from the community.

So that was the intention of getting the funding to do this piece of work so that it could open up again, for the first time, really, what the experience was like for people from Aboriginal communities and Aboriginal families who have disability and get caught up in the criminal justice system.

CHAIR: Was the common characteristic of all the First Nations people included in

this study that they had spent time in prison?

PROFESSOR BALDRY: Yes, it was. Yes.

5 DR MELLIFONT: Can you go to the next slide, please DRC.9999.0024.0012. Your statement sets out in some detail the findings of the studies, but also alludes to a further update. Can you inform the Commissioners to where that's at?

PROFESSOR BALDRY: Yes. So some years ago now, four years ago --- in fact
10 further ago --- I went back to all of the data custodians who contributed data to that original Mental Health Cognitive Disability study, and they all agreed, that's some 14 data sets or custodians, they all agreed to provide updated data to the date at which it was drawn. So because it has been so slow getting through all of the processes, we are --- we got agreement from everyone, we are now at the point where we have the
15 corrections and, yes, those two we already have that new data which was updated up to, I think, 2019, and the rest of it is all sitting in the CHeReL, which is the data linkage mechanisms for New South Wales. And I have every finger and toe crossed that it will be linked in the next month or two.

20 So what I intend and hope is that by the middle of the year I will be able to see what has happened since the data was drawn. So for some people --- you know, that's 10 years probably, 10 years update of data to see are they still in the criminal justice system, have they died. Of course, this group has a very high mortality rate, earlier death. To see whether they have gone into one of the programs that New South
25 Wales has been trying to run. So we hope we will see some good things out of that but I expect we will also see some sad outcomes.

DR MELLIFONT: Can I take you to the next slide please, DRC.9999.0024.0013 and I will put some propositions to you, tell me whether you agree or disagree. Is it
30 your view that although there are gaps in the data that is being kept with respect to people with disability in the criminal justice system, there is sufficient evidence to confidently state that people with a disability are significantly over-represented in the criminal justice system?

35 PROFESSOR BALDRY: Yes.

DR MELLIFONT: Okay. And that is particularly the case of people with psychosocial or mental health concerns, as well as for people with cognitive or neuro-diverse issues?

40

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: And that First Nations people are increasingly over-represented in all aspects of the criminal justice system?

45

PROFESSOR BALDRY: Yes.

DR MELLIFONT: And so it would follow that First Nations people with cognitive disability are significantly over-represented in all aspects of the criminal justice system?

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: Okay. Now, before moving to some specific data referred to in your statement, can I ask you, to your knowledge is there comprehensive data kept on the numbers of people with cognitive disability who are subject to forensic or mental health orders and the numbers subject to seclusion or other restrictive practices?

PROFESSOR BALDRY: No. There is not comprehensive data. It does vary across jurisdictions, but one of the major problems that we still have, despite really good work by a number of Law Reform Commission investigations and reports is that people with cognitive disability who are found not guilty by reason of their disability, it is still under the legislation which is termed by reason of mental health or mental illness.

And it then becomes blurred, so there is not necessarily data kept to say, well, this person is being held in a forensic unit in indefinite detention because they have a cognitive disability. And that data is still very poor. It's also the case that most people who end up in the criminal justice system who have cognitive disability also have some form of mental health disorder.

So, you know, it's a very blurred sort of picture. There is a final thing that is really important here and I know you will have heard this from others, and that is that treating someone who has cognitive disability, let us say intellectual disability or Foetal Alcohol Spectrum Disorder, that treating someone with one of those impairments, disabilities, as if they have mental health disorder is worse than useless, unless they're being treated for a mental illness that they do have, because mental health treatment does not address cognitive disability.

So it is a really important thing to know whether you've people with cognitive disability in a forensic unit. And I do believe that Jim Simpson will be talking with you at some point and there is, at least in New South Wales and I believe in some other jurisdictions, the situation where we have a number of people on the Mental Health Review Tribunal, such as Jim, who understand cognitive disability and know what they're looking at or reading or what the experience is.

But the short answer to your question after that very long explanation is no, there is not comprehensive data.

DR MELLIFONT: Thank you. And we will come in due course to the NDDA and your involvement with that. Can we turn to slide DRC.9999.0024.0014, please, which is the next slide. I will move through these relatively quickly. You report in paragraph 45 of your statement that in 2019 the Australian Institute of Health and

Welfare reported that two in five prison entrants in the survey sample, which included all States and Territories except New South Wales, had been told they had a mental health condition, and one in four were taking mental health-related medication. Is that correct?

