TRANSCRIPT OF PROCEEDINGS

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THE HON ROSLYN ATKINSON AO, Commissioner
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THE ROYAL COMMISSION INTO VIOLENCE, ABUSE, NEGLECT AND EXPLOITATION OF PEOPLE WITH DISABILITY

10.30 AM, TUESDAY, 16 FEBRUARY 2021

DAY 1

Dr Kerri Mellifont QC Senior Counsel Assisting
Janice Crawford, Counsel Assisting
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CHAIR: Good morning, everyone. I extend a very warm welcome to everyone who will be following this, the 11th Public Hearing of Royal Commission into Violence, Abuse, Neglect and Exploitation of People With Disability. This is our first hearing for 2021 after a year that has been difficult for so many people in this country, not least people with disability. I'm sure my colleagues join with me today in expressing the fervent wish that 2021, despite its rather inauspicious start on the COVID-19 front, will prove to be a more tranquil, stable, healthy and productive year than its predecessor.

This hearing will explore the experiences of violence, abuse, neglect and exploitation of people with disability, but especially people with cognitive disability in their interactions with the criminal justice systems in Australia. We shall be particularly, although not exclusively, examining the circumstances of people with cognitive disability who have complex needs and have been detained for indefinite periods. That can be because they've been found unfit to plead to charges of criminal conduct or because orders have been made for their detention under mental health legislation. We shall also be considering the factors that contribute to people with cognitive disability being imprisoned and subsequently cycling in and out of the prison system. Of course, of necessity, this will require close examination of the experiences of First Nations people with cognitive disability who are so heavily over-represented in the criminal justice system.

As always, we begin with an Acknowledgement of Country by Andrea Mason OAM who is in our Brisbane hearing room. I invite Commissioner Mason to give the Acknowledgement of Country.

COMMISSIONER MASON: We acknowledge the First Nations people on which this hearing is sitting.

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

We recognise Meanjin, Brisbane.

Nganana ngurkantananyi ngura Meeanjin-nga Brisbane-ta.

We recognise the country north and south of the Brisbane River as the home of 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 in which 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 like to now do a First Nations content warning. This hearing will include evidence that may bring about different responses for people. We 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 131114. 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.

OPENING BY CHAIR

CHAIR: Thank you very much, Commissioner Mason. Let me say something first about this hearing. We had hoped that the hearing would be conducted solely in our Brisbane hearing room with members of the public free to attend, as occurred in the early stages of the Royal Commission. We have, however, decided to take the cautious approach and maintain the format we adopted in the six hearings that were held in the second half of 2020 after the commencement of the pandemic.

Events in Victoria over the past week rather suggest that Shakespeare was right: "discretion is indeed the better part of valour". The hearing will be held with Commissioners in three locations on this occasion. Commissioner Mason is in the Brisbane hearing room. Commissioner Roslyn Atkinson AO is joining the hearing remotely. Commissioner Alistair McEwin AM is with me in the Sydney hearing room which naturally is not as spacious or well-appointed as the custom-built Brisbane hearing room, but we shall do our best to manage.

Dr Kerri Mellifont QC is the Senior Counsel Assisting the Royal Commission at this hearing. She appears with Ms Janice Crawford and Mr Ben Power of Counsel. All three counsel are in the Brisbane hearing room. They are assisted by the Office of the Solicitor Assisting the Royal Commission and by Ms Avelina Tarago, of Counsel. A number of parties have been granted leave to appear at this hearing. Their appearances will be announced shortly.

Subject to the possibility of changes to the best laid plans, evidence will be given at this hearing by 33 witnesses. Five witnesses will give evidence in person at the Brisbane hearing room, five in person in this, the Sydney hearing and 23 will give evidence remotely. Some evidence will be given by way of pre-recorded video. Of course, as always, the proceedings can be followed on the webcast on the Royal Commission's website. As with all our hearings, an Auslan-English interpreter will be visible on the webcast and our excellent Auslan interpreters will be operating from the Sydney hearing room.

Let me make brief reference of the progress. I wish to draw attention to the Third Progress Report of the Royal Commission which was published earlier this month. The report covers the half year from 1 July 2020 to 31 December 2020, a period, of course, which was heavily affected by the restrictions associated with the COVID-19 pandemic. Nonetheless, the Royal Commission developed new ways of conducting our public activities, including holding the six important virtual public hearings to which I've already referred. The details of the Commission's many activities during this period are set out in the report. I encourage people who are interested in our work to read that report which can be found on the website.

All of our hearings in one way or another concern the human rights of people with disability. Our Terms of Reference recognise that Australia has international obligations to take appropriate legislative, administrative and other measures to protect the human rights of people with disability, including rights recognised under the Convention on the Rights of Persons with Disabilities for short CRPD. Numerous provisions of the CRPD and other international agreements to which Australia is a party are relevant to the subject of this hearing and we shall hear more about that during the course of the hearing.

The provisions include the basic principle that there must be respect for the inherent dignity and individual autonomy of all persons. The right of people with disability to enjoy legal capacity on an equal basis with all others in all aspects of life, and the obligation on States Parties to take effective measures to prevent people with disability from being subjected to torture, or to cruel, inhuman or degrading treatment or punishment.

Let me now say something about attitudes towards the criminal justice system. These days we often hear the words "populism and populist" used. Like democracy, populism can take many different forms. In more recent times populism, especially of the authoritarian kind, is not seen as a sound approach to policy-making except perhaps by populists. That is because the essence of populism in its modern sense, and it has had different senses over time, is the belief that there are simple solutions to exceedingly complex problems.

Those solutions rarely work. What then is the relevance of the definition of populism, or this definition, to the subject matter of this hearing? The answer is that the criminal justice system is a lightning rod for simple answers to complex problems. We have all experienced what is usually described in the media as the law and order option that is a familiar feature of elections in Australia, particularly in the states and territories. This is not a phenomenon that is exclusively the responsibility of any one political party or group of political parties but it is also something that is much loved by large parts of the mass media, not only during elections.

The principal factor underlying the law and order option is a belief, or a belief at least attributed to the community, that what is needed to curb crime and enhance community safety is simply to adopt a more punitive approach to offenders.

Supporters of a punitive approach typically demand more severe penalties for offenders and agitate for more people to be denied bail pending their trial, on the ground that these are the most effective ways of enhancing community safety.

This belief is closely linked with another, that crime in this country is increasing and that we are all much less safe than we used to be. A book about to be published of which Professor Don Weatherburn, the former Director of the New South Wales Bureau of Crime Statistics and Research is a co-author, tells a different story. The Vanishing Criminal, as the book is entitled, reports that in Australia between 2001 and 2017, the rate of break and enters fell by 68 per cent. The overall homicide rate fell by 59 per cent and between 2009 and 2017 the rate of assaults fell by a third. Yet as Professor Weatherburn is reported to have said, this has not stopped most people thinking that there has been a big increase at least as in crime. In his view, public perceptions, and these are his words, at least as quoted, are "completely out of whack with what is happening".

One of the main objectives of this hearing is to demonstrate primarily through the experiences of people with cognitive disability that if we want to promote both community safety and the human rights of people with cognitive disability, we have to challenge some of the assumptions underlying the populist view of the criminal justice system. Much of the evidence will be directed to the proposition that there are much better ways of promoting community safety than relying on ever harsher penalties and longer periods of incarceration. These ways have the additional benefit of protecting and enhancing the human rights of people with disability who become embroiled in the criminal justice system.

Let me say something about the data and first about the prison population. As we have found in most areas of the Royal Commission's work, there is a dearth of data about people with disability, especially people with cognitive disability who are in custody. But let's consider some of the figures that are available. According to the Australian Bureau of Statistics, the ABS for short, on 30 January, 2020 41,060 people in Australia were prisoners of whom, 13,097, about a third, were on remand awaiting trial. That is, they had not been convicted. This was the first decrease in the Australian prison population in 10 years.

By 2018 the prison population had actually increased by 56 per cent over the previous decade compared with a 17 per cent increase in the general population. Of course, the prison population is fluid because people enter and leave all the time. Professor Eileen Baldry, from whom we will hear later in this hearing, in her statement, which will be tendered in evidence, estimates that about 70,000 people spent some time in prison in the 2018/2019 year.

Let me say something about First Nations people in custody. For a very long time we have heard a great deal about the massive over-representation of First Nations people in prisons in this country but unfortunately not much has changed. On 30 June 2020, according to the ABS, 29 per cent of all adult prisoners in Australia were First Nations people. I repeat that, 29 per cent. Yet First Nations people comprise

just 2.5 per cent of the Australian population. It is profoundly disturbing that in the Northern Territory, 84 per cent of the prison population comprises First Nations people when First Nations people comprise just 26.3 per cent of the adult population of the Northern Territory.

The ABS figures suggest that at any given time, that is on any given day, about 2.3 per cent of First Nations adults are in prison and more than 4 per cent of First Nations adult males are in prison. Over time, of course, it is likely that the proportion of First Nations people who have experienced some time in prison will be larger than those percentages. This is far from the whole story. Almost four-fifths, 79 per cent of First Nations prisoners, according to the ABS, had experienced prior adult imprisonment. It is hard to describe this phenomenon in any way other than a revolving door of First Nations people into and out of incarceration.

Let me come to people with cognitive disability. I have referred to the dearth of data referring to people with cognitive disability in prison or detained in closed institutions. Nonetheless, there is evidence that such people are also heavily over-represented in the criminal justice system. For example, a survey conducted by the Australian Institute of Health and Welfare in 2018 found that 29 per cent of prison entrants reported that they had a long-term health condition or disability that affected their participation in education, employment or every day activities. Of those reporting such a condition or disability, one-third of non-Indigenous entrants rated their disability as profound or severe, while nearly half of the First Nations entrants into custody reported a long-term condition or disability rated as profound or severe.

The same survey showed that almost one in four prison entrants were currently taking mental health medication. Professor Baldry will give evidence about important studies of prison populations that she and her collaborators have conducted. One study found that two-thirds of people who had been imprisoned between 2000 and 2008 had multiple complex needs. Nearly all these people were known to police as the victims of crime. Professor Baldry concluded that many thousands of people across Australia were being managed by the Australian criminal justice systems rather than being supported by the Australian community.

Of course, people with disability and First Nations people are not separate categories. We know from evidence at previous hearings that First Nations people have significantly higher rates of cognitive disability than people in the non-Indigenous community. We have also been repeatedly told, and indeed our Terms of Reference explicitly acknowledge the point, that First Nations people with disability experience multiple forms of disadvantage that have contributed to their appallingly high levels of incarceration.

A quarter of the people involved in Professor Baldry's study were First Nations people. It is not surprising that she and her collaborators found that those people were significantly more likely than the non-Indigenous participants in the survey to have had multiple and complex needs. We often hear talk of criminalisation of

people with disability and we will hear more of it during this hearing. What I've just referred to are some of the reasons why researchers, advocates and workers at the front line of the criminal justice systems refer to the criminalisation of disability.

Of course, there are some hardened criminals in prison. But a very large proportion of people in prison are there primarily, and sometimes entirely, because of their cognitive disability. This raises some obvious questions that we will have to consider during this hearing. How do we, consistently with community safety, prevent people with cognitive disability, especially First Nations people with cognitive disability, from coming in contact with a formal criminal justice system in the first place? If people with cognitive disability do come into contact with the criminal justice systems, what can be done, again, consistently with community safety, to provide the support necessary to avoid or minimise incarceration and to maximise their opportunities for integration or re-integration into their communities?

If people with cognitive disability are incarcerated, whether as the result of a conviction or an offence or otherwise, what culturally appropriate support should be provided to maximise the opportunities for rehabilitation and successful integration or reintegration into their communities?

In all cases, what measures are needed to ensure that the human rights of people with cognitive disability and custody are respected, and that in no circumstances in this country are they subjected to torture or cruel, inhuman or degrading treatment?

Is prolonged incarceration of people with cognitive disability particularly First Nations people, including people with cognitive disability subjected to indefinite detention, is this the most effective, constructive and cost-effective strategy for enhancing community safety?

Finally, I want to say something about the context. There are some important things to bear in mind as we consider the evidence. First, the policy questions that will arise are complex and difficult. There are no easy answers. Workable solutions require a full understanding of the factors contributing to this current state of affairs, careful consideration of options for change and, as a practical matter, a good deal of trial and error.

The particular case studies that we shall be examining and about which Dr Mellifont will speak in more detail demonstrate the difficulty. It is necessary on the one hand to protect the safety of the community and of staff in forensic units or prisons. And on the other to safeguard the human rights, health and wellbeing of people in custody who have complex and long standing needs. Institutions and staff responsible for people with cognitive disability in custody undoubtedly are usually very well-intentioned. Yet, the results not only from the perspective of the person in custody, but also from that of the community, may be far from optimal.

Secondly, this is not the first time the issues have been examined by an official inquiry. Far from it. There is a very good reason why the Royal Commission's

Terms of Reference direct us to take into account the findings of previous reports and inquiries. Dr Mellifont will tender in due course a document prepared within the Royal Commission which summarises relevant recommendations from previous inquiries. The document records the extensive and detailed work done by a multitude of bodies in this country to ameliorate the violence, abuse and neglect experienced by people with disability in the various criminal justice systems. Many of these reports deal specifically with the problems created by the incarceration of so many First Nations people, especially those with cognitive disability.

The reports have been prepared by a remarkable range of bodies, parliamentary committees, state and territory Royal Commissions, Law Reform Commissions, the Productivity Commission, the Australian Human Rights Commission, representative legal bodies like the Law Council of Australia, Ombudsman, and numerous ad hoc inquiries. In addition, we have the benefit of path breaking research undertaken within our universities and other academic institutions, some of which will be referred to in the evidence.

It follows, of course, that we do not need and nor should we re-invent the wheel. Rather, we have to build on the excellent work that has been done. The difficult part is to ensure that worthwhile recommendations for changes in legislation, policy and practice are implemented and properly evaluated.

Thirdly, and somewhat paradoxically, governments in fact have shown themselves willing to introduce significant reforms and innovative programs that move away from reliance on criminal punishment as the primary means of addressing harmful behaviour by people with cognitive disability. The regular law and order options to which I have referred have not prevented governments from acting on sound advice, although the process often takes considerable time.

For example, a working group established by the Law, Crime and Community Safety Council, now the Council of Attorneys-General, has developed the National Statement of Principles relating to Persons Unfit to Plead or Not Guilty by Reason of Cognitive or Mental Health Impairment. I will refer to these as the National Principles. The National Principles state a number of overarching principles together with some more specific propositions. They include the following: decision-making should be guided by the least restriction of the rights of a person with cognitive or mental health impairment, taking into account the risk of harm they may pose to themselves, victims or others.

The settings in which people are detained should aim to be inclusive and recovery-oriented, acknowledging that there will be individual difference in the meaning of recovery or rehabilitation and what that may entail.

