TRANSCRIPT OF PROCEEDINGS

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

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

11:18 AM, MONDAY, 22 FEBRUARY 2021

DAY 5

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

CHAIR: Good morning, everybody, welcome to the fifth day of this hearing of the Royal Commission. I shall invite Commissioner Mason to give the Acknowledgment of Country.

COMMISSIONER MASON: Thank you, Chair.

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

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

We recognise Meeanjin, Brisbane.

Nganana ngurkantananyi ngura Meeanjin-nga Brisbane-ta.

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

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

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

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

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

This hearing will include evidence that may bring about different responses for people. It will include accounts of violence, abuse, neglect and exploitation of First Nations people with disability. It will also include references to First Nations people who 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 13 11 14, Beyond Blue on 1300 224 636 or for First Nations viewers your local Aboriginal Medical Services for social and emotional wellbeing support.

Thank you, Chair.

CHAIR: Thank you very much, Commissioner Mason. Dr Mellifont, I understand there is an appearance today for the Northern Territory so I will invite the Northern Territory to announce the appearance.

MR JACOBI: May it please the Commission. My name is Jacobi, I appear for the Northern Territory Government and specifically this morning for Mr Tom Langcake.

CHAIR: Thank you, Mr Jacobi.

DR MELLIFONT: Chair, just to let you know, we are getting an echo from the Sydney hearing room. Perhaps that might be seen to whilst I'm delivering the opening.

CHAIR: Perhaps if we pause for one moment, I am told that it was actually from Mr Jacobi's end, presumably in the Northern Territory.

DR MELLIFONT: Right. Thanks, Chair. We might briefly adjourn after the opening just to do a double sound check. Thank you.

CHAIR: Yes, please go ahead.

OPENING BY DR MELLIFONT

DR MELLIFONT: Today is the fifth day of this eight-day hearing in respect of criminal justice. Today is the second day of a forensic case study in relation to Winmartie. We will hear from three witnesses who will be examined about matters which are individual to Winmartie's case and about matters which concern systemic impact on people with cognitive disability in custodial-type environments. Some of the issues traversed in the evidence will touch on the interplay with the NDIS and, as I said at the opening of the first day of this hearing, there will be a part 2 of this hearing, at which time evidence from the Commonwealth will be heard.

I pause to reflect on the use of the word "forensic" in this context. Those who have had experience of Royal Commissions will already know and understand the meaning of that word in the context of Commission hearings. Others may not, and so it may be useful for me to clarify.

I use it in this sense: the hearing process brings with it compulsory powers; that is, powers to compel witnesses to attend and to answer questions. It permits the Royal Commission to examine witnesses, including witnesses from governments and organisations, about what might have happened in any given case; to seek to get the root causes, which in turn assists the Royal Commission in developing sound recommendations for the future.

It is an important and fundamental part of the work of the Royal Commission that a significant portion of its hearings are utilised in this very way. We appreciate that some people may be unfamiliar with the role of Royal Commissions and so therefore are unfamiliar with the full range of functions, responsibilities and constraints that apply to this and to other Royal Commissions generally. Any Royal Commission, every Royal Commission, must take into account the entirety of the Terms of Reference, not just particular parts, but all of the Terms of Reference, as we are

doing, and to comply with the laws, which is not only the *Royal Commission Act*, but other laws which impose requirements on the Royal Commission to observe procedural fairness.

May I pause to observe that there are many reasons why it is not only desirable but necessary to call evidence from witnesses, other than people with disability recounting their own stories. Some are parents or supporters and advocates of people with cognitive disability who give evidence in conjunction with and as essential support for the person with disability. Some witnesses are there to provide cultural support to people with disability, as we have seen in the course of this hearing, and so powerfully on Friday.

Some are parents and supporters of or advocates for people with disability who risk significant re-traumatisation if they were to retell their story, whether to the Royal Commission or to others. So hearing from their parents, supporters or advocates, who themselves may or may not have a disability, is a way to ensure that the voices of the person with disability, the voice of the person with disability, is heard, to ensure that their voice is not silenced.

We have heard in this hearing from such supporters and such advocates as we have at many other hearings. Some are government witnesses who are called to explain policies and practices which are under scrutiny and whose appearance is essential as a matter of law, for reasons of procedural fairness, and to ensure that the Commission understands precisely what needs to be changed as well as what is working.

Some are representatives of other organisations whose actions are under scrutiny and who also must be given the opportunity to appear and give evidence for the same reasons I have just set out.

Some are researchers and experts, who again may or may not have a disability themselves, but whose evidence is necessary to investigate and evaluate proposals to address violence against abuse, neglect and exploitation of people with disability, matters that are at the heart of our responsibilities under our Terms of Reference.

In this connection, our Terms of Reference expressly identify the need to focus the Royal Commission's inquiry and recommendations on systemic issues. This is of course not optional. It is required and necessary. Some are representatives of advocacy bodies. Again, some are people with disabilities, some are not, but who nonetheless wish to put their experiences and their proposals to the Royal Commission on behalf of the many --- hundreds sometimes, thousands sometimes --- of people with disability with whom they have worked and who they represent and who they seek to obtain a better life and progress for.

If such witnesses were confined to advocates with disability, the witnesses would be shorter but some advocacy organisations would not participate in the hearings. Some practitioners in education, health, criminal justice and other fields who again may or

may not themselves be people with disability, but whose insights are essential to understand the problems and identify solutions.

Some are First Nations people who help us to understand the reality of intersectionality or multiple forms of disadvantage that are expressly recognised in our Terms of Reference.

In this hearing, as with the First Nations hearing, the reality of a legacy of racism and profound disadvantage is abundantly clear. The witnesses who have told us of these matters may or may not be people with disability but their evidence is indispensable.

Another feature is relevant to observe. To state the obvious, not all disabilities are visibly obvious, visibly discernible. Nor are all disabilities visibly discernible or obvious through interaction in a hearing. There have, of course, been witnesses at our hearings who have disabilities which are not visible or necessarily discernible through the interaction of the hearing, but who have chosen not to have their disability publicly disclosed as part of their evidence. This is their absolute right. This is something which the Royal Commission has and will continue to completely respect.

In recent days there has been information dispersed in the public and it is incumbent upon me to correct something. Recently there has been a figure proffered by some in public forums that only 15 per cent of witnesses before this Commission have been people with disability, and that's just wrong. It's just wrong. The number more closely approximates 22.5 per cent, plus, when you add in and take into account witnesses who have, because of the features and circumstances I have already spoken of, shared with us the stories of people with disability by necessity through that course, the total is somewhere more closely approximating one-third.

These figures are likely to be underestimates, given the other feature I have just observed, which is some people, as is their right, have chosen not to disclose their disability.

Can I move now to the balance of this week. The evidence tomorrow, Wednesday and Thursday - and Thursday is the last day of this hearing will build on the evidence we have heard so far concerning the importance of early intervention, the provision of -disabilityappropriate- support at all stages of the criminal justice system, including diversionary programs, and the particular focus on Wednesday and Thursday will be on the Cognitive Impairment Diversion Program in New South Wales, a pilot program, the funding for which ceases in the middle of this year.

In the course of those three days the Commission will hear from Ms Dorothy Armstrong, Mr Justen Thomas, Mr Geoffrey Thomas and Ms Taylor Budin. These are witnesses with lived experience which join the many hundreds and hundreds of voices of people with disability from whom the Disability Royal Commission has heard.

It need hardly be said that these public hearings represent only a fraction of the information which comes to the Commission and which the Commission will take into account in formulating its recommendations for the future. As I've said, the Commission has had the privilege of hundreds of submissions from people with disability, including people with cognitive disability, as well as hearing directly from people with disability in private sessions. That is, in the forum in which the person with disability has chosen to communicate with this Commission.

This choice is one which is absolutely respected by this Commission. It need hardly be said that it is not for any person to seek to dictate how any person with a disability who wishes to share their experience with the Commission should do so. It is not for any person to seek to influence or impose pressure on how people with a disability would wish to share their experience with the Commission.

For many, the choice and the ability to speak with a Royal Commissioner directly, one on one, in a private session is precisely the manner in which they choose to convey their information to the Disability Royal Commission. Others choose to share their stories with the Commission public. Again, they are choices which are respected by us and for which we are grateful to be able to facilitate. No one wishing to engage with the Royal Commission should feel under any pressure by anything they see or hear in the media, whether it be mainstream or social, that their engagement with the Royal Commission should be in a specific mode. It is up to them. We respect that.

None of this should be misinterpreted as indicating that we are not also proactively reaching out to people in closed and hard-to-reach settings. We are very cognisant of the need for this to occur and we are doing so, to seek to ensure that we hear the voices of people with disability within those settings as well.

The Royal Commission has and will continue to put the voices of people with disability at the centre of its work. As I have noted, it is fundamental to the work of the Royal Commission and the autonomy of those who choose to participate with it, that the mode in which the person with disability wishes to engage with the Royal Commission is respected and respected fully. We will continue to do precisely that.

Chair, the next witness is Mr Tom Langcake, who is giving evidence remotely. Would you like a break just for a couple of minutes, to do a double sound check?

CHAIR: Certainly. Thank you, Dr Mellifont, for that opening. We will take a short break for two or three minutes, just to check sound systems and the like, and then we shall resume. Thank you.

ADJOURNED **[11.36 AM]**

RESUMED **[11.39 AM]**

CHAIR: Yes, thank you. Dr Mellifont.

DR MELLIFONT: Thank you, Chair, the next witness is Mr Tom Langcake who is on the screen. You will find the statement of Mr Langcake at Tab 6 of Tender Bundle C. I ask to tender his statement into evidence and for it to be marked as Exhibit 11.17.1. Attached to his statement are Tabs 4 to 18 of Tender Bundle E. I ask to tender these documents into evidence and for them to be marked Exhibit 11.17.2 through to 11.17.16 respectively.

CHAIR: Yes, those documents may be admitted into evidence and given the markings Dr Mellifont has indicated.

EXHIBIT #11.17.1 - STATEMENT OF MR TOM BRIAN LANGCAKE

EXHIBITS #11.17.2 TO #11.17.16 - ANNEXURES TO STATEMENT OF MR TOM BRIAN LANGCAKE

CHAIR: Mr Langcake, thank you very much for coming to the Royal Commission, at least in a metaphorical sense, in order to give evidence. If you would be good enough to follow the instructions of my Associate, she will administer the affirmation to you.

MR TOM BRIAN LANGCAKE, AFFIRMED

CHAIR: Thank you, Mr Langcake. Just to explain where everybody is, Dr Mellifont will be asking you some questions from the Brisbane hearing room, Commissioners Atkinson and Mason are also located in the Brisbane hearing room, Commissioner McEwin is with me in the Sydney hearing room and you are in the Northern Territory. That covers just about everybody. Dr Mellifont will now ask you some questions.

MR LANGCAKE: Thank you.

EXAMINATION-IN-CHIEF BY DR MELLIFONT

DR MELLIFONT: Thank you. What is your full name?

MR LANGCAKE: Tom Brian Langcake.

DR MELLIFONT: Your current position at the Forensic Disability Unit?

MR LANGCAKE: The Direct Services Manager which was formerly titled the Group Home Manager.

DR MELLIFONT: You were previously the Acting Direct Services Manager; is that correct?

MR LANGCAKE: I have been the Direct Services Manager since January 2020.

DR MELLIFONT: Thank you. Can I just clarify then, the Direct Services Manager, that was the - was the formal title for that role Group Home Manager?

MR LANGCAKE: It is currently titled the Direct Services Manager, formerly titled the Group Home Manager.

DR MELLIFONT: Do you have a recollection of when that title change occurred?

MR LANGCAKE: In the recent months, within the last couple of months.

DR MELLIFONT: Thank you. Have you been employed within the Forensic Disability Unit since 1 February 2017?

MR LANGCAKE: That's correct.

DR MELLIFONT: Since that period of time, apart from your current role, you have worked as coordinator, shift supervisor and disability worker; is that right?

MR LANGCAKE: Yes, correct.

DR MELLIFONT: Can you help me, Mr Langcake, to understand the reporting line? Who do you report up to? I don't need the name specifically but to understand the reporting hierarchy above you.

MR LANGCAKE: Sure. My direct line manager is the Senior Manager, who is based in Darwin, and her manager is the Senior Director, which is Ms Cecilia Gore.

DR MELLIFONT: The Senior Manager in Darwin is Senior Manager of the Forensic Disability Unit or more broadly than that?

MR LANGCAKE: Yes, the Forensic Disability Unit.

DR MELLIFONT: Just to let you know, Mr Langcake, sometimes I'll be looking down and it will look like I'm not looking at you, but I have another screen in front of me and it's a bit of a habit, I'm afraid, one I can't seem to break.

MR LANGCAKE: Sure.

DR MELLIFONT: Can I take you to your qualifications. You have mentioned at paragraph 6 that you completed Professional Development in Applied Behavioural Analysis. Do I understand correctly from your CV that is - was it a two-week course; is that right?

MR LANGCAKE: Yes, that's correct.

DR MELLIFONT: How long ago did you do that?

MR LANGCAKE: Last year, in 2020.

DR MELLIFONT: Who was it delivered by?

MR LANGCAKE: The Institute of Applied Behavioural Analysis.

DR MELLIFONT: In the Northern Territory?

MR LANGCAKE: I believe they are based in the United States.

DR MELLIFONT: Was it an online course?

MR LANGCAKE: Yes, they were interactive webinars.

DR MELLIFONT: Was that something at the behest of your employer or was it a self-initiated study?

MR LANGCAKE: Self-initiated.

DR MELLIFONT: Do you know whether for your particular role that you hold there are minimum qualifications and what they are?

MR LANGCAKE: I believe the selection criteria was included with my statement.

DR MELLIFONT: Yes.

MR LANGCAKE: I'm not sure - I don't believe there's any minimum qualifications outlined in that selection criteria.

DR MELLIFONT: Yes. Beyond what's in the selection criteria, you are not aware of there being any additional requirements in order to be qualified for your particular job; is that right?

MR LANGCAKE: Not qualifications as such.

DR MELLIFONT: Yes, okay. You have also done the Assessment of Risk and

Manageability of Individuals With Developmental and Intellect Equal Limitations Who Offend. When did you do that?

MR LANGCAKE: I believe that was in 2020 as well.

DR MELLIFONT: Who was that through?

MR LANGCAKE: I will have to check who that was facilitated by.

DR MELLIFONT: Was it an online course?

MR LANGCAKE: No, that was face-to-face, I completed that course in Darwin.

DR MELLIFONT: For how long did the course go?

MR LANGCAKE: I believe it was a two-day course.

DR MELLIFONT: Again, was that self-initiated or something required by your employer to do?

MR LANGCAKE: That was a discussion I had with my manager at the time, who asked if I would like to attend that course.

DR MELLIFONT: Okay, thank you. You have done the Social Safety, SoSAFE! training, which we hear about elsewhere in the evidence when did you do that?

MR LANGCAKE: Again I believe that was 2020 as well.

DR MELLIFONT: Who is that delivered by?

MR LANGCAKE: I'm not sure of the person that delivered that training or what the company is called.

DR MELLIFONT: Can you tell me how long it went for?

MR LANGCAKE: I believe that was two days as well.

DR MELLIFONT: I will move off this in a second. I'm just trying to get a sense of this, if you don't mind.

MR LANGCAKE: Sure.

DR MELLIFONT: You did the Recognising Restrictive Practices training. Who was that delivered by?

MR LANGCAKE: That was a workshop. It was through the NDIA, from memory.

DR MELLIFONT: Is that something your work initiated or you did?

MR LANGCAKE: Yes, again similar, I spoke to my manager and got approval to attend that.

DR MELLIFONT: How long did it go for?

MR LANGCAKE: That was just a workshop, a one-day workshop.

DR MELLIFONT: Was that last year as well?

MR LANGCAKE: Yes. It may have been 2019 or 2020.

DR MELLIFONT: Thank you.

You mention in your statement that prior to joining the FDU you were a Senior Correctional Officer at the Alice Springs Correctional Centre. Is that correct?

MR LANGCAKE: Yes, that's correct.

DR MELLIFONT: Whilst you were there you did work at the John Bens Unit, which is a unit for prisoners identified with special needs?

MR LANGCAKE: Yes. During my time with Alice Springs Correctional Centre I worked in a number of different areas, but I spent some time working in the John Bens Unit, which is a unit where there's prisoners with identified special needs, and any people that are on custodial supervision orders, including Winmartie.

DR MELLIFONT: Winmartie was there when you worked in that unit?

MR LANGCAKE: Yes, that's correct.

DR MELLIFONT: Do you have a recollection of how long you were there and he was there at the same time - months, years?

MR LANGCAKE: Yes, I started in 2010. Winmartie's full transition was in May 2018. That was - so that was approximately seven years.