PROFESSOR BALDRY: That's correct.

DR MELLIFONT: Next slide please, DRC.9999.0024.0015.

CHAIR: Before we get to the next slide, why didn't New South Wales participate?

PROFESSOR BALDRY: I don't know. It would be interesting to ask them.

CHAIR: They were asked, though, weren't they?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: So DRC.9999.0024.0015, please. Again, out of that same report, what we see is approximately one in three prison entrants reported they had a chronic condition or disability that affected their participation in day-to-day activities, education or employment. That's correct?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: Okay. And that's compared with a lesser number in the general population about one in five?

PROFESSOR BALDRY: Yes, that's correct. Can I make a comment about that particular figure?

DR MELLIFONT: Please do.

PROFESSOR BALDRY: These figures are based on self-report, and so the prison entrants were asked, "Do you have a chronic condition or disability affecting your day-to-day activities?"

What we see in our data, because our data is collected from health, from not self-report, this is data that is provided through a whole range of other means, juvenile justice, for example, we see a much higher rate of people who have a chronic disability. And what we have seen in all of the interviews and so on that we have been doing, particularly First Nations people, don't necessarily want to say when they enter a prison that they have a disability. Or they may not perceive themselves as having a disability. They nevertheless may have one.

And so I will --- you know, I'm 99 per cent certain that that figure, the 29 per cent is a very low estimate, and it's still over the general population but I think it should be much higher than that.

DR MELLIFONT: Thank you for that clarification. Can I take you to the next slide, DRC.9999.0024.0016.

This schematic reflects some results on the 2015 patient health survey report on New South Wales prison entrants, and that report reflected that 62.9 per cent of the sample had previously received a diagnosis of mental illness and 49.2 per cent had received some form of psychiatric care over the course of their lifetime. That's correct?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: And the report also reflects that more than a third reported a diagnosis for depression and more than a third reported a diagnosis of anxiety?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: And is it correct that your research also indicates that children and young people in Australian youth detention have even higher rates of disability, and you conclude that the contemporary evidence is overwhelming that persons with mental and cognitive disabilities continue to crowd prisons?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: Is that correct?

PROFESSOR BALDRY: That's correct.

DR MELLIFONT: This is a phenomenon not just peculiar to Australia; correct?

PROFESSOR BALDRY: That's correct.

DR MELLIFONT: You've seen it in research in western jurisdictions such as the United States?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: And similar concerns in the UK, New Zealand and Canada?

PROFESSOR BALDRY: That's right.

DR MELLIFONT: All right, now, one of the documents you've kindly provided us and which is in the Tender Bundle is chapter 6 of the book "Youth Justice and Penalty in Comparative Context" by Goldson, Cunneen, Russell, Browne, yourself, Schwartz and Briggs. And in chapter 6 which is entitled "Disabling effects of youth justice and penalty" ---

PROFESSOR BALDRY: Penality. It has an "i" in it.

DR MELLIFONT: Sorry, my typo. Can I ask you to draw out some of the key themes from that chapter from the research relevant to it?

5 PROFESSOR BALDRY: Yes. The first thing to say is that this was also an ARC grant that Chris Cunneen led that I was a chief investigator on, and it did a whole range of things. It drew on the mental health cognitive disability data set but more importantly, it got new information, we interviewed across many --- most, actually --- jurisdictions in Australia that we were allowed to, we interviewed magistrates and
10 lawyers, we interviewed juvenile justice workers and superintendents. We interviewed young people, particularly First Nations young people in Australia, and exactly the same was found in the UK, which included England, Wales and it was only England and Wales.

15 And what came out of that, I wrote the chapter around disability because part of what we were investigating was, you know, what do all of these people think and understand by the young people that they're seeing, either come into the court that they represent or that come into juvenile justice. And there was not one person we interviewed who did not say, "Look, you know, they're full of kids who have special
20 needs or who have some kind of developmental problem or, you know, they use different sort of terms."

But it was extraordinary that it was universal. And some of the key things for the Commission to know is that the lawyers felt totally frustrated that they did not have
25 reasonable places to recommend to the court or even to the police, for that matter, that a young person who has disability could go and be safe and also be safe from offending. That they would get the right kind of support they needed.