Planning is required to facilitate the provision of appropriate supports, accommodation and community-based alternatives to detention. The needs of particular population groups, including First Nations people, and their understanding and experience of impairment, disability, health and wellbeing, should inform policy

and practice relating to persons who are found unfit to plead or who are found to be of unsound mind or not guilty by reason of cognitive or mental health impairment.

People found unfit to plead or unsound of mind or not guilty by reason of cognitive or mental health impairment should have access to tailored assistance, service pathways and reasonable adjustments, including those needed to facilitate their effective participation in the criminal justice system or the forensic mental health system. When making orders, people should be detained for the minimum period necessary to address the risk they pose to themselves, victims or others. And where time limits on orders apply, that is time limits fixed by a court or tribunal, jurisdiction should avoid time limits that exceed the maximum term of imprisonment that could have been imposed if the person had been convicted of the offence charged.

It is significant that these National Principles have been endorsed by five states and both mainland territories. Governments in Australia have also demonstrated that they are prepared to introduce legislative reforms even if, typically, there is a long delay between the reforms being proposed and the legislation being enacted. A very recent example is the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020 (NSW)* which will come into force later this year. The Act implements proposals in two important reports by the New South Wales Law Reform Commission dating from 2012 and 2013 to which Professor Baldry and Mr Jim Simpson of the Council for Intellectual Disability, both of whom will give evidence at this hearing, both of those people contributed to those important reports.

The legislation aims to ensure that people with mental or cognitive impairment who commit crime receive the treatment, support and supervision they need to be reintegrated into the community while also seeking to protect public safety. Among other things, the Act aims to divert more people with cognitive or mental health impairment system into treatment support and rehabilitation, rewrites the current test for the so-called offensive mental illness which actually dates from an English decision of 1840 and alters procedures for determining whether the person is fit to stand trial and provides greater protection for the rights of such a person once incarcerated.

The task of the reformer, as I know from my own experience over many years, is strewn with obstacles but there is reason to hope that this hearing and what flows from it will not be in vain.

Yes, Dr Mellifont.

OPENING BY COUNSEL ASSISTING

DR MELLIFONT: Good morning. It's my pleasure to appear in this hearing together with Ms Crawford of Counsel Assisting and Mr Power of Counsel Assisting

and to be assisted by Ms Tarago, of Counsel, all of whom are very experienced criminal law practitioners here in Queensland, and we are grateful to be assisted by the Office of the Solicitor Assisting the Royal Commission.

We acknowledge and pay our respects to the traditional custodians of the various lands on which we meet and participate in this public hearing. We pay our respect to Elders past, present and emerging as well as to a First Nations people involved in and following this hearing.

As the Chair said, this is the 11th Public Hearing of the Royal Commission and it is the first to focus on criminal justice.

There are two key topics to be explored in this hearing. The first is criminalisation of people with disability and how enmeshment, that is, cycling in and out of the criminal justice system, for people with disability comes to occur. How there is a desperate need for support, proper support to break this cycle.

In this context, one witness you will hear from is Ms Dorothy Armstrong, a person with an acquired brain injury, who was first a victim of terrible violence, then an offender and now an advocate. She will tell you, "If someone asks when I was offending in my 20s why I was alone and helped link me to a service, if someone asked me in my 30s why I had so many injuries and helped me find a way out of my situation, I can only imagine what difference someone asking me the question and offering support could have made to my life. Maybe I would haven't have had some of the horrendous experiences I can only imagine." They are her words.

A second topic we will cover is indefinite detention. In this hearing that term is used not just to include orders which are in fact called indefinite detention but also orders whereby there is no definite ceiling for the period of time the person is in custody before being released to the community. For example, limited term orders in the New South Wales system. This hearing is being held, as you've heard, in Brisbane and in Sydney, and while the hearing rooms are not open to the general public due to COVID risk management, the hearing can be followed online on the Royal Commission website.

As you've heard, over the next eight days we will hear from approximately 33 witness. We want to thank all of these individuals for their contribution to our inquiry. We particularly acknowledge the people with disability who are giving evidence in this hearing. Each of them will give evidence in the way that accords with their individual wishes. That means some will give their evidence through pre-recorded evidence, while others will give their evidence live.

We are acutely aware of how challenging it might feel to revisit difficult events in their lives or the lives of those they love in such a public way and we acknowledge and thank each of them for their contribution. Their voices, their evidence is critical to our work.

In addition to hearing from people with direct lived experience of these issues, we will hear from academics, health professionals, advocates and government representatives from New South Wales and the Northern Territory.

This Royal Commission is committed to taking a trauma-informed approach in all that it does. That extends to the way in which evidence is taken in hearings. That will mean, from time to time, that some evidence will be taken in closed session, that is not open to the public. That is not an unusual course. It is one taken in courts, tribunals and commissions across Australia when the circumstances call for it.

Such decisions are not taken lightly. They are taken with the principle of open justice very much in front of mind. All relevant considerations are taken into account, those relevant to the public interest including those relevant to risk and to wellbeing. Such a decision to take evidence in closed session has been taken with respect to a witness this afternoon. To take his evidence in a closed session is the only mode consistent with their trauma-informed approach.

This hearing builds upon what we have heard through submissions, responses to issues papers and our community engagements with people across Australia about the experiences of people with disability in the criminal justice system. It also contains links to the First Nations hearing held last year and the First Nations hearing planned for later this year. This hearing is just one piece of the Royal Commission's continued work and commitment to the area of criminal justice.

We thank everyone who has engaged with the Commissioners so far and we continue to welcome contributions. As Commissioner Mason observed, some of the evidence in this hearing may be distressing and the names of some First Nations persons who have passed may be mentioned. The hearing will include references to acts of violence, abuse, neglect and exploitation of people with disability and will likely include references to suicide and self-harming behaviour. The first of the case studies we will hear, that is of Melanie, will include references to such matters.

Once again, we encourage you to seek support if you want or need to, and can I just remind people of the telephone number for the National Counselling and Referral Service, 1800 421 468.

Let me now turn to the criminal justice system.

At its core, that system is about the rule of law. It's a process whereby parts of the government, including police, corrections and the courts, seek to execute and administer the law to promote a safe society for us all by detecting and deterring crime. However, the data, such as is it, shows that people with cognitive disability are significantly over-represented in the criminal justice system, particularly First Nations people with cognitive disability. Why is this so? Is the justice system being used as a de facto disability service, one that proceeds by punitive rather than therapeutic measures? And if that is so, why and what can be done about it and by whom?

We explore these issues by two case studies concerning two people held in long-term detention, and by a case study of a pilot diversion program as well as by hearing evidence from experts and advocates about systemic features and failures. As the Chair has noted, there have been many past reports on these topics. Our work includes examining past reports and inquiries to see what others have looked at to consider what has happened since.

As the Chair has observed, a document prepared within the Royal Commission by the policy division sets out an analysis of key themes arising out of past reports and that will in due course form part of the record of this hearing. To set the context of this hearing against relevant past inquiries, reports and recommendations, in addition to the points made by the Chair, it's useful to note here some of the key themes emerging from those past inquiries.

First is the principle of least restriction. Many reports have recommended that governments ensure people with cognitive impairment who have not been convicted of an offence are detained as a measure of last resort for the shortest appropriate period of time and in the least restrictive appropriate environment. If there is a less restrictive alternative that would achieve the same aim, then that should be applied.

Secondly, early intervention and prevention. Several reports recommended that governments should focus on increasing resources for targeted prevention and early intervention approaches and programs that ensure that people who are at high risk of coming into contact with the criminal justice system are identified and provided appropriate support, including mental healthcare and housing.

Third is cost benefits of early intervention and prevention. People tell us all the time it's all about the money. Well, a number of reports have noted economic savings through providing early support and diversion. The benefits of a justice re-investment approach has also been a frequent theme and there have been many recommendations concerning this.

The fourth is disability training, education and awareness. Several reports have recommended that governments should take steps to ensure regular disability training, education and awareness raising initiatives for justice system personnel who are likely to have close contact with people with disability, so such justice system personnel including police, legal practitioners, judiciary and Corrective Services officers. Those recommendations include that First Nations people should be involved in developing training resources and training should include consideration of trauma-informed and recovery-oriented approaches within the justice system.

The fifth is the role of supports. Some reports have found that support persons and/or communication assistants or intermediaries can improve the accessibility of proceedings and may reduce the need for unfitness to stand trial proceedings. Other reports have recommended that support persons or guardians should be available at various stages of the criminal justice process, including detention and questioning

and contact with police and the trial process.

The sixth is community supports, and several reports have recommended increased mental health reports and supported accommodation in the community to transitioning people back into the community.

The seventh is NDIS eligibility for people found not guilty by reason of mental illness or are found unfit to plead. Reports have raised the need to identify and link NDIS services for people post-release. Some have recommended governments should ensure that there is automatic eligibility to participate in the NDIS for people found not guilty by reason of mental illness or being unfit to plead.

The next is data collection. Much has been said about data so far, I'll keep this short, but several reports have recommended that governments should lead a coordinated and sustained effort to improve data collection about the interaction between people with disability and the justice system to ensure policy and law reform is evidence-based.

The next is topic of disability justice strategies, and we observe that the AHRC's 2014 report, Equal Before the Law: Towards Disability Justice Strategies recommended the development of disability justice strategies in each state and territory. Such strategies set actions to implement and promote access to justice for people with disability based upon appropriate communication, early intervention and diversion, increased service capacity and support, effective training, enhanced accountability and monitoring, and having better policies and frameworks. The past reports recommend that the strategy should be linked to the National Disability Strategy and the National Disability Agreement.

Finally on this topic, many reports have recommended whole of government action and reform is what is needed to develop a comprehensive response to the needs of people with disability who are in contact or are at risk of contact within the criminal justice, system and this notion of whole-of-government approach is something we are seeing in various areas across the Commission's work, and the notion that one must do what one can to guard against splitting and pushback between and amongst government agencies, federal and state.

Can I turn then to the international obligations. Our government has committed to international agreements that place a responsibility on us to meet agreed international standards. They include commitments to protect the human rights of citizens including specific commitments relevant to forensic patients.

It's relevant to note something here about the concept of fitness to plead. The legal issue of fitness to plead arises principally in the context of a person's mental or physical capacity and so, for example, at common law, a person suffering from mental or physical incapacity may be unfit to plead and, if so, no plea can be taken and the trial cannot proceed.

The law relating to fitness to plead is complex and it differs across the jurisdictions and some of these issues will arise in the course of this hearing.

Can I turn to the Mandela Rules, that is the United Nations Standard Rules for the Treatment of Prisoners. They tell us that:

> *Persons who are found to be not criminally responsible, or who are later diagnosed with severe mental disabilities and/or health conditions, for whom staying in prison would mean an exacerbation of their condition, shall not be detained in prisons, and arrangements shall be made to transfer them to mental health facilities as soon as possible.*

There are also obligations to ensure, if necessary, the continuation of psychiatric treatment after release and the provision of social psychiatric aftercare.

According to the Principles for the protection of persons with mental illness and for the improvement of mental healthcare, United Nations General Assembly 1991, all patients have the right to best available mental healthcare, and:

> *Every patient have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health status and the need to protect the physical safety of others.*

The Australian Health Ministers' Advisory Council has reaffirmed these principles and expanded on them in the National Statement of Principles for Forensic Mental Health and those principles are to be read together with the National Statement of Principles referred to by the Chair, as well as with the National Framework for Recovery-Oriented Mental Health Services and the National Framework for Reducing and Eliminating Use of Restricted Practices.

As we all know, Australia has ratified the *Convention on the Rights of Persons with Disabilities*, the CRPD, which commits to taking all necessary measures to combat stigma and enables disabled people to fully participate in society. The Chair has noted some of the specific provisions of the CRPD relevant to this hearing in his opening. We have also ratified the associated Optional Protocol, which provides a monitoring mechanism for breaches of the Convention. The Convention and the Protocol apply to forensic patients.

In its concluding observations on Australia's combined second and third periodic reports, the CRPD Committee expressed its concerns about laws that result in the arbitrary and indefinite detention of people with disability, and that such laws disproportionately affect First Nations people with disability and people with cognitive and/or social, psychosocial disability. They also express concern about the absence of national disaggregated data in respect to the criminal justice system.

We also know that the Royal Australian and New Zealand College of Psychiatrists position statement notes that "the rights to justice and freedom from arbitrary

detention have been breached in Australia by the indefinite incarceration of forensic patients and a lack of needed treatment support and planning for their return to the community."

They express concern that the right to freedom from cruel and degrading treatment may have been compromised by detention in prison due to lack of forensic facilities, the excessive use of solitary confinement or seclusion and the lack of effective legal remedies for mistreatment.

The Fifth National Mental Health Plan acknowledges that international norms and standards are generally seen as the medium acceptable standard for health policy. In addition to the international agreements mentioned previously, other relevant agreements are the *International Covenant on Civil and Political Rights*, the *Convention Against Torture and Other Cruel, Inhumane and Degrading Treatment Or Punishment*, the *Convention on the Rights of the Child*, the *International Covenant on Economic Social and Cultural Rights*, the *Convention on the Elimination of All Forms of Discrimination Against Women*, the *International Convention on the Elimination of All Forms of Racial Discrimination* and the *United Nations Declarations on the Rights of Indigenous Peoples*.

Can I turn back to data. Despite these international aspirations, the data indicates, as we have said, people with disability are disproportionately represented in the criminal justice system. I want to take you, just as one example, to the research piece --- one of many --- referred to by Professor Baldry AO in her statement. There, Professor Baldry refers to a limited study of people before the WA, Western Australian local courts, which showed that more than 50 per cent of the people coming before the court in that study had an intellectual impairment --- you see that on the left --- compared with just 2 per cent of the general population. It's an extraordinary, extraordinary comparison.

Turning then to other aspects of data, the Chair has referred to there being approximately 41,060 prisoners in Australia as at 30 June 2020. The figure which is about to come up on screen shows the number and proportion of prisoners by state and territory. And you will see that the most amount of prisoners are in New South Wales. And, obviously, this hasn't been rationalised out for all population.

But despite state obligations under Article 31 of the *Convention to Collect Appropriate Information*, including statistical and research data, there is insufficient high quality data on the number of prisoners with disability. Work that is currently underway as part of the criminal justice case study for the National Disability Data Asset is reportedly attempting to fill that gap. That's being conducted by the NSW Bureau of Crime Statistics in partnership with the Commonwealth Government and the New South Wales Department of Premier and Cabinet, and we understand is due to report early findings in April or May of this year.

The best available data we have at the moment on prisoners with disability comes out of the Australian Institute of Health and Welfare's National Prisoner Health Data

Collection from May 2019. We have heard the Chair state that 29 per cent of prisoners had long-term health condition or disability. That's much higher than the proportion of people with disability in the general population, which is at around 13 per cent, so 29 compared to 13 per cent, and that's for persons aged 18 to 64.

