TRANSCRIPT OF PROCEEDINGS

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

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

10:30 AM, WEDNESDAY, 24 FEBRUARY 2021

DAY 7

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

CHAIR: Good morning, all. Welcome to the seventh day of this hearing on people with cognitive disability and the criminal justice system. I now invite Commissioner Mason to give the Acknowledgment of Country this morning.

COMMISSIONER MASON: Thank you, Chair.

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

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

We recognise Meeanjin, Brisbane.

Nganana ngurkantananyi ngura Meeanjin-nga Brisbane-ta.

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

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

And we pay respect to the Gadigal people of the Eora Nation. Their land is where the city of Sydney is now located. We pay deep respects to all Elders past, present and future and especially Elders, parents and young people with disability.

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

This hearing will include evidence that may bring about different responses for people. It will include accounts of violence, abuse, neglect and exploitation of First Nations people with disability. It will also include references to First Nations people who are deceased.

If the evidence raises concerns for you, please contact the National Counselling and Referral Service on 1800 421 468. You can also contact Lifeline on 13 11 14, Beyond Blue on 1300 224 636 or for First Nations viewers your local Aboriginal Medical Service for social and emotional wellbeing.

Thank you.

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

DR MELLIFONT: Thank you, good morning. Today is the first of two days in respect of a case study as to the Cognitive Impairment Diversion Program which was a pilot program run by the Intellectual Disability Rights Service, IDRS, between 2017 and 2020 and funded by the New South Wales Government.

The object of the program 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* (NSW) or through other non-custodial sentences. 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 and representation.

Funding for that project was ceased by the New South Wales Government on 30 June 2020. Today we will hear from four witnesses in respect of this case study. After the morning break, we will hear from Mr Michael Baker, Advocate from IDRS and Ms Janene Cootes AM, Executive Officer from IDRS, who will speak to what the CIDP was able to accomplish, as well as the challenges of short-term and uncertain funding.

We will also hear from two lived experience witnesses who were recipients of the service. The first will be Mr Geoffrey Thomas who has participated by way of pre-recording his evidence. His written statement and extracts of his pre-recorded oral statement are found at Tabs 7 and 8 of Tender Bundle A and I ask for those documents to be tendered into evidence and for them to be marked as Exhibits 11.28.1 to 11.28.10 respectively.

EXHIBIT #11.28.1 - STATEMENT OF MR GEOFFREY THOMAS

EXHIBIT #11.28.2 – EXHIBIT 11.28.10 - EXTRACTS OF PRE-RECORDED EVIDENCE OF MR GEOFFREY THOMAS

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

DR MELLIFONT: Thank you.

Later today we will hear from Ms Taylor Budin. I apologise, I have been mispronouncing her surname until now. Her evidence was taken again by pre-recording and we will have that played later today.

If we can therefore commence by playing the extracts of the pre-record from Mr Thomas. There are a number of extracts but they will be played sequentially. I don't intend to pause between them. Thank you.

[VIDEO RECORDING PLAYED]

MR FOGARTY: Good morning, Geoff. I wonder if you could tell the Royal Commission your full name?

MR THOMAS: My name is Geoffrey Allan Thomas.

MR FOGARTY: To be clear, we have Taylah and Mike with you in the room today with us supporting you?

MR THOMAS: Correct.

MR FOGARTY: How old are you at the moment?

MR THOMAS: 59.

MR FOGARTY: All right. You prepared and signed a statement for the Royal Commission?

MR THOMAS: Yes, that's right.

MR FOGARTY: You've have got a copy of it here with you today?

MR THOMAS: I do.

MR FOGARTY: All right. You signed it on 15 January 2021; is that right?

MR THOMAS: That's right.

MR FOGARTY: And I think it's 17 pages, does that sound right?

MR THOMAS: About right, yes.

MR FOGARTY: All right. Can you confirm that what's in it is truth to the best of your knowledge and belief?

MR THOMAS: Yes, it is.

MR FOGARTY: I am going to ask you questions about the topics that you cover in your statement. If you want to have a look at your statement, feel free. But let's discuss it as best we can one on one, as you remember it. If there's anything you forget or think you need to add as you go, just pipe up and let me know.

MR THOMAS: Okay.

MR FOGARTY: The first thing I wanted to talk about and you discuss it at the start in a topic entitled "About me" are your disabilities or disability. What are your disabilities?

MR THOMAS: I have cognitive brain impairment, anxiety, chronic depression, suicidal ideation, ADD and a few other problems. But that's basically the outline.

MR FOGARTY: Can you tell the Royal Commission about how those disabilities affect you today?

MR THOMAS: It's quite challenging. I struggle socially and I struggle with most authoritarian-type organisations or communicating is sometimes very hard.

MR FOGARTY: I think you talk a bit about those frustrations with authoritarian organisations in your statement, and I'll come to some of those topics. Yeah, is that right?

MR THOMAS: Yeah. That's right.

MR FOGARTY: You are an NDIS participant, yep?

MR THOMAS: I am.

MR FOGARTY: And you live in public housing?

MR THOMAS: I do, that's right.

MR FOGARTY: Can you tell the Royal Commission a bit about where you live? Is it a specific type of accommodation or ---

MR THOMAS: My residence is an over-55s complex and it's New South Wales Housing, and I've worked there as the Chairperson for the Residents' Committee and do work with Greening Australia for the common garden area.

MR FOGARTY: So you're pretty involved in the place.

MR THOMAS: Yes, I try to keep my finger in the pie.

MR FOGARTY: How long have you lived there?

MR THOMAS: Uh, five years, maybe, yeah.

MR FOGARTY: One thing that is clear, and it comes out in your statement when I read it is how much you relish your independence, that's something that's very important to you?

MR THOMAS: That's true, yes.

MR FOGARTY: Do you feel at the moment in your life that you have that

independence or are there ways that could improve, do you think?

MR THOMAS: Uh, there's lots of ways it could improve. Some of it is just issues that I need to address, personally. Others are organisational-type things, systemic problems within those organisations, communication issues.

MR FOGARTY: Yep.

MR THOMAS: So, anything to do with government organisations is difficult at the best of times, but --- and presently, COVID has made it even more stressful.

MR FOGARTY: Yeah.

MR THOMAS: And harder to deal with a lot of issues.

MR FOGARTY: I see. And again I'll come back to some of the systemic changes that you talk about at the end of your statement. You make a number of suggestions and recommendations based on your lived experience; correct?

MR THOMAS: Yes, that's right.

MR FOGARTY: You're an Aboriginal man. Can you tell the Royal Commission about your cultural identity and what being an Aboriginal person means to you?

MR THOMAS: Um, it --- for me, it was late in life that I pursued that course, because it was information that was given to me later on in life.

MR FOGARTY: Yep.

MR THOMAS: I've pursued that through Close the Gap, Aboriginal men's groups, and Stride, for when we go to things like NAIDOC and stuff, we experience some cultural education.

At present, everything has come to a standstill, so nothing much is happening at all, face to face. But Close the Gap and Stride have been supportive in facilitating things in that area and that was working pre-COVID.

MR FOGARTY: You mentioned Stride. Just for context, Stride are the people who support you, and Taylah is from Stride today?

MR THOMAS: That's right, yes.

MR FOGARTY: You grew up in the 60s and 70s. What was it like then growing up with a disability? You may not have the diagnoses, as I understand it, but can you tell the Royal Commission about your experience of a person with disability then?

MR THOMAS: Well, the diagnoses had just started to occur, and they weren't as

educated then as to how to go about child diagnosis with mental health and stuff --- so there definitely weren't support systems. But I found it --- because in education, in school, there was still corporal punishment, so the cane, being hit by teachers, being basically stood over by teachers. If you were a person who was different in the classroom ---

MR FOGARTY: Yes.

MR THOMAS: They didn't accommodate, um, facilities for students like myself.

MR FOGARTY: So behavioural challenges were dealt with fairly brutally.

MR THOMAS: You were punished, you were caned, or you were slapped or you were sent out of the room or you were sent home. There was nothing that was ---

MR FOGARTY: Did you have a support teacher, for example?

MR THOMAS: Not until high school, but that was in the form of a special class. That was pretty irrelevant to me. I was --- just by the way, I met an English teacher and she realised I couldn't read or write, and so she set about putting time aside to teach me, and that was the first good experience I had within the public school system.

MR FOGARTY: That was in high school?

MR THOMAS: Yes. And I went to many different public schools, so ---

MR FOGARTY: Because you moved around with mum?

MR THOMAS: Yes.

MR FOGARTY: You grew up with mum and moved around quite a bit.

MR THOMAS: Doing seasonal work, picking potatoes, orange, apples, working on sheep stations, mum was the cook. So we moved, yeah, to support us.

[VIDEO RECORDING ENDED]

CHAIR: Yes, Dr Mellifont.

DR MELLIFONT: The next one we will play in sequence. It will just take a minute or two between each.

CHAIR: Thank you.

[VIDEO RECORDING PLAYED]

MR THOMAS: It came about that the courts --- I tried to move out of home as soon as I could, 14 I suppose was when I started working, while still going to high school, and tried to separate myself from family and home. But I had gone to court and it was the first time I'd ever had anything to do with the police. And they charged me for a crime I didn't commit. And I can say that all these years later, it won't change anything, but I have no reason to lie, but that was the beginning of my criminal record and I absolutely did not do what they accused me of doing. And as a result of that, the Magistrate ordered that I go and live with a Baptist Minister and his family. So he identified maybe that home wasn't the best place and maybe, because I was going to a youth group in this church, he saw that as an option, because the Minister turned up to give ---

MR FOGARTY: Support?

MR THOMAS: Yes, support.

MR FOGARTY: How did you feel about that arrangement that the court had ordered for you at the time, do you remember?

MR THOMAS: I personally --- most probably would have taken up the offer. Like, in the end, I was teaching scripture classes, I was going to go to Missouri, Springfield to become a Minister and the whole - and I had a job at Airlite Windows at Windsor, working --- paying for the airfare, as I say, saving the money to go over there, which was all good and all.

But at the time I thought, "I have met a Magistrate and these police," and all --- in five minutes of my life would be the total time that they know me and they're deciding what's best for me, and I couldn't work that one out.

And then I couldn't work out, like, my mum's behaviour. But there wasn't much I could do about that. There was --- I don't even think at that time, from my memory, it wasn't a question of whether I wanted to plead guilty or not guilty, it was what my mum had decided, the Minister had decided and the police and the Magistrate had decided, and that was that I must have done it because the police said so, and there must be this consequence, and that's what you would be doing, and I didn't have much choice. I certainly didn't have a say. No one talked to me pre-court, or ---

MR FOGARTY: Or advised you or said, "I'm your lawyer" or?