And exactly the same was said by magistrates. You know, from things like saying,
30 "Look, I sit and I see these kids come every day and I shake my head, I think this is so sad." And so, you know, the take-home message in all of that is they all want much better service in the community to support those kids so that they do not get caught up in as youth and juveniles in the criminal justice system.

35 And then perhaps just two final things. One is that in this book, we took a very strong children's rights perspective and the book starts with it and finishes with it, and within that chapter we discussed not only the rights of the child but the rights of person with a disability. And we felt we were able to show that neither the rights of the child nor the rights of people with disabilities, persons with disabilities were
40 upheld in any of those circumstances because none of those people have the capacity to give that child the right of the kind of disability support and housing, for example, that they needed.

DR MELLIFONT: Was another aspect of this, that you observed that the people
45 within the criminal justice system that you spoke to, although well-intentioned and wanting to know and understand, and sympathetic, had little understanding truly of what it would mean to be, say, a 14-year old with a cognitive disability?

PROFESSOR BALDRY: Absolutely right. And they all admit it. They said, "Look, you know, we observe that this kid has real trouble communicating", or "has huge trouble with their impulse control" or, you know, "is clearly very vulnerable to being influenced". But we don't know really what that experience means for that child, and we don't know how to address it or how to approach, particularly police, for example. You know, and this is mitigated, for example, and it's exemplified actually by a counterexample where there was a police unit in, I've forgotten, it might have been Liverpool, but in the UK in England, where a disability group got together with the police and said, "Look, you're constantly picking up these particular kids, they have disability. Now, you know, this is not the right thing to be doing with them." The police said, "You know, they're misbehaving, they're a menace." And they say, "Well, they don't have to be. We will show you how you can interact with those kids and how you can take them somewhere safe." And it made a huge difference. And so there are ways to do it that actually don't cost any more money, in fact cost less money because those kids in the end were not arrested. Or they stopped being arrested. So that gives you an example of how we can do it differently.

DR MELLIFONT: Thank you. I will take you through the next slide and some of this I will work through fairly quickly so I get you home at a reasonable hour. Slide DRC.9999.0024.0017. We showed this slide during the opening and this was a study in respect of a WA Magistrates Court showing quite a disparity between persons going to the local courts in that study with a mental impairment compared to an intellectual disability. Can I ask you, is this an outlier so far as your overall research is concerned, is it consistent or is it roughly consistent with what you're seeing?

PROFESSOR BALDRY: No, it's consistent. Now, I'm thinking it's 50 per cent have cognitive disability and/or mental health impairment rather than 50 per cent have just a mental impairment. I think it would be good to go back and confirm that. But, no, it's not at all. And why do I say that? For a number of reasons. One is that there have been not many, but a few studies done both here and in the UK and for that matter in the USA, but they are more comparable with the UK, showing that a Magistrates Court has high levels of people with cognitive disability and mental health disorder turning up in their courtroom.

Now, this is also supported by a number of other studies. The UK has had a number of investigations and reports into developmental delay or variously call it various names, but it's cognitive disability, showing that the average IQ, for example, across prisons in the UK is 82, 83. Now, if you know anything about IQ measurement, 100 is the norm, is the average, and so you are then situated along that continuum of 100 to genius at 200 and downwards towards lower cognitive or intellectual capacity.

Now, 83, that is exceptionally low. So, you know, the prisons, yes, are full of people who have lower intellectual capability and it's even worse in juvenile justice. We have, I think, two lots in New South Wales, in particular, of research surveys. Not self-report, these are measures that were taken showing again that the average of juvenile --- kids in JJ, whether actually it's in detention or in the community is

around 80, 81, 82. So this is absolutely --- this is spot on.

CHAIR: I suppose the difference between a Western Australian Magistrates Court and courts in other states would be the heavy preponderance of First Nations people who appear in those courts. The results may be the same in terms of the proportion with cognitive disability or mental illness. That would be a distinctive characteristic of the Western Australian court, I would think?

PROFESSOR BALDRY: Yes. No, you're absolutely right. But it's also the case that, as we all know, as you know, that First Nations people are over-represented in every jurisdiction and in arrests and so on. So that and you would see the same in the Northern Territory, of course. Yes.

DR MELLIFONT: Thank you.