We have also heard this morning that June 2020 figures have 29 per cent of all prisoners as First Nations people. The figure coming up now shows the overall number of First Nations prisoners in the various states, together with the overall percentage of First Nations prisoners to general prison population. So you will see, for example, that in New South Wales it's 26 per cent, Victoria 10 per cent, Queensland 35 per cent, and so on.

The data that we have also indicates, and this is a startling figure, that First Nations people were overall 15 times more likely to be in prison at some point in time than non-Indigenous people. Can I turn then to the two main topics of this hearing.

First, criminalisation and enmeshment. As you've heard, the Commission will hear from eminent criminologist, Professor Eileen Baldry AO, who will explain the concept of criminalisation, how studies have shown that people with cognitive disability who are not provided with the necessary support cycle in and out of the criminal justice system. Her evidence explores the systemic issues that brings people with a disability into contact with the system and how they can become trapped in a cycle of incarceration and release lending to a sense of hopelessness.

The Chair has spoken this morning of a large proportion of prisoners being in prison entirely because of or related to their cognitive disability and the questions that that gives rise to. Professor Baldry's evidence, like that of some of the other witnesses, will also shine a light on this. There is actually an evidential basis for the argument that in addition to obvious social benefits, there is economic benefit to the community in investing in provision of supports to people with cognitive disability. That is, such supports not only provide meaningful benefit to the direct recipient but actually provide, can provide an economic benefit to all of society. In a sense, putting it crudely, it's a case of spending money to save money.

You will hear from Dr Piers Gooding, who is a Research Fellow with the Melbourne Social Equity Institute. His evidence is relevant both to criminalisation and the topic of indefinite detention. He will discuss different legal frameworks that exist across Australian jurisdictions that give rise to a risk of indefinite detention for people with cognitive disability. He will discuss the potential use of disability justice support persons to assist persons with cognitive disabilities in their interactions with the criminal justice system, and he will discuss the long-term cost benefits of providing intensive support for people with cognitive disability at an early stage of their involvement in the criminal justice system to improve their access to justice and to reduce the risk of their indefinite detention.

A schematic will come up on the screen in a moment and Dr Gooding will speak to this in more detail in the course of his evidence, but it shows that the cost of different

hypothetical pathways through the criminal justice system, based on a person with disability in the study that he did, and his findings show a vast, vast differential in the expenditure for where there has been early diversion up until and including the circumstance of full blown criminal justice process which you will see there is up near the 400k mark.

Professor Patrick Keyzer is a Professor of Law and Public Policy, and the Dean of Law School at Australian Catholic University. He was also involved in making complaints to the United Nations in 2017 regarding one of the case studies we will explore in this hearing, Winmartie's case, as well as representing him in other court hearings.

He will discuss some of the challenges faced by First Nations people with cognitive disability who come into contact with the criminal system. He will describe the systemic changes that he suggests can be made to reduce the disproportionately negative effect of the criminal justice people on First Nations people with cognitive disability.

Dr Kathy Ellem is a Senior Lecturer in the Faculty of Health and Behavioural Sciences at the University of Queensland. Her evidence will explain some of the reasons for the over-representation of people with cognitive disability in a criminal justice system.

Through the use of individual case studies, Dr Ellem will illustrate the shortcomings of the supports available for people with cognitive disability who are at risk of becoming enmeshed in the criminal justice system. A key part of her evidence will relate to her 2019 research on the need for relation-based supports.

You will hear by way of a panel by way of four advocates: Lewis Shillito, Director of Criminal Law, Aboriginal, & Torres Strait Islander Legal Service here in Queensland; Cheryl Axleby, former Co-Chair of the National Aboriginal & Torres Strait Islander Legal Services; Tanya Wolff, Principal and Director of Legal Services of First Step, President of the Law Institute of Victoria and Sessional Legal Member of the Mental Health Review Tribunal; and James Simpson, Senior Advocate, Council for Intellectual Disability. Collectively, that panel has broad experience about common barriers experienced by people with disability in the criminal justice system.

The panel will speak to the proposition that people with cognitive disability, particularly First Nations people, are over-represented in the system, including on remand. Their evidence supports the notion that criminalisation of disability may result in a process of cycling; when people with disability become caught in a cycle of social exclusion and criminalisation, resulting in their incarceration and re-incarceration in the criminal justice system, rather than being supported through community-based programs.

They will speak to other services which can assist people with cognitive disability

and breaking through that cycle. They will speak of their views as to the need of appropriate supports to be in place in addition to legal representation to assist people with disability to navigate the criminal justice system and to connect with supports which might reduce the likelihood of re-offending and, at best, ending that cycle of being in and out of the system.

I will say something now about lived experience witnesses we will hear from this week and next week. They will tell us of their stories of past offending and incarceration and share with us what and who assisted them to break the cycle.

Mr Justen Thomas is a 42-year old Aboriginal man. He has epilepsy and intellectual disability. He will give evidence of his experience with the criminal justice system and the assistance he received from the Intellectual Disability Rights Service and another community legal centre to enable him to make a fresh start.

Since that time, he has worked as an advocate with agencies such as the Council for Intellectual Disability and the Intellectual Disability Rights Service. He also addressed the United Nations in 2019. He will speak about the changes that he believes should be made to better support people.

I've spoken already about Dorothy Armstrong. She is a 49-year old woman with an acquired brain injury. She will be giving evidence in a panel discussion with Mr Michael Haralambous. Her first experience with police was when she was 17. As I've observed, she had experience in the system as an offender and as a victim.

She went to prison for 16 months when she was 37 years old. It was the first and the last time she went to prison. She was diagnosed with an acquired brain injury which was shortly before she was incarcerated in a maximum security prison, and after her release on parole, she was homeless and without support. Gradually, she found her way, though. The first step was finding accommodation provided under a community/government initiative.

In 2015 she became involved with the Centre for Innovative Justice at RMIT University after having been invited to participate in the "Justice User Group". That group comprised people with acquired brain injuries who had experience with the criminal justice system. She was the first woman to participate in that program, and the project resulted in a report called "Recognition, respect and support: Enabling justice for people with an acquired brain injury".

Ms Armstrong is now employed by the CIJ as an adviser and is a self-advocate. Hers is a success story.

As I've said, she will be giving evidence together with Mr Haralambous, who is an advocate and senior adviser at the Centre of Innovative Justice. They will together give evidence about the Centre's work which includes research on therapeutic jurisprudence, restorative justice, victim services, family violence, women's incarceration, disability in a criminal justice system as well as the application of a

human-centred design to legal services, legal issues and processes.

I mentioned we will be running a case study about a diversionary program. This is the CIDP. It was a pilot program run by IDRS between 2017 and 2020 and it was funded by the New South Wales Government. The objective of the CIDP was to increase the diversion of people with a cognitive impairment charged with low-level offences away from the criminal justice system under section 32 of the *Mental Health (Forensic Provisions) Act 1990* or through to other non-custodial sentences. Now, this was primarily achieved by providing dedicated support people, who would arrange and coordinate expert reports to support applications for diversion orders, apply for additional NDIS funding, and assist with coordinating services, and help legal representatives to provide accessible advice or representation.

The NSW Government decided not to continue funding beyond 30 June 2020.

That program, which acted in a holistic way to provide support and assistance to people with cognitive impairment before the court, was felt to be highly effective.

In this case study we will explore issues that caused people with cognitive disability to become enmeshed in the criminal justice system, including specific shortcomings of the criminal justice system and the barriers it creates; the issue of disability programs being "trialled", and trialled on a short-term basis; how a program's value is assessed. And it's considered that as the CIDP funding ended only recently, this provides an opportunity to explore the specific reasons for the decision to cease funding with the individuals involved, including their reliance on cost-benefit analyses, in respect of which the Royal Commission will also have the evidence of actuarial consultant John Walsh, who has expertise in cost assessment and cost-benefit analysis.

His evidence will assist the Royal Commission to understand the limitations of such assessment, depending on the scope of terms of reference and available data.

In determining benefits for cost-benefit analysis, particular regard must be had to inputs which accurately take into account the effect of the program under review for people with disability. Such considerations are not always easily quantified but there are ways they can be factor into cost benefit calculations.

Mr Michael Coutts-Trotter, Secretary of the NSW Department of Communities and Justice, will provide information about the CIDP, including: the reasons for its introduction as a pilot program in 2017; the success or otherwise of its implementation; its operation at pilot sites in Penrith and Gosford; and the rationale behind the Department's decision to cease the funding in 2020.

Chair, I might go a little bit longer and then take the morning break, if that's convenient, and finish the opening after the morning break? I appreciate that people will be wanting a break fairly shortly.

CHAIR: Yes. Thank you. What we might do, just before the break, I think is take appearances from parties that have leave to appear, we will then take a break. I will first take appearances from those in the Brisbane hearing room, starting with the Commonwealth of Australia.

DR MELLIFONT: Thank you, would you like to take those appearances now?

CHAIR: Yes, please.

MR DIGHTON: If it please the Commissioners, my name is Dighton, appearing for the Commonwealth instructed by Gilbert & Tobin.

CHAIR: Thank you, Mr Dighton. I think also the State of Queensland has representatives in the Brisbane hearing room.

MS McMILLAN: Yes, Chair, my name is McMillan, initials KA, Queen's Counsel, and I appear with Ms Clohessy, instructed by Crown Law for Queensland.

CHAIR: Thank you, Ms McMillan.

Can I now take the appearance for the State of New South Wales?

MS FURNESS: Thank you, Commission. My name is Gail Furness, I appear on behalf of the State of New South Wales instructed by Crown Solicitors Office.

CHAIR: Thank you, Ms Furness. We have an appearance, I think, from the State of Victoria? Or possibly not.

MS BEDFORD: Thank you, Commissioner. My name is Rebecca Bedford and I appear for the State of Victoria.

CHAIR: Thank you, Ms Bedford.

And the Northern Territory, I think, is represented by Counsel?

Is there an appearance for the Northern Territory today? If not, we will defer the taking of that appearance until later in the hearing. And, finally, I think the NSW Public Guardian is represented at the hearing.

MS NEEDHAM: Yes, may it please you, Chair and Commissioners. My name is Needham, N-E-E-D-H-A-M, and I appear with leave for the New South Wales Public Guardian.

CHAIR: Thank you very much, Ms Needham.

I think that is the totality of parties that have leave to appear at this hearing. If any other party seeks leave to appear at a later stage, we will deal with that. We will now

adjourn and resume at 12 o'clock Sydney time, which will be 11 o'clock in Queensland.

ADJOURNED **[11.42 AM]**

RESUMED **[11.59 AM]**

CHAIR: Yes, Dr Mellifont.

DR MELLIFONT: Thank you. In this hearing you will also hear from Mr Baker who is an advocate with IDRS and Ms Janene Cootes AM, Executive Officer of IDRS, which is the Intellectual Disability Rights Service, who will speak to what the CIDP was able to accomplish, as well as the challenges of short-term and uncertain funding.

Mr Baker speaks of one of his clients having cycled in and out of custody for 10 years. He was facing five criminal charges and would have most likely ordinarily have received a term of imprisonment. He had never before been identified by the criminal justice system as having a cognitive impairment. But CIDP worked with him and a diagnostic report was used to obtain a successful application to the NDIS to get the Disability Support Pension, to get stable accommodation through Housing NSW and to get a diversionary order, thereby avoiding a very likely custodial sentence.

Ms Cootes also recounts a poignant example of the impact of the program. She speaks of having worked with a 19-year old Aboriginal man with Autism Spectrum Disorder. The Magistrate asked JAS to support him, another support program within the community. Now, that man had had frequent criminal justice contact from the age of 14 and was on remand in an adult Correctional Centre. Now, the Justice Advocacy Service ascertained that he was an NDIS participant but he didn't know what NDIS was, and he had never used any funds or services. So they brought his case to the attention of prison welfare staff who involved the NDIS Justice Liaison Officer to address this.

Now, his criminal history made a custodial sentence likely, but they were successful in getting a diversionary order, and that was the first time he had received a section 32 order from the court.

You will hear from Taylor Budin and Geoffrey Thomas who will tell you what a difference the CIDP has made to their lives, and their belief about how important a program like CIDP is.

Mr Geoffrey Thomas, unrelated to Mr Justen Thomas, so far as we know, is a 59-year old First Nations man with a cognitive impairment, depression, anxiety,

Post-Traumatic Stress Disorder and Attention Deficit Disorder. You will hear his pre-recorded evidence. Across four decades he spent time in juvenile detention, adult prisons, mental health hospitals on both a voluntary and involuntary basis, and was last in prison in 2003. Despite this, he has been able to qualify and work as a nurse. And while he was in prison, he advocated for the rights of others.

In 2019 he was charged with offences. Through the CIDP he was assisted. An assessment by a neuropsychologist was obtained that confirmed his cognitive impairment. That formal assessment helped him with his criminal charges and with his NDIS support. With assistance, the initially serious charges were negotiated to a lesser charge. A Good Behaviour Bond was imposed. And he has also had the support of Stride Mental Health. Mr Thomas is playing a vital role in our community and improving his education. We will show an extract of Mr Geoffrey Thomas. He explains how his experience of going to court with the help of CIDP was very different to his past experiences.

[VIDEORECORDING PLAYED]

MR THOMAS: .... it was a whole different --- it was an absolute totally different perspective because people communicated from the minute we walked in the door, from my support worker to the solicitor, from the solicitor to the prosecution, from the prosecution to the Magistrate. So everyone knew where we were at.

INTERVIEWER: Yeah.

MR THOMAS: Instead of they always knew and I was just sitting in the chair.

INTERVIEWER: And you were sitting there. I think in your statement you talk about Michael --- at the end of that court case, the outcome on the day, obviously, you were so stressed, but words were being spoken in the court that were just not computing with you and, at the end of the day, it was a good outcome and you said essentially to Michael, "What just happened?", and he explained to you what had happened.

MR THOMAS: Yeah.

INTERVIEWER: Whereas in the past, presumably, you got to the end of the day and if you were experiencing those sorts of experiences because of your disability, you would have either walked out of the court or you got taken back downstairs and out in a truck and you worked it out when you got back to prison.

MR THOMAS: Yeah.

INTERVIEWER: So is that how fundamental that support in court through CIDP has been?

MR THOMAS: Yeah. It went from --- like, hearing what the Magistrate had to say and being taken down and then seeing a solicitor for two minutes between bails going this is what just happened.

INTERVIEWER: Yeah.

MR THOMAS: Not understanding any of it and getting on the truck and then, like, reading whatever you got and going, "How do I work this out?", and then realising it doesn't matter if you want to appeal because you'll spend more time waiting on remand before that so you just cop it anyway."

INTERVIEWER: Yeah, you cop it.

MR THOMAS: So the system is broken in that way, too. But on this day --- I think I wasn't --- I was overawed. I was flabbergasted. I was there --- I had witnessed something that was a good thing that had happened, involving several groups of people that were funded by the government. Now, I believe that that funding should be not only kept on board, but most probably it should --- further funding, they should look at that even harder because it will save money in the long run.

INTERVIEWER: Yeah.