MR THOMAS: There was no representation. There was no one in that court that was there for me to say, "Geoffrey, what do you want to do, did you do this? How do you feel about it? Do you want to fight this? Do you want to appeal? Do you

want to do that?" None of that.

MR FOGARTY: That was your first contact with the court and police?

MR THOMAS: With the judicial system, yes.

MR FOGARTY: In your statement, after you talk about that experience, you talk about, I think, six more times that you were incarcerated, the last being about 2003.

This is a very open-ended question, there's lots to it and I'll probably return to some of them, but can you tell the Royal Commission about your experiences in prison?

MR THOMAS: Experiences in prison. Where corruption meets corruption. So I went in, I saw that there was not much loyalty between inmates even though there was supposed to be a code. It was much like the bullies at school; the bigger you were, the better off you were. Unless you were the type of person that would put a knife in someone's back or something, then you could aspire to great heights. But it was --- the way the system, for me, the people that were there to facilitate your incarceration and make sure that you were safe and did the things that were required were the very people that when it came down to it --- in my case I was writing letters to the Ombudsman, to the Independent Commission Against Corruption, I was in touch with Justice Action and trying to make things better inside the prison system and I was representing inmates that couldn't get legal representation, I was involved in Royal Commissions about building New South Wales prisons, more principles, yea or nay to that. I thought prevention was better than building more prisons, but they're still building them.

So the more I used the system that was put there to make sure corruption didn't exist, the more I was threatened and the more my life was in danger and even my mother was made aware of that and was told if I didn't stop, that something bad was going to happen. And I never --- I've worked all through and I got education as much as I could and I achieved work release, but I did all of that --- I had to fight for, I had to --- and once you upset one of the officers, getting a job is really difficult, but I was a good worker. Getting other --- I put myself in a precarious position and --- but there were some --- as I say, there's always good and bad everywhere, but some officers saw the good in me and said, "This fellow is trying to help people, inmates who are not getting fed, inmates who aren't being [indistinct], what can be so bad about that?" So they helped me.

[REDACTED], and things far worse than that, but none of it was --- there is no corrective in corrective services, there's no rehabilitation.

MR FOGARTY: With your disability that we talked about as at the current time, were they recognised then or recognised in prison?

MR THOMAS: Sorry?

MR FOGARTY: The disabilities you have, the diagnoses, were they something that was recognised in the prison system?

MR THOMAS: When I first got to prison, I was suicidal, to say the least, I was scared, very scared. So I ended up in what they call D Ward, which was a wing of cells in the middle of nowhere and you were naked when you went into the cell and had nothing but a blanket. And that was mental health.

MR FOGARTY: Right.

MR THOMAS: And you could spend it in a demountable-type thing, maybe an hour or two during the day and you were back in for 7, 9 hours, naked in the cell, and that was it, and your meal would be passed through. And the Largactil would be your medication to keep you calm, and that was ---

MR FOGARTY: That was it?

MR THOMAS: That was --- yeah.

MR FOGARTY: They were your adjustments to disability?

MR THOMAS: Yes, that was the full and complete healthcare package.

MR FOGARTY: I might jump towards --- you want to talk about changes you suggest or propose with a number of institutions. One is the police. You talk about cultural change?

MR THOMAS: Yep.

MR FOGARTY: And you talk also, I think, about education of police and also some of these other institutions we talked about, like courts, et cetera. What, in your reform suggestions, what's your idea on education for them and who should give it?

MR THOMAS: I think they could make a regular situation where mental health officials come into the police station or the police attend an in-service at the hospital, and then they are taken through what would be the most likely case scenarios, like patients with drug-related psychosis or chronic mental health issues, suicidal ideation, things where they might have to talk a person down from suicide or where they can stop a potential situation escalating to violence by having the skills necessary to relate to a person and understand where they're coming from.

MR FOGARTY: Yeah.

MR THOMAS: Whether they're affected by medication, lack of medication, whether there's alcohol involved or drugs involved or --- so they can put things into context, so there's a better chance of a good outcome rather than a negative one.

MR FOGARTY: Do you think there's scope for people with psychiatric disability as well to do some work with police, people with disability, to hear from those who have gone through these lived experiences?

MR THOMAS: I think that --- hearing from somebody interacting with police, so the police can get first-hand situation where that person isn't in full-blown psychosis or suffering a catastrophic episode from [indistinct], so hears the person behind the mental health issue that, whatever that might be, this is who they are. They have a life, they do certain things. They interact in society and the community. Rather than that person that you only get to hear from when there's something seriously wrong or sometimes when there's nothing wrong and the assumption is ---

MR FOGARTY: The assumption there is ---

MR THOMAS: --- is that because there's a history, it must be because we're responding to that address --- because with the police and ambulance, every address that they respond to is flagged. So if there's a person with mental illness and the police have had a welfare check there or a mental health clinic has been involved, it's flagged, so that police officer is then alerted so he has a preconceived idea. And that might be based on a previous visit.

MR FOGARTY: Is that where that education, that specialised education and understanding you think would help, where those preconceived ideas --- may be better preconceived ideas and better educated ideas about how they might respond when they get there?

MR THOMAS: I think it's paramount.

MR FOGARTY: You've been involved with the Cognitive Impairment Diversion Program. Can you tell the Royal Commission about your contact with that program and what that program has done for you?

MR THOMAS: Given that until I met Michael I didn't know anything about that, so that was a whole world of resources that I didn't know were available to me.

MR FOGARTY: Yeah.

MR THOMAS: And that went for everything from getting a diagnosis, seeing a neuropsychologist ---

MR FOGARTY: They helped you with that?

MR THOMAS: They did. Financially, as well as transport, as well as support to follow through, to go through --- like it was a very long, arduous procedure. And then there was, in the court system, everything from finding the legal representation, having support people sit in the courtroom --- because I suffer anxiety --- and when

I get depressed or I get a bit manic, I can't sit still, especially when it could be a bad outcome, and then it's all day, why stay, and all this. So someone is sitting there going, "Geoff, it's all right."

MR FOGARTY: This was the first time, this is 2019, right, that you got that support in court?

MR THOMAS: Ever. Ever. It was a whole different --- it was an absolute totally different perspective there, right, because people were communicating 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, instead of they always knew, and I was just sitting in the chair.

MR FOGARTY: You were sitting there, yeah. 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, 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 essentially you said to Michael, "What has happened" and he explained to you what happened. 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 either walked out of the court or got taken back downstairs and out in a truck and you worked it out when you got back to the prison?

MR THOMAS: Yes.

MR FOGARTY: Is that how fundamental that support in court through CIDP has been?

MR THOMAS: Yes, it went from hearing what the Magistrate had to say and being taken down and then seeing a solicitor for two minutes between bars, going, "This is what just happened," not understanding any of it, and getting on the truck and then like reading whatever you got and going, "I've got to work this out," and then realising it doesn't matter if you want to people because you will spend more time waiting for it on remand before it, so you just cop it anyway.

MR FOGARTY: 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 that 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 be further funding, they should look at that even harder because it will save money in the long run. Because if I had got up and walked out, then you have police officers looking for me, you have potential for a violent confrontation with them because they threaten me, if I end up in hospital or on remand, it costs, I don't know, $150,000 a year to keep someone in prison, so it's

not cheap.

MR FOGARTY: The CIDP support, funding for that, much less than that, would have kept you ---

MR THOMAS: Stable and on board and focused for the period of time that I had to go to court, and for the day-long episodes that we had to go through ---

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

MR THOMAS: That was a benefit that even further past court, it was further useful in the NDIS.

MR FOGARTY: The NDIS, yes.

MR THOMAS: So with Close the Gap, Stride took the stuff out of that and applied it to my care. So it wasn't just that bit of money spent for that report --

MR FOGARTY: Yeah, for that time, it was ongoing ---

MR THOMAS: --- used for one little issue and then thrown in the bin, it was then passed on to other government organisations, NDIS, Close the Gap ---

MR FOGARTY: To support you, yes.

MR THOMAS: --- and then the other support teams that were involved. So we had the whole picture again, rather than little bits of Geoffrey all over the place. And that's what we are starting to get through what Michael does.

MR FOGARTY: Through CIDP.

MR THOMAS: Yes. So through that we're getting a database that's complete on the people that it's relevant to, so that --- and the good thing is, because people like Michael, he communicates so well to different organisations, so he will go the distance and go, "No, no, you've only got a bit of information and we're happy to share the information we've got." So it doesn't have to be redone, you don't have to rehash it and relive it and go through it over and over.

MR FOGARTY: Yeah.

MR THOMAS: They just ask me, are you happy for us to share this information?

MR FOGARTY: To share this information on your behalf, so that's the advocacy they are doing for you, it saves you the trauma of going through it all again feeling like you've said it a million times.

MR THOMAS: It also gives a voice, because I can say what I want to say, the courts aren't happy, the hospital doesn't want me. But when Michael says, "Listen, we've referred him, we've been involved in," they go, "Now it's believable."

MR FOGARTY: That's right, he comes to them --- with a 35-page criminal history that is going to form assumptions, he comes as an Advocate for you, whereas if you walked to the police station to say "A, B and C, this is what I want you to know," different, it's a totally different experience.

MR THOMAS: Straight over the head, no one will pay attention. He gives me a voice. They give me a voice. That's very important to me. Which to me, I don't know, it might be like I'm overstating it, but when you spend as many years as I have trying to fight corruption within the system and even sometimes trying to fight that corruption within the very system that investigates that system, through omission even, they do not even have to do something, unfortunately just by omission, you're guilty for not advocating for that person.

It's refreshing to see that something new is on the horizon, that we can grow and grow and grow into what should be the future. Because more jails is not the answer. More police is not the --- we need to be looking at what we can do to assist people who have these situations in their lives.

MR FOGARTY: Yeah.

MR THOMAS: Because not everyone has control, like --- we all have different levels of control in our lives and what happens to us, and some of us need to have somebody guide us through and support us --

MR FOGARTY: Yep.

MR THOMAS: --- and if we don't have that, we become even more so victim, and more broken, and that's a tragedy.

So if they don't listen to people like Michael and take on board what he's learning, what they are learning from people, you know, who have got what I've got, I'm sure there's many people like me out there, and take it on board any form of change, then all it means is he's basically doing their job.

MR FOGARTY: Their work, yeah.