COMMISSIONER ATKINSON: Is it fair to deduce from that, that one of the causes of the over-representation of First Nations people in the criminal justice system is their over representation particularly as juveniles with cognitive disability?

PROFESSOR BALDRY: Look, it's a complicated relationship. Yes, First Nations people on the whole and in the community have higher mental health disorder and higher cognitive disability and higher hearing impairment. So that is true. But that does not account for their over-representation in general. And I ---

COMMISSIONER ATKINSON: Perhaps I put it badly, it is a factor.

PROFESSOR BALDRY: It is a factor, that's right. And I think a key factor is that police, you know, the evidence is quite clear from work that people like Chris Cunneen have done, that police over-police some Aboriginal communities. For example, Walgett, which is a community that our university has a partnership with, there are 40 police for 2000 people. Now, that over-policing, you know, that is a population 70 per cent Aboriginal. And so there is a much greater likelihood that Aboriginal kids are going to be picked up by the police in that circumstance unless they have a policing policy and a policing approach which is different to what most police jurisdictions have.

DR MELLIFONT: If I can move to the next slide, DRC.9999.0024.0018. Now, you deal with the notion of cycling in and out of custody in some detail in your statement. Do you mind if I just briefly provide a snapshot and then we will move into the life course pathways.

PROFESSOR BALDRY: Sure.

DR MELLIFONT: But in essence you speak about socially disadvantaged persons with disability being accused of minor offences, being picked up frequently by police, often held overnight in police cells, frequently incarcerated in remand, given short sentences, cycling in and out of the custodial system, which you describe

effectively as serial detention. You also acknowledge that there has been attempts by States and Territories with varying success for diversion, but that what you're seeing from the data is that none seem to sufficiently provide the level of early intervention needed to keep significant numbers of people with disability out of the criminal justice system, and that's supported by the latest AIHW reports. Is that correct?

PROFESSOR BALDRY: Yes, that's correct.

DR MELLIFONT: So in short this is a call to do something and to do a lot, in effect?

PROFESSOR BALDRY: Yes.

DR MELLIFONT: Okay. Can I take you to the next slide which is DRC.9999.0024.0019, "Life Course Pathways", and your statement sets out some detail about life course pathways and your view that understanding why people with disability are so over-represented in the criminal justice system is vital to early intervention and to reducing this over representation. But until relevantly recently little was known of their life pathways; correct?

PROFESSOR BALDRY: That's right.

DR MELLIFONT: Now, the MHDCD assists us to understand some of these features. If we look at slide DRC.9999.0024.0020, what that study showed was over 2,000 people in the cohort had complex needs. 96 per cent of people with complex needs were known to police as victims. As a whole, the cohort experienced very poor housing, and that is consistent with a lot of your research which shows a very clear link between homelessness and interaction with the criminal justice system. Is that correct?

PROFESSOR BALDRY: Yes, that's right.

DR MELLIFONT: People with complex needs were 6.2 times likely to experience homelessness than those without.

PROFESSOR BALDRY: That's right.

DR MELLIFONT: And you had some other findings that were 80 per cent had first police contact as an offender as a young person before the age of 19?

PROFESSOR BALDRY: Yes, that's right.

DR MELLIFONT: Now, understanding these life course pathways, we are assisted to do that by slide DRC.9999.0024.0021 which I think we are all calling the spiderweb.

PROFESSOR BALDRY: Yes.

5 10 15 20 25 30 35 40 45

DR MELLIFONT: This comes from a book entitled Policing and the Mentally Ill: International Perspectives, edited by Duncan Chappell, and specifically from Chapter 11, Compounding Mental Disability and Disadvantage: Police As Care Managers, as written by yourself and Leanne Dowse. Can you give us synopsis of what this spiderweb tells us?

PROFESSOR BALDRY: Yes, indeed. What you're seeing in front of you is a social map, in a way. You can see blue lines on that. That is sort of a make-believe person, but what we have put in that spiderweb, we've got health and disability, social and economic issues, early life, criminal justice contact, demographic identity issues, and under each of those are many aspects. These are all drawn from all of our case studies and what we're seeing in the data. And what you see here is what another of my colleagues, Ruth McCausland and I have been coming to over the last few years, and that is we are coming to a position of calling this the social determinants of justice, or injustice, probably.