MR THOMAS: Because if I had have got up and walked out ---

INTERVIEWER: Yeah.

MR THOMAS: --- then you've got police officers who will perform --- you've got ---

INTERVIEWER: A bench warrant.

MR THOMAS: You've got the potential for a violent confrontation with them because they've tracked you down, then I end up in hospital; I'm on remand. It costs like $150,000 a year to keep someone in prison so it's not cheap.

INTERVIEWER: So the CIDP support, the funding for that, much less than all of that ---

MR THOMAS: Yeah.

INTERVIEWER: Kept you stable ---

MR THOMAS: Stable and on board and focused for the period of time that I had to go to court.

INTERVIEWER: Yeah.

MR THOMAS: --- and for the day-long episodes that we had to go through.

INTERVIEWER: And it got to a neuropsychological report which was used in court, is that right, as well?

MR THOMAS: That was a benefit --- it was further useful for NDIS.

[VIDEORECORDING ENDED]

DR MELLIFONT: We thank Mr Fogarty, of Counsel, for his assistance in that pre-record.

Ms Taylor Budin is a 26-year old woman with autism. She has also given pre-recorded evidence. From a young age she wanted to work in disability services. At age 17, she commenced working and training in that area. At age 20 she was convicted of an offence of violence. Although sentenced only to a good behaviour bond, the result was that she lost her job in disability services. She felt that her life fell apart and has conveyed to the Royal Commission that she is not proud of her actions during this time in her life. She was ultimately held in prison on remand for three months. That was her first and last time in prison.

CIDP, working with her lawyer, helped arrange for suitable housing and documentation which allowed her to obtain bail, and whilst on bail, assessments were arranged, they were able to be used for both the criminal matter and to get NDIS support. And that included her being formally diagnosed with autism for the very first time. The steps that Ms Budin took with CIDP and the IDRS support allowed her to receive a Community Corrections order rather than being returned to prison.

She has been working within IDRS since 2019 as part of the Making Rights Real Advisory Group and she has also worked with NSW government agencies to give her experience, to share her experience as a person with disability in criminal justice system.

In this extract you will hear her speak of the belief of an ongoing need for a program like the CIDP.

[VIDEORECORDING PLAYED]

MS BUDIN: Give us funding, please. Well, we need something in the court systems because like where I can of --- sorry, just 'cause I'm answering. What I can't comprehend is why you get rid of something that was going so well.

INTERVIEWER: Yeah.

MS BUDIN: Because if I was in the prison system still, I wouldn't have this support now and I'd be sitting there screwed.

INTERVIEWER: Yeah.

MS BUDIN: And that worries me and that worries --- because how many other people are still in there that needs to be on the program?

INTERVIEWER: Yeah.

MS BUDIN: They could be out, not in.

INTERVIEWER: And they just don't know about it or the system just ---

MS BUDIN: And they just don't know about it, or it just doesn't exist. So, really, I really would like to get something back into the system.

INTERVIEWER: Yes.

MS BUDIN: It's not fair. There's a lot of people in there.

INTERVIEWER: Who just don't have the support.

MS BUDIN: Who just don't have the support or the advocacy.

INTERVIEWER: All right.

MS BUDIN: They're just getting pushed under the rug, it's another number.

[VIDEORECORDING ENDED]

DR MELLIFONT: That's just a short extract of Ms Budin's pre-record which will be played later in this hearing. As already noted, the funding for CIDP was not extended beyond 1 July 2020 and we will be exploring that in the course of this hearing.

Can I hand now, please, to Ms Crawford, of Counsel, to finish the delivery of the opening.

MS CRAWFORD: As we've already noted, funding for the CIPD was not extended beyond 1 July 2020. The next part of the opening involves indefinite detention. This hearing will consider the cases of two people who have been held in indefinite

detention-type arrangements for a very long time, one from NSW and one from the Northern Territory. Both involve First Nations people with disability.

Melanie and Winmartie were both known to children's services from an early age as children in need of care and protection. Both entered the criminal justice system as teenagers and both have been detained indefinitely since being found unfit to plead to charges of manslaughter.

Both case studies were brought to the attention of the Commission by their appointed guardians. The main policy areas of interest to the two case studies are cultural safety and forensic disability units; behaviour management and the use of restrictive practices, specifically seclusion and chemical restraint; access to meaningful activities or opportunities to build skills in forensic units --- greater emphasis should be based on developing a patient's functional skill to support their reintegration into the community; decision-making and the voice of the person with the disability will have some focus; culturally appropriate accommodation and forensic units, with connection to country; the role of guardians and family in supporting people in these environments; maintaining connection and communication between the forensic units and family and guardians; as well as review mechanisms for treatments that are instituted; and transition planning and the challenges that arise when considering care in the community.

We will be examining what caused them to be placed in each setting, the conditions within which each of them has been held and is held, the types of restrictive practices that are employed in their day-to-day management, the objectives of treatment, risk assessment and risk management, transition planning, barriers to community living, the role of the guardian and what review mechanisms are in place for each of them.

These cases will be confronting for many. The two individuals have engaged in seriously violent behaviour from time-to-time. Many will be unsympathetic to their plight. Others will be open to trying to understand how each came to be where they are and want to know how we as a society can do better for them. A non-publication order has been made in relation to Melanie, her biological mother, her former foster mother and her victim.

A non-publication order has been made in relation to Winmartie.

The cases of Melanie and Winmartie are unfortunately not isolated cases. The evidence this Commission will hear includes concerns expressed by experts and advocates that people are being held within prisons or forensic facilities in seclusion for extensive periods and in unsatisfactory conditions.

Another case that the Commission has considered in the preparation for this hearing is that of a person in Queensland who I shall refer to as A. A, now aged 33, has had various diagnoses, including the chromosome disorder 47,XYY. This disorder is said to occur in approximately 1 in 1000 men who are usually unaware of it.

A has also been diagnosed with an Acquired Brain Injury, Autism, oppositional disorder and his IQ has been recorded in 1999 at 40. A has displayed very aggressive and damaging behaviour over his life and has high criminogenic support needs.

On 24 September 2012, he was found by the Mental Health Court of Queensland to be permanently unfit for trial and was transferred to the Forensic Disability Service in Wacol. He had previously been on a forensic order which had been revoked by the Queensland Mental Health Tribunal in 2010 with alternate procedures being put in place by the Adult Guardian.

The Forensic Disability Service is a purpose-built medium secure residential specialist rehabilitation facility. It is designed to provide support and care for a small number of individuals with intellectual or cognitive disability with complex needs who have been found not responsible for serious criminal offences because of their disability, and who are subject to forensic orders under the *Mental Health Act*, and who are detained for treatment or care in order to protect the community from the risk of harm considered to be posed by them. These individuals are subject to forensic orders under the Queensland *Mental Health Act*.

In March 2013, a review of A's time at the Forensic Disability Service was compiled for the Mental Health Review Tribunal. That review stated that A's time had had no enduring improvement or reduction in his assaultive behaviour. An assessment in August of 2014 indicated that he was a high risk of future serious offending.

On occasion, police have been requested to attend the Forensic Disability Unit to assist with situations involving A when his behaviours presented an imminent or serious risk to the safety of staff or posed a self-harm or suicide risk to A himself, when that risk could not be managed without additional assistance.

On all of those occasions, it was police who determined the appropriate response. They would sometimes attend with police dogs as a method of de-escalation of A's behaviour. This includes a specific occasion in September of 2018 when a police dog physically entered A's seclusion unit. It is understood that this practice has now stopped.

The Queensland Ombudsman produced a report in August 2019 and found that A had been subjected to continuous seclusion for more than six years. That is, the investigation found that he had been in seclusion for 99 per cent of the time between his admission in September 2012 and 18 June 2018.

The physical circumstances of his seclusion were: a custom-built seclusion area with closed caption television monitoring --- closed circuit television monitoring --- a bedroom, a shower and toilet; a small concrete undercover yard. He communicated with staff through a servery window, described as a narrow horizontal slot through which meals were passed to him.

The circumstances were held to be severe and concerning and gave rise to serious human rights concerns including indicators of systemic abuse.

The Queensland Ombudsman found that organisational culture towards the use of restraints and seclusion can influence whether or not seclusion is used and that the use of seclusion can have traumatising and other harmful effects both on the person secluded but also on the staff.

The Ombudsman considered a number of organisational factors may have influenced the use of seclusion for A. Specifically, the Forensic Disability Service did not question the use of seclusion as necessary. They considered seclusion to be legitimate and effective. The FDS staff did not have good quality behaviour support plans that were well adopted and implemented. And they had normalised permanent seclusion, for example, by using the name "House 3" and "A's room" rather than accurately describing the space as a seclusion area.

A number of factors suggested also that there had been considerable organisational cost associated with the use of seclusion for A, including financial costs, WorkCover claims, absenteeism, workplace-related volatility and staff turnover.

Overarching principles of human rights promoting rehabilitation, meeting individual needs and goals, maintaining supportive relationships and community participation, and empowering a person to be involved in decision-making and exercising their rights are all principles that apply to the administration of the *Forensic Disability Act*. Those principles were found by the Ombudsman not to have been promoted or applied in the seclusion of A at the Forensic Disability Service.

Since this report, there have been developments and we are advised that most residents have now been able to proceed through the facility and transition to appropriate accommodation in the community.

The 2018-2019 Annual Report of the Director of Forensic Disability in Queensland included a pathways analysis of the enablers and barriers for the Forensic Disability Service clients who had transitioned from the service.

In the hearing we will hear from Professor James Ogloff. Professor Ogloff is a clinical and forensic psychologist who has worked in clinical and forensic psychology in a variety of settings for more than 35 years and published extensively in these areas. Professor Ogloff will speak to the general issues experienced across jurisdictions with the management and treatment of individuals with disability and challenging behaviours.

Professor Ogloff will speak to the case studies as being at the extreme end of the spectrum but identifies their usefulness to this Commission as illustrating issues for individuals at that end of the forensic spectrum.

Professor Ogloff will speak to the importance of early identification of disability, risk

assessment and risk management, and a balancing of rights as between the individual patient and the protection of staff and the broader community. He will speak to the perceptions of dangerousness and the impact that such perceptions have on staff. Professor Ogloff will also identify forensic disability expertise and the need for a qualified and experienced workforce. Professor Ogloff will address transition planning and barriers, and options available to forensic disability patients, including the service provider of last resort issue as between the NDIS and individual states and territories.

We turn now to the case study of Melanie. Melanie is a 38-year old First Nations woman who is currently detained as an involuntary civil patient at the Forensic Hospital in NSW. Melanie has received varying diagnoses over the course of her life but is presently described as having an intellectual disability, borderline personality disorder and extreme self-harm behaviour on a background of severe childhood trauma. Melanie was known to the Department of Child Safety since April 1986 and was taken into state care at the age of 5 after clear indications of childhood sexual abuse.

Documentary records indicate that Melanie experienced severe and prolonged childhood trauma including sexual and emotional abuse and neglect, along with multiple placement changes, including living in a residential institution between the ages of 7 and 10.

Melanie was also prescribed up to 50 milligrams of anti-psychotic medication twice daily, at the ages of 7 and 8.

At the ages of 15 and 17, Melanie engaged in two very serious acts of violence. The second of these acts took place inside a juvenile detention centre where Melanie was held. During an activity she perpetrated an act of violence that resulted in the tragic death of a staff member. Soon afterwards Melanie was transferred to an adult prison. She was found unfit to be tried in relation to two acts.

Notably, the State of NSW entered a plea of guilty to a breach of an occupational health and safety duty insofar as it was acknowledged that Melanie should not have been permitted into that activity and to gain access to the weapon that she used in committing the manslaughter.

After a special hearing, the Supreme Court found Melanie had committed the offence of malicious wounding and the offence of manslaughter, and terms of 3 years and 10 years were imposed. She has now been detained for over 20 years.

At the relevant time, under NSW law, a person found unfit to plead could not be detained beyond their limiting term. The legislation now permits extensions of the limiting term by an order of the Supreme Court. A person may be released or be subject to less stringent custody before the expiration of their limiting term by order of the Mental Health Review Tribunal.

Melanie was detained in prison until 2011, at which time she was transferred to the Long Bay Forensic Hospital. Throughout her incarceration, Melanie has spent time in seclusion as she was considered either a high risk or extreme high risk inmate due to her varying but often high levels of violent and self-harming behaviour.

Following the expiration of her limiting term in 2012, Melanie has continued to be detained at the Forensic Hospital as a civil patient as it was considered that she required containment and it was determined that there was no alternative location that could adequately meet her needs. Melanie's mental state and behaviour deteriorated over the course of 2012 to 2014 and she was moved to a special seclusion area within the Forensic Hospital.

She remained in that seclusion environment almost constantly for seven years, sometimes spending more than 23 hours a day in her cell. This regime of seclusion ended on 13 November 2020.

In 2006 a forensic psychiatrist described Melanie's conditions as "Dickensian". In 2017, that is more than 10 years later, the Mental Health Review Tribunal visited Melanie's rooms and said that the “rooms were filthy and degrading; the area was substandard and clearly not conducive to any form of recovery”.

Melanie's treating psychiatrist has documented his concerns, for example in 2018, that Melanie's “placement and restrictive practices are not clinically indicated and have not been sanctioned” by him and that the “lack of time out of seclusion [was] causing iatrogenic harm”.

While Melanie had sporadic contact with her biological and foster family when incarcerated, her personal visits at the Forensic Hospital are limited to that from a former patient.

In 2019, the Integrated Service Response, an initiative by NSW Health for people with multiple and complex needs, was working towards identifying appropriately secure and supportive accommodation in the community for Melanie. From mid-2020, a governance group in respect of Melanie was established.

Melanie's story is a distressing one. It is troubling indeed that a woman is held in such an environment in Australia, in 2020, with little apparent hope of improvement and release. It is more concerning that these conditions have been at times presented and promoted as being therapeutic.

Witnesses who will be called to tell and explore Melanie's story in this hearing are first, and most importantly, Melanie herself. You will hear an audio recording of a statement prepared by Melanie, facilitated by the NSW Public Guardian.

In her own words, Melanie says that she “was in seclusion for nearly eight years”. These are her words, she says:

... not one day of my life that I didn't want to get out and have a life and be happy again on the ward ...

In February 2020, in a letter to the Mental Health Review Tribunal, Melanie wrote:

I deserve a chance on the outside, no one will give me a go and I don't understand why ... I have days where I get so frustrated that I don't see hope or light and I try and hurt myself or suicide because I am so frustrated ... I don't understand .. why I cannot go back to the ward because it's too complicated.

The Commission will hear evidence today from Megan Osborne. Megan Osborne is the NSW Public Guardian and has been in that role since 2019. The NSW Public Guardian has been the legal guardian of Melanie since 2011. Ms Osborne will describe the challenges that the Public Guardian has faced in improving Melanie's conditions over the years. She will speak to the current attempts to secure NDIA funding for Melanie to be supported appropriately to live in the community.