MR THOMAS: So --- and he's saving meltdowns, he's saving confrontations with police, he's saving people walking out of court and having first instance warrants served on them. He's saving people's lives by having a neuropsychologist's report done and saying, you know, because the NDIS weren't going to pay for it --- they wanted it but they weren't going to pay for. So intergovernmental, or interdepartmental, I suppose you would say, even though they look at the money that is spent, look at the government organisations that saved by having that information

and then being able to streamline my care. Because NDIS required information, Stride required information, and the courts wanted information, my solicitor required information to provide a reasonable defence for me, or explanation as to who and what I was about, and my mental health situation. So it wasn't --- it was never about one thing. And if you followed the money trail, if you followed how that affected the whole scenario, you would see that that little bit of money that was spent saved a fortune.

MR FOGARTY: So we need you up at Senate Estimates with Michael, next time it's round, showing them the cost savings to keep CIDP going, and in fact more so to spread that change to the big institutions, to the mental health units, to the police, to say that CIDP isn't doing their work but it's doing the work that consumers like you who speak directly to the program, need ---

MR THOMAS: If you had in-services, like involving a cross-section of all, and then they knew that that was there --- because I'm sure that there are many people in mental health units all around that have no idea about what's going on here and who he can call and what's available.

MR FOGARTY: Yep.

MR THOMAS: So they are not represented, so they are not, you know --- and unless we get that information inside that organisation, so that people know, so that a nurse might refer a patient, and we might save further court matters and that, but it can be resolved in the mental health unit and then through some conversation with the court and the police, and resolving that issue there. Whereas if you have someone sitting in the mental health facilities and they're just waiting for court to go, and then you've got the court costs, you've got the Magistrate, the police, you've got the ambulance, you've got all that stuff, and what we could do is save --- "Look, we've got all of that person's information here," and then that person is represented fairly across the board by these people, which is rightly so, given their circumstances, and we can deal with this a lot more efficiently and effectively and then look at what we can do to stop it happening in the future. So it would be a good thing.

MR FOGARTY: Geoff, that comes to the end of the questions I have for you. As a wrap-up, I want to ask you if there's anything finally you want to suggest or say to the Royal Commission, perhaps what you would like to see as a recommendation from the Royal Commission?

MR THOMAS: Yeah, I would say or recommend, I think, the CIDP is an excellent portal for people like myself to be represented, to have people advocate on our behalf, and cost effective. We attack a problem that we have, and I think that's what we identified here today in some way, and other people are identifying it by coming forth, the Government needs to fund CIDP, I believe, because it's cost-effective, saving the money in the long run. The taxpayers are paying less money because we can identify issues that can be solved amicably without having confrontation with police, involving ambulance officers, dragging it through the courts. We can have a

process that can have some support networks there for people in my circumstances and instead of exacerbating the situation, we can resolve and we can have conflict resolution, rather than aggro and police involvement, court involvement.

MR FOGARTY: So the savings are greater in the long run?

MR THOMAS: I would say, given the amount of people that are involved in one single episode, definitely, 100 per cent. This is a long-term saving for the government.

MR FOGARTY: Brilliant, Geoff. Thanks for your time today.

MR THOMAS: Thank you.

[END OF VIDEO RECORDING]

DR MELLIFONT: Thank you. On behalf of Counsel Assisting, can I thank Mr Thomas for his prerecording of that video with Mr Fogarty of Counsel. Can we have a break before we commence the next session, please, perhaps until 10.25 Brisbane time?

CHAIR: Certainly, we will adjourn then for 15 minutes.

DR MELLIFONT: Thank you.

ADJOURNED **[11.10 AM]**

RESUMED **[11.25 AM]**

CHAIR: The witnesses are on their way.

Dr Mellifont, we have Ms Cootes and Mr Baker with us in the Sydney hearing room. It is over to you.

DR MELLIFONT: Thank you. Before I proceed to the evidence of Ms Cootes and Mr Baker, can I just clarify that the Taylah who was present with Mr Thomas in that interview with Mr Fogarty is not the Taylor Budin we will hear from this afternoon, it is Taylah from Stride, and the Michael who was present also in that interview is Michael Baker, who is on screen with us now. Thank you.

Commissioners, the next two witnesses are Ms Janene Cootes AM, Mr Michael Baker. You will find the witness statement of Ms Cootes at Tab 10 of Tender

Bundle B2. Can I make one correction to that statement at paragraph 35, and it is a relevant correction. The figures for the 1 July through 31 December 2020 year should be 3,711 supports to 1,100 people. If I can ask that that statement be tendered into evidence, please.

CHAIR: Yes, and to be given which marking?

DR MELLIFONT: Exhibit 11.30.1.

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

EXHIBIT #11.30.1 - STATEMENT OF MS JANENE COOTES

DR MELLIFONT: Thank you. You will find the written statement of Michael Baker at Tab 121 of Tender Bundle B2. I ask to tender this statement in evidence and for it to be marked as Exhibit 11.31.1. You will also find an attachment to Mr Baker's statement at Tab 53 of Tender Bundle D2, and I ask to tender this document into evidence and for it to be marked Exhibit 11.31.2.

EXHIBIT #11.31.1 - STATEMENT OF MR MICHAEL JOHN BAKER

EXHIBIT #11.31.2 - ANNEXURE TO STATEMENT OF MR MICHAEL JOHN BAKER

CHAIR: Yes, those documents can be admitted into evidence with those markings.

DR MELLIFONT: Thank you. We are ready to proceed with the evidence.

CHAIR: Thank you very much, Ms Cootes and Mr Baker for coming to the Sydney hearing room to give evidence. Just to explain where everybody is, we tend to be a little scattered: Dr Mellifont on the screen is in our Brisbane hearing room. Also in the Brisbane hearing room are Commissioners Atkinson and Mason, although I don't think you can see them on screen at the moment. Commissioner McEwin, as you know, is with me in the Sydney hearing room. If you would each be good enough to follow the instructions of my Associate, who is to your right, she will administer the affirmations to you.

MS JANENE COOTES AM, AFFIRMED

MR MICHAEL JOHN BAKER, AFFIRMED

CHAIR: Thank you very much and thank you for coming to the Commission to give evidence. I will now ask Dr Mellifont to ask you some questions.

EXAMINATION-IN-CHIEF BY DR MELLIFONT

DR MELLIFONT: Ms Cootes, could you state your full name, please?

MS COOTES: Janene Cootes.

DR MELLIFONT: You provided a statement to the Royal Commission dated 2 February 2021; is that correct?

MS COOTES: Yes, that's right.

DR MELLIFONT: Subject to the correction that I just read into the record about the numbers for the July through December 2020 period, is that statement true and correct to the best of your knowledge and ability?

MS COOTES: Yes, it is.

DR MELLIFONT: Ms Cootes, are you the Executive Officer at the Intellectual Disability Rights Service, IDRS?

MS COOTES: Yes, I am.

DR MELLIFONT: Have you been in that role since 2008?

MS COOTES: Yes, that's right.

DR MELLIFONT: Your statement sets out your experience and your qualifications, but they include being a General Community Member of the Guardianship Division of the New South Wales Civil and Administrative Tribunal, formerly the New South Wales Guardianship Tribunal.

MS COOTES: That's right.

DR MELLIFONT: That's from 2002 until the present time?

MS COOTES: Yes.

DR MELLIFONT: Okay. You have approximately 24 years working together with people with disability with their journey through the criminal justice system?

MS COOTES: Yes, that's right.

DR MELLIFONT: What is the IDRS?

MS COOTES: Intellectual Disability Rights Service, in short IDRS, is both a community legal centre and a disability advocacy service and the disability advocacy part of our service, a lot of that is directly related to criminal justice work. I'm not sure whether you want me to go through detail about the Centre, do you?

DR MELLIFONT: No, that's probably sufficient. But it's reasonable to say that IDRS has delivered court support for people with intellectual disability in New South Wales courts since 2004?

MS COOTES: That's right.

CHAIR: And we can add that it owes its origins to the Redfern Legal Centre, historically associated with that splendid institution, the Law School of the University of New South Wales. Apart from that, we don't need to know anything extra!

DR MELLIFONT: No manifest bias there!

MS COOTES: Court support and police station support and generally supporting people through their criminal justice experience.

DR MELLIFONT: Is it correct to say that the service intends to seek to fulfil the needs, so far as it can, to facilitate applications --- assistance for people with cognitive impairment, cognitive disability, through the criminal justice system?

MS COOTES: Yes, that's right.

DR MELLIFONT: Can I turn now to you, please, Mr Michael Baker. Your full name, please?

MR BAKER: Michael John Baker.

DR MELLIFONT: You have provided a statement dated 2 February 2021?

MR BAKER: That's right.

DR MELLIFONT: Is that statement correct and true to the best of your knowledge and ability?

MR BAKER: Yes, it is.

DR MELLIFONT: Are you an advocate employed by the IDRS in New South Wales?

MR BAKER: Yes, I am.

DR MELLIFONT: How long have you had that role for?

MR BAKER: That particular role commenced in July 2020.

DR MELLIFONT: Where were you before then?

MR BAKER: I was at IDRS and working on the Cognitive Impairment Diversion Program.

DR MELLIFONT: And for how long were you working on that program?

MR BAKER: I started that role as a Case Manager in January of 2018.

DR MELLIFONT: Amongst your qualifications is a Bachelor of Social Science, Criminology and Criminal Justice, and you are about to commence another degree; is that correct?

MR BAKER: Yes, I've commenced a Bachelor of Criminology and Criminal Justice this year --- an Honours degree in Criminology and Criminal Justice.

DR MELLIFONT: Honours degree, thank you. From January 2018 you were the Case Manager in the Cognitive Impairment Diversion Program; is that correct?

MR BAKER: Yes, I was one of the case managers, yes.

DR MELLIFONT: Your statement sets out your industry experience, but in short terms, it has included supporting people who have a primary diagnosis of being on the autism spectrum and people who are deemed to have complex behaviour or complex support needs; is that correct?

MR BAKER: Yes, that's right.

DR MELLIFONT: From 2014 through 2018 you worked for Autism Spectrum Australia, called Aspect, in a variety of roles; is that right?

MR BAKER: Correct, yes.

DR MELLIFONT: Within that work you came to do work with respect to positive behaviour support?

MR BAKER: That's right.

DR MELLIFONT: Okay. Is it correct that it was not uncommon for the people you supported at Aspect to have dealings with the police and the court system?

MR BAKER: Yes, that's correct.

DR MELLIFONT: All right. I will ask questions of each of you as we go along, but if there is a particular topic you want to come in on, just give me an indication and I will make that happen.

Perhaps Mr Baker, if I can start with you, can you just provide a brief summary of what the CIDP was?

MR BAKER: The CIDP was a diversion program targeted specifically at defendants of the local court who had a diagnosed or a suspected cognitive impairment. It aims to provide the best possible opportunity for those defendants to access diversion and participate in diversion opportunities successfully --

DR MELLIFONT: And --- go ahead.