DR MELLIFONT: So you are aware that during that period of time there was the use of physical restraints, the use of a chair, in respect of Winmartie?

MR LANGCAKE: I can't recall any uses of a restraint chair but I did hear people talking about that and in this Royal Commission as well.

DR MELLIFONT: Insofar as there may have been use of a restraint chair, you didn't have any positional authority with respect to decisions to use such a restraint?

MR LANGCAKE: No. I wasn't involved in any use of a restraint chair with Winmartie.

DR MELLIFONT: What about chemical restraints? Were you involved in any decision to give him chemical restraints?

MR LANGCAKE: Yes, in my seven years, I was also given the opportunity to act up on higher duty as a Senior Correctional Officer of the John Bens Unit for a short period of time. So during that period there was chemical restraints in the form of PRN that were administered to Winmartie. The decisions on those weren't made by me, though.

DR MELLIFONT: Can I get an understanding of the decision to administer the PRN medication. We are talking there about sedating medication, are we not?

MR LANGCAKE: Yes, that's my understanding.

DR MELLIFONT: The decision to administer such medication was made by a clinician, is that your recollection?

MR LANGCAKE: There's a medical unit of Alice Springs Correctional Centre and they would be contacted and advised of our - when Winmartie was presenting and they would make decisions around that.

DR MELLIFONT: Can you tell me your recollection of the minimum level of seniority of clinician who was permitted to authorise the administration of the PRN at the correctional centre?

MR LANGCAKE: I'm not sure.

DR MELLIFONT: Nurse, psychiatrist, any recollection?

MR LANGCAKE: No, no recollection at all about who - I know that the medical unit would be contacted and they would attend and administer PRN medication. I'm not sure who made those decisions.

DR MELLIFONT: I want to move on. We are aware, of course, that the Alice Springs Secure Care Facility has been a gazetted facility under the *Disability Services Act* since 2013. That's your understanding as well?

MR LANGCAKE: Yes, that's my understanding.

DR MELLIFONT: You set out in your statement that you understand the role of the facility to be to provide secure accommodation for clients of the Forensic Disability Unit that are subject to custodial supervision orders? That's your understanding?

MR LANGCAKE: Yes. So we also have other clients on non-custodial supervision

orders and we provide direct service to those clients who are at houses in the community. We also oversee a number of other clients who are clients that have their direct support provided by NDIS providers.

DR MELLIFONT: So there is - as you have indicated - a role of the unit which involves external-type services to people. But the facility itself, am I correct to say it can accommodate up to eight people?

MR LANGCAKE: Yes, there are eight rooms there, so that would be the capability.

DR MELLIFONT: Is it correct that it currently only holds Winmartie?

MR LANGCAKE: That's correct.

DR MELLIFONT: How long has that been the case for?

MR LANGCAKE: I believe it is a duration of the time since he's completed his transition under our full-time care.

DR MELLIFONT: So, insofar as you have direct knowledge, you know for sure he's been there since you have been with the FDU, since 1 February 2017, but your understanding is that even for the time before that, he was the only resident of the unit? Is that your understanding?

MR LANGCAKE: Okay, I'll just clarify. I transitioned to the Forensic Disability Unit on 1 February 2017.

DR MELLIFONT: Yes.

MR LANGCAKE: Winmartie's full transition didn't happen until May 2018.

DR MELLIFONT: Yes, I'm sorry, my correction, I had my chronology out of whack. So since he has been transitioned, he's been the only person there?

MR LANGCAKE: I believe so, yes.

DR MELLIFONT: As I go through, Mr Langcake, and I ask you questions, could you let us know what you know from direct knowledge, and if it's a belief based on something somebody has told you, let us know that, and if it's something you don't know, also let us know that, so we can get an understanding of what's in your direct knowledge.

MR LANGCAKE: Okay.

DR MELLIFONT: Thank you.

You speak in your statement about the aims of the FDU being to decrease offending

through provision of at the moment and when necessary external disability support works and there being an aim to reduce and eliminate where possible the use of restrictive practices, including transitioning clients from restrictive environments to less restrictive environments. That's your understanding of the aims and goals of the unit?

MR LANGCAKE: Yes.

DR MELLIFONT: And that's been your understanding throughout the period of time you have been there?

MR LANGCAKE: Yes.

DR MELLIFONT: Can I take you to paragraph 13 of your statement. Do you have that there with you?

MR LANGCAKE: I do.

DR MELLIFONT: There you say that during the weekday day shifts, he gets support from a Disability Support Worker and a shift supervisor. Then you say "and may receive", and this is:

> *.... in the event of a behavioural incident [he] may receive an Occupational Therapist, Case Manager, Coordinator/s and/or Group Home Manager.*

So who is the Group Home Manager?

MR LANGCAKE: At that time of this statement, that was my title.

DR MELLIFONT: Yes.

MR LANGCAKE: However, it is now changed to Direct Services Manager, so that's myself.

DR MELLIFONT: If we wanted to, we could delete the words "group manager" and say "me"?

MR LANGCAKE: Yes.

DR MELLIFONT: What I'm trying to understand, Mr Langcake, is why are those supports - that is, an occupational therapist, a case manager, a coordinator and/or yourself - only in the event, and then even so may be in the event, of a behavioural incident? Why are those supports available?

MR LANGCAKE: Okay. So it's a little bit unclear the way that's written, my apologies for that. All of those people have contact with Winmartie throughout the duties of their positions. What this is referring to is if Winmartie was to display

challenging behaviours, one of these staff members may assist with providing direct care and support to Winmartie, often Winmartie displays challenging behaviours such as self-harm or targeting staff members or attempted assaults, and they might have to swap out with one of those staff members to assist.

DR MELLIFONT: Beyond that proposition, you would agree that, given the aim of the FDU is to decrease offending behaviour through provision of treatment and external support, it is really necessary for Winmartie to have the support of occupational therapists and case managers and coordinators, and perhaps yourself, on a continued and consistent basis towards that end? Would you be agreed about that?

MR LANGCAKE: Yes.

DR MELLIFONT: This is particularly so given that he does have complex needs, are we agreed about that?

MR LANGCAKE: Yes.

DR MELLIFONT: I want to get a better understanding of the staffing. Who decides how many staff you get and what type of staff? What level is that decision taken?

MR LANGCAKE: As far as how many staff are directly supporting the client on any day?

DR MELLIFONT: Let's start with staff within the FDU, as a blanket proposition. Who makes the decisions about how many staff the FDU has?

MR LANGCAKE: I'm not sure who makes that decision. I only know what the staffing model is now.

DR MELLIFONT: Someone up the tree from you?

MR LANGCAKE: Yes, that's right.

DR MELLIFONT: Do you get to have input into the staffing model, that is how many people you have, who they are, what their qualifications are?

MR LANGCAKE: I haven't had input in the past around the staffing model. As far as the recruitment of staffing, I haven't had input into the selection criteria, but I do have input into our shortlisting criteria and what we would be looking for with our recruitment process.

DR MELLIFONT: Under the current staffing model, which you are obviously aware of, in your role there, have you formed a view about, if you could have more staff or different staff, position types, what that might be? If you had a wishlist as to what you would like to have in that unit, in order to best support the aims and goals

of the FDU, what would that look like?

MR LANGCAKE: I'll just give you a bit of information about what we do have already, and the services that we seek to provide externally. We have got a number of disability support workers, shift supervisors, we have got two coordinators, myself as the direct services management. We have a case manager and an occupational therapist based in Alice Springs. We also have a behavioural clinician that is based in Darwin but visits Alice Springs regularly, every month for a week. There is a senior clinician, there's a senior manager and there's some other clinical positions in Darwin as well.

DR MELLIFONT: Can you just go a little bit slower on the last few? Because we have the positions within the FDU itself --- so you have a behavioural clinician in Darwin?

MR LANGCAKE: Yes.

DR MELLIFONT: Is that a psychologist, a psychiatrist, a --- do you know?

MR LANGCAKE: It's somebody that's worked in the clinical team that's done professional development in behaviour. I'm not sure exactly of the qualifications, I don't have them handy.

DR MELLIFONT: You said there's a senior clinical person. Do you know what position they hold? Are they a psychiatrist, or do you know?

MR LANGCAKE: The senior clinician is a psychologist, I believe. There's been some movement in some of our positions recently, but that's my understanding. I'm not sure of any other additional qualifications.

DR MELLIFONT: Then you said there was a senior manager?

MR LANGCAKE: Yes, who is also a psychologist.

DR MELLIFONT: Is that senior manager the person you spoke of before as being upwards in your reporting line or somebody different?

MR LANGCAKE: Yes, that's correct.

DR MELLIFONT: Is it the person up in the reporting line?

MR LANGCAKE: Yes, that's my direct line manager.

DR MELLIFONT: You said that the behavioural clinician comes from Darwin for about a week a month; is that correct?

MR LANGCAKE: The behavioural clinician is based in Darwin and visits us in

Alice Springs for a week every month.

DR MELLIFONT: What does that person do when they are there, that is with you, in Alice Springs?

MR LANGCAKE: So direct observations of the clients, working on different behaviour support plans and liaising with internal and external stakeholders about development of those plans.

DR MELLIFONT: To your direct knowledge, has the behavioural clinician ever met and assessed Winmartie?

MR LANGCAKE: Assessed him in what regard?

DR MELLIFONT: Assessed him in terms of his behavioural needs, functional analysis, medical needs.

MR LANGCAKE: Yes. That's my understanding. The behavioural clinician has met Winmartie a number of times and assessed.

DR MELLIFONT: Does that clinician report back to you as to what the clinician has done and found and provide guidance?

MR LANGCAKE: I don't have oversight of the clinical team, that falls under the senior manager and senior clinician, but there is consultation with myself and other employees at the unit. So there's regular meetings on different topics.

DR MELLIFONT: When I say report back to you, I'm trying a get a sense as to whether or not there is a direct and clear connection between what the behavioural clinician is doing when - is it she?

MR LANGCAKE: Yes.

DR MELLIFONT: --- sees Winmartie, and the work of the FDU. So is there a formalised reporting process whereby the information gathered by the behavioural clinician is fed through to you for you to be able to disseminate to others within the FDU to capture that information?

MR LANGCAKE: Yes.

DR MELLIFONT: And to capture any guidance provided? There is?

MR LANGCAKE: We work closely with the clinical team. In development of the behaviour support plans, we definitely receive that information throughout the process and when the behaviour support plan has been completed or updated.

DR MELLIFONT: I'll ask my question more directly. Behavioural clinician comes

out. Sees Winmartie. Is there a written report back to you and your team in terms of the results of that consultation with Winmartie?

MR LANGCAKE: Not a written report as such. I don't receive reports on the behavioural clinician's visits.

DR MELLIFONT: Rather, it is an informal discussion, an information exchange. Is that what I understand to be the case?

MR LANGCAKE: It depends on what the behavioural clinician is doing at the time and what she might be focusing on. That information would be liaised with anyone that is required to have those conversations, depending on what the task is. It might be, if we are developing the behaviour support plan, as I said, we receive that information, yeah, when that plan is being developed, or during that plan.

DR MELLIFONT: Is there a written procedural document which requires information exchange as between the behavioural clinician and the staff of the FDU?

MR LANGCAKE: Not that I'm aware of.

DR MELLIFONT: Has the senior clinician you referred to before seen and assessed Winmartie?

MR LANGCAKE: She has recently moved into the senior clinician position. She has visited Alice Springs and met Winmartie.

DR MELLIFONT: The extent of your knowledge as to her interactions is that she has met Winmartie; is that correct?

MR LANGCAKE: Yes. I'm not sure of the details of that exactly. She has visited and she has met Winmartie. I'm not sure of any assessment she may have conducted.

DR MELLIFONT: Again, there is no written report back to the FDU of the visit by the senior clinician; is that correct?

MR LANGCAKE: Yes, that's right.

DR MELLIFONT: Looking at paragraph 14 of your statement, can you tell me whether, of those 28 positions, are they part-time or full-time?

MR LANGCAKE: All of the employees at the Forensic Disability Unit are full time.

DR MELLIFONT: Thank you. Only eight of those staff have been there for more two years. In your position as manager, do you regard staff turnover as being a problem?

MR LANGCAKE: Staff turnover and recruiting and retaining staff is an issue in

Alice Springs more broadly and particularly in the disability sector. It's a remote town and quite a transient place. We do provide a lot of support and training and oversight to our staff.

DR MELLIFONT: Let me come back to that. Can I ask the question without it being judgment-laden, that is, without implying any particular criticism? Does the essentially of staff turnover make it more difficult for you to deliver the services to Winmartie you would like to see delivered to Winmartie, having regard to the aims of the FDU?

MR LANGCAKE: Having new staff members, I think the process that we have got in place is pretty good, where we have shift supervisors that are generally more experienced, that are able to coach and mentor our staff members. But obviously having staff with more experience would be beneficial to the unit.

DR MELLIFONT: What is the minimal level of training or qualifications that a Disability Support Worker has to have in order to be able to work in the FDU?

MR LANGCAKE: The selection criteria was submitted as a part of my documents that I've submitted. However, I can tell you about the shortlisting requirements that we generally use.

DR MELLIFONT: Yes, that would be helpful, because we are truly trying to get a sense of what is the minimal level before somebody gets to come and work in the FDU.

MR LANGCAKE: When shortlisting, we shortlist based on experience working with complex clients who display challenging behaviours, as well as experience working with Aboriginal people, sound written and oral communication skills and what's desirable is a Certificate IV in disability as well.

DR MELLIFONT: Okay, that's a desirable ---

MR LANGCAKE: Sorry, I'll just add to that. And generally the shortlisting criteria is well is that they have a minimum of two years' experience as a Disability Support Worker.

DR MELLIFONT: Are they desirable criteria or mandatory?

MR LANGCAKE: The Certificate IV in disability?

DR MELLIFONT: Yes.

MR LANGCAKE: That's desirable.

DR MELLIFONT: So in practice, does the shortage of staff from which to recruit mean that you are sometimes employing people without a Certificate IV and/or

without the two years' experience?

MR LANGCAKE: I can't comment on recruitment processes that have happened in the past before I have been in that position, but my understanding of the --- as I understand, I think everyone has met the two years' experience, not always the Certificate IV in disability or similar. But the rest of the shortlisting criteria is met.

DR MELLIFONT: Your statement refers to the fact that agency staff are sometimes used. What process is there to check, to make sure that the agency staff has the minimum criteria that the employed staff would need? Is there a check and balance for that?

MR LANGCAKE: I would have to take that question on notice. What I can tell you is that I'm aware that they have certain criteria that their staff members need to meet, and that in respect to Winmartie we partner experienced staff members with any non-experienced staff members if that is the case. Generally with agency staff, they wouldn't be utilised with Winmartie unless there was an emergency. We would move staff members working with other clients to work with Winmartie and the agency staff would work with the other client, due to his complex needs.

DR MELLIFONT: Right, but you will take on notice the question I've asked?

MR LANGCAKE: Yes, if that's okay.

DR MELLIFONT: Thank you.

Can I take you to paragraph 16, please. How long is that positive behaviour support training? How long does it go for?

MR LANGCAKE: Which one are you referring to, the general or the one specific to Winmartie?

DR MELLIFONT: Yes, the general.

MR LANGCAKE: The general positive behaviour support, I believe that's a day of training.

DR MELLIFONT: Provided by?

MR LANGCAKE: One of the clinical staff members.

DR MELLIFONT: Who do you regard as being a clinical staff member?

MR LANGCAKE: So we have got two local clinicians, the case manager and the occupational therapist.

DR MELLIFONT: What's the case manager's clinical qualification?

MR LANGCAKE: I don't have that information, unfortunately.

DR MELLIFONT: Would you take that on notice for me, please?

MR LANGCAKE: Yes.

DR MELLIFONT: Thank you. All right, so either the occupational therapist or the case manager delivers that training and it's a one-day training?

MR LANGCAKE: That's (overspeaking) ---

DR MELLIFONT: Is it a once-off training?

MR LANGCAKE: Ideally that training should happen annually, that's my understanding.

DR MELLIFONT: But does it? Or is that outside your knowledge?

MR LANGCAKE: That's outside my knowledge. I would have to check the training records.

DR MELLIFONT: Okay.

Because the question I'm going to ask you is how many of these staff or do all of these staff that you have listed in paragraph 14 have all of their annual competencies? Can I ask you to take that one on notice, please?

MR LANGCAKE: Yes.

DR MELLIFONT: Thank you.

In respect of subparagraph (b), the "Positive Behaviour Support", is that a once-off training provided to new staff?

MR LANGCAKE: No, the positive behaviour support for Winmartie is something that is part of the induction process. That training package is renewed with the new behaviour support plan or the amended behaviour support plan, I should say, which happens annually, and then that's delivered to staff members annually.