Because what you can see here is that the more of these things in each of these sectors of the spiderweb, the more of those things that accumulate for someone from early in their life, you know, throughout their lives without there being a proper appropriate support or intervention means that those things accumulate, and it becomes a compounded life arrangement for that person. And the reason that we use this model is that, you know, it allows you to model what the impact of different aspects have on someone. But the intent of this is to show, also as you say, it's a spiderweb, that it becomes stickier and stickier the more of these things that accumulate in your life. And eventually it is almost impossible to get out of that web. Because you do not have the leverages, you do not have the capacities, you don't have a community, you don't have the resilience, you don't have what other people who might have had supports throughout their lives do have.

So that is the intention of that and it's to help us understand that this is not a linear progression, that, oh, when you're 14 you offend and you get picked up by the police and you go into juvenile justice. There is far more to it than that. Poverty is a huge aspect of it. Being in a disadvantaged community is a huge aspect. Your family not having the capacity or ability, all of these things contribute.

DR MELLIFONT: Thank you. And to briefly express the converse, as I understand, hypothesis for you, is that there are very clear points at which had a possible disability-appropriate intervention occurred, that might have removed one of the factors that led to enmeshment within the criminal justice system; is that correct?

PROFESSOR BALDRY: Yes, correct. I think we are going to talk about those in the costings later. Yes.

DR MELLIFONT: Yes, and I will get to that shortly, Chair. I've probably got another 10 minutes.

Slide DRC.9999.0024.0022, your statement summarises this findings with respect to the Indigenous study, but it's important to observe that that study found that First Nations people were significantly more likely to have been in and out-of-home care, have come into contact with police at a younger age and at a higher rate as a victim
5 and offender, higher numbers and rates of convictions, more episodes of remand and high rates of homelessness and so greater levels of multiple disadvantage, is that correct?

PROFESSOR BALDRY: That's correct, and when I use the word "significantly",
10 that is a statistical term. You know, we've used various forms of analyses and we show that it's anything between two times to eight times more likely that a First Nations person will have experienced this than a non-First Nations person who also has disability.

15 DR MELLIFONT: Thank you. Could we move then to some of the analysis at DRC.9999.0024.0023. There is a report, 2012 report entitled Life Course Institutional Costs of Homelessness For Vulnerable Groups. Can I take you through some dot points and let me know if you agree. Part of the purpose of that study was to develop estimates of past and current institutional costs associated with people
20 with mental health disorders, cognitive disability and complex needs cycling in and out of the criminal justice system and homelessness. Is that correct?

PROFESSOR BALDRY: Yes. Yes.

25 DR MELLIFONT: Now, the study differed from common forms of economic evaluation which tends to focused on cost effectiveness, cost saving, or cost offset, where the emphasis is on a specific program or service with the aim of comparing the merits of a particular approach based on funding or outcomes. Whereas this study focused on identifying the life course economic cost associated with certain
30 individuals who had high levels of engagement with human services and criminal justice agencies and had experienced homelessness. Correct?

PROFESSOR BALDRY: That's correct.

35 DR MELLIFONT: Okay. And so your study actually used real case studies with real trajectories of individuals as opposed to a simulation?

PROFESSOR BALDRY: That's right.

40 DR MELLIFONT: So let's move to --- again your statement details at length methodology, et cetera, et cetera, and that's available for the Commissioners. But let's look at an example. Slide DRC.9999.0024.0024, please.

If we take the case of "Peter" referred to in your statement, and I will very shortly
45 summarise this in the slide but it gives us the essence of it. A dual diagnosis of a mental health disorder and mild intellectual disability. Contact with police first time at age 26, and that was precipitated by mental illness.

Now, the analysis under the life course institutional cost by the age of 40 was just over $1 million.

5 PROFESSOR BALDRY: Correct. That's 2012 dollars.

DR MELLIFONT: Yes, thank you. But what you saw in your study is that after a period of custody in 2005, he was placed on a community order with a complex needs parole case officer where he got support, including drug and alcohol
10 counselling, a weekly group support program, was employed in a sheltered workshop, had support from his mental health team and GP, and he was free of contact with police for 19 months. But when that parole finished and those supports were no longer there, he cycled back into the system with costly interactions with police and psychiatric admissions. Is that correct?
15
PROFESSOR BALDRY: That's correct.

DR MELLIFONT: In your study you look at an alternative factual scenario and postulate that if at age 26 he had been provided with intensive case management
20 support services which helped him to get access to housing support from the age of 28 rather than 35, then the expected net saving was $385,390?