MR BAKER: --- by way of a section 32 order by the court.

CHAIR: Maybe just explain what a section 32 order is.

MR BAKER: Yes, sorry. Thanks, Chair. A section 32 diversion order refers to section 32 of the *Mental Health (Forensic Provisions) Act*, which allows a magistrate to make an order for a defendant on the basis of their mental illness or cognitive impairment, that they connect with community-based supports that meet their needs and reduce the likelihood that they appear before a court again, rather than be processed at law in a way that is punitive or punishing or results in a conviction.

CHAIR: Thank you.

DR MELLIFONT: It was initially a two-year pilot program; correct?

MR BAKER: That's right.

DR MELLIFONT: Out of two courts, two local courts, Penrith and Gosford?

MR BAKER: Correct.

DR MELLIFONT: Ultimately it extended for a third year?

MR BAKER: That's right.

DR MELLIFONT: But finished up in June 2020 when funding was ceased; is that right?

MR BAKER: Correct.

DR MELLIFONT: What was the role of the case manager in the CIDP?

MR BAKER: The case manager role was a holistic one. Initially, it differed a little bit in the two models, but the case manager was responsible for working intensively with the defendant, the participant in the Diversion Program, to identify their support needs, help them communicate with Legal Aid or whoever their solicitor might have been, so that they could understand the legal process as much as possible and make decisions around that.

We worked with them not only in court but in the community to help them access relevant support services, like NDIS support service, drug and alcohol, mental health, housing. So it was a dynamic role and really tailored to meet the individual needs of the individual person we were supporting.

DR MELLIFONT: I am going to come to the two iterations of the program shortly. Firstly, can I ask you, where do referrals to the program come from?

MR BAKER: Chiefly from court-based stakeholders, Legal Aid, magistrates, the court itself, so --- some registry staff. But as we sort of developed presence and reputation, we ended up receiving referrals as well from the NDIS rather than the NDIA, NDIS service providers in the local region, a whole variety of community-based services as well. Clients could refer themselves, family members could refer them.

DR MELLIFONT: In terms of the essential threshold for referral, was that on the basis of a confirmed or a suspected cognitive impairment?

MR BAKER: Yes, that's right.

DR MELLIFONT: So just to get everybody oriented here, there is the two-year pilot period, and then it was extended to a third year, which was the 2019/2020 financial year, under a revised model. Can you explain to the Commission the first model, compared to the second model, please?

MR BAKER: Sure. The first model was more of a multi-agency model, I suppose, so the primary stakeholders in delivering the CIDP in the first model were IDRS as the case management service, Justice Health as the clinical and diagnostic service, and Community Corrections as the monitoring service.

In the second iteration of the model, Justice Health and Community Corrections were no longer a part of that model. The monitoring function that Community Corrections provided had been eliminated from that model, and while of course there was that maintenance of an important diagnostic and clinical function as part of the CIDP model, that was instead --- we brokered those assessments privately to a whole suite of clinical physicians rather than court-based Justice Health neuropsychologists.

DR MELLIFONT: So just as with the first model, Justice Health were responsible

for screening and intake; is that right?

MR BAKER: That's correct.

DR MELLIFONT: There was a neuropsychologist employed at each court who did the screen and assessment and then the person was allocated to a CIDP case manager; is that right?

MR BAKER: That's correct.

DR MELLIFONT: Under that first model, Justice Health provided the final report to the court as part of the application for diversion or as part of sentencing?

MR BAKER: Correct.

DR MELLIFONT: IDRS had input, that is, authored a support plan covering activities undertaken and forthcoming within CIDP case management, is that right?

MR BAKER: Yes, that's right.

DR MELLIFONT: I want to then turn to what you just said about the monitoring function, and I will come to you, Ms Cootes, about this in a moment as well.

So that initial model had a monitoring function whereby Community Corrections monitored compliance with that order. Now, was it your experience --- Mr Baker or Ms Cootes, whoever would like to answer this question --- that was used often or seldomly?

MR BAKER: That was rarely used. I think it was used across both courts a handful of times.

DR MELLIFONT: Ms Cootes, did you see that particular function as being problematic?

MS COOTES: Yes. We were never in favour of that function because the diversionary order is meant to divert someone from the criminal justice system, and being monitored by Corrections --- and the monitoring involved a Community Corrections officer making a phone call to the service providers to --- basically to check whether they had been attending appointments or complying with their support plan. And I guess one particular criticism we had was that it didn't involve any contact with the person, the subject of the order. Yes, and so it was --- the magistrate could include it in on order if they chose to. It didn't become something that was necessarily part of every CIDP section 32 order.

DR MELLIFONT: Ultimately the New South Wales Government decided to get rid of that for the new model; is that correct?

MS COOTES: Yes. Yes, it hadn't had a lot of use and the Corrections people didn't feel it had a lot of utility either, I don't think.

DR MELLIFONT: Is it fair to say, both to you, Mr Baker, and to you, Ms Cootes, that the removal of that monitoring function was a welcome change from IDRS' perspective?

MR BAKER: Yes.

MS COOTES: Yes, to us it was, yes.

DR MELLIFONT: Mr Baker, I stopped you before but I'm going to ask you now to explain the second model.

MR BAKER: Yes. So the second model operated so that IDRS and the CIDP case managers were the core of that model. So we conducted brief screening to see if someone had a suspected or confirmed cognitive impairment, so in that way we determined eligibility for the program. If they did require a clinical assessment, we made that referral and supported them to attend and get or rule out a diagnosis. Of course, we continued to provide the case management component of the program, and we also assumed responsibility during that final year for the final court report, in conjunction with the neuropsychological or other clinical assessment that would sit with our line in the case management progress, and the support plan and support plan recommendations.

DR MELLIFONT: What would IDRS do if a referral came to you but the person was deemed ineligible?

MR BAKER: We would refer them on to somewhere appropriate, so sometimes we had people referred to us whose chief need was mental health, so we would refer them to the clinical nurse consultant at the court or refer them to an appropriate community service, just sort of a warm referral.

DR MELLIFONT: You spoke of a clinical nurse consultant being at the court.

MR BAKER: Yes.

DR MELLIFONT: Does that happen routinely at those two local courts and is that continuing?

MR BAKER: Yes, as far as I know that's continuing. So the clinical nurse consultants at Gosford Court and Penrith Court are sat under the state-wide court and community liaison service, so an arm of Justice Health.

CHAIR: Are there other officers, people like that, at other courts besides Gosford and Penrith?

MR BAKER: Yes, there is.

CHAIR: Why were Gosford and Penrith chosen?

MR BAKER: I can't really speak to that. Maybe Janene can.

MS COOTES: I don't really know, I know that they were keen to have one metropolitan and one regional court.

CHAIR: By "they", who do we mean?

MS COOTES: The Department.

CHAIR: The Government, in other words?

MS COOTES: Department of Communities and Justice?

CHAIR: They weren't marginal electorates or anything like that.

DR MELLIFONT: Mr Baker, in your statement you speak about referral to other pathways that you have just indicated, and you speak of the MERIT Program. What is that?

MR BAKER: That is the Magistrate's Early Referral into Treatment Program, so that is specifically a diversion Program really for people with substantial related needs or issues.

DR MELLIFONT: Can you tell me from your experience of the Program --- and let me know if I'm straying too far --- whether it has a particular focus on the coalescence of people with a cognitive disability and substance abuse?

MR BAKER: I wouldn't say it has a focus on that. I would say that there's an acknowledgment within their expert, cognitive impairment is --- it often precedes or is subsequent to substance issues. But I wouldn't necessarily say that MERIT works in a way that fully meets the needs of people with cognitive disability.

DR MELLIFONT: One more question before I move off this part. Are you aware of any support service, like the IDRS, which is developed to assist First Nations people with cognitive disability in the criminal justice system with substance abuse?

MR BAKER: No, I'm not aware of any such service.

DR MELLIFONT: Ms Cootes?

MS COOTES: No, I'm not aware of such a service either.

CHAIR: Why are you smiling?

MS COOTES: Just --- it's just very specific, a very specific group that that would be dealing with, and it will be a long time before we have services that cover that wide range of needs.

COMMISSIONER McEWIN: Dr Mellifont, could I ask a question before you continue. On the assumption that only two courts are chosen, Gosford and Penrith, do you agree that they were highest need areas, or would you have chosen other areas around New South Wales?

MR BAKER: For me, working in that space in a direct practice context?

COMMISSIONER McEWIN: Yes, in terms of high need.

MR BAKER: Definitely high needs areas, definitely. I can't speak to the other courts but certainly those two were high needs areas.

MS COOTES: I would agree with that, I think they are high needs but a similar level of need is in a lot of courts around the State. So it's not special; that level of need exists right around New South Wales.

DR MELLIFONT: Mr Baker, under both models clients needed to have or to obtain an expert report confirming the cognitive impairment; is that correct?

MR BAKER: That's correct.

DR MELLIFONT: Were those reports presented to the court as evidence of the impairment and of the ways in which the disability may have affected thinking and behaviour?

MR BAKER: That's correct.

DR MELLIFONT: On top of that, CIDP case managers prepare a report and support plan which links the various reports and documents to the practical circumstances, needs and goals of the individual to try to address types of situations and behaviours which resulted in the offending.

MR BAKER: That's exactly right.

DR MELLIFONT: Apart from using an assessment report, being able to use an assessment report for a section 32 diversion order application, how else could and did IDRS utilise those assessment reports in the course of a CIDP? That would be for either of you to answer.

MR BAKER: So the diagnostic reports became sort of a very central component to meeting the person's needs, not only in the criminal justice system, but certainly beyond that. So those same reports were used to apply for NDIS funding,

appropriate housing, to gain access in residential drug and alcohol rehabilitation, to help people directly supporting them and other clinicians in that their lives, to better understand their needs and how to support them. It was a key piece of information to provide continuity of support throughout all areas of their life.

DR MELLIFONT: Ms Cootes, if you want to add anything to that, please do, but I specifically wanted to ask you how such reports assisted with bail.

MS COOTES: I guess the assessment report assists with bail but also the support plan was key to that, because very often people don't --- they come before the court and they don't have any support services, and magistrates sometimes feel they have no option but to remand the person in custody. So the assessment report is important, but I would say the support report and the organisation of supports probably has a bigger influence on the person achieving bail.

DR MELLIFONT: Yes. Mr Baker, do you agree with that?

MR BAKER: Yes, definitely.

CHAIR: How many magistrates are there sitting in criminal matters at each of those courts, Gosford and Penrith?

MR BAKER: It varied a little. I think at Penrith we had four --- Gosford I'm not sure, actually.

MS COOTES: Probably a similar number.