DR MELLIFONT: How is competency in respect of the positive behaviour support for Winmartie assessed by you?

MR LANGCAKE: There are direct observations of staff members via shift supervisors, the clinical team and other management team members. We also have regular team meetings where formal supervision is completed during those meetings.

DR MELLIFONT: In respect of specific assessment by you to satisfy yourself that a particular staff member is able to deliver the intention of the positive behaviour support training, do I take it there is none?

MR LANGCAKE: You mean a specific assessment tool?

DR MELLIFONT: Yes.

MR LANGCAKE: Not that I'm aware of.

DR MELLIFONT: Okay. So you rely, do I take it, on what shift supervisors may or may not tell you about how the staff are going with respect to delivering services to Winmartie?

MR LANGCAKE: Not just the shift supervisors. There's clinical team members and myself and coordinators that have direct supervision at times of staff members.

DR MELLIFONT: Again, the clinical team, we are talking about the case manager and the OT. Your coordinators, what are their qualifications?

MR LANGCAKE: I don't have that information in front of me but I can take that on notice, if that's okay.

DR MELLIFONT: Okay. Do you know the extent of their own clinical training and thus ability to discern whether staff members are actually able to deliver this positive behavioural support? Is that something you're aware of?

MR LANGCAKE: They have completed similar courses as the other staff members have. There's one of the coordinators has a number of years experience working with Winmartie, who used to work at Alice Springs Correctional Centre as well. So they are there Monday to Friday, so they have got a lot of contact with Winmartie and the staff members. And there's a number of plans for our staff members to follow, the behaviour support plan and other plans. So that's something that enables us to be more consistent with the delivery of care and support to Winmartie.

DR MELLIFONT: I'll return to my question, which is: do you have specific knowledge of their clinical training, the coordinators?

MR LANGCAKE: No, they don't have any clinical training that I'm aware of specifically.

DR MELLIFONT: Right. If we go to subparagraph (c), "Person Centred Support Package", who is that delivered by?

MR LANGCAKE: Again, that's delivered by one of the clinical staff.

DR MELLIFONT: By "clinical staff" that means the OT or the case manager?

MR LANGCAKE: Correct.

DR MELLIFONT: Is there any formal assessment of how the staff have picked up or not picked up the competencies expected to be delivered as part of that person centred support package training?

MR LANGCAKE: Not that I'm aware of, no tool as such. Direct observations and formal supervision during meetings but no actual tool that I'm aware of.

DR MELLIFONT: You have used the words "formal supervision" a couple of times. I want to understand what you mean by that.

MR LANGCAKE: During meetings, we discuss a number of different topics and give people an opportunity to share experiences and talk about how we can upskill people or support people to perform their duties. That's a part of a structured meeting that we have, we have team meetings quite regularly.

DR MELLIFONT: Which clinicians are at that meeting?

MR LANGCAKE: It depends on the day, but generally there would be one of the clinicians, the occupational therapist or the case manager.

DR MELLIFONT: But sometimes neither?

MR LANGCAKE: That may be the case. I can't recall --- (overspeaking) ---

DR MELLIFONT: Sometimes there are these meetings which are intended to provide supervision but in respect of which there is no person with clinical training providing feedback and interchange with the staff; is that right?

MR LANGCAKE: Clinical - what are you referring to with clinical training, that would be --- (overspeaking) ---

DR MELLIFONT: I'm using it in the same way you're using it, that is, your occupational therapist or your case manager.

MR LANGCAKE: So I would be present at all of those meetings.

DR MELLIFONT: Mr Langcake, but you are not a clinician, are you?

MR LANGCAKE: No, I'm not.

DR MELLIFONT: You don't have formal - I'm not being critical but you don't have formal clinical training; correct?

MR LANGCAKE: Yes, just the professional development that I've done.

DR MELLIFONT: Okay. If I understand your evidence correctly, within that list of 28 people, the only staff who definitely have clinical training are the occupational therapist and perhaps the case manager, plus or minus your coordinators. Is that right?

MR LANGCAKE: On occasion there may be a senior clinician or senior manager that's present, but generally speaking that's correct.

DR MELLIFONT: On those occasions where you might have the senior clinician or the senior manager there, does that involve a formalised process by them of reviewing the records in respect of Winmartie and providing formal and structured feedback about how to make things better? Or is it more of a chat?

MR LANGCAKE: All of the meetings are documented. If there's any outcomes or identified training needs, they are assessed during those meetings. So they are documented and they are distributed to the staff members, all of the staff members, in fact. So yes, so it is documented.

DR MELLIFONT: I think we are at odds. Let me rephrase my question. I'm trying to understand when, when you have got the senior clinician or your senior manager coming to these meetings, have they done a full and formal consideration and assessment of the recent records of Winmartie and then provide feedback to the staff about how they can do things better or differently?

MR LANGCAKE: Not to my knowledge, no.

DR MELLIFONT: Or is it informal?

MR LANGCAKE: The meetings, they are formal, I would consider them formal supervision, and they are documented and sent out. But no, there's nothing provided by the senior manager or the senior clinician. The notes are completed by myself or one of the coordinators, not a clinical team member.

DR MELLIFONT: So you are unaware of the extent to which the senior clinician or the Senior Manager may have or have not closely interrogated the recent records of Winmartie before coming to such a meeting; is that correct?

MR LANGCAKE: Sorry, could you repeat that question?

DR MELLIFONT: You are unaware as to the extent to which the Senior Clinician or the Senior Manager may or may not have interrogated, looked at, examined, the full records of Winmartie before they come to that meeting?

MR LANGCAKE: I don't know the extent of that, no.

DR MELLIFONT: I want to take you please to page 6 of your statement. I want to

get up document - can I have a minute to make sure it is properly redacted. Operator, please don't bring up the first page. The document itself is NTT.0003.0010.0135, but the page I want to show on the screen is page NTT.0003.0010.0136.

Mr Langcake, can I orient you to what this is whilst the technology is occurring. This is the document which you refer to as Annexure TL-3, the Person Centred Support Package. Are you familiar with this document?

MR LANGCAKE: Yes.

DR MELLIFONT: Is this the Presentation which is given to new staff members in respect of Winmartie and the Person Centred Support Package?

MR LANGCAKE: That is one of a number of different training sessions that are provided to new staff members. That package would be updated when there's a new behaviour support plan.

DR MELLIFONT: I missed the last half of your sentence. You said this would be updated?

MR LANGCAKE: When there's an amendment to the behaviour support plan.

DR MELLIFONT: Can I let you know that the version I am showing you is the one you annexed to your statement to the Royal Commission. So your understanding, I take it, would be that that was the one that was current at the time of your statement?

MR LANGCAKE: That's my understanding, yes.

DR MELLIFONT: This is a PowerPoint presentation; correct?

MR LANGCAKE: Yes.

DR MELLIFONT: It's delivered as a once off to the new staff member; is that correct?

MR LANGCAKE: That particular version of that would be delivered to new staff. When there's changes to the behaviour support planor amendments, I should say, a new package would be developed, and that would be facilitated to the clinical team by one of the staff members.

DR MELLIFONT: If I understand this correctly, the new staff members get it and then everybody gets it when it's updated?

MR LANGCAKE: That's my understanding, yes.

DR MELLIFONT: What do we look to in terms of audit; that is, to satisfy ourselves

and yourselves that the staff are actually getting this training in those two ways at the times you have indicated? Do you have a record of that?

MR LANGCAKE: There's a training log, yes.

DR MELLIFONT: So we could have a look at that.

What I want to take you to is on page NTT.0003.0010.0136. This is a ---

MR LANGCAKE: We are looking at that training package?

DR MELLIFONT: Yes, the page which is on the screen. Can you see the screen in front of you, it says "Content of this Package"?

MR LANGCAKE: Yes.

DR MELLIFONT: What I read from number 8 is that new staff are told that the positive approaches to be taken to behaviour that challenges are Winmartie's support plan and restrictive practices.

MR LANGCAKE: I'm just trying to find that section.

DR MELLIFONT: It's the second page of the PowerPoint pack and it's up on the screen. Can you see it's highlighted?

MR LANGCAKE: Yes, I can see that.

DR MELLIFONT: Is that what new staff are told, that the positive approaches to behaviour that challenges are the behaviour support plan and restrictive practices?

MR LANGCAKE: I would have to look at that section. I'm sure there is more information in that section.

DR MELLIFONT: Can we agree at least that that is the very first slide that is shown, so far as you understand, to these new staff? Do you agree with that?

MR LANGCAKE: That is part of that package.

DR MELLIFONT: Do you have actual the hard copy document in front of you?

MR LANGCAKE: I do.

DR MELLIFONT: I don't want the document to come up on screen because there is a photograph on it. It is NTT.0003.0010.0178. Have you got that in front of you?

MR LANGCAKE: Yes, I've got number 8 here, about positive behaviour support.

DR MELLIFONT: You will see again that one of the things listed there is the:

Positive approaches to behaviour that challenges .... restrictive practices

MR LANGCAKE: That's on the title of the slide, yes.

DR MELLIFONT: Do you see a problem in that being the message which is being given to the new staff who are to look after Winmartie?

MR LANGCAKE: I think that is a heading. The content of that section of the training package is explained by the clinician that delivers that training, so it would be explained in detail what is being referred to there.

DR MELLIFONT: But this is what they get, isn't it? This is what they get as a take-away?

MR LANGCAKE: So that is the slide, the PowerPoint slides, yes.

DR MELLIFONT: Do they get that as a take-away, they get to that PowerPoint, take it away, keep it, have it electronically?

MR LANGCAKE: Normally it's not printed off, it's just a slide and there's discussion during that training package.

DR MELLIFONT: All right. Do they get it electronically?

MR LANGCAKE: Not that I'm aware of.

DR MELLIFONT: Is there a copy of this PowerPoint kept within the unit so people could have reference to this Person Centred Support Package when they are delivering services to Winmartie?

MR LANGCAKE: The behaviour support plan is available for staff members to read. That's accessible to all staff members. This particular PowerPoint slide, I don't believe that's available for everyone to access whenever they want, but the behaviour support plan, which is what this package was developed from, is available for everyone.

DR MELLIFONT: Let me see if I understand this. This PowerPoint package is, to your understanding, delivered verbally, delivered orally, to the new staff members; right?

MR LANGCAKE: Yes.

DR MELLIFONT: They may or may not get, electronically or in hard copy, this document; is that right?

MR LANGCAKE: I'm not sure if they receive a hard copy or not.

DR MELLIFONT: You are not sure if they get it electronically; is that right?

MR LANGCAKE: As I said, they have access to the full behaviour support plan and are encouraged to read that document.

DR MELLIFONT: Okay. What we have being communicated to these new staff members, on two slides at least, is that the positive approaches to behaviour that challenges, one of the things listed is restrictive practices. We are agreed on that. Yes?

MR LANGCAKE: It says that on the page. I think what would be included in that, I can't recall specifically, is strategies that staff members are to use before the use of restrictive practice, and that there's a number of different options available to our staff members which they use on a regular basis.

DR MELLIFONT: Do I take it that you see no concerns with the way in which this behaviour support plan on the second slide and the beginning part of part 8, just refers to in that way as restrictive practices?

MR LANGCAKE: I could see how that could be interpreted that that's hand in hand with behaviour support plan, but that's not the case.

DR MELLIFONT: How could it be interpreted problematically? You just said it might be.

MR LANGCAKE: I see that it says:

My behaviour support plan & restrictive practices.

And what you are getting at is that that's a concern.

DR MELLIFONT: Yes, because it rather indicates, doesn't it, that restrictive practices is a part of the positive approach to behaviour management. Agreed?

MR LANGCAKE: I can see what you're saying, yes.

DR MELLIFONT: But you're not too worried about it, is that what you say? You're not too worried about it because you say whoever is giving the presentation of this training would cover off on how you administer restrictive practices?

MR LANGCAKE: Yes, definitely, that's included in detail in that training.

DR MELLIFONT: But even seeing it now so starkly like that, is that something you would want to see changed in that documentation?

MR LANGCAKE: Yes, that makes sense to change it, but in the context of what's delivered, that doesn't marry up with what's delivered during those trainings.

DR MELLIFONT: Which you are at sometimes and not at other times; is that right?

MR LANGCAKE: That's correct.

DR MELLIFONT: So you are relying upon whoever the person is delivering those trainings to make sure that there's clarification in the message you are intending to convey? You are just hoping that's happening?

MR LANGCAKE: I'm sure that that's happening.

DR MELLIFONT: Well, how are you sure?

MR LANGCAKE: Because I've been involved in those training sessions and heard the content of the training sessions.

DR MELLIFONT: But you have heard them time and again. It's a different situation, isn't it, for a person who is hearing it for the first time? You would agree with me?

MR LANGCAKE: Sorry, can you clarify that?

DR MELLIFONT: You would agree that the situation of somebody such as yourself, being there and hearing it, time and again, is different from the circumstance of a first time, new staff member hearing it?

MR LANGCAKE: It is different. But what's included in that plan is a lot of detail around behaviour support plan and the strategies that staff need to use, and that's quite clear in that training session.

DR MELLIFONT: I'm going to move on.

At subparagraph (d) you refer to the Management of Actual Or Potential Aggression Course, and you say there is:

> *Informal refresher training may also be provided on occasions if it is requested by staff, if management identify that it may assist particular staff, or if it has been observed that Winmartie's behaviours of concern have increased and the risks to himself or others have subsequently increased.*

First, when was the last informal refresher training provided for staff?

MR LANGCAKE: I don't have a date on that. I can tell you that the management of actual or potential aggression is for all new staff members, and then there's an annual refresher that's completed for all staff members. The informal refreshers are

completed as needed, or if indicated by a staff member that they would like a refresher. I can't tell you the specifics on when that was last done, but it's normally with smaller groups and it has happened on a number of occasions.

DR MELLIFONT: Who provides this informal refresher training?

MR LANGCAKE: I'm one of the two MAPA instructors, so it would generally be myself, possibly - actually, I think all the informal refreshers have been done by myself and a former MAPA instructor that is no longer with the department.

DR MELLIFONT: What is an informal refresher? What is it?

MR LANGCAKE: Okay, so there's a formal foundation course that goes for two days. There's a formal refresher where assessment is assessed and documented. The informal refreshers, they are - there's a record kept but there's no formal assessing as such. It doesn't follow the guides from that program. It's just --- (overspeaking) ---

DR MELLIFONT: What is it?

MR LANGCAKE: Okay. So the informal refreshers might be talking about different aspects of that training. Would you like me to explain what's included in that training package?

DR MELLIFONT: Yes, I would.

MR LANGCAKE: Okay. Sure.

DR MELLIFONT: Hang on a second. Provided it goes beyond the information provided in your paragraphs (d). You listed the things in (a) to (j). What I'm trying to understand is, what is informal refresher training? Is it a chat? Is it a "Do you get this bit, let's have a discussion about that?" What is it?

MR LANGCAKE: It's a "sit down and have a chat". We could go through some the disengagement skills and holding skills. That's generally what it is, it's around disengagements and holding, but we can cover some of the other content in that program as well.

DR MELLIFONT: What precisely is documented in respect of the informal refresher training given? What do you document?

MR LANGCAKE: Just what was - what topics were covered in that informal training, so the date of the training, who was there, what was covered, whether it was holds or disengagements, or it might be talking about fear and anxiety or any other aspect of that.

DR MELLIFONT: You say in your statement it may be provided if it's requested by staff. Does that mean sometimes it's not?

MR LANGCAKE: Sometimes? When you say sometimes it's not, as in some days it's not, or?

DR MELLIFONT: Your statement says:

> *Informal refresher training may also be provided on occasions if it is requested by staff ....*

MR LANGCAKE: Okay ---

DR MELLIFONT: What I'm asking you is, does that mean that sometimes a staff member will request some extra training and not be given it? Is that what that means?

MR LANGCAKE: No, that's probably not written very well, but on every occasion that a staff member raises that they want to do MAPA training, that would be facilitated.

DR MELLIFONT: It says:

> *.... may also be provided .... if management identify that it may assist particular staff ....*

Does that mean sometimes management will have identified it may assist particular staff and the informal refresher training is not given?

MR LANGCAKE: No, that would always be provided as well.

DR MELLIFONT: It says it may be provided if it's been observed that Winmartie's behaviours of concern have increased, or the risks to himself or others have subsequently increased. Does that mean sometimes it's not provided in those circumstances?

MR LANGCAKE: That is what that means, sometimes it wouldn't be. It would depend on the discussions within the clinical and management team and a bit of a plan around what's recommended in that respect.

DR MELLIFONT: Right.

MR LANGCAKE: Keeping in mind that there are annual formal refreshers for all staff members.

DR MELLIFONT: Yes, I understand that. Let me come back to that.