PROFESSOR BALDRY: Correct.

25 DR MELLIFONT: By that one intervention?

PROFESSOR BALDRY: Correct.

DR MELLIFONT: Can we look at another example of
30 Casey ---

CHAIR: Sorry, what was the million dollar figure? How was that derived? Was that an estimate of actual cost?

35 PROFESSOR BALDRY: No, it's real cost, it's not an estimate. So what we did was we added up every single event, police event, psychiatric unit event, custody event, every single one. We costed each one separately because we were able to get the costing for each of them, added them up. And saw that just over a million dollars was the result of all of the costs of the police, of the psychiatric units and so on.
40
So most costing and cost benefit-type work deems or averages whereas we wanted to be sure that, you know, we really understood what was going on here. And I have to say this doesn't include everything because we didn't have data. We didn't have, for example, Commonwealth data. We had to guess a bit at that. But that would be the
45 minimum addition. But it's real money and real events.

CHAIR: Roughly $70,000, 2012 dollars, over a period of 14 years.

DR MELLIFONT: Can I then take you then to "Casey" which is DRC.9999.0024.0026, please. And again there is much more detail about this in your statement. Next slide, please.

So the statement traverses the detail but, in essence, comes to a life course institutional cost by the age of 20 of some $5.5 million. But then she became a client of a Community Justice Program and her interactions with the criminal justice system almost completely stopped. That was the first time that that had happened in her life since the age of 10. Is that right?

PROFESSOR BALDRY: That's correct.

DR MELLIFONT: Okay. And if we go to slide 27, when you looked at an alternative factual scenario, which was that she was given early intervention from the age of 7, and an assumption that she therefore did not offend, savings of up to $2.9 million by the age of 20 and in another five years, another further saving of $3.7 million was the expectation.

PROFESSOR BALDRY: Yes.

DR MELLIFONT: Is that right?

PROFESSOR BALDRY: That's correct.

CHAIR: What was the main component of $5.5 million by age 20?

PROFESSOR BALDRY: So Casey started off, a young Aboriginal girl, in a remote or regional place. By the age of 7 she was being homeless, wandering around the streets, so she was being picked up by the police, she was being taken to the hospital, she was being taken home. By the age of 12 she was in such a bad state there were circumstances in which the police had to fly her at huge cost to a bigger town to get some kind of assistance. But it was all band-aid stuff. None of it was structural, systemic intervention. So those costs are largely criminal justice. She went into juvenile justice and she went into adult corrections, the police. Huge levels of --- for example, you know, she would call 000 once she, you know, sort of worked out that would bring someone, because she was a very vulnerable, very --- she had a very, very difficult time.

Now, all of those, we costed. So, you know, had there been either appropriate and proper support for her mum to assist, reasonable and good and supportive housing. If the police had known, had a better avenue by which to support her when they picked her up rather than her being criminalised, which obviously happened, she would be taken into the psych unit. They would strap her down for an evening, give her some medication and then release her. You know, it was really --- the processes were really (audio distorted) in regard to the way she was treated as a child.

DR MELLIFONT: Thank you. Can I take you to the conclusions from that report. This is slide DRC.9999.0024.0029. I will run through them quite quickly. But they include that a lack of adequate services early in the lives of the individuals was associated with very costly criminal justice, health and homeless interactions and interventions later in their lives.

Millions of dollars worth of time and resources continue to be spent on a relatively small number of individuals with disability.

Next slide please, slide 30.

> *Costly criminal justice responses are applied to vulnerable people whose needs may well be better addressed in the health, rehabilitation or community space, which is able to provide access to integrated and responsive support services.*
>
> *The provision of secure housing and support for an individual to maintain a tenancy appears to be a key factor in reducing higher criminal justice and emergency services costs.*

Next slide, 31.

> *Early and well-timed interventions to establish and maintain secure housing and associated support services will likely reduce, if not obviate, the need for the future years of criminal justice interventions.*
>
> *Apart from the economic imperatives, equally as important is that the hidden social and human costs of a life course of offending and homelessness can also be reduced.*

Professor, I understand you are involved in a new project which is not yet completed, which is finding even further the model that you had developed in your earlier work across the cost and cost-benefit of disability, and complex needs support for people. Can we have the one-minute snapshot of what you are able to tell us about without getting into trouble about it given it's not out yet?