We will also hear evidence from a panel, Helen Seares and Todd Davis, both from the Mental Health Advocacy Service at Legal Aid in NSW. Ms Seares has been Melanie's legal representative for several years, and she and Mr Davis will speak to Melanie's circumstances and the broader systemic issues that they have observed, including the fact that Melanie's story is not an isolated case.

We will hear evidence this afternoon in-camera from Melanie's consultant psychiatrist, Dr Riordan. Taking a trauma and informed approach, his evidence will not be heard publicly today.

Tomorrow we will hear from Brett Holmes, a representative of the NSW Nurses and Midwives Association. Mr Holmes will speak to the tension between workplace health and safety considerations in Melanie's case. He considers a reduction in the use of seclusion is possible with appropriate resourcing, especially the funding of suitable environments with adequate numbers of appropriately trained staff.

He considers that many facilities are poorly designed and inadequately staffed. Training, education and support for staff within forensic units will be taken from him, and it will be explored further in his oral evidence.

Mr Holmes considers the areas where improvements can be made are areas of enforceable staffing ratios and an increase in skilled staff to address the staffing ratios and address the risks present in what he describes as a volatile high-risk environment.

Dr David Manchester is a clinical psychologist who was engaged by NSW Health in 2019 to provide a report about Melanie's support needs. Dr Manchester will speak to his findings and to Melanie's individual capacity to learn new things. He will address the impact of long-term seclusion and he will discuss a proposed way forward balancing safety concerns with best therapeutic practice.

Dr Manchester's thesis includes that there is a need for trained positive behaviour support staff in forensic units, including culturally competent staff, as a core team to work with those patients who present the most challenging behaviours and disabilities.

These staff aim to reduce the use of long-term seclusion and engage with patients to teach new skills which assist them to moderate their behavioural distress in response to identified triggers in a variety of settings.

Ultimately his evidence is that it is clinical leadership that builds trust in patients and staff. It is clinical leadership that effects lasting change, and lasting change takes time to achieve with consistent effort in order to become embedded within an organisation.

Dr Ellis is the Forensic Psychiatrist, Clinical Director and Medical Superintendent of Justice Health and Forensic Mental Health Network in NSW. Mr Gary Forrest is the Chief Executive of that network. The evidence of Dr Ellis and Mr Forrest will include the lengthy period of time that Melanie had been in seclusion and the more recent changes to her accommodation and treatment.

The second of our in-depth case studies involves a 30-year old First Nations man, Winmartie. Winmartie is currently detained under a custodial supervision order at the Alice Springs Secure Care Facility. Winmartie experienced severe childhood epilepsy and continues to have many seizures. He also has been diagnosed with an acquired brain injury and an intellectual disability. There is some artwork of Winmartie's coming on the screen now.

Like Melanie, Winmartie experienced significant childhood abuse and trauma, including isolation and bullying by members of his community. For example, Winmartie was referred to as "Mad Winmartie" when he was young, and on one occasion a group of adults and children threw rocks at him when he himself was just a child.

At the age of 16, Winmartie fatally stabbed his uncle, who at that time was his sole carer. That offence took place in their own home. Winmartie and his uncle were the only people present at the time, and his uncle's body was not found until the following day. Winmartie was initially held in juvenile detention and transferred to adult custody approximately two years later after he had turned 18.

On 17 November 2009, the Northern Territory Supreme Court found that Winmartie was not fit to plead. At the conclusion of a special hearing, a jury returned a qualified verdict of guilty of manslaughter by reason of diminished responsibility and an order was made by the Supreme Court that he be subject to a custodial supervision order.

Unlike Melanie, Winmartie's custodial order was for an indefinite period of time, as

is permitted by Northern Territory law. The Supreme Court ordered annual reports regarding the treatment and support of Winmartie's mental impairment, and a mandatory order itself no later than 8 years and 11 months from the date of the order.

Winmartie was incarcerated in an adult prison until 2018 at which time he was transferred to the Alice Springs Secure Care Facility.

In 2014 the Australian Human Rights Commissioner released a report that described Winmartie as having been "subject to the most severe treatment while in prison, including frequent use of physical, mechanical and chemical restraints, seclusion, and shackles when outside his cell."

While in the Secure Care Facility, Winmartie has had increased access to his family and community in Titjikala, which is approximately 120 kilometres south of Alice Springs. This has been generally positive. However, his guardians, advocate Patrick McGee and elder Aunty Margret Campbell, are concerned that Winmartie continues to be over-medicated and isolated, particularly during the COVID-19 pandemic and that the arrangements for him at the Secure Care Facility are not culturally appropriate or therapeutic. They wish for Winmartie to have supported accommodation on the edge of Alice Springs where they would be able to visit him and where he could access medical treatments when they are needed.

Winmartie's voice will be heard by a visual montage of Winmartie on country and by a number of photographs of Winmartie's artwork of which he is very proud.

The Commission will hear evidence from Aunty Margret Campbell who, as I've said, is one of Winmartie's guardians, and Lorelle Stoeckel. Aunty Margret and Lorelle will give their evidence together.

Aunty Margret Campbell is an elder in Winmartie's community and one of his legal guardians. Aunty Margret will give her evidence in her first language, which is Pitjantjatara. Aunty will speak to the importance and benefits of connection to country, family and community for First Nations people and specifically for Winmartie. She will also describe how the family has successfully managed Winmartie when he visits ancestral lands. Aunty Margret will tell the Commission about Winmartie's lack of access to professional help when he was young and the difficulties that Aunty Margret encountered when she sought information about his arrest and when she attempted to visit him.

She will speak to her concerns about the lack of cultural competency and safety exercised by the staff at the Forensic Disability Unit when dealing with Winmartie. She will explain what the indefinite nature of Winmartie's detention and barriers to his eventual pathway out of the unit mean to the family and to the community.

Lorelle Stoeckel is Aunty Margret's bush daughter. Winmartie stays with Lorelle and Aunty Margret when he returns home to the community. Her evidence will focus on the limited consultation that Northern Territory agencies have provided

Aunty Margret regarding Winmartie's care and the concerns of both women regarding the quality of Winmartie's care, including but not limited to cultural inappropriateness and the misuse of restrictive practices.

Lorelle is Winmartie's NDIS co-ordinator in Alice Springs. She will speak to his level of support and what service supports have been engaged for Winmartie.

She will tell of the current reduction with the NDIS support package, the requirement for a transition plan for Winmartie, and the challenges in engaging with the Forensic Disability Unit will be described.

We will also hear from Winmartie's other advocate and guardian, Patrick McGee. Patrick McGee is an advocate in the disability sector. He has known Winmartie and his family for over 20 years. His evidence will address the limited consultation by Northern Territory agencies concerning Winmartie's accommodation, treatment and care arrangements.

In this case study, we will also hear from Mr Tom Langcake, the Acting Direct Services Manager at the Forensic Disability Unit, about a variety of matters concerning the manner of detention of Winmartie, his treatment and issues relating to transition.

We will also hear from Professor Catherine Stoddart who held the position of Chief Executive Department of Health in the Northern Territory until January of this year, and Cecelia Gore, who is the Senior Director, Mental Health Alcohol and Other Drugs Branch, Health System, Policy and Strategy at the Department of Health regarding systemic issues within the Northern Territory.

Some of the evidence in this hearing speaks of people's experiences in trying to access services from States or through the NDIS, and the sense by some of responsibility being shuffled between the two.

We note that there will be a second part of this hearing, at a later time, which will enable the States and the NDIA to be heard on these issues.

To realise genuinely inclusive participation in society for people with disability, factors which contribute to the over-representation of people with disability need to be identified and addressed.

Attitude seems to be a logical place to start: the need to create a culture where it is recognised that there is no dissonance between the human rights of people with disability to receive support and treatment and the safety of the community. These are in fact complementary and supportive of each other.

It is expected that the evidence in this hearing to illuminate this truth and begin to explore ways in which we can improve. We start this hearing's journey off with the case of Melanie, the voice of Melanie.

CHAIR: Yes, thank you.

Dr Mellifont, can you now introduce the next part of the hearing?

DR MELLIFONT: Yes, I will. Thank you, Chair.

I referred before to there being non-publication orders in respect of Melanie and in respect of Winmartie. May I say that what those non-publications do is to prevent the publication of any name or information that will or is likely to reveal the identity of Melanie, the victim of the manslaughter, Melanie's mother, Melanie's former foster father and Winmartie.

We will next hear directly from Melanie through the pre-recorded video. Commissioners, you will find a copy of Melanie's pre-recorded audio statement in Tender Bundle A, Tab 1. I ask to tender this into evidence, that it be marked exhibit 11.1.1. I ask the transcript of the pre-recorded audio statement of Melanie at Tab 2 of the same bundle to be marked as exhibit 11.1.2.

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

EXHIBIT #11.1.1 - PRE-RECORDED AUDIO STATEMENT OF "MELANIE"

EXHIBIT #11.1.2 - TRANSCRIPT OF PRE-RECORDED AUDIO STATEMENT OF "MELANIE"

DR MELLIFONT: Might that recording be played.

[VIDEORECORDING PLAYED]

MELANIE: Welcome ladies and gentlemen my name is [REDACTED], I stand before you to hear my case and to get help with you today. Dear Royal Commission um I hereby stand before you today to hear my case and my future and well-being. I have had a bad upbringing but I'm a strong proud
black Aboriginal woman that is there here before you today to come and get help where I need it and fight for my rights.

I stand in a uhh I stayed in a black... African family home. Things didn't go right there with sexual abuse, then I got transferred to, to institutions, one in [BLEEP] and the other in [BLEEP]. They were terrible horrible and brutal they were no place for children. I had to fight to stay alive. I stayed strong even though I was sexually,

physically and psychologically abused until I was fostered out to a white family.

When I was, mmm, with my white family they showed me care, love and kindness. They gave me accommodation, education and everything a child needs. I love them them to this day. I went to two schools the first one was a normal school but I got expelled for fighting with the kids that bullied me I then went to a special school and I enjoyed this. My family then got me... told me I had ... problems with my intellect and I found out I had autism which made everything difficult. I was in and out of institutions at such as juvenile detention centres and that's when things went pa-pear shaped. From [REDACTED] to gaol my self-harm become severe I was in a dark horrible, horrible place in gaol at 16.

Then I came to the forensic hospital and went.... I came, ahh, I... when I was on the ward things ... brightened up it was excellent.
Ladies and gentlemen.... I just wanted to say when I was in seclusion for nearly, when I was in seclusion for 8 years not one day of my life that I didn't want to get out and have a life and be happy again on the ward. But then the kindness of nurses in the forensic hospital finally got me out um after 8 years ... because I showed her a big progress in transition in to my behaviour on in seclusion and out seclusion for the amount of periods of time that I was allowed out for an hour a day and then I transitioned so quickly that um I was amazed and everyone has been amazed now for how long? About a week....

UNKNOWN VOICE: A week.

MELANIE: A week, um even though I broke my foot, huh huh, but I'm still a proud, black Aborigine woman, um that will never change, ummm, I just wanted to say um I thank you for your time and support and your efforts that youse are trying to put in for me, even my guardian she's one in a million, [REDACTED] is one in a million. [REDACTED], [REDACTED], the whole team is one in a million that's raised me from um from when I first came down here till now um they've just been so good to me apart from wh like... like, when I got put in seclusion it was .... I didn't know that I would ever come out of seclusion I was like thinking y'know what I got no light at the end of the tunnel I don't see any light, where is the light? God show me something. I was down and depressed I was lonely I had no one to talk to, I was ... miserable, I needed... I needed hu .... I needed contact, I needed ... it was inhumane to keep someone locked up for that long, in a sec, in a seclusion area right, but I know what I needed to do to get out of there and I've done it and I've gone a long way and I don't know how I've done it. I keep asking um everyone to this day how I've done it and they just go, 'you've changed, your behaviours changed'. ‘One step at a time has gotten you so far now'. So ... yeah. Um ...

That's all I wanted to say is that, I've come a long way in psychology sessions. I thank you my [REDACTED] for that, the psychologist. I thank you [REDACTED] for that, um [REDACTED], um ... yeah so thank you everyone for tryna support me the best way they can and how um yeah I've done it is amazed me. Cause normally I wouldn't say I'm proud of myself ever but everyone is proud of me and so I'm proud

of myself so yeah, thank you guys and I'll always remember this till death do us part. Thank you, bye.

[VIDEORECORDING ENDED]

DR MELLIFONT: The bleeping is about privacy rather than profanity. Can I put some of the comments made by Melanie into chronological context. You heard in the opening that Melanie had been held in a seclusion arrangement for approximately 23 hours a day for many, many years. Now, that video was done on 18 November 2020, some five days after she came out of seclusion, which was five days after she had fractured her foot on the 8 November 2020.

The next witness is Megan Osborne. I call Megan Osborne. She will be giving evidence from a remote location. Whilst that is occurring, that is the technology is being set up, may I observe that you will find a copy of her statement in Tender Bundle C at Tab 1. I ask that be tendered into evidence and it be marked as 11.2.1. You will find copies of attachments to Megan Osborne's statement in Tender Bundle E at Tabs 1 to 3. The tender of those documents will occur at a later date. I'm seeing that Ms Osborne is on screen.

CHAIR: Yes, Ms Osborne's statement will be admitted given the marking you've indicated.

EXHIBIT #11.2.1 - STATEMENT OF MS MEGAN RUTH OSBORNE

Ms Osborne, I understand that you will be taking the affirmation?

MS OSBORNE: Yes.

CHAIR: If you would be good enough to follow the instructions. Thank you very much.

MS MEGAN RUTH OSBORNE, AFFIRMED

CHAIR: Thank you, Ms Osborne, very much for coming to give evidence to the Royal Commission. I will now ask Dr Mellifont to ask you some questions.

EXAMINATION-IN-CHIEF BY DR MELLIFONT

DR MELLIFONT: Thank you. Good morning, Ms Osborne. Could you state your full name, please.

MS OSBORNE: Megan Osborne.

DR MELLIFONT: Did you provide a statement to this Commission dated 8 December 2000?

MS OSBORNE: Yes, that is correct.

DR MELLIFONT: And is that statement true and correct to the best of your ability?

MS OSBORNE: Yes.

CHAIR: I think you mean 2020, actually.

DR MELLIFONT: Yes. Perhaps I feel I've been here that long!

Thank you. You hold the role of NSW Public Guardian, is that correct?

MS OSBORNE: Yes, it is.

DR MELLIFONT: Is that since October 2019?

MS OSBORNE: Yes.

DR MELLIFONT: And you are a member of the Executive Leadership Team at the NSW Trustee & Guardian and have been since 2016?

MS OSBORNE: Yes.

DR MELLIFONT: Right. Can you tell us about the role of the Public Guardian, please?

MS OSBORNE: The role of the Public Guardian is to make decisions for somebody who lacks the ability to be able to make health and lifestyle decisions for themselves, whether that is with or without support. And the Public Guardian is appointed by a court or tribunal as a guardian of last resort. So that means there is nobody else who is willing, or able, or suitable, to carry out that role for the person.