In respect of this part of your statement, what is it that management does in order to proactively identify that additional training may assist staff?

MR LANGCAKE: There's team meetings, the discussions that are had at team meetings might be a forum that that's discussed. We are always encouraging people to raise any concerns that they have around staff training. We also debrief critical incidents, so any serious incidents, we hold a staff debrief. Would you like me to explain what's involved in that debrief?

DR MELLIFONT: Yes, please.

MR LANGCAKE: Sure. During the debrief, we look at setting events, triggers, a --- at the behaviour and how staff responded to the behaviour, including the proactive and reactive strategies that they use. We look at the function of the behaviour, any consequences to do with that incident. We offer staff support and staff training and would identify any potential training needs during those debriefs as well. There are a number of outcomes normally from the incident debriefs and follow-up that's required.

DR MELLIFONT: Who is the "we" in this critical incident debrief?

MR LANGCAKE: It depends who is facilitating the debrief. It's normally the Behavioural Clinician, the Senior Clinician.

DR MELLIFONT: Can you tell me whether there is a formal procedure which requires an examination of patterns of administration of PRN?

MR LANGCAKE: That would be one of the clinical staff members' duties. I'm not aware of the detail of what's done in that regard.

DR MELLIFONT: So you're not aware as to whether there is a documented procedure which requires an analysis of patterns in respect of the administration of PRN? You don't know either way?

MR LANGCAKE: I understand that happens. I'm not aware of the particulars. All restrictive practices are documented and that information is provided to the clinicians and senior management team.

DR MELLIFONT: Have you yourself ever been part of a formal review of the patterns of administration of PRN medication which has looked to see whether or not patterns are emerging about who is giving the PRN, times of day that the PRN is being administered, or any other aspects which might emerge to provide some sort of analysis as to choices to administer PRN? Have you been part of a really formal process in that respect?

MR LANGCAKE: I'm not aware of any really formal process, I haven't been a part of that, but the use of restrictive interventions is discussed at the case conferences and during incident debriefs. The duties of the Behavioural Clinician or the Senior Clinician, you would be better to ask them about those.

DR MELLIFONT: You would never have seen a formalised system or pattern analysis of the administration of PRN for Winmartie; is that correct?

MR LANGCAKE: Definitely - all that information is definitely assessed in a formulation of the behaviour support plan.

DR MELLIFONT: I know. What I'm asking you is whether you yourself, as the Direct Services Manager, have ever seen a formal written analysis about patterns of administration of PRN medication to Winmartie.

MR LANGCAKE: I can't recall seeing anything specifically like that.

DR MELLIFONT: Can I take you to paragraph 17. Here you say:

> *Cultural competency and cultural safety is provided to staff who provide direct care and support to Winmartie in informal and formal ways.*

What is the informal cultural competency and cultural safety training?

MR LANGCAKE: We are receptive to input from family members about Winmartie's care and we act on that information when we receive it, where we can. It's informal conversations. Formerly we had a Cultural Mentor employed with the work unit, in 2017 and 2018, I believe it was. Currently we have an Aboriginal Liaison Officer. There are a lot of informal conversations and teaching of staff members languages and cultural competency in general. So we also have ---

DR MELLIFONT: Let me take you back and direct you specifically to the question, because what you were asked to answer in the Notice to Produce is whether any staff providing direct care and support to Winmartie between those dates have been trained in cultural competency and cultural safety. Okay? What you said there is that cultural competency and cultural safety is provided to staff who provide direct care and support in informal and formal ways.

What I'm trying to understand is not that the family might give you some ideas or the Liaison Officer might give you some ideas. I actually want to understand what training is provided.

MR LANGCAKE: Sure. So cultural competency is embedded in the behaviour support plans and training is delivered on those behaviour support plans. So there's a number of different things that are discussed during those training packages that are included in the behaviour support plans.

DR MELLIFONT: So beyond that, that's all; is that right?

MR LANGCAKE: So we have monthly meetings, often discussing cultural aspects specific to clients. During those monthly meetings or twice-monthly meetings there

are, we have the Aboriginal Liaison Officer deliver a section in that meeting. He talks about language and sign language and different cultural considerations.

DR MELLIFONT: I'll come back to the monthly meetings. What I want to understand is do I have this correct: At paragraph 20 you set out that all FDU are required to complete formal training through the Aboriginal Cultural Awareness Program, either online or in person, and then you set out the four learning outcomes. Is that the extent of the formal cultural training?

MR LANGCAKE: That information is drawn from the e-learning website, I understand. But there's more included in that, in my understanding, than what appears there. It's got - I guess under (b). It's pretty broad:

> *Understanding Cultural Awareness, Working Across Cultures, and Cultural Competency.*

DR MELLIFONT: Mr Langcake, you will understand that you were asked a specific question in this Notice to Produce and what we see here, insofar as formal training, are these four assessment points under paragraph (d). Do you have direct knowledge that there is other formal training which is mandatorily provided to staff within the FDU?

MR LANGCAKE: Outside of the Cultural Awareness Foundation and the team meetings?

DR MELLIFONT: Yes.

MR LANGCAKE: There's the cultural elements to the different training packages that are provided as well. Other than that, there's nothing that comes to mind.

DR MELLIFONT: Insofar as the cultural aspects of the packages you have just referred to, all of that has already been provided to the Royal Commission in your statement and annexures and that's the extent of it; is that correct?

MR LANGCAKE: So there's a number of ways that we include training on cultural competency, not necessarily just in those documents, but in the day-to-day activities that we do and the discussions that are had with staff and providing feedback to those staff members. So as far as information that I can provide you that's written, the training done, the behaviour support plans, the team meetings, the notes from those, that online training, the cultural awareness training, they are the only ones that come to mind.

DR MELLIFONT: Okay. Can I take you through these learning outcomes:

> *Understand what Acknowledgment of Country and Welcome to Country are (and the difference between the two) ....*

You would agree with me that that is fairly baseline competency in respect of cultural awareness?

MR LANGCAKE: Yes, it appears so, yes.

DR MELLIFONT: Insofar as your other learning outcomes, how are they assessed?

MR LANGCAKE: So on completion of that course, there's a test at the end of that course that assesses competency. And then through direct conversations during those team meetings, that's documented as well, so there's discussions and sharing of experiences and that's - that involves the Aboriginal Liaison Officer who is present at those meetings.

DR MELLIFONT: These team meetings you speak of are the monthly meetings; correct?

MR LANGCAKE: Yes.

DR MELLIFONT: Sometimes they don't go ahead; is that correct?

MR LANGCAKE: There have been times when we have been short-staffed and meetings haven't gone ahead because there wasn't staff available to attend any meetings, they were all working with other clients or working night shifts.

DR MELLIFONT: Yes, and you would agree with me that there's no formal assessment of competency, either cultural or otherwise, at these team meetings; it's more just a discussion? Is that correct?

MR LANGCAKE: There's no tool to assess competency outside of the course, the Aboriginal Cultural Awareness Program, that I'm aware of.

DR MELLIFONT: You say it's either online or in person. The online course, I take it, is a PowerPoint slide where you have to answer some questions at the end?

MR LANGCAKE: I'd say it's an actual program, so it's not a PowerPoint, it's a course that's attached to the NT Government Department of Health website and it's a training program with an assessment at the end, that staff are required to pass.

DR MELLIFONT: How long does it take to do?

MR LANGCAKE: I can't recall how long.

DR MELLIFONT: Finally, before lunch, I will take you, please, to this notion that you have already spoken of about the FDU being receptive to suggestions made by the family. By "the family", do you include in that both Guardians?

MR LANGCAKE: One of the Guardians is a family member of Winmartie. There

is also Lorelle Stoeckel, who is a family member. They are our main two contacts as far as family.

DR MELLIFONT: Insofar as you speak about being responsive to suggestion, do you say that applies both with respect to Aunty Margret and with respect to Mr McGee?

MR LANGCAKE: Yes. In what aspect? Are you - there's a current direction that's gone from the CE for Mr McGee to contact our staff members directly through a generic email account, not to those individual staff members.

DR MELLIFONT: Yes.

MR LANGCAKE: So consultation on various issues does happen with Mr McGee, but it's in a different forum than what it is with Margret and Lorelle.

DR MELLIFONT: Yes, I understand that the method of communication currently from Mr McGee is by a generic email. So when you speak of being responsive to suggestions, are you including there Mr McGee and Aunty Margret?

MR LANGCAKE: Yes.

DR MELLIFONT: But there are occasions on which suggestions are made by Aunty Margret and/or Mr McGee which have not been taken up by the FDU. Are we in agreement about that?

MR LANGCAKE: I'm sure that there have been, yes.

DR MELLIFONT: Chair, would that be a convenient time?

CHAIR: It would, subject to a couple of questions I would like to ask Mr Langcake.

What is humbugging, Mr Langcake?

MR LANGCAKE: Humbugging is referred to in the Behaviour Support Plan when Winmartie is asking for generally a tangible item and he becomes fixated on that item, and he's regularly asking for the same item. Often he's not able to obtain those tangible items for a variety of reasons, they might not exist or they might not be easily accessible. So that's what the humbug refers to in the Behaviour Support Plan.

CHAIR: Why is it called humbugging?

MR LANGCAKE: That's an Aboriginal term for that behaviour. That's my understanding.

CHAIR: What sort of behaviour?

MR LANGCAKE: The constant asking for an item.

CHAIR: I see. Does the term imply that it's within Winmartie's control as to whether he behaves like that?

MR LANGCAKE: I'm not sure on that.

CHAIR: Not sure?

MR LANGCAKE: It was a --- (inaudible).

CHAIR: What's the fishbowl?

MR LANGCAKE: The fishbowl is the staff office that's in the Secure Care Facility.

CHAIR: What is its relationship to where Winmartie is located?

MR LANGCAKE: Okay, so Winmartie has a room to - that comes off the fishbowl and has a lounge area, and around the fishbowl there's treadmills and a pool table and air hockey table. So that's all around the outside of the fishbowl.

CHAIR: Winmartie is observed at all times, is he, from the fishbowl?

MR LANGCAKE: That's the direction that staff have been given, that regular - sorry, constant direct line of sight is maintained where it's appropriate and possible.

CHAIR: The Behaviour Support Plan, or at least the interim one that is supposed to have expired on 29 January, talks about Winmartie hitting the glass wall of the fishbowl. What is that a reference to?

MR LANGCAKE: So the fishbowl has windows all around it, so staff are able to observe Winmartie if they weren't sitting down with him and providing support, so those windows into the fishbowl, that's what it refers to.

CHAIR: So Winmartie gets frustrated, he does bang on the windows?

MR LANGCAKE: Yeah, he often bangs on the windows for different reasons, sometimes to get people's attention, or sometimes because he's upset.

CHAIR: The Behaviour Support Plan that seems to be in the documentation is labelled "interim" and it says the end date is 29 January 2021. Is there any replacement for the Interim Behaviour Support Plan?

MR LANGCAKE: I believe that was submitted in a table that was submitted late last week with a number of actions.

CHAIR: There is a current Behaviour Support Plan that replaces the interim one, is there?

MR LANGCAKE: Yes, and that's a dynamic document that's updated.

CHAIR: Thank you. Dr Mellifont, shall we adjourn until 1 o'clock Brisbane time, 2 o'clock Sydney time?

DR MELLIFONT: Yes, thank you.

CHAIR: Yes, we will adjourn.

ADJOURNED **[1.02 PM]**

RESUMED **[2.02 PM]**

CHAIR: Thank you, Mr Langcake, for returning. Dr Mellifont will continue asking you some questions.

DR MELLIFONT: Thank you, Chair.

Mr Langcake, can I ask you whether there's a formal requirement for staff to bring to your attention any suggestions made by Winmartie's family or guardians about how FDU staff might provide care or interact with Winmartie?

MR LANGCAKE: Nothing normally. But I think our communication as it has been pretty good in that regard.

DR MELLIFONT: Just a general expectation that they will have a chat with you if something is raised by the family or guardians?

MR LANGCAKE: Yes, we do have daily notes that are completed by the staff members working with each client and I would expect that that would be documented in those daily notes and an email sent. Nothing formal though.

DR MELLIFONT: Email sent to who?

MR LANGCAKE: To myself.

DR MELLIFONT: How do you follow up up on that to make sure everything is followed up on? Do you have an audit tracker for yourself?

MR LANGCAKE: Specifically in regard to any suggestions from family?

DR MELLIFONT: Yes.

MR LANGCAKE: No, there is no tool in place for tracking that but I think being responsive to those concerns if they are raised.

DR MELLIFONT: So just self-reliant on, first of all, receiving communication and then doing something about it; is that right?

MR LANGCAKE: Yes.

DR MELLIFONT: Is it correct that there is no formal requirement for any of the staff within the FDU to learn Winmartie's first languages?

MR LANGCAKE: Under the current behaviour support plan has language incorporated in that plan, and that's an expectation and there is a plan around staff members learning certain phrases or certain words in Arrernte.

DR MELLIFONT: When do we expect that to be in place and assessed to see if it's working?

MR LANGCAKE: That's included in the behaviour support plan as well. My understanding, it's within six months of the start date of that behaviour support plan.

DR MELLIFONT: Is that the first time there's been a mandatory requirement on staff to learn language?

MR LANGCAKE: To my knowledge, I'm not aware of any mandatory requirements to learn language.

DR MELLIFONT: So it's still not mandatory; is that right?

MR LANGCAKE: In the behaviour support plan, the current one, it is an expectation that staff members learn certain words in Arrernte and sign language.

DR MELLIFONT: Do you agree with me there is no mandatory requirement on staff to learn Winmartie's language, just an expectation? Is that correct?

MR LANGCAKE: Well, it's part of that behaviour support plan that it's a requirement, so I would say that that is mandatory.

DR MELLIFONT: How are you going to make sure it's done? What is the audit tool on checking to make sure that's being done?

MR LANGCAKE: So I haven't developed the behaviour support plan. I have read it, I can't recall the specifics of the tools, if there's a tool around assessing competency. I would have to refer to that plan, if that's okay.

DR MELLIFONT: I won't get you to look it up now, I would rather you take that question on notice, we have got a bit more to get through. Okay?

MR LANGCAKE: Okay.

DR MELLIFONT: At paragraph 21 you say that:

> *.... guardians are consulted regarding [Winmartie's] behaviour support plan in line with the requirements set out in the Act.*

MR LANGCAKE: Yes.

DR MELLIFONT: What do you understand consultation to require?

MR LANGCAKE: That the guardians are given an opportunity to provide input around the behaviour support plan.

DR MELLIFONT: So it's not just a one-way process, is it, it's a two-way process of exchanging ideas in an collaborative and informed way, that's what you take consultation to mean?

MR LANGCAKE: Yes, so we would seek inputs from the guardians about their thoughts on a variety of different topics.

DR MELLIFONT: It's about exploring plans and options and taking their concerns into account before the plans are finalised; is that what you take it to mean?

MR LANGCAKE: That's my understanding.

DR MELLIFONT: At the time you wrote your statement you acknowledged that input from Winmartie's guardians is imperative for the ongoing provision of culturally positive behaviour support?

MR LANGCAKE: Which section is that, so I can check that?

DR MELLIFONT: Paragraph 21, middle of the first paragraph.

MR LANGCAKE: Okay.

DR MELLIFONT: Yes, you see that there?

MR LANGCAKE: Yes.

DR MELLIFONT: You meant it then and you stand by that statement now?

MR LANGCAKE: Definitely that the guardians are given an opportunity to have input, yes.

DR MELLIFONT: Okay, but more than that, Mr Langcake, what you are saying there - and I want to understand if this is what your current belief is - is that it is imperative that they have input for the ongoing provision of culturally safe positive behaviour support. Is that your current belief?

MR LANGCAKE: It's definitely something that's valuable and important for the development of the behaviour support plan.

DR MELLIFONT: So your answer is yes?

MR LANGCAKE: Sure, yes.

DR MELLIFONT: Thank you.

You would also accept that the importance of engagement with family and community and guardians is critical in continuing Winmartie's progress?

MR LANGCAKE: Yes.

DR MELLIFONT: And in that respect you would accept that having a very open, respectful and supportive line of communication with the family and guardians is absolutely critical?

MR LANGCAKE: I think moving forward that would be what's best for the client, the best outcomes that would be able to be achieved.

DR MELLIFONT: Not just moving forward, but that's the case all the time, isn't it?

MR LANGCAKE: Can you repeat the specifics of that question? Sorry.

DR MELLIFONT: Yes. Would you accept that the importance of engagement with the family and community and guardians is critical in continuing Winmartie's progress? That is the first part of the question. I think you agreed with me about that.

MR LANGCAKE: Yes.

DR MELLIFONT: Okay. Then I asked: in that respect, you would accept that having a very open, respectful and supportive line of communication with the family and guardians is absolutely critical?