PROFESSOR BALDRY: Certainly. It's in AHURI, an Australian housing urban research institute project, the chief investigators are at UNSW, in Victoria, and in Tasmania, so there are three jurisdictions involved.

Our job was looking at people getting out of prison and the impacts of who have complex support needs. And particularly looking at the impact of homelessness and housing.

What we were able --- what I can tell you and I will make sure you get the final report which probably will be available in May, shows that those people who get public house, social community housing but particularly public housing because that's the most available, there are significant savings that that group of people have

over those who get rental assistance, for example, or don't get any assistance, of course.

And so when you see the final report you will see the graph which shows that the costs and the offending, for example, go like this, and then at the point of public housing they go like that, whereas the others continue.

So this is yet another example of how beneficial both the cost to the State, and we included counting the cost of public housing against the other costs like police and prison. And so this is another example of where good, social, timely, appropriate disability housing support results in a good outcome for the State, for the person, for the community.

DR MELLIFONT: Thank you. I have two further questions.

They are, I would like you to tell us what you can about the National Disability Data Asset Strategic Advisory Group so far as it concerns persons with cognitive disability in the criminal justice system, and why you signed the letter to the Attorney-General seeking continuing funding for the CIDP. Can we start with the strategic advisory group please.

PROFESSOR BALDRY: Yes. So the National Disability Data asset is a piece of work across the whole of Australia which is seeking to get much, much better data linked and merged data, very much like the data bank that I and my team created. But much easier to do now because there is far more access to it. So the intent of this is to have a much, much better picture of all of the ways in which people with disability interact across Australia with a whole range of services, both NGOs and government.

I'm on the Aboriginal expert panel in New South Wales. New South Wales there are seven, I think, test cases being done across Australia, two in New South Wales and the one that I'm involved with is the test case on justice. It is being led by BOXARR in regard to actually gathering the data or pulling data together for the trial to see whether it can be done, basically. And they are very particularly focused and know that there is a particular even greater issue around Aboriginal people in the criminal justice system with disability and pooled data.

And so we have had our first expert meeting. The intent of the trial is to be able to provide places like the commission, but of course in general all agencies, with better data to try to prevent people ending up going into the criminal justice system. And of what could be done and at what point and what kind of, for example, Aboriginal --- in the Aboriginal data, what kind of cultural safety and protective factors could be looked for in the data. So it's a data-mining exercise and it will result in showing where all the gaps are. The Commission have already seen where many of the gaps are. But this asset will then attempt to address some of those gaps.

DR MELLIFONT: Thank you. And the last question was why did you sign the open

letter to the Attorney-General requesting reconsideration of the funding for the CIDP?

PROFESSOR BALDRY: Yes. So the Cognitive Impairment Diversion Program that was a trial set up some years ago funded by the Attorney-Generals of Justice and the State of New South Wales and run by the Intellectual Disability Rights Service and the Council on Intellectual Disability in New South Wales. It was exactly the kind of service that many of us had been advocating for for many years. There are a whole range of things we're advocating for. This one very specifically is about diverting people from a court and of assisting them.

And so there were two places in New South Wales that were part of that trial. The results of that trial were very good, that there were significantly more diverted than previously and were supported and were put in contact either with the NDIS or with an appropriate disability service or housing. And it was absolutely a good thing to do. It wasn't perfect and that was the point of the trial, to work out how they could do things better.

Yes, it was expensive. But, and one of the reasons that they said that they would stop the CIDP was because it was too expensive. And that analysis, I believe, was not done as fully as it should be. So, for example, had they taken the approach that I and my team have taken to costing everything, we would have --- I think we would have seen probably a different result. But all that aside, I to know that the NSW Government and that Department of Communities and Justice is actually very keen to re-establish it, perhaps a cheaper version, and that they're working towards that.

But, I mean, a key reason for signing that letter was to draw to the Attorney's attention that this was a successful intervention, it was a useful intervention and that it does need to be continued. Because once you've found something that works like this, you should keep them because what will happen in the end is that it will be of a cost benefit to the state in the end that fewer people are ending up going in.

Now in an immediate sense it might not have been as cost efficient or effective as they wanted it to be but I can guarantee that it would over time be better. In the same way, I have to say, as CJP, the Community Justice Program, which I'm sure you've heard about or will hear about, which was also a very useful and reasonably successful approach. It was expensive but it --- I mean, the example that we had of Casey sort of shows that that in the end is a great benefit personally to the community, not just financial cost.