The Guardian is able to make decisions based on the order that is made and dependent on the functions within that order. So, for example, we might be able to, under the order, make a decision about where a person lives.

DR MELLIFONT: Okay. So those orders might be made, for example, by the NSW Supreme Court or the Guardianship Division of the NSW Civil and Administrative Tribunal. Is that correct?

MS OSBORNE: Yes.

DR MELLIFONT: Okay. And in that role as guardian, that can be to help people in the community as their guardians or in the forensic system. Is that correct?

MS OSBORNE: Yes, that is correct, in the mental health system or out living in the community.

DR MELLIFONT: All right. You know the person we are referring to as Melanie?

MS OSBORNE: Yes, I do.

DR MELLIFONT: And is it the case the Public Guardian has been appointed as guardian since 2011 --

MS OSBORNE: Yes.

DR MELLIFONT: --- by the NSW Civil and Administrative Tribunal?

MS OSBORNE: Yes.

DR MELLIFONT: Is that correct? Okay. And as I understand it, under that appointment you have authority to make decisions for Melanie regarding accommodation, advocacy, healthcare, legal, medical and dental-concerned restrictive practices and services. Is that right?

MS OSBORNE: That's correct.

DR MELLIFONT: Okay. Now, within your office there has been a person who has been allocated to work with and for Melanie; is that correct?

MS OSBORNE: Yes. Melanie has an assigned guardian.

DR MELLIFONT: And that has been Ms Smith for quite a period of time?

MS OSBORNE: It has. For quite a length of time.

DR MELLIFONT: Now, in that role, did Ms Smith have contact with and visits to the Long Bay Forensic Hospital?

MS OSBORNE: Yes. So throughout the time that Ms Smith has been involved, there have been visits to the Forensic Hospital to see Melanie, as well as very regular phone calls, more recently because of COVID video calls, and also engagement with the team at the Forensic Hospital as well.

DR MELLIFONT: Okay. And attendance also at mental health review tribunals by

and for Melanie? That's correct?

MS OSBORNE: Yes.

DR MELLIFONT: Yes. To speak for her, to assist her in those processes?

MS OSBORNE: Yes.

DR MELLIFONT: Now, you've set out in your statement that the Public Guardian's understanding of Melanie's personal history is in part derived from various reports and assessments, and your statement does set out quite a detailed summary of that. In short, from your review of the material, she had an extraordinarily troubling childhood subjected to various abuses and neglect. She displayed concerning behaviours including impulsive risk taking, sexual contact with much older men, and violence, and various traumatising events on her over a long period of time. Is that correct?

MS OSBORNE: Yes.

DR MELLIFONT: Okay. Now, we've heard in the opening delivered today, so I won't repeat it, of Melanie's offending and the circumstances in which she came to be given a limiting term which ended in 2011. But I want to focus now on her seclusion which occurred within the Dee Why unit up to 23 hours a day until very recently, and the records recently received by the Commission indicate that that seclusion regime ended on 13 November 2020. That's your current understanding?

MS OSBORNE: Yes, it is.

CHAIR: Dr Mellifont, I wonder if you would mind if I just clarified a couple of points about the chronology.

As I understand the position and, of course, your knowledge will be limited to what you've seen in the record, the stabbing of Melanie's mother took place in January 1999. Do you know why it had been the case there was no guardian appointed at that time or was there a guardian appointed at that time for Melanie?

MS OSBORNE: My assumption why there would be no guardian at that time is she would have been a child so she would not have been at an age where the Public Guardian could have been appointed.

CHAIR: The Public Guardian could have then been appointed, as I understand it from your evidence, as soon as she became an adult?

MS OSBORNE: Yes, if there was a need for that to occur, then yes.

CHAIR: Do you know from your examination of the record why there was apparently no guardian appointed when she did become an adult?

MS OSBORNE: No, I do not know why.

CHAIR: And --- all right, I'll leave, I think, the rest of it to Dr Mellifont, but may I ask whether you're familiar, from the record, with the circumstances that led to the incident, if I describe it that way, that in turn led to Melanie being charged with manslaughter?

MS OSBORNE: I'm aware of it from the reports and documents that the Public Guardian has available to us.

CHAIR: And that would include the proceedings that were taken against the State of NSW for allowing the circumstances to occur that were a necessary pre-condition to the events that did occur ---

MS OSBORNE: Sorry, Commissioner, I don't have that level of detail available to me.

CHAIR: You don't. All right, thank you. Yes, Dr Mellifont.

DR MELLIFONT: All right. I want to come back to the question about the Dee Why unit. You've been there, correct?

MS OSBORNE: Yes, I have.

DR MELLIFONT: And was that last year together with a visit by Royal Commission staff?

MS OSBORNE: Yes, that was in March 2020.

DR MELLIFONT: Okay. Can you describe what it is that you saw and your reaction?

MS OSBORNE: So the visit to the Forensic Hospital was one that included a visit of most of the facility, but in particular visiting where Melanie is kept in seclusion.

At the time it took me a little bit of time to realise that we were going into actually where Melanie was secluded --- my apologies, my lights keep going off --- my understanding when I first entered I thought was going to be an example of one. It dawned on me, once I was in there for a little while, that was in fact where Melanie was living for the majority of the time.

The entrance is straight into what I would describe as a nurse's station where particular equipment can be held for monitoring Melanie, as well as an area where Melanie's things were stored, such as her clothes. That heads straight into a very large steel door that has a window slit at eye level, and as you enter the room there is a moulded bed to the left. There is a small bathroom to the right. The floor

coverings are all hard and there were multiple types of lighting available in that room. It's only a small room and on the visit it was a struggle to fit all of us in the room.

That seclusion room 1 which I will refer to, had a high window that was not at eye level for anybody, and it was actually blacked out so there was no natural light coming into that room. At the opposite end of the room where we had entered was another steel door. Upon opening, that leads into what's known as the courtyard for Melanie. My description and memory of the courtyard is that it is surrounded by a very high brick fence. The flooring is of a rubbery asphalt that you would find in a playground, so that means that the person could not see out of that courtyard.

I would imagine that that courtyard would be very hot in summer as there's no cover, and would be extremely cold in winter, and of course she would get wet if it was raining.

The main purpose of the courtyard, from my understanding is that it's a way for Melanie to use as a thoroughfare between seclusion room 1 and seclusion room 2. And my account is it's not the courtyard that we would normally think of sitting and enjoying some time. It's not a place that I would like to sit for any period of time.

The courtyard then takes you around to another steel door which through you enter into seclusion room 2 which is very similar to seclusion room 1. However, the layout is slightly different and there is a TV mounted high on the wall and encased in some protective safety coverings as well. That room also has another steel door that exits out back into the nurse's station and there is again a window at eye level as well.

Upon entering the nurse's station back out into the main part, there were photos of Melanie at different times. Some of those were at Christmas and I do note that it was pleasing to see Melanie with one of her great loves in life, which is the dog that visits her. There was her schedule and there were her meals for the week as well on there, some information about the management of Melanie.

The feeling that I had visiting those seclusion rooms was one that I will never forget and will never leave me. I know I'm in a very privileged and lucky position and I felt quite anxious and overwhelmed and knew that I wouldn't do very well if I had to spend any period of time in those rooms.

DR MELLIFONT: Your understanding of the seclusion regime was that --- was that Melanie was to remain in seclusion, to be permitted out twice a day for one hour on weekdays and 45 minutes on the weekend. Is that correct?

MS OSBORNE: Yes, that's my understanding.

COMMISSIONER ATKINSON: May I interrupt, Ms Mellifont.

DR MELLIFONT: Thank you, Commissioner.

COMMISSIONER ATKINSON: When you say seclusion, it's actually a nice term for complete isolation?

MS OSBORNE: Yes.

COMMISSIONER ATKINSON: Thank you.

DR MELLIFONT: Now, your statement says that in respect of those hours out of seclusion, it depended on various factors. Do we take from that that she did not always get those twice a day, one-hour on weekdays out of the seclusion arrangement?

MS OSBORNE: Yes, that is correct. The records that the Public Guardian has and continues to --- or continued to ask for throughout the period that Melanie was secluded was some days there was no time out of seclusion at all, and there were many days in succession where there was no period out of seclusion at all.

DR MELLIFONT: Okay. And so far as the Public Guardian has been told or read from records, what are the reasons for not having time out of seclusion?

MS OSBORNE: So some of those varied, and they weren't all of the time all of the same. Sometimes it was due to there weren't enough staff available to meet the staffing ratio to have Melanie come out of seclusion. So that was one factor. Behaviour was another factor. I believe a traffic light system is in place, and if the behaviour didn't match the traffic light system then those periods were either reduced or did not occur.

As well, my understanding and from talking with Melanie's appointed guardian, if the activity that Melanie was due to do whilst out of seclusion was not something that she did not want to do, there was a variance in what was offered. Sometimes staff would offer an alternative and Melanie would take that up and come out of seclusion, but at times Melanie was not offered an alternative and therefore there was no other option and seclusion was left.

DR MELLIFONT: You spoke about the number of staff needed to come out of seclusion. Was it your understanding for most of that period of time there was a requirement of five staff?

MS OSBORNE: Yes.

DR MELLIFONT: Okay. And you spoke about the traffic light system. Can you explain your understanding of it, and to ask a double-barrelled question, I'm sorry, the Public Guardian's view as to the appropriateness of it in Melanie's case?

MS OSBORNE: So my understanding of the traffic light system is that it's based on

a red, amber, green, and relates to behaviour or following direction, and is a way that Melanie's behaviour was managed whilst in seclusion. My understanding is if at any time the traffic light went to red, then there would be repercussions and one of those would be reduced or no time out of seclusion.

DR MELLIFONT: And was that system of concern to you?

MS OSBORNE: Yes, and continues to be.

DR MELLIFONT: Why is that?

MS OSBORNE: I don't think that the use of a restrictive practice like seclusion should be based purely on somebody's behaviour. I acknowledge that Melanie has been difficult to manage within the forensic system and I acknowledge also it's not the ideal system for Melanie, but using a traffic light system to determine whether somebody gets to leave a very small space for a short period of time is not something that the Public Guardian has ever supported.

DR MELLIFONT: Okay. Your statement acknowledges that there has been provision intermittently of some therapeutic and recreational activities. You make reference to seeing such music, pet and art therapy, swimming, perimeter walks, bike riding and Indigenous cultural activities. Can I ask you to expand on that for us, including the consistency or otherwise of the provision of such activities, please?

MS OSBORNE: So my understanding, from the information available to Public Guardian, as well as talking in-depth with the assigned guardian, is that there are a range of activities available to people within the Forensic Hospital, but I will say that they're not all available all the time, particularly for Melanie. I know that she has had some therapies that she has greatly enjoyed, one of those being pet therapy and my reference to her love of dogs. That was available to her. That's no longer available to her. There were periods where she was able to do art therapy but for whatever reason that I'm not sure what they are, that therapy is not available.

Some activities, again back to your previous question, are based on the behaviour of Melanie and whether she can engage in them. So the records that I have seen that we have, for example, access to hairdressers, beauty time, et cetera, were based on not only availability but also behaviour as well. Melanie enjoys swimming and loves it and in the visit to the Forensic Hospital we were able to see both the activities hall and the pool, but I believe Melanie has not done any swimming activities for quite some time because there is no lifesaver available at the pool to be able to watch over people swimming.

DR MELLIFONT: When you say quite some time, are you talking weeks, months or longer?

MS OSBORNE: I'm talking about before I visited in March 2020. If there has been occasions, I'm not aware of them.

DR MELLIFONT: Okay. What about going for a walk? What is your current understanding on that?

MS OSBORNE: I think walking is probably something that has been very regular for Melanie. Usually her time out of seclusion, a lot of the time was perimeter walks so that meant walking around the perimeter of the Forensic Hospital with the staff with her accompanying her. And that has been something that has been obviously more difficult lately with her recent foot fracture.

DR MELLIFONT: What about provision to Melanie of culturally appropriate activities given her First Nations background? To your knowledge, to what extent has such activities been provided to Melanie?

MS OSBORNE: Melanie has been able to participate in cultural activities that are available at the Forensic Hospital, but my understanding is that they are celebrations that happen annually. So, for example, NAIDOC Week would be one. I'm not aware of any ongoing regular cultural activities that she's engaged in.

DR MELLIFONT: Okay. Any bespoke one-on-one cultural connection with Melanie that you're aware of?

MS OSBORNE: Not that I'm aware of. I do know that Forensic Hospital have tried to research Melanie's linkages back to her people, but I haven't seen any activities where it's one-on-one with her.

DR MELLIFONT: Okay. Now, your statement reflects the Public Guardian's view that there is an acknowledgement that Melanie will require a highly structured and well-planned living arrangements, and you express your view that seclusion, what you've seen, has not been in her best interest, that it has impacted her general wellbeing and mental health. Can you expand on that for the Commission, please.

MS OSBORNE: In the time I have been in the role of Public Guardian and have been aware of Melanie's case, the long-term seclusion has impacted Melanie's health. She has had significant weight gain, which means it's very difficult for her to do the most basic things. Sometimes even walking can be a challenge for Melanie, and can take her quite some time to get from where she needs to go to where she needs to be. She currently has been facing some issues with her renal function as well, which is a concern to us, and she has from time to time had other associated issues with her weight gain.

As well from time to time she has issues with her teeth and needs to regularly see a dentist for some significant dental work, as well as you can imagine, and this is speaking from my experience in visiting the seclusion rooms, Melanie's mental health is obviously drastically impacted as well, a large amount of time that she spends on her own and in seclusion.

CHAIR: Ms Osborne, can I get a clearer idea for myself and I apologise if I've overlooked something you've said or that is in your statement.

As I follow your evidence, the Public Guardian became involved in 2011. You joined the Public Guardian in 2016 and took up your current position in 2019. Melanie was moved at the beginning of 2011, Melanie was in the Long Bay Forensic Hospital, then she was moved in April 2012 to the Austinmer Ward, if that's the way you pronounce it, and then moved in November 2014 to the specially modified seclusion unit within the Dee Why ward. Have I got that chronology right?

MS OSBORNE: Yes, only that I joined NSW Trustee & Guardian Executive Leadership Team in 2016 and started in the role as Public Guardian in 2019, that's correct.

CHAIR: Yes, I understand that. I'm trying to understand how far your observations are based upon your personal observation, and how far they're based on either your study of records or what has been reported to you by somebody else within the Public Guardian's office. I wonder if you would just mind clarifying that for me covering the period that I've just described?

MS OSBORNE: So a lot of the information I have read has been based on the lengthy notes that we have in relation to Melanie on our system, and how we manage Melanie as our --- under guardianship. I have also spent a significant amount of time with the current guardian assigned, and I've also spent a significant amount of time with other people who have been involved with Melanie over a number of years, as well as chairing a governance group which is trying to work towards Melanie living in the community, so that has enabled me to see a wide range of information and documents as well around how her history has played out, but also the planning for the future.