MR LANGCAKE: Yes, that's an important area, yes.

DR MELLIFONT: Okay. Do you agree that the restriction on communication with Mr McGee, that is the direction to him to only engage by way of emails to a generic email address, is hindering the way in which the behaviour support plan can be

produced?

MR LANGCAKE: I don't agree that it's hindering the behaviour support plan.

DR MELLIFONT: Why not?

MR LANGCAKE: My understanding is that both guardians have been provided an opportunity to have input into that plan.

DR MELLIFONT: When you say "my understanding", you're not involved at that level; is that right?

MR LANGCAKE: That's not a part of my duties. That would be with the person that's developing the behaviour support plan and the clinical team.

DR MELLIFONT: So really my question perhaps is misplaced. Given that you are not involved at that level, you can't directly speak to how the very limited nature of the communication with Mr McGee is impacting the preparation and development of such plans?

MR LANGCAKE: That's not something that I can comment on.

DR MELLIFONT: Well, can I ask you this: would you agree that that restriction on the way in which Mr McGee is able to communicate the Forensic Disability Unit does not assist you in having full input from a guardian and a person who has known Winmartie for a very long time? Do you agree it doesn't help you?

MR LANGCAKE: So the direction from the Chief Executive, for Mr McGee to communicate with us through the generic email account, isn't helpful, is that your question?

DR MELLIFONT: I'm suggesting to you it is unhelpful for you to do your work to carry out the aims and intentions of the FDU.

MR LANGCAKE: I think it's important that we move forward and communicate with the guardians a bit better. I would like to see it rectified in the future.

DR MELLIFONT: Thank you. Whose decision is it, so far as you understand, moving forward?

MR LANGCAKE: On Mr McGee? That's with the CEO. So my understanding is that mediation has been offered around some concerns, and that direction that was given to Mr McGee to communicate through the generic email.

DR MELLIFONT: I will let you to stop there, because as you say, it was your understanding and we already have evidence about the mediation, et cetera, I want to ask you about your direct knowledge and understanding. You have told us that you

think it would be good if you can re-establish the lines of communication with Mr McGee. Are you being consulted by those within Health about making such a move? Are they asking you what you want?

MR LANGCAKE: I liaise with - through my direct line manager, so I'm not having those conversations with the CEO. But I expect people at higher levels in the senior management team would be having those conversations --- (overspeaking) ---

DR MELLIFONT: I didn't mean to cut you off, sorry.

MR LANGCAKE: With the CEO.

DR MELLIFONT: But you yourself have at least communicated one rung up the chain that you would like to see those lines of communication reopened?

MR LANGCAKE: I have expressed that before, yes.

DR MELLIFONT: Thank you. I take you to paragraph 33 of your statement. Here you observe that when you started that job, that recordkeeping with respect to incidents was not consistent, and you said you observed that when you commenced your role of coordinator on 21 February 2019. Are you oriented to your statement there?

MR LANGCAKE: Yes.

DR MELLIFONT: Paragraph 33?

MR LANGCAKE: Yes.

DR MELLIFONT: As I understand it - tell me if I'm understanding your statement correctly - is that although so far as you could tell incidents had been recorded contemporaneously in daily progress notes, a RiskMan report had not been created for all incidents? Is that right?

MR LANGCAKE: Yes.

DR MELLIFONT: I take it that the purpose of RiskMan, which presumably is an electronic program; is that right?

MR LANGCAKE: That's correct.

DR MELLIFONT: The purpose of it is to send electronic reports about incidents to certain people within the FDU or the Department of Health; is that right?

MR LANGCAKE: Yes. So all critical incidents, whether there's restrictive interventions used or not, would be - should be documented on RiskMan and then notifications go to a number of clinical and management staff.

DR MELLIFONT: So that they can then take such action as is necessary with respect to those incidents; is that right?

MR LANGCAKE: Yes, and there's the debriefing process as well, with regards to actions.

DR MELLIFONT: All right. Now, you say in your statement that you subsequently arranged for staff to complete RiskMan reports so as to back-capture the entry, I suppose. Is that right?

MR LANGCAKE: Yes, so there were a number of incidents, from memory they were low-level incidents that didn't require restrictive interventions, that were captured in the daily notes but they weren't uploaded to RiskMan and an incidents report wasn't completed. So that might be what we refer to as orange behaviour, which could be threatening self-harm or threatening an assault but not necessarily carrying through with those threats.

DR MELLIFONT: Did you identify what the systemic failure was which underpinned the incidents not being recorded in RiskMan?

MR LANGCAKE: I think there was a change in reporting requirements. I'm not sure if that - if that was monitored and who that was monitored by before I was in that position. So I can't really comment on what happened before I was in that role.

DR MELLIFONT: So do you have direct knowledge as to whether that RiskMan program is now being audited to ensure that the incidents are being captured in RiskMan as required or is that outside your direct knowledge?

MR LANGCAKE: So the daily notes are checked often to cross-reference with incident reports that are uploaded to RiskMan. It's a requirement of staff members to upload incident reports the day of the incident, and my understanding is that that is happening. My understanding is it happens on all occasions where there's an incident.

DR MELLIFONT: Mr Langcake, I'm trying to understand if there's a formal audit to make sure it's working as it should. Is that within your direct knowledge or not?

MR LANGCAKE: A formal audit?

DR MELLIFONT: Yes.

MR LANGCAKE: As I said, the daily notes are checked, and -

DR MELLIFONT: Sometimes. You said sometimes.

MR LANGCAKE: The daily notes are checked regularly. There is a process that's

been delegated to the coordinator and supervisors to check all daily notes, and that is documented in a specific spreadsheet and then cross-referenced with incidents. So yes.

DR MELLIFONT: You would be able to assist the Commission with records which demonstrate that RiskMan is a currently audited process; is that right?

MR LANGCAKE: I can provide that spreadsheet which shows that the daily notes are being checked and that would highlight if any incidents weren't uploaded to RiskMan.

DR MELLIFONT: Can I take you then to paragraph 41. You observe that:

An issue being considered by [Winmartie's] medical practitioners at present ....

And "at present" which was 20 January 2021, the date of your statement:

> *.... is that Winmartie experiences some lethargy following his morning medication.*

And sleeps for about two hours in the morning each day. You speak about a neurologist review currently pending. The last review of the identified medication, so far as we can ascertain, was 11 September, and that appears also in paragraph 42 of your statement.

When is this review going to happen?

MR LANGCAKE: My understanding - and keeping in mind I haven't been in Alice Springs over the last week, but there has been a review, I understand, by Dr Fernando that took place yesterday. I think my understanding is that that other review from a neurologist has been arranged or is waiting on being confirmed. Does that answer your question?

DR MELLIFONT: Sort of. I probably need to clarify something. Dr Fernando is a consultant psychiatrist. When you understand - I'll start again.

The neurologist review is pending but you don't know when, you can't help us with when that's going to happen?

MR LANGCAKE: No. I can provide that information, if you like. That would sit with the case manager to arrange.

DR MELLIFONT: Do you know when the last neurologist review was?

MR LANGCAKE: I'm not aware of that, sorry.

DR MELLIFONT: Is that something you can find out for us, please?

MR LANGCAKE: Yes, certainly.

DR MELLIFONT: Thank you.

You say at paragraph 44 that guardians are invited by email and phone to attend specialist appointments. But insofar as that paragraph is concerned, that's not the subject of your direct knowledge; is that correct?

MR LANGCAKE: That duty doesn't sit with my position. That's the case manager duty, so that's --- (overspeaking) ---

DR MELLIFONT: So that's something that somebody has told you?

MR LANGCAKE: That's my understanding of what's been --- (overspeaking) ---

DR MELLIFONT: Yes, okay.

At paragraph 45 you say the guardians were, up until July 2020, invited by email to attend monthly case conferences to discuss key issues, and they provided information to include in the meeting agenda and they actively contributed during such conferences. I take it you found such contributions to be important and helpful to you in the discharge of your work?

MR LANGCAKE: It's not something that I can really comment on around medication. There were conversations around the guardians' thoughts around medications. But I'm not a doctor, I don't know how much I can say about whether they were helpful or not, it's not a part of my duties.

DR MELLIFONT: All right.

Again within paragraph 45 you speak about the direction to Mr McGee, and you state that:

> *This direction effects FDU staff only and has not impacted .... general practitioner and prescribing doctors ....*

Again, that is not knowledge you actually have, is it?

MR LANGCAKE: That's my understanding.

DR MELLIFONT: So do you agree with me?

MR LANGCAKE: I believe that I understand that issue and that that's correct.

DR MELLIFONT: You don't have any direct knowledge of it, we're agreed?

MR LANGCAKE: I'm not sure who's contacted Mr McGee and --- who has been advised they can't. My understanding is that direction relates just to the Forensic Disability Unit and our staff members.

DR MELLIFONT: I'm just going to leave it.

I want to take you to Winmartie's trips to country. We have already got before the Commission the chronology of visits last year so I won't go into the detail of it, but to note this. As you know, he went to country in June 2020. There was an incident with respect to the ute. You are familiar with that generally?

MR LANGCAKE: Yes, I wasn't present for that incident, but I did receive phone calls and I participated in both the staff debrief and the family debrief following that incident.

DR MELLIFONT: Then the next trip was not until December. That's correct?

MR LANGCAKE: That's correct. Would you like me to provide some context around that?

DR MELLIFONT: Let me ask you a couple of questions first and then we'll see if we need some more. Okay?

MR LANGCAKE: Sure.

DR MELLIFONT: It was about five months after that visit in June that the risk assessment was completed, that is the risk assessment wasn't completed until 30 November 2020. Is that your understanding?

MR LANGCAKE: Yes, that sounds right.

DR MELLIFONT: Did you have any role in the preparation of that risk assessment?

MR LANGCAKE: I think you're referring to the environmental risk assessment? That was one of a number of things that needed to be completed for those trips to recommence.

DR MELLIFONT: Then shortly thereafter, shortly after 30 November, the trip to country was organised for December. That's the correct chronology, isn't it?

MR LANGCAKE: Yes, 5 December.

DR MELLIFONT: Why did it take five months or so before a trip, another trip to country could be organised for Winmartie?

MR LANGCAKE: There were a number of actions that came out of that incident

and a number of other concerning incidents, where Winmartie - there was some serious self-harm. It wasn't just that incident, there were a number of other incidents. Relating to that trip, there was information submitted with the table that was submitted late last week, that details those action items that were required to be completed. Do you want me to talk about some of those?

DR MELLIFONT: I want to understand if it's your evidence that notwithstanding the fact that Winmartie is the only inpatient, as it were, within the Forensic Disability Unit, that it takes five months to organise a trip to country.

MR LANGCAKE: I'm happy to read out some of the actions that were required in that five-month period.

DR MELLIFONT: We can read the actions, we have got them in the evidence, thank you.

MR LANGCAKE: Okay.

DR MELLIFONT: Is that truly the fastest time, -sorry, I'll rephrase the question.

Is that the quickest you could get a trip to country organised for Winmartie?

MR LANGCAKE: There were a number of different stakeholders that were required to complete actions, including external parties, on forensic - so there was a forensic psychiatrist that was providing a report, there was a psychologist that needed to provide a report, there was a vehicle that was severely damaged in that incident, there was staffing considerations that needed to be taken into account. We had to organise some additional satellite phones to increase our capability for communication. And a number of other tasks that were required. So when all of those tasks were completed, I think there was a meeting shortly after that and a trip was organised soon thereafter.

DR MELLIFONT: You say all of this was necessary, even though a specific trigger for the ute incident was identified within three days of the incident, namely that the car was being moved to pack up and leave? Is that right?

MR LANGCAKE: Would you like me to explain a little bit about the sequence of events in that incident?

DR MELLIFONT: Yes, go ahead.

CHAIR: Mr Langcake, can I just encourage you, if you don't mind, just listen to Dr Mellifont's questions, do the best you can to answer her questions. Don't worry about asking Dr Mellifont what she wants, just listen to the question and answer the question, if you would be good enough to do that. Thank you.

MR LANGCAKE: Sure.

DR MELLIFONT: Let me come back to that question. Do you accept that in three days or so, the trigger for Winmartie's behaviour was identified and it was identified as being the car was being moved to pack up and leave? Is that correct?

MR LANGCAKE: Yes.

DR MELLIFONT: And you understand, do you, that the car being moved to pack up and leave was not how things were ordinarily done on these visits, was not how Winmartie would ordinarily experience what was done on these visits? You understand that?

MR LANGCAKE: That's my understanding.

DR MELLIFONT: Did you understand therefore that the fact that things were being done in a different order was such as to trigger Winmartie? Correct?

MR LANGCAKE: I think that's a contributing factor to that behaviour. There was a clear trigger, but there were a number of other contributing factors.

DR MELLIFONT: I'm reading from - I don't think we can put it up on screen because I don't think it's redacted, but I'm reading from a note that is recorded as family debrief, NTT.0003.0005.2385, and the one thing that was listed as a trigger/s, is "car being moved to pack up and leave."

MR LANGCAKE: That's the trigger but there are other setting events and things that may not have been an obvious trigger but contributed to that escalation and that behaviour.

DR MELLIFONT: Right, and those setting events are that Winmartie has a long history of violence behaviours, it reads; environmental factors; Winmartie hasn't been out to country for an extended period of time; client and environment, there are a number of family members present who have not been exposed to Winmartie's behaviour of concerns. There are also weapons or shovels that were easily accessible to Winmartie. They are the setting factors?

MR LANGCAKE: That's some of the setting events. There was also a number of others.

DR MELLIFONT: What were the others?

MR LANGCAKE: There was also a number of medication reductions leading up to that and there was growing concerns about Winmartie's escalations following some of those medication reductions.

DR MELLIFONT: I'm just going to suggest this to you, Mr Langcake: that the prioritisation of getting Winmartie back to community was not put into effect by the

FDU. Do you agree or disagree with that?

MR LANGCAKE: I disagree. That was a high priority.

DR MELLIFONT: Can I take you now to paragraph 62 where you speak about sex education and you speak about a modified SoSAFE! program currently being in development.

You would agree with me that the guardians and/or family recommended quite a period of time ago that Winmartie be given some sex education? Do you agree with that?

MR LANGCAKE: Yes, that's my understanding. I'm not sure when that was raised but I'm aware that that was raised.

DR MELLIFONT: When will this SoSAFE! training actually be delivered to Winmartie?

MR LANGCAKE: The first stage of that program, it's my understanding it's been developed and it's ready to go. Because of some of the concerns raised about cultural appropriateness recently, that's been put on hold temporarily until we can liaise with family further, specifically around that SoSAFE! program.

DR MELLIFONT: So we have got no idea of timing as to when he will actually get some sexual education, is that the position?

MR LANGCAKE: I can't say a date but I expect it would be within the coming weeks.

DR MELLIFONT: You say ---

MR LANGCAKE: I'm aware that.

DR MELLIFONT: Sorry, go ahead.

MR LANGCAKE: I'm aware that there's been input from our Aboriginal Liaison Officer around that program, but we do want to seek the family's input into that as well.

DR MELLIFONT: Okay.

You spoke before about there being some holds, H-O-L-D-S, used with Winmartie. Are you talking there about the application of force by a staff member on Winmartie, that is physically holding them?

MR LANGCAKE: Are you referring to an incident in particular or -

DR MELLIFONT: I'm referring to the evidence you gave earlier where you spoke of there being some holds and that being something which might have triggered you to give some informal training.

MR LANGCAKE: I believe what I was talking about is MAPA training, and a part of that MAPA training includes disengagements and holds.

DR MELLIFONT: Yes. So have some holds been used on Winmartie?

MR LANGCAKE: Yes. I believe that's happened, from memory, on two occasions and that was in response to serious escalations.

DR MELLIFONT: Are they recorded?

MR LANGCAKE: Yes. They are recorded on the restrictive intervention reports as an emergency use of restrictive practice.

DR MELLIFONT: To the extent they are not already provided to the Royal Commission, can they be?

MR LANGCAKE: I believe they both are. But of course I can -

DR MELLIFONT: Excuse me just a minute. Can I take you to NTT.0003.0010.0262 at page 0267. Firstly, can I ask you, is this a table that you put together or you asked to be put together, setting out all restrictive interventions from 1 May 2018 to 30 December 2020?

MR LANGCAKE: Yes, that was put together as part of my evidence.

DR MELLIFONT: The two incidents of physical restraint that we see on 9 July at 12.50 and 14 October 2020 at 10.30, are they the two incidents you have just referred to?

MR LANGCAKE: There may have been - I think there was another one. I can't remember the specific incidents. I'm just trying to recall.

DR MELLIFONT: Is it something you can look for, for us, and provide to the Commission?