CHAIR: Were the approaches of each of those magistrates in those locations similar, once the program became involved in some way?

MR BAKER: Chair, what do you mean by approaches?

CHAIR: Did you find that your applications to the court were dealt with in a similar fashion? I'm not talking individual decisions but that magistrates understood what was being put forward, sympathetic to the program, did it vary between magistrates?

MR BAKER: It varied at the start of the program I think. But as we went on, that was less so. I think there was a general approach to understanding the type of support we were providing and --- yeah.

CHAIR: And a willingness to regard it as helpful to the process.

MR BAKER: Yes, absolutely.

CHAIR: Sorry to have interrupted again, carry on.

DR MELLIFONT: You have in fact received some feedback about how helpful the

program has been, without naming names; is that correct?

MR BAKER: Yes; isn't that right.

DR MELLIFONT: I want to come back to the point we were discussing before, which is how you got the assessment report and how you got the CIDP case manager report, and how these reports were able to be used by the client outside the diversion, so can I just summarise and make sure I have got them all down.

They helped with bail, they helped with sentencing if that was the route that was ultimately undertaken, they were used to apply for access to services through the NDIS or to seek to increase funding through the NDIS, they were used to help support other applications, like housing, Disability Support Pension and residential rehabilitation. Is that correct?

MR BAKER: That's correct.

DR MELLIFONT: I want to ask you both, which of the two models do you prefer and why? Ms Cootes, would you like to go first?

MS COOTES: Well, from our point of view we preferred the second model because we were involved in the initial referral and the screening, it gave our case managers an opportunity to be involved with the person from the beginning, and also to begin to develop a relationship with them from that early stage and to get to know them very well.

It also gave us options in relation to the type of assessment that might be needed, so not a neuropsychological assessment is not necessarily the best sort of assessment for every person with cognitive impairment, so we were able to broker different types of assessments depending on what seemed most needed, and also to brief the person who was doing the assessment about specific issues and needs that we wanted to be covered in those reports.

So I guess that --- it was good to have continuity, I think, all the way through. Not that there were problems with the previous model in that regard, but we just found it easier to work with people in that --- (overspeaking) ---

DR MELLIFONT: Thank you.

Mr Baker, just picking up on Ms Cootes' point there about the continuity, you speak in your statement about there being one point of contact rather than three, which meant you could start working with clients earlier because you were involved before the diagnostic assessment was complete. So what did that look like in practice for you as an advantage?

MR BAKER: So having referrals come directly to the IDRS case manager, rather than have to kind of bounce through other parties and stakeholders, just reduced the

complexity of the program generally, which was great for obviously the court, which is complex enough and busy enough as it is, but certainly for the clients we were supporting. We were just the face of the program and they worked with us in a more streamlined way because we had been with them from the start and we were responsible for each function.

DR MELLIFONT: Ms Cootes spoke then about not always having to get neuropsychologists but you could get a different type of report, depending on what the circumstances called for. Might that be a psychologist's report? Is that right, that one example?

MS COOTES: Yes, that would be the main other alternative.

DR MELLIFONT: What about occupational therapy?

MR BAKER: Depending on the particular needs of the person, so that was really our core ethos. So sometimes we had people referred to us that had a sufficient psychological and neuropsychological report, I can think of one particular gentleman whose primary need in the diagnostic sense towards his diversion application and enhancing his support was an autism sensory assessment. So yes, that is one example where we utilised an occupational therapist report.

MS COOTES: And also, different psychologists might have different specialisations as well, so we could refer to somebody who was a specialist in intellectual disability and behaviour support or to someone who was a specialist in brain injury. The other thing I might just mention is that just having one person to do the assessments at the court had the effect sometimes of creating a bottleneck. So being able to refer to a number of professionals for assessments meant that that bottleneck was avoided.

DR MELLIFONT: So that improved time frames overall; is that right?

MS COOTES: Yes.

DR MELLIFONT: Mr Baker, you do speak as to one of the advantages of the second program being the improvement of time frames.

MR BAKER: Yes.

DR MELLIFONT: Apart from the point we have just indicated, were there other aspects of the second program which helped make things move more quickly?

MR BAKER: I just think that again the operational complexity was less so than in the first model because it was one service responsible for all aspects of the program.

DR MELLIFONT: Just a couple more points I want to take you to in your statement about your reasons for your premierships of the second model. The first is you say assessments could take place in a more comfortable and less intimidating

environment than the court. Could you explain that, please?

MR BAKER: Sure thing. So criminalised people with cognitive disability certainly find court a confusing and intimidating place, hence the need for a service like this, but particularly the diagnostic process I think can be quite intimidating as well, and for that to be taking place at the court I think probably has some implications and tie-ins with the criminal justice process that I don't think necessarily is helpful. So I think for our client group being able to go through the diagnostic process off-site in a safe space, a comfortable place, either the clinician's office --- sometimes it would take place at our offices as well --- that enabled them to participate more fully in that process as well and I would assume have a diagnostic report produced that probably has a little bit more efficacy as well.

DR MELLIFONT: Ms Cootes, do you agree with all of those points?

MS COOTES: Yes, I do.

DR MELLIFONT: Finally on this topic, Mr Baker, unless there is something I have forgotten in terms of the reasons you each prefer the second model, Mr Baker, you state that the reports under the second model included a focus on their impairment and support needs in addition to diagnosis and offending, which made them fit for multiple purposes. Can you just give me a little bit of context so I can understand how it was that the second reports were superior in that respect?

MR BAKER: What I'm trying to get at there is that because we were brokering out the diagnostic assessments to a number of different clinicians in the second model that were not court-based clinicians that had sort of a forensic aspect to them, I think that meant that the reports kind of covered a broader area rather than just the reason for the alleged offending, I think it was able to cover the need for NDIS access, functional challenges as well, in a way that gave the reports greater utility overall. That would be my view.

And the fact that the case manager was able to sort of work with those clinicians and provide information to them about our work with that person up until that point as well, also enhanced the usefulness of those reports in broader terms.

DR MELLIFONT: Thank you.

Ms Cootes, I want to come to the general approach of the CIDP and can you let me know if this is a reasonable summary? Is it the approach was a commitment to working for the best outcome for the person with cognitive impairment and supporting them to be actively involved in choices and decisions which, although takes time, is more likely to equip the client to be able to comply with the order and achieve real change? Is that the approach?

MS COOTES: Yes, that's exactly the approach. And more based on the person's needs than a program approach which is defined and where you can't really adjust to

the individual's needs. So yes, my observation all the time of the staff was that they worked in that way.

And one of the things we mention is that trust is a big issue often for people with disability in the criminal justice system. They have often been let down by services, have long history of being let down and losing faith really, and lack of trust. And so we think it's an important aspect of the work to build that trust again and that was an important basis for people accepting services that we recommended to them and linked them with.

I think you can't underestimate that because many people have had many tries, but I do think having that approach makes it much more likely that the person will persevere and that they will be able to trust a service provider. I think it's important to say that disability services aren't always reliable, they are not always person-centred, and there often does need to be a bit of a bridge created so that relationship will work. And particularly when someone has a reputation of a criminal background, that might be difficult for some disability services, so --- but working on that, the foundation that relationship could be built on in the future was a really important part of the service, I think.

DR MELLIFONT: Thank you.

Can I ask you to comment on this observation in Mr Baker's statement:

> *[Many clients] had .... reported feeling something was 'not right' .... [but] their involvement with CIDP was the first time that they had a [confirmed] cognitive impairment and the extent of [it, citing] one-third of [the] CIDP participants in 2019-20 ....*

Is that your experience?

MS COOTES: Yes, it is. I think you will find that research that shows that many people with cognitive impairment who are tied up in the criminal justice system have been often diagnosed for the first time as they go into prison. So I guess what was happening here is it was moving one step forward. But the real advantage of it happening at this point, when you have got a case manager working with you, is that somebody could help you to deal with that and understand the meaning of it and for the person then to be able to use that as parent of their understanding of how they could move forward.

DR MELLIFONT: Mr Baker, you say that the IDRS does not insist on labels and that some of your clients felt they were being labelled once they received a diagnosis, but instead what you were seeking to do was to frame the disability in terms of the client's individual needs. Can you explain that?

MR BAKER: So what I'm referring to there is the way we work with people, which is that extremely individualistic and humanistic way. Some clients who had a

diagnostic label or received a diagnostic label really embraced that and that sort of became or was an important part of their identity, and that's absolutely fine. Other clients didn't want to be defined by a diagnostic label, so we just made sure to respect that. But across the board, whether or not they wanted to be seen as someone with a disability or not, we just treated them as individual human beings and respected their individual wishes for interaction, support, referral.

DR MELLIFONT: So the focus was on need rather than tethering it to a diagnosis?

MR BAKER: Yes, that's exactly right.

Ms Cootes, in the course of the program, sometimes court appearances were adjourned for a number of months; is that correct?

MS COOTES: Yes. So the court process took a long time in itself, on average probably three to four months if you were seeking a section 32 order. But some magistrates preferred to see the services put in place, rather than receive a plan which says the service will happen in the future. I think that's the way the staff worked, was to try and put the services in place so that the magistrate could actually see that the person was complying with them, that they were perhaps even making a difference by the time the person came before the court for the actual section 32 decision to be made.

So I think the staff found that that was --- and the solicitors that they worked in partnership with, found that that was often reassuring to the magistrates considering making section 32 orders, often for people who had been before them many times before and had not received a diversion order.

DR MELLIFONT: Thank you.

I want to take you to a statement of Mr Michael Coutts-Trotter, which we received yesterday, at STAT.0332.001.0001, and I want to go to page 0011.

Can we go back two pages to page 0009, please.

I think, Ms Cootes, you have had an opportunity to read this statement.

MS COOTES: Yes, I have.

DR MELLIFONT: I want to ask you a couple of questions.

CHAIR: I think Ms Cootes might require quite good eyesight to see what the pages actually say, so I'm not sure whether you want to refer her to something specific.

MS COOTES: Could you give me a paragraph number? I have the statement in front of me.

DR MELLIFONT: I am going to take you to paragraph 37, and I am going to take you initially to the first three lines of paragraph 37, up to the colon.

MS COOTES: Yes.

DR MELLIFONT: Just to put into context, Connect to Divert is a possible program in development by the New South Wales Government, as we understand it. Is that your understanding?

MS COOTES: Yes, that's my understanding.

DR MELLIFONT: But what I wanted to ask you about is the concept of timeliness. The paragraph reads:

> *Connect to Divert, if adopted, is intended to increase CIDP's capacity so that more participants can be assisted, and improve the timeliness of service delivery....*

Are you aware of any problems with the service --- with the timeliness of service delivery by IDRS of the CIDP?