I have visited the Forensic Hospital and I've also been a participant in the Mental Health Review Tribunal that occurred last year as well for Melanie.

CHAIR: And I rather gathered from your evidence you've actually visited the seclusion unit in which Melanie was confined?

MS OSBORNE: Yes, that is correct.

CHAIR: How often did that occur and over what period of time?

MS OSBORNE: I've only visited the seclusion unit once and that was for approximately 15 minutes.

CHAIR: Melanie's current position as from November 2020 is now different. Dr Mellifont may be coming to that and I don't want to intrude on Dr Mellifont's questioning, so on the assumption that Dr Mellifont is going to ask you, I won't ask you anything further, but at some stage I certainly would like to understand the

difference.

DR MELLIFONT: Thank you, Chair. I should just clarify with you, Ms Osborne, although you've only visited on the one occasion and that was as part of a visit organised by the Royal Commission together with Royal Commission staff, Ms Smith, the appointed guardian, has been to that unit on a number of occasions over the years. Is that correct?

MS OSBORNE: That is correct.

DR MELLIFONT: Okay. Now, there are two quite distinct periods I want to turn to with respect to the balance of your evidence. One is the period from --- really from your involvement in 2016 through to November 2020 and then we will speak about the very significant change which occurred on 13 November 2020, which is that Melanie is out of that seclusion unit and on to the sub-acute ward. Okay.

So can I speak first of all about the pre-13 November 2020 position, and can you outline to the Commission the attempts that the Public Guardian has made in order to try and address this 23-hour seclusion arrangement that was in place?

MS OSBORNE: So the history of this goes back to the former Public Guardian, Mr Graeme Smith, who was very active and advocated quite a lot around the planning for discharge and the future plans for Melanie, which resulted in several reports that the Commission has as part of our submissions. That has continued since 2012 through the assigned guardian and through previous Public Guardians as well to try and bring about change in Melanie's circumstances.

There have been no less than three different attempts by government agencies to formulate a plan for Melanie to leave the Forensic Hospital, and in each of those occasions the Public Guardian or a representative of the Public Guardian has been front and centre advocating for change, not only to the seclusion but also to the options that could be available to Melanie to be able to live in the community.

DR MELLIFONT: Can you tell me what the governance group is?

MS OSBORNE: The governance group brings together a range of government agencies, Federal and State, as well as some non-government agencies as well. And the group has a membership at a senior executive level and that is quite on purpose, the reason being the previous attempts, one of the learnings has been that not senior enough people were on those working groups, therefore direction and decisions fizzled out and didn't go any further. So it was a very targeted approach when we started the governance group to ensure that we had senior executives on the governance group who could make decisions or could reach back into their organisations and know where to escalate if decisions needed to be made.

The governance group is essentially looking for a well-planned transition for Melanie to live in the community which aligns to her goal, and it's also looking at what are

the supports, what is the funding, what are the things that we need to be taking into account as we plan for that transition, and it is very much a governance group that is being done in partnership, and some very key stakeholders have allowed us to be able to make great progress in that.

DR MELLIFONT: Okay. Now, I want to come back to the barriers previously experienced by the Public Guardian in getting traction and in getting progress, so we will come back to that in just a moment.

MS OSBORNE: Sure.

DR MELLIFONT: But I just want to understand that the Public Guardian does acknowledge the recent move out of seclusion and on to the sub-acute ward is a step forward?

MS OSBORNE: Absolutely.

DR MELLIFONT: That the Public Guardian does acknowledge the need for a highly-resourced trauma informed model based on a more appropriate and sympathetic living environment to that experienced prior to 13 November 2020?

MS OSBORNE: Yes.

DR MELLIFONT: Is that correct? And that what the Public Guardian wants to see is consistent management, access to appropriate behavioural and/or psychological therapy, and recreational and cultural activity. Is that correct?

MS OSBORNE: Yes.

DR MELLIFONT: And an incrementally less restrictive and contained environment. Is that correct?

MS OSBORNE: Yes.

DR MELLIFONT: The Public Guardian accepts the views of Dr Manchester, that Melanie does remain a risk, but that any improvement and continued improvement will be contingent on the availability of a highly developed and resourced model of service; is that correct?

MS OSBORNE: Yes, that is correct.

DR MELLIFONT: Okay. Can I just bring you back a little bit in time? What were the barriers the Public Guardian was facing in trying to get traction to get Melanie out of this arrangement of 23 hours' seclusion a day?

MS OSBORNE: So I think the challenges were many. Some of those --- well, the most obvious one from my understanding is that the options of what else there was to

be able to move Melanie into either didn't exist or couldn't be funded, so there were many attempts to try and source alternate accommodation or ways that Melanie could be living that didn't mean that she was living in seclusion.

I think a lot of the barriers related to the fear of Melanie and her behaviours and what that brought and the risk profile, and also the lack of planning. You know, if I was to look at this now, one of the biggest barriers I see is that when somebody comes into the forensic system, the discharge planning for them should start immediately. It shouldn't start at the point where we are now, where we're trying to make something work.

DR MELLIFONT: Thank you. Now, as I understand it, you have some quiet optimism that the governance group is going to be able to get to a bespoke model flexible to Melanie's needs; is that right?

MS OSBORNE: I am confident, yes.

DR MELLIFONT: All right. But not without challenges?

MS OSBORNE: That's right.

DR MELLIFONT: Can you speak in that context of the challenges you feel are occurring as related to the NDIS?

MS OSBORNE: I can. So some of the challenges that we currently are working through is, I guess, a clear way to ensure the funding that Melanie requires can be achieved, so, particularly funding around supported independent living. We are in discussions with the agency around how to achieve that and what it might look like but there are no guarantees, particularly for somebody like Melanie, with her complexity, any level of disability support she would require in the community, that we would get the funding she requires.

The other part to that is, and I'm sure many people have spoken to this and will speak to this, that as soon as there is a level of complexity with somebody who is a participant, it is very challenging to find a model or to find accommodation or a disability support provider who can support that person or that there is a vacancy available. We are seeing at the Public Guardian an increase in the number of people who have got complex disabilities and behaviours, and it is very difficult and challenging to be able to find them appropriate accommodation and services to be able to support them to live in the community.

DR MELLIFONT: Okay. So is that a reflection by you on the market maturity to cater for people with complex presentations under the scheme?

MS OSBORNE: Yes, it is. I think the market grew at such a rapid rate but it also didn't grow alongside the complexity and the depth of complexity that there is for people with disability who are accessing the scheme.

DR MELLIFONT: Okay. And in your role, obviously Melanie is not the only person you assist. You assist very many people. Do you have a general observation in terms of your experience of the more complex the disability and the needs of the person, and how that seems to interface with the NDIA at the moment?

MS OSBORNE: I think the key for me, and the word that comes to mind is "consistency", we obviously spend a lot of time advocating for people under guardianship with the Public Guardian where the funding they are receiving is not going to cover the supports they require. That in turn leaves them at risk of further abuse or exploitation or unfortunately ending back in another system such as the criminal justice system which we see unfortunately on a regular basis as well. I think we do our best to try and advocate and show the evidence required for somebody to get the appropriate level of funding to have those supports, but the outcome of that decision is not always the way that we would like it to go, and we have seen instances where people are left in accommodation that is not fit for purpose or suitable for them. For example, in a hotel, and they have drop-in supports for a few hours a day, and that results in them either potentially re-offending or ending up in another service system and not being in the community where they're wanting to be.

DR MELLIFONT: Now, you've read Professor Ogloff's statement that he has provided to the Commission for this hearing; is that correct?

MS OSBORNE: Yes, I have.

DR MELLIFONT: Are you in agreement or disagreement with his observations about the lack of disability support expertise in the market for complex needs?

MS OSBORNE: Yes, I am in agreement with it.

DR MELLIFONT: Thank you. So where are you now for funding for Melanie?

MS OSBORNE: For Melanie, we have just gone through a plan review and we have got approval for the FDA which enables us to engage a provider for the build of the property that we would like her to live in, which is positive. We continue to have conversations about the supported independent living funding and where that's at and the next decision point on that. That is such a key piece of the puzzle in relation to the governance group, and the reason being is that once the supported independent living funding is agreed to, that allows us to engage who the provider will be to provide day-to-day supports and will also allow us to start working with them with Melanie so that they can build a rapport and they can understand what support they are going to need and how to do that.

The other part of it is also means that NSW Government agencies can start to do the pieces of work that they're responsible for once we know where Melanie will be living. So, for example, my colleagues in NSW Health and mental health can start to make referrals to the local area health district to ensure they know who Melanie is

and what her needs will be and how they are going to interact with her. Without that supported independent living piece, it's hard for us to progress those next pieces of work that need to happen.

DR MELLIFONT: Putting aside my usual Pollyanna type attitude, can we just play this out. So you've got some FDA funding which goes towards a service provider for the actual accommodation. You've got that?

MS OSBORNE: Yes.

DR MELLIFONT: Okay. And you've got a service provider who is building a facility that is going to be able to take Melanie, if everything else aligns, by October of this year. Is that right?

MS OSBORNE: That is the hope. It may stretch out a little bit but that is what we're working towards, yes.

DR MELLIFONT: All right. But that service provider is not going to hold that position forever if there is no SIL funding; is that right?

MS OSBORNE: That's correct.

DR MELLIFONT: So if you don't get your SIL funding, and that's what gets given to someone else and one can understand why that would happen, where are we then?

MS OSBORNE: Unfortunately the governance group needs to go back to where we were in say May or June of last year and reassess the market and what other options are available. I will say at the time when we selected the provider that we would like to go with, we did a scan of the market and we invited providers to show some interest in what we were looking for. And the one that we went with impressed us but was also the last provider standing. So we don't exactly have a line of providers ready to go, which is to my earlier points around the thinness of the market, particularly in relation to people with complex disability and behaviours.

DR MELLIFONT: So, and I shouldn't ask people to guess, but if funding doesn't come through and you lose that spot, how far could that put Melanie back in terms of timing?

MS OSBORNE: I think it essentially would take us nearly back 18 months, two years.

DR MELLIFONT: Okay. Chair, I have another 15 minutes or so questions for Ms Osborne. I'm content to proceed now or to return after lunch. I'm entirely in your hands.

CHAIR: Well, I think we might perhaps invite some questions from Commissioners and then we might take a break and come back.

DR MELLIFONT: Thank you.

CHAIR: I will invite myself to ask you a couple of questions so that I can understand better the chronology again. And I think perhaps for people who may be watching this, there are some elements in the chronology that are important. When we're finished, by the way, we will fund a timer on your lighting system.

MS OSBORNE: Thank you.

CHAIR: For the future. When Melanie was given what's called a limiting term in ultimately 2002 when the Court of Criminal Appeal in NSW increased the limiting term from five years, that meant that that was a term that was equivalent to what she would have been imprisoned for a maximum term had she been found guilty of the offence of manslaughter without the particular circumstances the court took into account. Do you understand it that way?

MS OSBORNE: Yes.

CHAIR: All right. So as from 2012 Melanie was not serving any time in custody attributable, as such, to the unlawful act that she committed that was characterised as equivalent to manslaughter?

MS OSBORNE: That's correct. She became a civil patient.

CHAIR: How did she become a civil patient in 2012?

MS OSBORNE: My understanding is that that was through the Mental Health Review Tribunal and from a transfer from prison to the Forensic Hospital.

CHAIR: So that is made by the tribunal pursuant to powers conferred under a different act and that is by Melanie being regarded as a threat to her own safety and/or to the safety of other people in the community?

MS OSBORNE: Yes.

CHAIR: We know that in November 2020 something changed. What changed?

MS OSBORNE: So in November 2020 Melanie was moved from full-time seclusion to the sub-acute ward in, I believe, the Austinmer unit which means that she now lives in a bedroom in the ward and is not in seclusion.

CHAIR: Right. How did that come about?

MS OSBORNE: It came about or the Public Guardian became aware of it after it had occurred. We were notified two hours by email after the move had happened. That's the information I have available on the move.

CHAIR: Is that the totality of the information you have?

MS OSBORNE: I would say that there was plans in place with the Forensic Hospital for time out of seclusion to be increased and eventually for there to be a full-time move out of seclusion. The timeframe in which it happened was something that I was not aware of or prepared for.

CHAIR: Do you have a view --- and if you don't it's fine, and if you don't feel there is sufficient information for you to have a view, that is also fine --- but do you have a view as to why a different approach was taken towards Melanie in the latter half of 2020?

MS OSBORNE: I think that the move from the seclusion unit into the sub-acute ward happened a lot quicker due to a foot fracture that she sustained from moving out of one of the seclusion rooms to the courtyard. She had a fall. And my view would be that caring for Melanie in a moon boot would be very difficult in seclusion versus on the ward.

CHAIR: So you think that was a trigger event for the change in circumstances?

MS OSBORNE: I do.

CHAIR: All right. Thank you.

I will ask Commissioner Mason whether Commissioner Mason has questions to put to you.

COMMISSIONER MASON: No, thank you, Chair.

CHAIR: Commissioner Atkinson?

COMMISSIONER ATKINSON: Not at this stage, thank you.

CHAIR: Commissioner McEwin.

COMMISSIONER McEWIN: I have one question, Ms Osborne. I'm interested in your observations or from your observations and knowledge of Melanie, the support that she received. You mentioned at paragraph 37 in your statement, she appeared recreational. I'm interested to know, this may come out in evidence later, what support did Melanie receive to understand the situation that was happening to her in terms of, you know, this seclusion, I'm really interested to know what support was she provided to understand what was happening to her, as opposed to pet therapy, et cetera?

MS OSBORNE: So, Commissioner, my understanding is the assigned guardian would regularly talk to Melanie and Melanie would ask questions about what was

happening, and the assigned guardian, to the best of her knowledge, would answer those. I don't have any information that tells me what support and what provision for explaining what was happening to Melanie happened within the Forensic Hospital.

COMMISSIONER McEWIN: Thank you.

CHAIR: Thank you. Dr Mellifont, we will adjourn now and resume at 2.40pm Sydney time, 1.40pm Brisbane time.

Ms Osborne, if you would be good enough to return in time to enable Dr Mellifont to continue asking you some questions and I understand from Dr Mellifont that we won't need you much longer after we resume.

MS OSBORNE: Yes.

CHAIR: We will adjourn until then.

ADJOURNED **[1.39 PM]**

RESUMED **[2.39 PM]**

CHAIR: Yes, Dr Mellifont.

DR MELLIFONT: Thank you, Chair.

Ms Osborne, do you have any observations about cultural change in recent years in your observation at the Forensic Hospital?

MS OSBORNE: Sorry, I will comment in relation to my most recent joining of the Public Guardian being involved in Melanie's matter. But I also will firstly just reflect in the notes that I've been able to view on our system as well as talking to the guardian who is currently looking after Melanie. I think working with the Forensic Hospital and the MDT at times has been challenging and we have had to really push for information and ask for a on multiple occasions particularly data and reports around seclusion and when Melanie has had time out of seclusion.