MR LANGCAKE: I know that one of those was definitely on 14 October 2020. Is that one of the ones that you said?

DR MELLIFONT: Yes, it is.

MR LANGCAKE: Yes, so that was one of them. 9 July, did you say?

DR MELLIFONT: Yes, I did. That's correct.

MR LANGCAKE: Would you like further information in regards to that? Do you want me to talk to the incident on 14 October?

DR MELLIFONT: I will ask you to provide to the Commission, to the extent it has not already been provided, any details with respect to those two incidents of physical restraint, and also to check if there have been any more which have not been recorded in this table, please.

MR JACOBI: Apologise to Counsel Assisting, I am reluctant to interrupt, but at the bottom of page 5 of the annexure which is which is TL-4 to our numbering, think there is a further occasion of 22 June 2020.

DR MELLIFONT: That is quite right, thank you, Mr Jacobi, I did have it highlighted and missed it. So there are three there.

Mr Langcake, can you take the last question and alter it to if there are any more than the three.

Thank you, Mr Jacobi.

CHAIR: Dr Mellifont, I am observing the time and noting what we have to get through today. I wonder if there are other matters you would like Mr Langcake to provide additional information, if they could be provided in writing so that he has an opportunity to respond and we can move on to our next witnesses.

DR MELLIFONT: Quite so. There's just two more things I need to ask, Chair, if that's okay.

CHAIR: Yes, go ahead.

DR MELLIFONT: Can I ask, Mr Langcake, who is it within Alice Springs who approves the administration of PRN medication?

MR LANGCAKE: So there's a PRN protocol which sets out the circumstances when that medication can be administered. We have an on-call service, a 24/7 service that is staffed by someone in the management or clinical team and they - the staff members working with the client are required to contact on-call if there's any suggested use of PRN medication. Those conversations are had between the staff member working with the client and the on-call person.

DR MELLIFONT: Just for my understanding, the on-call person, that's not the occupational therapist, it's somebody else?

MR LANGCAKE: There's a number of different people that could be the on-call person. There's the clinical - members of the clinical team and management team.

DR MELLIFONT: The last thing I want to ask you about is the transition plan for Winmartie, DRC.9999.0027.0190. While that is coming up, you are aware that a transition plan has been developed for Winmartie?

MR LANGCAKE: Yes.

DR MELLIFONT: That was developed on 17 July 2020 is the date of the document we have.

MR LANGCAKE: Yes, I have got that in front of me.

DR MELLIFONT: You are one of the stakeholders in that transition plan?

MR LANGCAKE: Yes.

DR MELLIFONT: Can you go to page 16, which is page 0205.

MR LANGCAKE: Okay.

DR MELLIFONT: This is about stage 3, "Progression criteria to Stage 4."

Do you know what the plans are for the provision by the FDU of the treatment programs demonstrating increased capacity? Do you have direct knowledge of that?

MR LANGCAKE: So that's detailed in the behaviour support plan, so there are a number of skill development areas included in that plan, as well as a number of other different areas that are addressed.

DR MELLIFONT: All right, so that's where we find the answer to my question, is it?

MR LANGCAKE: I believe so.

DR MELLIFONT: In respect of the stages after that, 4 and 5, some aspects of it involve an interplay with the NDIS. Do you have an active role in that respect?

MR LANGCAKE: In liaising with the NDIS?

DR MELLIFONT: Yes.

MR LANGCAKE: That would be a duty of the case manager. But ideally I would like to be involved in those meetings as well.

DR MELLIFONT: But currently there aren't active steps with respect to NDIS service provision transitioning into the community, is that right?

MR LANGCAKE: No, that's not what I was saying. My understanding is that

there's meetings that are pending regarding the NDIS package, there was a review done - unfortunately we weren't involved in the last review, and we have been contacted by My Voice around that next meeting and we will be present at that meeting.

DR MELLIFONT: All right. Finally, there are some emails before the Commission where NT Health staff have engaged with the NDIS, suggesting double-dipping in terms of NDIS service provision. Have you had anything to do with any of that?

MR LANGCAKE: Sorry, could you repeat that question?

DR MELLIFONT: There are some emails before the Commission in which NT Health have engaged with the NDIS, suggesting that NDIS allocation, which was around $114,000 involved some double-dipping or doubling up. Have you had anything to do with any of that?

MR LANGCAKE: Am I able to see that email so I could provide comment on it?

DR MELLIFONT: Certainly. Chair, I appreciate the time, we might deal with this particular question in correspondence, if that's okay. I just realised how late in the day it's going to be.

CHAIR: Yes, I think that might be a good idea, Dr Mellifont. Thank you. Does that conclude the questions you wanted to ask Mr Langcake?

DR MELLIFONT: It does.

CHAIR: Thank you. What I will do, Mr Langcake, is ask any of the Commissioners if they have questions of you and then I will invite the counsel for the Northern Territory, I will invite him to ask any questions he may have.

First, I'll ask Commissioner Mason, do you have any questions of Mr Langcake?

QUESTIONS BY THE COMISSION

COMMISSIONER MASON: Yes, thank you, Chair.

I was interested in the Aboriginal Liaison Officer, that position and its seniority at the forensic unit, where it sits in the structure.

MR LANGCAKE: Okay, that position sits under myself. It's not - it's separate to the other positions, so it's supervised by me, not by any of the shift supervisors or coordinator, it's directly under me.

COMMISSIONER MASON: And the change of title from "mentoring" to "liaising",

was there some thinking behind that?

MR LANGCAKE: I'm not sure. Previously that was before I was in any management position, I'm not sure what the reasons were for calling it "mentor". It seemed fitting at the time as a support worker and as a supervisor, but I'm not sure why there is a title change, and Aboriginal liaison, I'm not sure of the difference between those.

COMMISSIONER MASON: Based on the training provided through the Department of Health around cultural awareness and cultural competency, what's your understanding of cultural awareness and cultural competency within the Forensic Disability Unit, in terms of the service provision to First Nations people? What do those terms mean?

MR LANGCAKE: Sorry, which terms, if you could repeat?

COMMISSIONER MASON: Those terms, "cultural awareness" and "cultural competency", in the context of the training but also the provision of service by staff to First Nations people in the Forensic Disability Unit, what's your understanding of those terms?

MR LANGCAKE: So there's a number of different Aboriginal groups. What we do is tailor things to individual clients and require input from those clients' family members, to be flexible in the way that we do things and ensure that.

COMMISSIONER MASON: The question I was asking is: what's the definition of those two terms, "cultural awareness" and "cultural competency"?

MR LANGCAKE: I can't tell you off the top of my head the definition of those terms. My understanding is that all aspects of the client's life and culture are considered with the way that we develop and care for that client.

COMMISSIONER MASON: They are pretty important terms in creating an environment for First Nations people to have a strong sense of cultural security, and to not have a working knowledge, a practice knowledge of those terms as a leader is pretty critical. So just - I was just interested in understanding your understanding as a leader, your practice framework around those terms, because it's a term that's used right through your statement, but they are not terms that you easily recall, can recall, around definitions. Thank you for that.

MR LANGCAKE: I think I do have a good working knowledge. I can't recall the definitions of those terms, but that culture is something that is embedded in the way that we do things, and we try to be flexible and responsive to cultural needs.

COMMISSIONER MASON: Thank you.

CHAIR: Thank you, Commissioner Mason.

Commissioner Atkinson, do you have any questions of Mr Langcake?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

CHAIR: The new behaviour support plan that came into operation at the end of January, are you familiar with that?

MR LANGCAKE: Yes, I am.

CHAIR: As far as I can tell, the only reference to culturally sympathetic programs for Winmartie is towards the end when there's a sentence that reads:

> *Improving Winmartie's quality of life through increased access to family homelands and culturally appropriate, personcentred activities.*

Am I right in thinking that's all the behaviour support plan says about culturally appropriate person-centred activities?

MR LANGCAKE: No, that's not correct, there are a number of different cultural considerations throughout that plan, including activities --- (overspeaking) ---

CHAIR: Mr Langcake, give me a couple of examples from the document, please.

MR LANGCAKE: Activities that are included in that?

CHAIR: Yes.

MR LANGCAKE: Cooking kangaroo tail, damper, Billy tea, different activities like painting and access to spending time with a dog, bush walks and long drives. There are a number of other examples of activities. Also included in there is Arrernte language and sign language, and teaching functionally equivalent behaviours around the use of those words and signs.

CHAIR: I thought you said that there wasn't much language training going on within the unit.

MR LANGCAKE: I don't think that I said that. There's language involved in all of our team meetings, and it's included in the behaviour support plan.

CHAIR: I see. All right, thank you very much.

I will ask Mr Jacobi, do you have any questions of Mr Langcake?

MR JACOBI: Commissioner, I don't. I'm going to take up, I hope, the invitation from Counsel Assisting. I understand that this witness has taken certain questions on notice and I undertake that we will provide a statement that is responsive to those matters at a time that is agreeable either to yourselves or Counsel Assisting.

CHAIR: I'm sure Counsel Assisting will be in touch with you to provide some kind of timetable for that to be done, Mr Jacobi.

MR JACOBI: Thank you. I hope if there are matters of clarification which we wish to raise, and there are a few, we will address those in statements as well, to save your time today.

CHAIR: Thank you very much. Thank you.

THE WITNESS WITHDREW

CHAIR: Dr Mellifont, I understand that the next witnesses are going to join the Commission from the same location as Mr Langcake and we need a couple of minutes to set that up. Is that correct?

DR MELLIFONT: Yes, that's correct.

CHAIR: We will take a five-minute break and return after that break. Thank you.

ADJOURNED **[2.51 PM]**

RESUMED **[2.56 PM]**

CHAIR: Dr Mellifont.

DR MELLIFONT: Thank you. We have in panel Professor Catherine Stoddart and Ms Cecilia Gore. You will find two written statements of Professor Stoddart at tabs 7 and 8 of Tender Bundle C. Can they please be tendered into evidence and marked 11.18.1 and 11.18.2 respectively.

CHAIR: Yes.

EXHIBITS #11.18.1 and #11.18.2 - STATEMENTS OF PROFESSOR CATHERINE ANNE STODDART

DR MELLIFONT: I ask that attachments to Professor Stoddart's statements which are at tabs 19 to 22 of Tender Bundle E be received into evidence and marked as Exhibits 11.18.3 through 11.18.6 respectively.

CHAIR: Those exhibits can be admitted into evidence and given the markings to which Dr Mellifont has referred.

EXHIBITS #11.18.3 TO #11.18.6 - ANNEXURES TO STATEMENTS OF PROFESSOR CATHERINE ANNE STODDART

Professor Stoddart and Ms Gore, thank you to coming to the Commission to give evidence. I will ask you to follow the instructions of my Associate, who will administer the oath or affirmation as the case may be.

PROFESSOR CATHERINE ANNE STODDART, SWORN

MS CECILIA ANNE GORE, AFFIRMED

CHAIR: Dr Mellifont will ask you some questions. Just by way of explanation as to where everybody is, Dr Mellifont is in our Brisbane hearing room together with Commissioners Mason and Atkinson. Commissioner McEwin is with me in our Sydney hearing room. Dr Mellifont will now ask you some questions. Thank you.

EXAMINATION-IN-CHIEF BY DR MELLIFONT

DR MELLIFONT: Thank you.

Can I start with you, Professor Stoddart. Is your full name Catherine Anne Stoddart?

PROFESSOR STODDART: Catherine Anne Stoddart, yes.

DR MELLIFONT: Have you provided a statement to the commission dated 15 January, a statement provided 20 January and also an earlier statement last year, 27 April 2020?

PROFESSOR STODDART: I have.

DR MELLIFONT: Are the contents of those statements true and correct, to the best of your knowledge and ability?

PROFESSOR STODDART: They are.

DR MELLIFONT: At the time you signed each of those statements, you were the Chief Executive of the Department of Health in the Northern Territory?

PROFESSOR STODDART: I was. I finished with the Northern Territory on 22 January 2021.

DR MELLIFONT: You have taken up a position in another State?

PROFESSOR STODDART: I have indeed, yes.

DR MELLIFONT: Your qualifications are set out in some detail. Just a couple of features. Prior to your appointment as Chief Executive of the Department of Health, you were Deputy Chief Executive and Chief Nurse of Oxford University Hospital in the United Kingdom, 2014 to 2017; is that right?

PROFESSOR STODDART: That's correct, yes.

DR MELLIFONT: And Chief Nurse and Midwifery Officer of the Western Australian Department of Health 2009 to 2014?

PROFESSOR STODDART: That's correct.

DR MELLIFONT: And also, you have been a Visiting Professor of Nursing at Oxford Brooks University?

PROFESSOR STODDART: That's correct.

DR MELLIFONT: Is that ongoing?

PROFESSOR STODDART: Yes, it is.

DR MELLIFONT: You hold a Bachelor of Science in Nursing, a Masters in Project Management and a Master's Degree in Business Administration?

PROFESSOR STODDART: I do.

DR MELLIFONT: Ms Gore, would you state your full name, please?

MS GORE: Cecilia Anne Gore.

DR MELLIFONT: Thank you. Are you the Senior Director of Mental Health, Alcohol and Other Drugs Branch, Health System Policy and Strategy, Northern Territory Department of Health?

MS GORE: I am.

DR MELLIFONT: There has been a new Chief Executive appointed to replace Professor Stoddart; is that correct?

MS GORE: I'm not aware. There is a person ---

DR MELLIFONT: I'm sorry, acting.

MS GORE: Yes, there is an Acting Chief Executive.

DR MELLIFONT: Insofar as the McGrath Report and the extent of the recommendations implemented by the Northern Territory Government, do I understand you to be the Senior Government Officer with most operational knowledge?

MS GORE: Yes, that would be right.

DR MELLIFONT: You have provided a resume to the Commission which will be tendered in due course, but just briefly, you hold a Master of Public Policy, a Master of Education (Adult Education), and a Bachelor of Education (Adult Education)?

MS GORE: I have not yet completed my Masters in Public Policy. I'm currently undertaking it.

DR MELLIFONT: Thank you. You commenced that in 2016?

MS GORE: Yes.

DR MELLIFONT: Did you, Ms Gore, listen to the evidence of Mr Langcake this afternoon?

MS GORE: Yes, I did.

DR MELLIFONT: You are aware of Mr Langcake's view that he feels he would be assisted in the discharge of his role if the lines of communication with Mr McGee are reopened? You heard that?

MS GORE: Yes, I heard Mr Langcake say that he felt he would like the current situation rectified.

DR MELLIFONT: Can I ask you, do you know whether that position has been communicated up to the acting Chief Executive?

MS GORE: Yes, it has.

DR MELLIFONT: Do you know whether that position has urged current active

consideration by the acting Chief Executive?

MS GORE: We have in the last month twice written to Mr McGee, once again offering to recommence mediation. He has - and that's been both directly and also through the Office of the Principal Community Visitor. Mr McGee has indicated on both occasions he doesn't want to do that.

DR MELLIFONT: Is that therefore - are you therefore at a standstill from your perspective?

MS GORE: No, we are not. What has happened since the second refusal is that there is a new Senior Manager of the Forensic Disability Unit. She has prepared a plan for trying to re-engage the guardians directly and again with the assistance of the Community Visitor Program we are going to reach out again and see whether that would be acceptable as a way forward, contingent upon the subset of mediation or a discussion of appropriate communication.

DR MELLIFONT: When is it planned to do that reach-out?

MS GORE: I have written to the Community Visitor, I think that was on Wednesday of last week, so any minute now, I think.

DR MELLIFONT: Okay. Chair, can I indicate I will ask some limited questions this afternoon but there might be a subsequent follow-up of the notice to produce to Ms Gore, given the time of the day.

Can I ask you, Ms Gore, do you know what the Northern Territory is doing, if anything, with respect to improving the data collection of people with cognitive disability in the criminal justice system and in particular First Nations people? Or is that outside your remit?

MS GORE: It's outside my remit. Most of the data that is being sought would sit within Corrections, it would not be the Department of Health's area.

DR MELLIFONT: All right, okay. Can I ask you again, Ms Gore: the Commission has heard evidence last week from Aunty Margret and Lorelle Stoeckel about the importance of access to Ngangkaris, the traditional healers for First Nations people, to be connected to their cultural and healing practices. Are you able to tell us whether the Department of Health is or is willing to support a request through the NDIS for access by Winmartie to Ngangkaris or a Ngangkari?

MS GORE: My answer to that would be, yes. I don't know about the NDIS component of that. I sit on an Aboriginal Social and Emotional Wellbeing Working Group which is chaired by our Aboriginal Medical Services Alliance where access to traditional healing practices and practitioners is a key priority. We work regularly with our community-controlled Health Service to seek opportunities for culturally secure practices, and I would certainly support that work through the Central

Australian Aboriginal Congress, who I understand are directly involved in Winmartie's care now. I think that would be a really helpful pathway and we would certainly respond positively to that request.