MS COOTES: No, not really. So I don't think we knocked back anyone because we didn't have the capacity to take them on in the whole history of the service. No. And I don't think delays in the court process happened because of any delays related to the work of the case manager. So not really. Actually, Michael and I were discussing this this morning, and our estimate would be that the average time that CIDP was involved --- average --- was about four months with a lot of people. But the court process itself often took three to four months. So I'm not 100 per cent sure what that refers to because, as I say, we never were over capacity, we never brought on any delays in the process.

I will add that there were some people who --- in our experience, long experience, a diversionary order can often fall through because of what happens after the court process, and that might be that things just don't work out between the service providers or there are new disasters in the person's life that throw things off course. So for some people we would have stayed involved for a bit longer, to make sure their relationship with their support coordinator, for example, from NDIS was established and working, because we don't want to see the fruits of all our earlier work fall apart because there are problems with that.

But that, in our view --- you can comment --- I don't think that extended our involvement much longer and I don't think it affected timeliness for people who were actually in the program.

DR MELLIFONT: Mr Baker, do you have any comment you would like to add?

MR BAKER: No. I would agree with that and then just endorse that certainly for

some people, once they receive a diversion order, they do require some assistance to implement that and make sure that the services contained in that order are functioning well for them, and they are given a chance to --- for us to support them to make sure they do.

MS COOTES: Can I just say, I think often in the criminal justice system people can easily forget the impact of the cognitive impairment, so it's not --- the person still is going to have trouble with planning or with memory or with understanding or reading and there are just so many things that occur that will trip them up along the way. So their support coordinator should be able to help them with some of that, but we were focused on making the order work for the person, both in the planning of it, the reporting about it and actually making it work, so just staying involved long enough to make sure it was on a stable path.

And I just think it is important to note the criminal justice system often talks about disability but doesn't really acknowledge the impact of that disability on the person and why they need additional help, that you might say somebody else didn't do what they were told to do, okay, but a person with cognitive impairment, there could be a hundred little reasons why things fell through that are not necessarily their fault. I think it's just a very important understanding.

DR MELLIFONT: Thank you, Ms Cootes.

I now want to take you ---

COMMISSIONER ATKINSON: Dr Mellifont, if I could ask a question.

Is it also true that in fact someone with a cognitive disability is likely to take longer to understand what is going on and to communicate what they want and what they understand, so efficiency is not perhaps the best measure? Time efficiency is not perhaps the best measure for someone with a cognitive disability?

MS COOTES: I think that's a very good point. It's certainly not the most important measure because the efficiency may lead to a subsequent failure, because you haven't helped the person to be set up well enough.

COMMISSIONER ATKINSON: Thank you.

DR MELLIFONT: I want to take you back to paragraph 37, because what this paragraph does is set out the anticipated features of the Connect to Divert program if it's adopted. I'm going to take you to each of them and ask you whether or not this was a feature of the CIDP. Can we start with a and bring that up. In your view, Ms Cootes, under the CIDP was there a service provider with appropriate expertise in working with people with cognitive impairment?

MS COOTES: Yes, definitely.

DR MELLIFONT: Paragraph (b), did the provider accept referrals and conduct none clinical screening of defendants to determine eligibility and possible cognitive impairment?

MS COOTES: Yes.

DR MELLIFONT: Did the provider collect historical reports and other elements of a prior cognitive impairment diagnosis to support applications for adjournments to court to have time to develop a defendant's support plan?

MS COOTES: Yes, we did.

DR MELLIFONT: Did brokering private clinical assessments occur when needed under the CIDP?

MS COOTES: Yes, they did.

DR MELLIFONT: Paragraph (c), were diversion programs developed to respond to the defendant's needs and to support defendants to contribute to the community safely?

MS COOTES: Yes, they were.

DR MELLIFONT: Paragraph (d), did the service provider continue to focus on connecting the participant with the NDIS and relevant communicate-based supports?

MS COOTES: Yes, we did, and I would just like to emphasise, a lot of the supports we connected people to were mainstream supports; not always disability.

DR MELLIFONT: Okay. For more prolonged case management and coordination of the ongoing need of the participant, was the participant supported to transition to the NDIS and other relevant services to implement their support plan and exit from the program?

MS COOTES: Yes, that's true.

DR MELLIFONT: Paragraph (e), did your staff prepare a court report with evidence of clinical diagnosis and support plan to support a defendant's diversion application?

MS COOTES: Yes, they did.

DR MELLIFONT: Was their progress monitored?

MS COOTES: Yes, that's exactly which they did.

DR MELLIFONT: I will read that into the record. Was the participant's progress monitored until they were comfortably engaged with appropriate support service?

MS COOTES: Yes, monitored and supported.

DR MELLIFONT: Mr Baker, in respect of the answers that Ms Cootes has just given with respect to paragraph 37a to 37e, do you agree with her answers?

MR BAKER: Yes, I do.

DR MELLIFONT: Mr Baker, your statement sets out that while the CIDP was envisaged as a short-term intervention, there were some difficulties in transitioning clients to NDIS-funded supporting coordinators and the reasons for this. What was CIDP able to do for its clients in respect of this issue?

MR BAKER: We were able to work with them intensively and individualistically to find the right support coordinator. Perhaps it was a matter of the participant's NDIS plan not having enough support coordination funding, so we would work with them to address that, sort of begin that review or appeal process to garner more funding that matched their needs more adequately.

We did a lot of community engagement work to find appropriate organisations that could reliably provide support coordination services to criminalised people with cognitive disability in relation to the whole suite of service systems which oftentimes they rely upon. So the difficulty really sat with the notion that oftentimes this client group is involved in multiple service systems, so as I mentioned earlier, mental health, drug and alcohol, the criminal justice system, NDIS, housing and homelessness, family and domestic violence; so for a support coordinator to be able to effectively work with that person to manage that range of needs, there certainly needs to be enough NDIS funding there for that, and also that support coordinator certainly needs to have a level of skill and experience to negotiate and coordinate that range of supporting services and the problems that will ultimately arise, because I do just want to add that those many different service systems, while they all touch and get involved with people with cognitive disability, don't necessarily speak to each other; when they do, they don't necessarily speak the same language. So that certainly requires a centralised person that is experienced enough and funded enough to manage that with and for the person.

DR MELLIFONT: Thank you, Mr Baker.

Ms Cootes, do you agree with those comments by Mr Baker?

MS COOTES: Yes, 100 per cent.

DR MELLIFONT: Mr Baker, in your role as case manager, did you have occasion to see clients get community-based or diversion orders where they were otherwise pretty likely to get a custodial sentence?

MR BAKER: Absolutely. I'm confident that that's the case, not least because

magistrates and solicitors indicated that in individual matters. So yes, I'm confident that that's the case.

DR MELLIFONT: Again in your statement you speak about over time observing a real change in the way that people in the court system responded to people with cognitive impairment. You have spoken to the Chair a little bit about this and you observed changes in behaviours and practices in magistrates, lawyers, court staff and police. I want to ask you, though, what was something that stood out for you in respect of your client's response? The participant response to the CIDP?

And can I just touch on this --- Ms Cootes, you have picked up on this already, Mr Baker's point --- that clients appear to have increased trust and participation in the legal and justice process. Was that a particular feature you observed, Mr Baker?

MR BAKER: Absolutely. I think because the clients had intensive humanistic support throughout the criminal justice process at each stage, so whether that's interacting with their solicitor, liaising with the registry staff, understanding what's going on in their court matter, having someone sort of co-design and co-produce a support plan that works for them, so that the magistrate and the court can understand what that person's needs and perspective of their needs really is. So yes, I think because of that process where the person is really centralised, not only in the criminal justice aspect of the case management but certainly their disability supports and their wider supports as well, I feel that --- I feel confident to say that clients developed a greater level of understanding and trust of the support service ecosystem, including a understanding of the criminal justice system. I think that there was a positive feedback, I think is the best way I can phrase that, between that sense, that experience for the client, and also the court and court stakeholders better understanding the needs of the client. So yes, I would describe that as a positive feedback.

DR MELLIFONT: Your statement speaks about observing that clients left the program with a greater capacity to meet their own needs by learning where and how to seek support and to self-advocate. Ms Cootes, is that something you would agree with?

MS COOTES: Yes, definitely. I think one of the features of the way that we felt was important to do this work was to build a person's capacity, and a big way of doing that was to involve them in the decision-making. Too often in court processes, decisions are made for people, but the more somebody can learn the way things happen and make their own decisions and have their decision respected, I think that makes a very big difference to how the person goes forward and to their skills to cope better and do better.

DR MELLIFONT: Thank you. Mr Baker, you observed a difference in families and other informal supports; is that correct?

MR BAKER: That's correct.

DR MELLIFONT: What was that?

MR BAKER: So because of the way we worked, a holistic way, oftentimes we were involving the person's chosen community in their support planning. So that might be a partner, that might be family, that might be a good friend, whatever that person or people was for them. And sort of towards the exit stage of the case management pipeline, we often received positive feedback from partners and families to say, you know, things are so much better at home with this person now, or I understand their needs more. We found, through the support of CIDP, an appropriate service that is meeting that person's needs and taking various financial, emotional, psychological pressure off of the family unit, for example. And yes.

CHAIR: If I may say so, these are important observations but they are impressionistic. Was there a formal evaluation of the program in terms of its goals, its outcomes, whether it could be --- we live in a world where measurements count for a great deal, even if measurements are entirely inappropriate, which is quite often true of the way in which the legal system is approached, particularly by bodies like the Productivity Commission, but we will put that editorial comment to one side and just ask whether there was formal evaluation and, if so, what were the results?

MS COOTES: There was a formal evaluation. Certainly in that evaluation a lot of the positive sort of feedback came from clients and from families. The evaluation had been in some ways controversial.

CHAIR: Can I just ask, where do we find it? I don't want to divert a lot of time, just to know where it is.

MS COOTES: It is on the website of the Department of Communities and Justice.

CHAIR: So that was the Department that carried out the evaluation?

MS COOTES: That's correct. They contracted an organisation to carry it out.

CHAIR: Dr Mellifont may well be coming to that, either today or tomorrow, but I just want to be clear that there is some kind of evaluation.

DR MELLIFONT: We are indeed going to come to that in later evidence. But I want to speak about data whilst we are here. Mr Baker, at paragraph 37 you say that IDRS has not seen the final data produced by the Department of Communities and Justice in relation to the 2019/2020 year. Can I just clarify this with you. Is it the case that in that third year, IDRS kept a significant amount of data?

MR BAKER: Yes, that's right.