What I will say, though, is that since starting the governance group and starting working with the Executive Director of Clinical Operations Wendy (inaudible) at the Forensic Hospital, I have seen a change in the approach and am heartened by Wendy's approach. It's very person-centred and she very much aligns with what the Public Guardian would like to achieve, which is for Melanie to live in the community.

DR MELLIFONT: Thank you. To your knowledge, does the Public Guardian have

any information regarding how Melanie's foot was fractured?

MS OSBORNE: My understanding from the report I've read is that Melanie was exiting one of the seclusion rooms to enter the courtyard and had an incident where she blacked out for a moment. She fell and hit her head and also injured her ankle, which is how the fracture happened.

DR MELLIFONT: Right. Now, the records we've received indicate the fracture was on 8 November. Do you know when the Public Guardian first became aware of the fact that she had fractured her foot?

MS OSBORNE: I would have to check that and come back to you, but I do believe it was around that time.

DR MELLIFONT: Thank you. And just in terms of orientation as to time, Melanie came out of seclusion on 13 November and you've already answered the Chair that you were told about that after it occurred. Now, in recent records we've received indicates that there is now a core team in place to assist Melanie. When was the public guardian first aware there was a core team in place.

MS OSBORNE: We was aware there was a core team in place once she had been moved to the sub-acute ward. There was some discussions at the governance group about what would be required to support Melanie for her transition, but actually finding out the core team has been put together and was in place was after she had moved out.

DR MELLIFONT: Do you know how long after she moved out?

MS OSBORNE: I would have to come back you. I can verify that and check it for you.

DR MELLIFONT: Thank you. And, again, come back to us if you need to check this with Ms Smith, was the Public Guardian specifically consulted with respect to a seclusion reduction plan in respect of Melanie?

MS OSBORNE: No.

DR MELLIFONT: In respect of the core team, do you know whether they were picked from within the unit or recruited from elsewhere or recruited from other parts of the hospital, or is that outside your knowledge?

MS OSBORNE: That's outside my knowledge. I do know that one of the mental health nurse who do form part of that core team is somebody that Melanie has worked with for a reasonable amount of time and has a good relationship with.

DR MELLIFONT: Okay. Now, recent documents received by the Commission indicate that there is an Aboriginal mental health worker who has been in the role of

Aboriginal mental health worker for five months. Are you aware of that?

MS OSBORNE: I don't have any information about that.

DR MELLIFONT: So is it news to you that there is somebody who holds that position?

MS OSBORNE: Yes.

DR MELLIFONT: And what has the Public Guardian been told, and I mean from sources other than the Royal Commission, about whether there has been any return to seclusion since 13 November?

MS OSBORNE: So my understanding from talking to the guardian is that there has been two incidents of seclusion since Melanie left on the 13th of November. One instance was of Melanie's choice and is probably not the seclusion that I would deem has occurred previously. It was a return to the seclusion unit but with the doors open, so she was free to leave at any time. The second incident happened, and I believe it was overnight, and it was a result of Melanie being too loud and linked to behaviour.

DR MELLIFONT: Okay. And in terms of the source of those pieces of information about those two seclusions, where did it come from?

MS OSBORNE: So two sources, some information via email from the Forensic Hospital and also from Melanie herself.

DR MELLIFONT: Now, can I take you back to pre-13 November 2020 and in fact pretty much for all of 2020, at any stage did anybody from the Forensic Hospital indicate to you that a reason for Melanie being kept in seclusion was due to the pandemic?

MS OSBORNE: No.

DR MELLIFONT: So, so far as you are aware, no one has communicated to the Public Guardian that the pandemic was used as a justification for keeping Melanie where she was?

MS OSBORNE: No. I do know that at times they mentioned in the governance group that COVID was having an impact in what they were able to do in relation to activities and services but not as a reason to continue seclusion.

DR MELLIFONT: Now, we've received a statement from Dr Ellis which states by November 2020, Melanie was successfully engaging in therapy. Now, taking that statement, do you know when that started?

MS OSBORNE: No, I don't know when it started. And I think interesting,

engagement in therapy, and what that means because from my understanding, Melanie has engaged with different types of therapy throughout her time; whether it has been successful always is a different question, but I wouldn't say that's just when it began.

DR MELLIFONT: Okay. Now, you've had the opportunity to review the evidence of Professor Ogloff and Dr Manchester who both draw a distinction between the paradigm that exists in mental health treatment and what is best practice in disability treatment, that things are not the same. Do you have any observations you wish to make about this given your experience as the Public Guardian?

MS OSBORNE: I think our experience in relation to supporting somebody appropriately with a disability like Melanie in a forensic system is very challenging. It's not the type of facility that you would use to deliver therapies and to build capacity and support that somebody might need to use in the community. I do acknowledge that the Forensic Hospital itself is not the ideal environment to be delivering those services, which means even more pressure and reason why Melanie should be afforded the opportunity to live in the community and be properly supported from a disability point of view, but also for her to have the opportunity to do very simple things such as learning how to cook properly, have her own room, her own things.

I also think, in my experience, what is difficult is where the *Mental Health Act* is in place for a person and there's also a guardian trying to carry out their role under the New South Wales *Guardianship Act*. There are times when it is difficult and it's not the same for somebody we would normally be supporting in the community to be able to make the same decisions to the same level as well. There are times when the *Mental Health Act*, I guess, trumps *Guardianship Act*. That doesn't excuse us from our role. We still need to do what we need to do and still need to make decisions, but it doesn't operate in the same way that it would if somebody was living in the community and the *Mental Health Act* wasn't at play.

DR MELLIFONT: Okay. So your view is that the relationship between the two pieces of legislation is very important, sometimes they rub up against each other?

MS OSBORNE: They do, and sometimes they're silent on things that make it difficult. Each piece of legislation is silent on parts that make it difficult for us to be able to do our roles well and know that we're doing the right things against those pieces of legislation. So it's something that we struggle with in a whole range of cases.

DR MELLIFONT: Okay. Do you have any views about how the NDIS might assist persons in detention? Particularly in a forensic environment and in transition?

MS OSBORNE: I think definitely the NDIA, what would be great to see is to have experienced planners who know what these systems are like and what it is like to have to transition a person from a forensic system into the community. So what are

the kind of supports they're going to need, what is the level of planning and detail that's going to be required to enable them to safely transition, and not only safely but successfully. We don't want people to transition out of the forensic system and into the community and then immediately fail because the planning hasn't been adequate or the planning hasn't thought about the wraparound support that that person is going to need. That's not to say it's wholly and solely on the agencies' shoulders, I don't believe that at all. NSW Government has a part to play as well, but I think by being able to work successfully with people like planners, for planners to also be relying on the experience of the Forensic Hospital, the MDT, and what they can bring to those discussions would be incredibly important.

I also think what's important is that the work that we're doing to transition Melanie to the community is not sustainable to do every single time. It takes an enormous amount of effort, and is complex, and I would hate to think how would somebody who didn't have the Public Guardian involved, how would they navigate this because it has been incredibly hard and it's taken a lot of work just to get us to this point.

DR MELLIFONT: Am I correct that it's your view that getting the community service provider in to see Melanie before she actually goes out into the community to develop relationships et cetera is something you would like to see happen?

MS OSBORNE: I think it's incredibly important and I think if it doesn't happen, it may impact how successful we will be in that transition. I think by having the provider who is going to be caring for Melanie in the community learn about Melanie and what she likes and what she doesn't like, and how she sort of navigates the day, I think that's incredibly important to allow them to go away ---

[Pause - video feed disconnected]

CHAIR: I take it, Brisbane, you can't hear us?

UNKNOWN SPEAKER: I can hear you now, Chair.

DR MELLIFONT: I think we've got everybody back. I need confirmation from Law In Order we are good to go.

CHAIR: Are we ready to proceed? I think we're now ready to proceed, Dr Mellifont. Normal service has been restored. Possibly temporarily.

DR MELLIFONT: Right. No one has used a cat filter so I think we're doing pretty well so far!

Ms Osborne, what we were up to is you were saying it's important about people going in --- the NDIS service provider going in to develop a relationship with Melanie and then you just cut off. I think you were about to finish that comment?

MS OSBORNE: Thank you. I was just going to say the important part of that is that they get to know Melanie and learn how best to support her but then they've got the opportunity to go away and put that planning into place before Melanie does transition into community. I think if they don't have that opportunity it will be very difficult for them to navigate, and we do see other instances where that doesn't occur or doesn't occur to the level we'd like it to, and it fails and then the service relinquishes. So I would like to make sure that as much as we can, we can have them engaged.

DR MELLIFONT: Okay. Two last questions and I think you've answered the first in part already; looking back, is there anything you would like to see done differently?

MS OSBORNE: I think one of the things that really sticks out for me is that the planning for discharge for people going into the forensic system should begin at the time that they enter the system, not wait until there's been, you know, significant events and it becomes more difficult. I think the other thing is that there needs to be a way forward to be able to do this level of planning for complexity. That doesn't mean we have to pull together a huge amount of people, you know. There should be, I guess, a way that this model could be put in place that is simple for navigate and know what supports and services need to be lined up. I don't think I've necessarily got the answer to that but I would hate for somebody who was supporting a family member through this to even begin to know where to start. That is just unrealistic and not helpful. It will also impact the time it takes for people to be transitioned out of forensic settings where they shouldn't be, and that's my greatest fear, and it shouldn't take that long.

DR MELLIFONT: Lastly, moving forward, how would you like for Melanie's voice to be taken into account?

MS OSBORNE: I think Melanie's voice needs to be heard more often. I think in the time I've gotten to know her and have listened to letters that she has written or times that she has addressed the Mental Health Review Tribunal, the thing that strikes me is her hopes and dreams are very simple. She wants to live in the community, she wants to have her own bedroom with her toys and own things in it, she wants to have a dog, she wants to go to the beach. They are really simple things and I think that being able to hear that regularly has had a great impact on the governance group. I think it's really reminded them that we are here to be person-centred. This is about a person and it's about their actual life. And I think, for me, Melanie has such strength and resilience, I don't think many people could have lasted what she survived and still have hopes and dreams and still be working towards transition and living in the community.

So I think Melanie's voice being in everything we do is incredibly important and should be something that we continue to do for all people that we're supporting.

DR MELLIFONT: Thank you, Ms Osborne.

Chair, that's the balance of my questions.

QUESTIONS BY THE COMMISSION

CHAIR: Thank you, Dr Mellifont.

Ms Osborne, can I ask you a couple of things. First, I understand that Melanie has been an NDIS participant since at least September 2018?

MS OSBORNE: Yes.

CHAIR: During that time, would restraints have been imposed on her, whether physical, chemical or otherwise in addition to being confined into a particular environment?

MS OSBORNE: Yes, they would have been used. An example would be when she has transferred to a hospital externally, and mechanical restraints have been used to be able to do that transfer or to apply treatment.

CHAIR: As the guardian for Melanie, are you required to consent to the application of physical restraints in those circumstances?

MS OSBORNE: Not in the circumstances for treatment at hospital, no.

CHAIR: And that is because why?

MS OSBORNE: I will come back to you but I believe under the *Mental Health Act* and with the Forensic Hospital, they are able to do that without us having to consent to the restrictive practice.

CHAIR: So is it the case that any restrictive practice imposed upon Melanie during her period of confinement would not be communicated to you and your consent is not required?

MS OSBORNE: That's correct.

CHAIR: You've said on a couple of occasions that you weren't aware of certain things. I judge from your evidence that it's Ms Smith who is in close contact with Melanie and those who are caring for her. Is it possible that some of the matters that you've been asked about that you're not aware about, Ms Smith would be aware of?

MS OSBORNE: Yes.

CHAIR: Thank you. I will ask first Commissioner Mason if she has any questions.

COMMISSIONER MASON: No, thank you, Chair.

CHAIR: Thank you. Commissioner Atkinson?

COMMISSIONER ATKINSON: Yes, thank you. I do. You referred in your evidence, Ms Osborne, to Melanie being resilient and you said, "Not many people could have survived what she has experienced." By that you mean the experience in seclusion?

MS OSBORNE: Yes, I do. That is something that I think is extraordinary character for her to have survived that given the length of time that she's had to experience it.

COMMISSIONER ATKINSON: And that experience of seclusion, together with the length of time she has experienced it, has that made her recovery and rehabilitation more difficult or less difficult?

MS OSBORNE: I think in my opinion it is more difficult. I don't think that the same amount of services --- so an example I would give is, at a point in time, some of the therapies that were being given to Melanie were through that steel door, and was through people shouting to her on the other side. Now, that can't be the best way to deliver a psychology session, for example.

COMMISSIONER ATKINSON: All right. So that's inimicable to a therapeutic relationship?

MS OSBORNE: Yes.

COMMISSIONER ATKINSON: And therefore to her recovery?

MS OSBORNE: Yes.

COMMISSIONER ATKINSON: So does that mean the conditions in which she has been kept have made her recovery much more difficult?

MS OSBORNE: I believe so, yes.

COMMISSIONER ATKINSON: Thank you.

DR MELLIFONT: Chair, just before we finish, I might ask Ms Osborne to take on notice the question you just asked about whether Ms Smith might have notice of the things that I addressed with Ms Osborne. We will just have that confirmed either way, by way of questions on notice.

CHAIR: I was going to ask Commissioner McEwin if he has any questions.

COMMISSIONER McEWIN: No. Thank you.

CHAIR: Thank you very much. One thing perhaps that might be checked, this is not necessarily for Ms Osborne, is the fact that the law of NSW has nothing to say about restraints being imposed on someone who is in confinement, as Melanie was, doesn't necessarily answer the question as to what the NDIS Rules require and that is something that perhaps we might have a look at. I don't know the answer but there are provisions in the NDIS Rules that are expressed to apply if there are no relevant provisions under State law. And we do have an interconnection here between Federal and State law and, as we know, when there is a conflict, it's Federal law that prevails.

DR MELLIFONT: Yes, Chair.

CHAIR: Ms Osborne, thank you for giving your evidence which has been extremely helpful. We appreciate the evidence you and your office has provided to the Royal Commission. Thank you very much.

MS OSBORNE: Thank you.

THE WITNESS WITHDREW

CHAIR: Dr Mellifont, I understand you want to have a short adjournment in order that we might transition into a hearing that is to be in-camera?

DR MELLIFONT: That is so, Chair, and so that will mean this is now the end of the public livestream for the day. Thank you.

CHAIR: Thank you. We will resume in 10 minutes in-camera. There won't be any further hearing publicly for today. As far as the public hearing is concerned, that will resume at 9.30 am Brisbane time tomorrow, 10.30 am Sydney time tomorrow. Thank you.

ADJOURNED **[3.03 PM]**

RESUMED **[3.09 PM]**

[PRIVATE SESSION COMMENCES]

ADJOURNED AT 4.30 PM UNTIL WEDNESDAY, 17 FEBRUARY 2021 AT 10.30 AM

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