DR MELLIFONT: That's something that you would actively support and encourage the Forensic Disability Unit to explore?

MS GORE: Absolutely. Again, within the context of coordinated care that some of that service delivery is best achieved through his relationship with the Aboriginal Medical Service in Alice Springs, but we would certainly assist.

DR MELLIFONT: Thank you. Sticking with you for the moment, Ms Gore, in one of the statements we have received from Minister Fyles, she speaks about two forensic patients which were declined NDIS funding due to a high functionality. Are you aware of those two cases?

MS GORE: Yes.

DR MELLIFONT: Can you tell me if the Northern Territory Government is doing anything in respect of the NDIS funding being declined?

MS GORE: Yes. So both of those patients were clients of our Forensic Mental Health Service here in Darwin, they were both assessed by the NDIS as being sufficiently high functioning so as not to require disability support. So they remain clients of our service with access to appropriate case management, care coordination. They can still access services throughout other funded NGOs. Both of those patients are currently resident in one of our facilities and so have access to day-to-day life skills and other supports. We would continue to provide a service, we just don't get additional resources from the NDIS to do that.

DR MELLIFONT: Is it the case that it's your belief that those two persons are still getting all of the services they had asked for under the NDIS but it is being provided by the Northern Territory? Do I have that correct?

MS GORE: No.

DR MELLIFONT: Sorry.

MS GORE: If they were assessed as eligible for an NDIS package, that would most often land in the supported independent living set of resources, so they have not been successful in getting that. We, however, are providing their accommodation and the range of services that we are able to provide as we would usually provide. It's not a direct comparison to what's available in NDIS packages.

DR MELLIFONT: So it's not the case that appeals processes or further engagement with the NDIS to seek them to get them to change their position is something that the Northern Territory is undertaking?

MS GORE: Not with these two clients. We have done that in previous historical situations.

DR MELLIFONT: Is that because Northern Territory Health agreed with the reason for ineligibility given by the NDIS, that is, high functionality?

MS GORE: Yes.

DR MELLIFONT: Professor Stoddart, you are obviously familiar with the McGrath Report.

PROFESSOR STODDART: I am indeed.

DR MELLIFONT: One of the suggestions in the McGrath Report is that a person not guilty by reason of mental impairment, who is not criminally convicted, should be managed by the Department of Health and should be eligible for NDIS. So I ask you, as a person with 30 years in nursing and the experience across the industry, is that something you agree with, both of those two things - one is that they should be managed by Health and two is that they should be eligible for the NDIS?

PROFESSOR STODDART: In terms of the McGrath Review, it was specifically around mental health. But I would agree there is a role for Health in providing the ongoing support and therapeutic environment for the clients but they still currently sit as pathway clients under the *Criminal Code*, so we need to make sure that for that part of it, there are obviously other agencies involved in that in certain directions, but there is definitely a role of Health oversight.

DR MELLIFONT: I will come back to the question, Professor Stoddart, because I'm not asking you as a representative of the Northern Territory because you are not there any more. I'm asking you, as somebody who has worked in the field for 30 years, do you agree with both of those things, that they should be managed by Health as opposed to the Corrective Services Department, and they should be managed by NDIS, is it something which you agree with philosophically, as a matter of ---

PROFESSOR STODDART: Philosophically, Health as the overarching organisation, I think, has a significant role to play and so I would agree with that. In terms of the NDIS, there are a difference between those that are under a non-custodial order versus a custodial order in terms of how Health might interact, I think because those under a custodial order may be in prison or secure care, and we do provide a therapeutic environment but we have a bigger role to play, I think, with those that are in non-custodial care.

DR MELLIFONT: But again, coming back to the principle of it, do you see an importance for the NDIS in providing services to people found not guilty of reason of mental impairment to assist them, to support them in their pathways?

PROFESSOR STODDART: Speaking in my own role as myself, I would say the NDIS has a real opportunity to provide a broader range of individual services, individualised care for that group of clients, so it would be very useful.

CHAIR: When I read your statement, I may be misunderstanding, but if a supervision order is made by a court in the Northern Territory in respect of something who is found not guilty by reason of mental impairment, it is the Health Department, or however you describe it, that is responsible for the custody, care and treatment of that person; is that not right?

PROFESSOR STODDART: That is correct. It's under the care of the CEO, with other agencies having input, that is correct.

CHAIR: So in your --

PROFESSOR STODDART: --- (overspeaking) ---

CHAIR: In your answers to Dr Mellifont, are you effectively agreeing with the current position in the Northern Territory?

PROFESSOR STODDART: I am in fact agreeing with it, yes.

CHAIR: Right. All right. Let's see if we are going to advance from there.

Yes, Dr Mellifont.

DR MELLIFONT: Why?

PROFESSOR STODDART: Because - why should Health lead? The use of the Part IIA orders and Health having oversight of those clients has meant that we can provide a therapeutic environment and see transitions of clients. We have 47 clients currently in that environment and a large number of them, 34 of those, have moved into a transition into more independence and further into the community, and I think that is a significant role for Health to play.

DR MELLIFONT: Ms Gore, can I ask you this: does the Northern Territory intend to provide step-down secure community-based accommodation for persons like Winmartie?

MS GORE: In part. It is difficult to answer that on behalf of the entirety of the Northern Territory. We at Northern Territory Health are tasked with providing the treatment and support for people. The provision of specific housing and accommodation sits across a number of departments. I think that what we have seen in the last two years, as the NDIS roll-out has reached greater strength in the Territory, is resources are coming to the Territory on which have enabled community-based providers to establish a range of community-based housing options, and we have in fact got a number of our clients in other forms of community

housing in quite remote locations like Tennant Creek and the Tiwi Islands in a mixture of such housing options. So, right now, I'm not seeing a demand for a specific step-down secure facility; what we are seeing is an intention to move people further into community-supported independent living arrangements that might involve in-reach supports, regular visits, family structures, but not so much the sub-acute. We are not seeing a demand in our current population.

CHAIR: Ms Gore, can you help me understand how what used to be a somewhat fragmented system in the Northern Territory works. You said, I think you or Professor Stoddart said there were 47 people in a particular category. What is that category? Are these people who have been found not guilty by reason of mental impairment or have been found unfit to plead? Is that the cohort we are talking about?

MS GORE: Yes, the 47 are those people who are currently under supervision order as a result of Part IIA findings through the Criminal Code, so they are either on non-custodial supervision orders or custodial supervision orders. Currently they are managed across the two services, so the Forensic Disability Unit and the Forensic Mental Health Service.

CHAIR: The division is according to whether they are in custody or not in custody?

MS GORE: No, the division relates to functional assessment. So there are people who are clients of the Forensic Disability Unit because of the definition of disability (audio distorted) and there are clients of the Forensic Mental Health team who have been found unfit to plead due to mental impairment.

CHAIR: Of the 47, how many of those are First Nations people?

MS GORE: I would need to double-check my figures, but all of the Forensic Disability clients, so I think there are 13 of those currently, and the overwhelming majority of the Forensic Mental Health clients as well.

CHAIR: We have been talking about culturally appropriate services. Can you at least help me: what are the facilities that are available to provide culturally appropriate services to this cohort of 47 or however many of them are First Nations people?

MS GORE: I think there's a few different initiatives underway, and I would bring up the Territory's development of the *Aboriginal Justice Agreement*. It documents this issue in great detail and actually puts a roadmap together for Government around things that we should aspirationally be doing. Stepping back to what we are currently doing right now, what we did last year as one example is we have a facility in Darwin which houses all currently Aboriginal men on non-custodial supervision order, and we transition that service from Health, from the government service to a non-government service provider. That non-government service provider has --- a much higher proportion of its staffing are Aboriginal people from this (audio

distorted). It also has opportunities to links in with cultural Elders and be a much more community-focused approach. That transition took us the best part of eight months, to ensure we are doing it in a culturally safe way as well as in a sustainable way in terms of the resourcing. I think you heard from Mr Langcake this morning, our commitment to these interpreters, trying to increase the presence and engagement of people from country in our services, we have developed a range of outreach programs and in-reach programs, and we do try and work really closely with agencies like NAJA, with our Aboriginal community-controlled health service to change the way we do service, change the starting point of that service.

CHAIR: Thank you.

DR MELLIFONT: Can I take you to the point about interpreters, Ms Gore. Is the expectation that interpreters will be used to assist, say, the clinicians engaging with a patient? Is that the expectation for interpreters?

MS GORE: Yes. Sorry, I'm hesitating because it's a little bit of a nuanced answer. We did some work last year with the Royal Darwin Hospital around the types of information that people needed when they presented to a hospital setting and tried to work out how to best mobilise the resources we've got. Some of the information, it's entirely appropriate for a family member or a friend to be the person who helps the engagement with the clinician. Sometimes it's another well-trained staff member. And then when we are at really sensitive areas of consenting and those kinds of things, we need a formally trained interpreter to assist the clinician in their communicating.

In our services, we have a similar sort of nuancing of what we'd like to do is the build the capacity of our staff to be able to communicate effectively all of the time, and to then bring interpreters into the room --- and I have to say this out loud, COVID has let us use Telehealth and phones in ways that we had never imagined before, so we have increased access in that way. But we need to be led by the client as well around what they want to see in terms of assistance in communication. Some of our remote communities, it's really difficult because then there's privacy and family relationship concerns as much as there is worries around being understood properly.

DR MELLIFONT: The reason I ask, Ms Gore, is you wouldn't expect an interpreter to be booked just so, say, somebody like Winmartie could have a chat with somebody in his own language? That's not your expectation as to how the interpreters would be utilised?

MS GORE: No, that wouldn't be how I would expect interpreters to be utilised.

DR MELLIFONT: Thank you. Ms Gore, NT Health's 2019 response to the McGrath Report noted that specific training in forensic work would require provision of such training by an education provider, and there's no current program available nationally. To your knowledge, is it still the case that there is no forensic work

training program which is culturally appropriate in the Northern Territory or nationally?

MS GORE: It is my understanding that there is not an accredited training program available nationally. What I am aware of, though, again through the work of our Attorney-General's Department in the development of the *Aboriginal Justice Agreement*, is they have developed an alternative to prison program in Alice Springs, which has a really strong focus on criminogenic factors, and they are using the development of that service to try and bring together, if you like, a training package for some of the human services providers in Alice Springs. I think that that has massive potential to actually become something really valuable, not just for that service, but across the Territory and in fact around Australia, because I think that understanding around what are the criminogenic things that we need to address, as well as the mental health concerns or the AOD concerns or the functional disability, that is a big missing piece and I think it was a fantastic initiative that will hopefully continue.

DR MELLIFONT: What do you need to make sure that can be rolled out?

MS GORE: Well, I have what I need, which is I have a really good working relationship with the person leading it in that Department. I think what we need across government is broad understandings of working with a person holistically, that people don't live single-issue lives, and I think often what happens is we start at, it's a mental health client, or it's a person with a disability or it's a person who has got an addiction and then we get stuck in our service system. I think what we can do and should do --- and that is again the leadership of how the *Aboriginal Justice Agreement* works --- is to take a view, which is we have got a range of social problems which are determined through poverty, trauma, racism, poor resources, dispersed population, let's tackle them as a complex problem and get all the bits to help, rather than trying to give the responsibility to one area of the service system. I think if we did that, that would be much easier for me to say, I want all of our staff trained in criminogenic factors, not just the ones working in the Forensic Disability Unit.

DR MELLIFONT: Right, and that speaks to the need, doesn't it, for a whole-of-government coordinated approach to the issues that we are seeing?

MS GORE: Very much so. Very much so. But I think just to note, again, I'll just keep plugging it, I think what we want government to pay attention to has to be big enough so they can't just keep putting it back in a corner. That's why I think, particularly for the Northern Territory, the *Aboriginal Justice Agreement* process is a really big piece of work and it picks up the intersection of people in the justice system, it notes cognitive disability, it notes the huge impact of early hearing loss, it notes structural racism, social poverty, as all big factors that need to be tackled whole of government. I think that's what will give our service system the foundation it needs to really make a difference.

DR MELLIFONT: I take it you are of the view that the over-representation of people with cognitive disability in the criminal justice system, in particular First Nations people, and in respect of the forensic system, is such a big item that it cannot, in any good conscience, be put into the corner. You would agree with that?

MS GORE: Absolutely. And Health gets to pick up the pieces and try and provide treatment and care for people. What we need is some real upstream work that tackles these problems at a community level, at a prevention level and at an early intervention level and that is cross-government.

DR MELLIFONT: Professor Stoddart, you have been nodding. That's good, nodding in agreement, let me get that on the record. Is there something you would like to add to the response by Ms Gore?

PROFESSOR STODDART: I think that Ms Gore probably covered all of it, other than to say that the whole-of-government focus has been the work of the Children and Families Standing Committee in the Northern Territory over the last four years, but it is embryonic, really, in terms of the whole-system approach that Ms Gore has been talking about. So inroads have started and I support that.

DR MELLIFONT: Can I put this to you both: that unless we break down the barriers that exist from department to department, we are not going to get to where we need to get to in terms of transformational change in Australia for people with disability and people with cognitive disability. Are we agreed?

MS GORE: Agreed.

PROFESSOR STODDART: Agreed.

DR MELLIFONT: Two nods?

CHAIR: Can we translate those two nods into some practical action in the Northern Territory?

Professor Stoddart, you are a bit freer to talk, I imagine, than Ms Gore because you are fleeing the jurisdiction.

PROFESSOR STODDART: I am, but I might see you in Western Australia yet!

CHAIR: What has to be done as a practical matter to bring this about? The description to someone untutored as I am, that is to say the governmental arrangements within the Northern Territory, one gets the impression of considerable fragmentation. You have said there needs to be a whole-of-government approach; what does that mean in practical terms? What needs to be done?

PROFESSOR STODDART: One of the first steps that's happened with being the Minister for Disability is a recognition that this is a whole-of-government approach,

that it needs that leadership and that has been provided. The other piece of work that has happened, as I mentioned, has focused on children and families, which is a cross-government work in the human services, so that includes police, education, community, disability, all of those factors, working together and looking at the data, so we can see where the areas of concern are, so is there a hotspot in a particular region where we might have children who are not attending school, might have increased hearing loss? We could have extensive family domestic violence. That work has been happening over the last four years so that we can work it out, at the prevention end, where we should focus. I think it is one example of a system that is working, but in saying that, the big partner in the Northern Territory is the Aboriginal Community Controlled Sector and the Aboriginal organisations because they provide, in terms of Health, they provide a large majority of that primary care really well to remote communities - we do some of it - but there is also other Aboriginal Community Controlled Organisations, and working out --- the part that is probably missing that we try hard to do is pulling all of this together so that we're actually focusing on the same thing, because as you know we have different funding environments between Commonwealth and State, that can create fragmented services and different agendas, frankly.

So I think that is an element of it. We have been working on this specifically around mental health with the Aboriginal Community Controlled Organisations and the Northern Territory PHN to try and have a joined-up approach to mental health, so not just a government agency but the broader whole-of-system. I hope that answers your question.

CHAIR: Is there a protocol of some kind or a methodology for involving the First Nations controlled organisations within these governmental decision-making processes?

PROFESSOR STODDART: There is in the Northern Territory, there's two forums that come to mind straight away - three actually, the *Aboriginal Justice Agreement* involves significant mechanisms of consultation in a structured way, that has seen a really good outcome. In terms of Health --- and I'm saying this is fragmented again, of course --- Health has a forum where the peak body of Aboriginal Community Controlled Organisations works with Health and the Commonwealth to get joint agreements. And there is also a forum called the Tripartite forum which looks at whole of family and children risk factors and brings together the Commonwealth, the jurisdiction of the Northern Territory and the peak bodies for Aboriginal Community Controlled Organisations. So there are mechanisms. It is early stages though.

CHAIR: Thank you. Ms Gore, I didn't want to cut you out, I wondered whether you had anything to add, bearing in mind your approach may be a little more circumscribed than Professor Stoddart.

MS GORE: I think Professor Stoddart has covered the big ticket things. I think that a very practical example which is currently occurring is in Katherine Region, where we have been doing some re-design of what services are available to whom and from

what source of funding with the PHN, with the National Indigenous Australians Agency, to go, we need more preventative work, and the problem around we want to reduce unnecessary acute mental health retrievals via care flight, and rather than looking at how much more money we could spend on funding care flights to bring people out of Katherine, it was, how do we engage our local Aboriginal organisation to increase social emotional wellbeing programs, change how do we change funding mix so that we have more people available after hours, how do we engage hospital staff so they are more confident in responding appropriately, and how we got some liaison officers in that setting.

So that is really practical, local, on-the-ground, and coming together to coordinate effort and change what we are currently buying from services which will have that long-term change.