DR MELLIFONT: That was as a result of the change in model and IDRS were given greater data-keeping functions? Is that a fair statement?

MR BAKER: Yes, that's exactly right.

MS COOTES: Yes, and we developed a specific database to collect that information, so that hadn't been there until the third year.

DR MELLIFONT: Yes. In those first two years there was just a spreadsheet that you were asked to keep; is that right?

MR BAKER: Yes, that's right. Each stakeholder --- Justice Health, Community Corrections and IDRS --- kept separate forms of data which correlated our function in the program.

DR MELLIFONT: Ms Cootes, is it your opinion that the data kept in the third year on the database was much superior to the data which had been earlier kept --- kept earlier?

MS COOTES: I don't know that I would say it was much superior. Because we had more control of it and we understood the database, it was certainly much clearer to us than the data from the previous years had been. So it was --- we could draw a lot more from that information than we had been able to in the two previous years.

DR MELLIFONT: Thank you, Ms Cootes.

Coming back to you, Mr Baker, am I correct in saying that the data kept by your service for last year has been provided to the Department?

MR BAKER: Yes, that's right.

DR MELLIFONT: Together with your views on some qualitative analysis?

MR BAKER: Yes, that's correct.

DR MELLIFONT: At this stage you haven't seen how that has been analysed and don't know how or to whom that might be presented; is that right?

MR BAKER: That's right. I don't know how it's going to be analysed in the end. I did have some back-and-forth with the Department when I provided that raw data, to talk about how that would be used, but I don't know what decisions were made in the end or what that will look like.

MS COOTES: If I could explain that the final --- what we mean by the final data is the data that's been put together about the whole of CIDP over the whole period. We don't know how it's been put together and what the combined findings are. We have some knowledge of the early stats but we don't know how that's presented, no.

DR MELLIFONT: If that analysis of that 2020 data hasn't in fact been finalised, is

that something that you would like to be able to see and provide feedback on before it's finalised?

MS COOTES: We have provided a lot of feedback along the way, so yes, of course, we would like to see the final result. But --- and I'm sure we will at some point.

DR MELLIFONT: Mr Baker, do you have any comment in respect of whether you would like to see and provide feedback on the government analysis before it takes final form, if that in fact hasn't already happened?

MR BAKER: I mean, yes, I would certainly be open to that.

CHAIR: You have had a final form in the sense that I assume you have been told that funding terminated for this program as of when, mid-2020?

MR BAKER: That's correct.

CHAIR: Did you get reasons?

MS COOTES: I think the Department had genuinely been trying to put enough money together to keep it going and they had a plan to put a Budget bid in for something like the CTD that was mentioned there. But the main reason that was given to us for ending was really that it was the tight budgetary situation as a result of COVID. So that was the main reason put to us for not being able to extend it until there was some further decision about the new model.

CHAIR: I'm sure in due course we will hear about what the cost of the program was and so forth, so we will get to that.

DR MELLIFONT: Thank you, I'm just going to ask you a couple more questions about data, Ms Cootes, and then I'm going to ask for a five-minute break and for us to return. Was there baseline data at the commencement of the pilot against which the results of the project could be compared to?

MS COOTES: No, not that I'm aware of, so something that would have been very good to know was what the level of diversion in the courts that we were operating in was already, but we weren't able to get that information. That would have been a very useful comparator for us to have. But as far as I know, the Department didn't have that comparator either for people with cognitive impairment.

DR MELLIFONT: Not having baseline data, does that present a challenge for an organisation like yours when you are trying to get funding continued?

MS COOTES: Yes. So one of the points I have made in my submission is that we think there's a data gap there, that really, information about people with cognitive impairment is not routinely collected. So it's very hard to know how many people with cognitive impairment are going through the courts or --- even in the police

database at this stage, that data is not collected either. So that --- yes, that lack of collecting data that would give us some baselines is a problem and it would be great if there was more data kept.

DR MELLIFONT: Have you ever experienced the situation when applying for funding to continue for a project - not necessarily the CIDP but in general --- where what's been put against you is you haven't been able to demonstrate sufficient improvement or progress as a lack of having a baseline --- as a consequence of having a lack of baseline data in the first place?

MS COOTES: I haven't personally had that experience. But I think it's a recent trend really that funding is so short term, so to me this is an emerging issue of the last 5 or 10 years, that you have to justify certain criteria so quickly.

DR MELLIFONT: Can I ask you, Mr Baker, one of your recommendations for change is not having just short-term pilot programs. Why do you recommend that to be longer?

MR BAKER: I think that it inevitably with these types of programs that are engaging with various complex service systems and certainly a client group that can have rather complex lives and needs, it takes a while to set up, to build buy-in from the various stakeholders, including the court-based stakeholders, so that everyone understands the parameters of the program, to demonstrate momentum and reputation and effectiveness. I think that can take some time. So when you're on this sort of timeline of two years to try and achieve quite significant outcomes, that sometimes can be --- that is extremely challenging.

So I really felt sort of by two and a half years we had really arrived, you know, we had a reputation, all the local services and the courts knew what we were doing and how we were doing it and had confidence in us. And certainly the level of referrals from the broad variety of agencies we were receiving referrals from stood to that. So yes, I think perhaps that answers your question.

DR MELLIFONT: It does.

Ms Cootes, do you agree with that?

MS COOTES: I do. And I think it's such an investment in getting to that stage that it's a real shame to cut something off when it's just reaching its peak, perhaps. And I think the other frustration is that particularly in courts, it's almost an expectation that you won't be there for long, so it stops people in the court system from investing and relying on your service for a while, until they are satisfied, you are actually okay and you will be here longer than two years.

DR MELLIFONT: Thank you.

Chair, do you mind if we have just a five-minute break, please?

CHAIR: Yes, we will have a break until your time 11.50 and our time 12.50.

DR MELLIFONT: Thank you.

ADJOURNED **[12.42 PM]**

RESUMED **[12.50 PM]**

CHAIR: Yes, Dr Mellifont.

DR MELLIFONT: Thank you.

Mr Baker, can I take you, please, to paragraph 45 of your statement at subparagraph (h). Paragraph 45 is where you set out your recommendations to the Royal Commission, and (h) specifically speaks to a recommendation that there be better and more expansive residential and outpatient alcohol and other drug rehabilitation services adapted to be accessible for people with cognitive disability. We have touched on this a little already.

How significant do you see the need for this is?

MR BAKER: I see that as crucial. So I think approximately 50 per cent of the CIDP client cohort over the life of the program had both a mental health and substance use comorbidity. I can't recall off the top of my head what percentage it was for clients who only had a substance use comorbidity but I think that early statistic is significant.

For a lot of people with cognitive disability, they don't necessarily have the support systems around them or even perhaps the cognitive skills and ability to sort of engage in some of the modules that these type of residential services expect people to be able to manage. So to me, knowing that alcohol and the substance use issues have particular significance for people that have cognitive impairment, and can also contribute to cognitive impairment, I think it's really important that services are able to meet their needs, particularly in residential settings. Often magistrates would understandably like some of the CIDP participants to demonstrate participation in a residential rehab service, but those either weren't available to meet the needs of our clients, or there were so few beds, or the timing just didn't work with their court matter, so it wasn't able to go ahead. But the chief reason is that, yes, these services just don't really exist for my client group.

DR MELLIFONT: Can I take you to (j), please. You recommend specified provisions within the Drug Court, MERIT and custodial alcohol and other drug programs, be adapted to be accessible for people with cognitive disability. What is

the gap you are seeing there?

MR BAKER: That substance use issues are a huge problem for people with cognitive disability involved in the criminal justice system, and that while there is on the surface a number of referral pathways and avenues that are court-based and community-based for people with substance use issues, those are not effectively adapted for our client group, people with cognitive disability, they are just unable to meet their needs.

DR MELLIFONT: Thank you, Mr Baker.

Ms Cootes, can I take you, please, to page 6 of your statement, paragraph 19. Here you touch on a project called the Community Justice Program, which commenced in 2005 and it is New South Wales Government funded.

MS COOTES: Yes.

DR MELLIFONT: Can I ask you whether you have noticed any difference in terms of what you are seeing with respect to the Community Justice Program since the introduction of the NDIS?

MS COOTES: Yes. Looking back before the introduction of the NDIS, there was a very --- this was a very well-established service with a well-established pathway for assisting people who were leaving prison, and it provided a range of services, including case work, but also most importantly accommodation options for people with cognitive impairment leaving prison.

That pathway is just, it's not clear at all now, compared with that time.

DR MELLIFONT: Mr Baker, do you have any observations on that topic?

MR BAKER: Yes. When I commenced as a case manager with CIDP in January 2018, it was clear that CJP was dissolving in its current form. So at that time a lot of clients that I personally was providing case management to were CJP transitional clients, so their NDIS plans, I recall, at that time, had provisions for clinical and therapeutic supports, direct supports, but I recall at that time, CJP, the State, was still providing for their housing and accommodation needs. But once that portion of the NDIS plan --- once that portion of their support was converted to an NDIS model, so supported independent living and what have you, I haven't had much or any real interaction with the CJP since then.

DR MELLIFONT: Thank you.

Ms Cootes, I want to take you in a moment to the Justice Advocacy Service which you start to speak about in your statement at paragraph 26. Before doing so, I want to clarify something that was said before the break. In respect of the formal evaluation of the CIDP, it was only with respect to the first iteration of the model; is

that correct?

MS COOTES: That's right. It was conducted within that first two-year period. It didn't cover the third year at all.

DR MELLIFONT: Thank you.

Moving on to --- I'm sorry, go ahead.

MS COOTES: The evaluation that was conducted by WestWood Spice didn't deal with the third year. I just wanted to make that clear. The department

DR MELLIFONT: Yes.

MS COOTES: --- was possibly still assessing --- (overspeaking) ---

DR MELLIFONT: Thank you. In your statement you speak about the Justice Advocacy Service and of it adopting a prior service model, that is the Criminal Justice Support Network model, extending the client group to young people and adults experiencing cognitive impairment, and you set out --- what that service, that is the Justice Advocacy Service does, is to provide services to victims, accused persons, defendants and witnesses. Is that correct?

MS COOTES: That's right.

DR MELLIFONT: What occurs, or at least part of what occurs under that program --- sorry, the funding allowed for enough JAS staff to be located across regional and rural New South Wales? Is that right?

MS COOTES: Yes --- (overspeaking) --- that change.

DR MELLIFONT: Okay, and it provided for analysis of the training needs of police, court staff and legal practitioners?

MS COOTES: Yes. That was one of the specific requirements of the service, yes.

DR MELLIFONT: IDRS were successful in tendering for funding for two years from 2019 to June of this year.

MS COOTES: Yes.