DR MELLIFONT: Thank you, Professor Baldry. They are all my questions.

CHAIR: Thank you. I will ask Commissioners if they have any questions of Professor Baldry. Bearing in mind the time no doubt they will be few and concise. Commissioner Mason, do you have any questions?

QUESTIONS BY THE COMMISSION

COMMISSIONER MASON: I just wanted to say thank you --- I'm losing my voice
5 in this room with the air conditioning --- for your evidence today. What really struck
me was the evidence showing the double disadvantage of First Nations people with
disability and the beginning of that story and how things can, with interventions, put
people on a positive path. I was just interested in your views around this idea of
circuit breakers, early interventions and whether we are there yet or whether the
10 attitudinal change still needs to happen? Sorry about the voice, it is failing me today.
Thank you.

PROFESSOR BALDRY: Not at all. We're not there yet. And one of the things that
I didn't really have time or you have time to look at was the recommendations that
15 the communities gave to us. So the Aboriginal communities with whom we worked
in that project gave us very clear guides as to what the solutions were or at least the
beginnings of the solution, starting with self-determination that they know their
communities better. So, you know, you might take a place like Alice Springs which
was one of the communities that were partnered with us.
20
And there the Aboriginal community Elders in particular there, those also who
worked with people with disability who were going in and out of prison all the time,
being arrested was, "Look, we can deal with this better. We know how to work with
our communities better than the white police or the justice system." So that would be
25 the first port of call from their perspective, partner with us so we can work together
on how to support these kids early. And then, of course, there were a range of other
things which I'm very happy to --- I'm sure that the commission can take a snapshot
of that page in the report of what the Aboriginal communities told us.

30 And we are not really seeing that happening. There may be one or two examples. I
think in the Kimberley there has been quite a lot of good work, particularly around
FASD and working with the police so that I think that's probably one example that
could be looked at. But there are very few.

35 CHAIR: Thank you. Commissioner Atkinson?

COMMISSIONER ATKINSON: Yes, sorry, Chair.

Professor Baldry, when you were doing economical analysis, I didn't note whether or
40 not you had included the economic benefit of not having victims of crime. If there's
less offending, then there's an economic cost to victims, of course there is also a
social and emotional cost, but did you factor in also the economic benefit of not
having victims of crime?

45 PROFESSOR BALDRY: No, we didn't in that study. As the decade has gone on
since we did that first one, we have been refining it significantly. One of the things
we found extremely difficult to sort of bring into focus in that first one was things

like that, like the broader benefit to society because those are not directly associated with that particular person necessarily. I mean, it's certainly --- if you extend your trajectory out 20 years or 15 years and you say, well, you know, this person will victimise, you know, 20 fewer people based on the evidence that you've in their previous trajectory, we could have done that. But we didn't really have the tools to do it. But I think you're absolutely right, there are so many more things that we should be adding in to this --- it should be holistic, and we don't yet really have the tools to do that as well as we would like.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No. Thank you.

CHAIR: Professor Baldry, there are many questions that we could ask but I think we will, at least I will refrain at this stage. Thank you very much for your evidence. But I will just check whether there are any other counsel present that would like to ask you any questions.

MS FURNESS: No, thank you, Chair.

CHAIR: In that case, thank you for your evidence, for your contributions to the work of the Royal Commission which are greatly appreciated, and you might convey the thanks of the Commission to your collaborators for the excellent work they have done that has been communicated to the Commission and that we find so valuable. So thank you very much.

PROFESSOR BALDRY: Thank you very much.

THE WITNESS WITHDREW

CHAIR: I take it, Dr Mellifont, we will adjourn until 9.30 tomorrow morning Brisbane time, 10.30 Sydney time.

DR MELLIFONT: Yes, please, Chair.

CHAIR: I know we've gone over, and I want to say thank you to all staff and others, because I know when we do have a long day, they're the ones who stick around as well as everybody else, and that's a pretty long and heavy day. So thank you very much for assisting us to get to the end of an important day of evidence. So thank you very much.

DR MELLIFONT: Thank you, Chair.

ADJOURNED AT 5.26 PM (AEDT) UNTIL FRIDAY, 19 FEBRUARY 2021 AT 10.30 AM (AEDT)

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