CHAIR: Thank you.

DR MELLIFONT: Ms Gore, was there anything you disagreed with in terms of what Professor Stoddart answered in respect of the Chair's question? Any point of disagreement?

MS GORE: No.

DR MELLIFONT: Thank you. Professor Stoddart, I want to take you to some parts of your statement of ---

COMMISSIONER ATKINSON: May I ask some questions?

DR MELLIFONT: Thank you.

COMMISSIONER ATKINSON: The questions I have relate to Winmartie but also other people who are in indefinite detention. I don't know if you heard the evidence from Aunty Margret of what their wish was for Winmartie and how he would live. I imagine - I expect he's not - we know he's not the only person in indefinite detention for whom there is no alternative accommodation currently available with the services that that person needs. What is the Northern Territory plan to provide accommodation and services outside that very restricted environment that Winmartie, for example, find himself in?

MS GORE: If I could perhaps tackle that. What we have got is each of our clients is on a very specific individual plan with a view to hopefully transitioning back to community eventually. We also have in the last year had two of our clients have their custodial orders discharged, so they are no longer under supervision, so they have been on an NCS for a period and then through the therapeutic supports and the community supports, they are now living independently with no supervision order. That would be our goal for them all.

Along that continuum of service we do have community-based supported

accommodation provided by often non-government organisations. Some of our clients have two-to-one support 24/7, some have one-to-one support 24/7, some have one-to-one support during daylight hours. So there are a wide range of options but they are matched to the needs and the particular concerns or the issues for the individual person. It's my understanding with Winmartie that there are absolutely plans in place to continue his development with supports to a different space of living and in the last four years he has gone from a correctional facility, locked down in a cell, to now an environment where he is most days being taken out into the community, going on drives, going fishing, still he's not free to do exactly what he wants but he's actually learning life skills, to one day get to that aspirational place of independent or supported community living. But it needs to be matched to his development and what is required.

COMMISSIONER ATKINSON: And the Northern Territory Government will financially support whatever each one of these people need to live in their communities with sufficient support?

MS GORE: I think that - this is where I go back to, as the Commissioner said before, about circumspection. All Government needs to provide services within a resource envelope, and one of the unique characteristics of the Territory is how dispersed our population is, we have a small population and a really big area. To be able to provide supports for people in their communities, there needs to be a workforce, and some of our smaller communities that's not going to be possible. We have done very well with some of our clients where we have managed to house someone in Tennant Creek with appropriate supports, we have one person across on the Islands with appropriate community supports but there will be some areas of the Territory we just do not have a workforce that can provide the level of intensive support and care for some of the people with more complex needs and we will need to look at locating them on country which is close to but may not be their home country or their birth country.

COMMISSIONER ATKINSON: What are the plans to create that workforce that is necessary?

MS GORE: We are always working with our NGO providers to look at where our investments are, where some of the work is, where it can be. We have done very well to increase that in the last two or three years and we will continue on that trajectory.

COMMISSIONER ATKINSON: That's a bit broad. Are there specific documents that set this out?

MS GORE: We have an Aboriginal Employment Plan for the NT which looks to general social and economic development in all of our regions and in all of our communities. We are looking again in that non-siloed way I was talking about earlier, around how do we increase the proportion of people who have general community services qualifications. There may never be a full-time job available just

doing, say, mental health support, but if someone could work two days a week in aged care and two days a week in mental health support in the social community services, that is a way we can grow our workforce. We have a range of traineeship programs, we also interact with Commonwealth programs in this regard. With anything, we have to work on an economy of scale, so we can write individual support plans and then we have to work with the realities of how much resources are available through the NDIS and others at an individual level.

COMMISSIONER ATKINSON: I'm responding, from what you can see, from judgments written byJudges who review these people who are in indefinite detention, that one of the extremely frustrating aspects is that justice can't be provided to these people because there are not the services available to allow them to live where they need to live to be culturally safe and that are appropriate for them. So I think the Commission would be very interested in any concrete plans there are to respond to that concern that has been marked in review of these cases when they come to court.

MS GORE: Yes.

COMMISSIONER ATKINSON: Thank you.

DR MELLIFONT: Ms Gore, is that something you are prepared to take on notice and provide a written response about?

MS GORE: Yes, we can certainly look to examples.

COMMISSIONER ATKINSON: I don't mean examples, I mean concrete plans overall, as well as examples.

MS GORE: If I could repeat - I am aware of a range of initiatives again under the framework of the *Aboriginal Justice Agreement* around alternatives to custody and alternatives to prison which require whole-of-government investment. We at Health will be tasked with providing services which is not necessarily infrastructure and buildings. So we don't currently have a specific plan which says we are going to go and establish a facility in Ramingining, in part because we don't necessarily know where our next client is coming from. In terms of what we have in place for the current client group, most of them have transitioned into supported housing in either NGOs or private markets. They have not transitioned into a health service facility, and I think that's our ultimate goal. So if --- we don't have a current plan for a particular set of investments but I imagine that will emerge as the *Aboriginal Justice Agreement* continues to get some legs.

PROFESSOR STODDART: I was going to add that the success we have had to date in transitioning or providing additional supports to the NDIS to some of our non-custodial supervision order clients will also have an impact on that because we are able to access a different way of providing community-based services. But of course, for those small number of people, 13 in total, that have supervision orders that are custodial, there is a different range of requirements for that, that needs that

transition before we can really maximise it.

COMMISSIONER ATKINSON: Anyway, no doubt you will give us whatever plans you have.

MS GORE: We will.

DR MELLIFONT: Can I just clarify - is it the case that there are still 13 Part IIA clients in institutional settings? Do I have that right?

PROFESSOR STODDART: Yes, 13 custodial supervision, not all forensic - sorry, not all disability. It is a mixture of mental health forensic clients and disability forensic clients across a range of areas. I will just - I will confirm that number, though. My last understanding of it, it may have changed.

DR MELLIFONT: All right, Ms Gore might need to confirm that number for us.

MS GORE: Yes.

DR MELLIFONT: And also, where they are.

MR JACOBI: Counsel Assisting, I hesitate to interrupt, but in response to a notice issued to the Northern Territory in relation to closed institutions, I believe that we provided that underlying data. I can confirm that the number is 13 and I think that information may include a breakdown of the institutions. But we will provide an email tonight to identify that number.

DR MELLIFONT: Thank you, Mr Jacobi. I just want to understand whether that information is still current. Thank you.

MR JACOBI: Thank you.

DR MELLIFONT: Can I take you, Professor Stoddart, to your 20 January 2021 statement and go to paragraph 19, which is STAT.0275.0001.0001 at page 4?

PROFESSOR STODDART: I think I've found it.

DR MELLIFONT: Thank you. This part of your statement which speaks about the need for direct support workers to provide direct face-to-face services and telehealth can provide for video consultations with specialist clinicians. You speak about it overcoming some of the difficulty described in paragraph 16, which is where you reflect that forensic psychiatrists are a very thin workforce, and attraction and retention in the sparse population of the Northern Territory has been historically difficult.

PROFESSOR STODDART: Yes.

DR MELLIFONT: I want to ask you, in order for the level of telehealth and video consultations that were able to be provided during COVID, does the Northern Territory need anything from the Commonwealth in terms of changes of approach to Medicare service provision, or is it the case, so far as you understand, that those telehealth services can be provided with the psychiatrists under the existing Medicare regime?

PROFESSOR STODDART: If I answer that, and I'm sure Ms Gore can add further colour to it, but ---

(Technical difficulties)

DR MELLIFONT: We have lost you.

MR JACOBI: We will go around the corner and hope to get everything working.

CHAIR: Dr Mellifont, I think we will break for a couple of minutes to see whether we can unfreeze ourselves.

DR MELLIFONT: Thank you.

ADJOURNED **[3.46 PM]**

RESUMED **[3.47 PM]**

CHAIR: We deem the Commission to have been put back into session.

DR MELLIFONT: Professor Stoddart, before you froze, you said, "Let me answer that, and Ms Gore might have some input."

PROFESSOR STODDART: Thank you. It's a really important question because during the period of COVID when we were required to move towards -

CHAIR: Dr Mellifont, there seems to be a problem. Sorry. We will just connect and carry on.

DR MELLIFONT: Okay, Professor Stoddart, thank you.

PROFESSOR STODDART: During COVID there were some positive effects, one of which was in health and particularly in remote locations, utilised technology in a way that fast tracked access for clients. It was one of those opportunities that we want to hold on to. We did do some of it with NTG funding, Northern Territory

Government funding. However, during that period of time the Commonwealth provided a Medicare item number to allow client interaction action in a different way.

The element that is missing now is clinician to clinician: a nurse in a remote community or a support worker in the Forensic Disability Unit being able to access a clinician --- for example, a forensic psychiatrist or psychologist --- in a different state. That doesn't have necessarily the Commonwealth funding for it, so that probably is a lever to improve access as much as a way of reducing some of the disadvantage.

DR MELLIFONT: Okay. Can I take you to paragraph 20. It says:

> *Thirdly, the overall model(s) of care are evolving in light of NDIS supports, the importance of culturally appropriate support workers and the potential efficiencies which could be achieved by integration of forensic mental health and disability services ....*

What does that mean?

PROFESSOR STODDART: There are two parts to that really. We have noticed that through the evolving NDIS supports we had very thin markets in terms of NDIS providers; as you can imagine, very small communities, one or two providers. But as we have been able to transition some of our clients --- not just those that are forensic, more broadly --- we have been able to grow the workforce in some of our nongovernment providers, so they may employ Disability Support Workers or Aboriginal Liaison Officers, and so that has had a really positive effect. We have seen it across the Territory, but maybe in the larger spots, Alice Springs and Darwin, more than the very small ones.

If I go to the second part of that, which is around trying to integrate forensic mental health and disability, as we talked about, the total number of clients we have is 47, so there are no economies of scale in terms of our workforce, which has been traditionally separate, and it was a recommendation of the McGrath Review that we pull it together. In fact we have started that work and for a short period of time, subject to recruitment, we had a director across the combined services to look at how we might do that in a way that meets the clinical needs of the clients and does pull together the best of our services, because a lot of the way that we actually manage these two client groups separately could be done together. So they are the parts to the question.

DR MELLIFONT: Ms Gore, can I ask you whether, in respect of the Medicare issue I raised with Professor Stoddart, NT Health has requested the Commonwealth to consider expansion of the Medicare service provider so that there can be longer client appointments for clients with complex needs?

MS GORE: I think that the main advocacy that the NT has made in the mental

health space to date with the Commonwealth has been allowing for case consultation between more senior clinicians and frontline clinicians. The demand is around being able to have a forensic psychiatrist on the line doing clinical case review with, say, a general practitioner or clinical nurse, rather than having to send the forensic psychiatrist necessarily to the patient. I think that's the piece that would really enhance our service systems, being able to have that clinical mentoring and case review, not just one on one with the client.

DR MELLIFONT: This question is actually for Ms Gore but it's by reference to Professor Stoddart's statement, where at paragraph 26, Professor Stoddart, you observed that the development of a Mental Health Workforce Plan for the Northern Territory will be progressed following the appointment of the Chief Psychiatrist to the Northern Territory. What is the current position, Ms Gore, with respect to the appointment of the Chief Psychiatrist?

MS GORE: The position was the recruitment wasn't successful when we attempted it at the end of last year. What we have - what we are now doing, there is a series of other reform projects occurring in mental health, one of which is the review of our Act, the mental health and related services legislation. We are planning to finalise the first round of community consultation of that in May and we are fully expecting that will result in suggested amendments to the legislation which would make the position statutory. Once that is settled then we would seek to advertise the position again.

DR MELLIFONT: What's the shortest period of time you foresee before you would advertise for a Chief Psychiatrist?

MS GORE: Not being 100 percent sure about my Minister's intention, following the normal processes, we should be able to advertise before the end of this year.

DR MELLIFONT: Does that mean that the development of a Mental Health Workforce Plan for the Northern Territory is on hold until not only the position is advertised but it is actually successfully filled?

MS GORE: No. There are a number of initiatives currently under way which will all contribute to an NT Mental Health Workforce Plan. The NT Government has a health collaboration with Charles Darwin University and it has a specific working group which is on to it now, which is looking at mental health workforce needs. The NT has also contributed to the National Mental Health Workforce Strategy development. We have a range of other pieces of work occurring in areas of priority that we have identified where we need to move more quickly.

I think what the appointment of the Chief Psychiatrist does is it provides a very strong leadership support to the clinical part of the workforce and to bring those initiatives together within a whole system. But in the meantime, we are getting on with what we can get on with.

DR MELLIFONT: Again, what's the least minimum period of time you see before you have a workable Mental Health Workforce Plan, or may I say close to a final or a final Mental Health Workforce Plan?

MS GORE: I would anticipate that about this time next year would be when we would seek to launch something like that, but it would be very much the collection of a series of strategies all pulled together into one document.

DR MELLIFONT: The last question I have for you, for both of you --- I'll ask you each to comment about this --- comes from paragraph 36 of Professor Stoddart's statement. Can I ask you to read most of that paragraph to yourselves and I'm going to read out the very last sentence. The last sentence reads:

> *Clients that are highly complex and pose ongoing risk to themselves and/or the community will also not be deemed suitable for NDIS SILs.*

Professor Stoddart, why do you say that?

PROFESSOR STODDART: SILs is the supported independent living environment and those clients that are actually high risk to themselves or to the community are usually under the custodial supervision orders and therefore not able to be transitioned into the NDIS supported independent living environment because they require custodial care. So that's the key challenge between the NDIS support packages and those forensic clients that are still under custodial supervision orders.

DR MELLIFONT: Ms Gore, you were nodding to that. Do you agree with that answer?

MS GORE: Yes. It's a technical funding agreement between what the Commonwealth has deemed eligible or not eligible.

DR MELLIFONT: Moving on to NDIS providers or nongovernment providers, there's a real risk to the Northern Territory that the private sector or nongovernment providers will say that the forensic clients are just too complex for them. Do you agree with that?

PROFESSOR STODDART: Yes, without adequate funding and supports for them to provide it, and all the same issues that we have, including workforce, it would be difficult for them to provide it to some groups, to some clients. However, the work that Ms Gore has been doing in relation to moving some of our very acute clients out into the NGO sector would say that there are options and potential there if we get it right.

MS GORE: Just to note in the last two years, we have had one particular provider come to the Territory who specialises in this area and that they very much describe themselves as a provider who takes people that others don't have the skills to manage. And so, yes, there is a risk and it returns back to the concentration of

numbers. But I think that we do have providers up here who are trying to develop their capabilities in this regard, recognising that there is a need.

DR MELLIFONT: It rather speaks to the need for the Northern Territory Government to ensure that it prepares itself to be a provider of last resort in the circumstances that the NDIS market can't cater for these complex needs clients. Would you agree with that?

PROFESSOR STODDART: Currently the Northern Territory Government is the provider of last resort, in fact, because where there are thin markets and perhaps some of the services that are required for our clients are not available, we will provide them where we can.

DR MELLIFONT: So you are agreeing with my proposition?

PROFESSOR STODDART: I am agreeing, yes. Sorry.

DR MELLIFONT: Ms Gore, you as well are agreeing with that proposition?

MS GORE: Yes, we are already providing those services.

DR MELLIFONT: But it is more than that. My question is the Northern Territory needs to plan for being able to provide these services in the future, in case the non-government sector simply can't. Would you both agree?

MS GORE: Yes, agree.

PROFESSOR STODDART: Yes.

DR MELLIFONT: I have no further questions. Thank you.

CHAIR: Thank you very much. I'll ask the other Commissioners if they have any questions of you, Professor Stoddart and Ms Gore. I will first ask Commissioner Mason, who is in our Brisbane hearing room.

COMMISSIONER MASON: No, thank you, Chair.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

CHAIR: I will ask Mr Jacobi if he has any questions of you.

MR JACOBI: I don't, Commissioner. Again, I will indicate that I understood that a number of the questions asked required material to be supplied and we will liaise with Senior Counsel Assisting with respect to that and ensure that that is provided to the Commission.

CHAIR: Thank you, Mr Jacobi. Thank you, Ms Gore and Professor Stoddart for coming to give you evidence. We appreciate the assistance you have given the Commission. Professor Stoddart, we wish you all the best in your new position.

PROFESSOR STODDART: Thank you so much.

THE WITNESSES WITHDREW

CHAIR: Dr Mellifont, do we adjourn until tomorrow?

DR MELLIFONT: Yes, 9.30 am Brisbane time.

CHAIR: And 10.30 am Sydney time. Thank you very much. We will adjourn until then.

HEARING ADJOURNED AT 4.01 PM UNTIL 10.30 AM ON TUESDAY, 23 FEBRUARY 2021

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