DR MELLIFONT: At this stage has a decision been made about whether your funding for JAS will extend beyond June 2021?

MS COOTES: No, there's no decision made at this stage. And just to add to that, there has been an evaluation done of the JAS service which has only just been finished, so I understand that that's part of the consideration.

DR MELLIFONT: That evaluation, is that the Ernst & Young evaluation that we read about in Mr Coutts-Trotter's statement yesterday at paragraph 43, is that the evaluation that you are referring to?

MS COOTES: Yes, that's right.

DR MELLIFONT: You haven't actually seen that evaluation?

MS COOTES: Yes, we have. We saw drafts of it and had the opportunity to comment on the drafts and we have seen what we understand to be the final draft. But my understanding is that it's not public at this stage.

DR MELLIFONT: Thank you. What does it mean for your service to be here in late February and still not knowing whether you are going to have funding for JAS beyond 30 June 2021?

MS COOTES: It's very difficult. I just note that already we have people booked in for court support in July, there are about 60 people who have already got court dates who are expecting us to support them at that time, so I guess that's just an indicator of the difficulty of not knowing at this stage. And of course there's the --- staff are beginning to look elsewhere because they are uncertain about having positions beyond June. So that's a great concern too because there's a big investment in building the skills of those staff, and in those staff building the services in so many areas. So it's a threat of big loss, really. And because the service has been around for so long, so since 2004 in a lot of areas, but not across the whole State --- so it's a bit like we said with CIDP, we are really just hitting our straps, particularly with COVID in the background which closed courts for a good period, it meant we couldn't be in person with clients for a good period as well. So it's been an extremely disruptive two years and we are feeling like we are hitting our straps now and it would be very sad to have it end. But it is a service that has been around for a long time, and people will miss it. The system relies on it to a very large extent and certainly people with cognitive impairment rely on it.

DR MELLIFONT: My next question will help the Commissioners understand what it is the JAS provides. If I can take you to paragraph 35 of your statement, you say:

> *In the 6 month period 1 July to 31 December 2020 JAS has provided 3,711 supports to 1,100 people with cognitive impairment.*

We will take that screen down because that number has been corrected. What equals support in those numbers?

MS COOTES: What we are actually counting is an occasion when a Justice Advocacy support person was present at either a police station or a court or at a legal interview with a person with disability. And the other category is being present in a correctional centre for someone who is participating by audiovisual link into a court

hearing and speaking with their solicitor. So what we are actually counting there is those occasions. But there's a lot more that goes into a support than just being there with the client.

For example, we call people a couple of days before they are due to go to court because we know that a lot of people get warrants because they haven't turned up at court because their disability meant that they either weren't organised to get there, they had forgotten it --- yeah, so there are lots of things, there's lots of problem solving on the way through, maintaining contact with the person's solicitor and in a lot of occasions trying to link people to services, particularly if they are in remand, in custody.

DR MELLIFONT: Can I ask you --- the service provides support to victims within the criminal justice system; is that right?

MS COOTES: Yes.

DR MELLIFONT: What does it do in that respect?

MS COOTES: In that respect, what we hope to do is be at the police station with the victim so that they can have assistance to make a statement to the police. And then, depending on the severity, it might be over a period of two years we're involved with them in dealing with the Office of the ---

DR MELLIFONT: DPP?

MS COOTES: Yes, that's right --- being involved with them to help them with communication in that area, to help them with preparation for court, and being with them throughout the trial. We are aware of one case where we had a three-week trial on recently where we were sharing that between staff and volunteers, so that there was someone there with the person the whole time.

DR MELLIFONT: Is that assistance sometimes in partnership with the Witness Assistance Program?

MS COOTES: Yes, that's right, because the level of support a witness with cognitive impairment needs is often greater than they are able to provide.

DR MELLIFONT: Is that assistance provided in all levels of courts, not just local courts?

MS COOTES: Yes, that's right.

DR MELLIFONT: Tell me if I have this fairly summarised. Your service tries for somebody with cognitive impairment not to be alone in their journey through the criminal justice system. Is that a fair statement?

MS COOTES: Well, it's more than not being alone. It's not to be disadvantaged by their disability as they go through the criminal justice system.

DR MELLIFONT: And the funding that you are waiting to hear about, that's for victim support, defendant support, suspect support, witness support; is that right?

MS COOTES: Yes, that's right.

DR MELLIFONT: All of it?

MS COOTES: Yes.

DR MELLIFONT: I want to take you, please, to paragraph 36 of your statement.

MS COOTES: Yes.

DR MELLIFONT: It can come up on the screen.

> .... *30% of the people using JAS services are First Nations People.*

Is that, say, for that period of six months 1 July to 31 December, we are talking about 330 or 350 roughly?

MS COOTES: Yes, that's right.

DR MELLIFONT: Taking the figure of 1,100?

MS COOTES: Yes. Then you say:

> *Our Aboriginal Engagement worker is crucial to building collaborative links with First Nations community organisations.*

Do I take it to mean that you have one and one only Aboriginal engagement worker?

MS COOTES: Yes, that's right, although three of the Justice Advocates are Aboriginal people.

DR MELLIFONT: Would you like to have more if funding could be provided?

MS COOTES: I think the funding is not the problem there. We would like to recruit more staff from First Nations people. So it's not --- and it would be very helpful to have another Aboriginal Engagement Officer, but we would like a good proportion of the frontline staff to be Aboriginal or Torres Strait Islander as well.

DR MELLIFONT: Apart from the benefits that your Aboriginal Engagement Worker brings directly to your clients, what does that worker bring to other staff at the service?

MS COOTES: The role of the Aboriginal Engagement Worker, who actually was a CIDP case manager before he came into this job, is to build the skills of the staff to work effectively and culturally --- in a culturally safe way with Aboriginal and Torres Strait Islander people, and that's a big part of the role.

Another important part is that he is reaching out to Aboriginal organisations and trying to establish trust with those organisations so that they can use our services and we can help people to use their services, so that's another big part of the role.

Another task that he has had is to work to review our volunteer training and our volunteer recruitment, and to work with Aboriginal and Torres Strait Islander people to undertake that review. And we are working with a group on the North Coast to pilot our training, first training that is specifically targeted for Aboriginal volunteers.

I didn't mention before either, we also have a pool of casual staff who provide support at police stations, and 25 per cent --- or 20 per cent I think, of those people recruited for that job are Aboriginal and Torres Strait Islander people. So we are trying to --- his job is to help us in all aspects of our service to become a service that is acceptable and effective for Aboriginal people specifically.

DR MELLIFONT: Thank you, Ms Cootes.

Can I take you, please, to paragraph 54 of your statement. You speak here about the changes to legislation in New South Wales in respect to *Mental Health and Cognitive Impairment Forensic* Provisions. I want to clarify something you said in your statement. In the last sentence in paragraph 54, you say:

> *In my view, while the new legislation brings some welcome clarification, it will not address the practical barriers to diversion that currently exist in NSW.*

Can you tell me if I'm reading this correctly. The practical barriers to which you refer there are those set out in paragraphs 55, 56 and 57 of your statement?

MS COOTES: Yes, that's correct. So that is that really, without a diversionary service available in the court, it is up to the solicitor to do all the work to put a section 32 application together and in the very small amount of time that most criminal Local Court lawyers have, that's a huge barrier to people achieving diversion.

So the legislation wasn't the key barrier and isn't the key barrier now, it's really having the practical support for the legal representatives to put the evidence together and to satisfy magistrates that it will make a real difference and that it is safe.

DR MELLIFONT: Thank you, Ms Cootes, can I take you to paragraph 64 of your statement, and this is where you set out recommendations for change. I want to pick up on a couple of them and ask you to clarify. Paragraph 64d, you recommend:

NSW Police Force should establish 'Disability Liaison Officer' positions equivalent to their liaison officer positions for youth and LGBTIQ.

MS COOTES: Yes.

DR MELLIFONT: Can you expand on that for me, why do you recommend that?

MS COOTES: I think that positions like the mental health officers and the youth liaison officers make a big difference to the pathway of people in the criminal justice system. For example, having options of cautions might be an appropriate option to avoid people unnecessarily coming before the court, people with cognitive impairment. I will just provide an example of that. A man who left his group home, went for a walk, which was not an unusual thing to do but he was later than usual coming back, the police were called to search for him, they came in numbers and they came with a dog. They found him but didn't approach him in a safe way really. He had a phobia of dogs and he kicked the police dog in all this process. He was very worked up. And he was --- he was charged with assault on the dog and had to go through the whole process of court. That, to me, seems --- there should be some work done about in the --- in the police force about instances like that, where a person should not be charged because their disability has contributed in such a way and circumstances to them getting arrested.

I mentioned also in my submission that there's --- we find there's increasing criminalisation of people in group homes because police are often called to incidents, and that's fair enough, but then people are sometimes arrested and sometimes get AVOs made against them, which they have no way of understanding or adhering to. So I guess what I think one role for Disability Liaison Officers would be to get --- to build the understanding within the Police Force about cognitive disability in the same way that understanding has been built about people with mental illnesses, so that there can be experts in the force who can advise about these sorts of situations and contribute to training, and just to build the knowledge and build the understanding in the force, so that there's a wider range of options open.

DR MELLIFONT: So you would recommend that the New South Wales Police Force has, in addition to their Mental Health Liaison Officers, that there are specific Disability Liaison Officers; is that correct?

MS COOTES: I think that would be very helpful and I think it would lead to some improvements in the way that the police deal with people with cognitive impairment. So training is part of that. But I think there needs to be people within the force who own that area, so that there are big steps forward made.

DR MELLIFONT: Ms Cootes, I have about three or four minutes of questions to you ask you and then I'll hand over to the Commissioners.

Can I take you to paragraph 64(e). You refer there to a Bail Assistance Line, which is an a

fter-hours service --

MS COOTES: Yes.

DR MELLIFONT: --- to police who are considering granting conditional bail to a young person who can't be released because they can't meet their bail conditions. In your understanding, that Bail Assistance Line is currently just for people under the age of 18?

MS COOTES: Yes, so it is specifically for young people, yes.

DR MELLIFONT: Is it something that you see as a good thing and perhaps being worthy of expanding beyond people under the age of 18?

MS COOTES: Yes. I think it would well meet the situations that we often see in police stations when we are supporting people there, that the police --- it's a bit like in the courts; that because the person doesn't have support, because they don't have accommodation, because they don't have any service, the police feel that they almost need to hold them in custody because --- maybe for other people's safety, maybe for their own safety, they don't feel that they can let them go into exactly the same circumstances because they will probably be back again very soon.

And often it's in that crisis situation that the police do decide to keep somebody in custody until they go to court. So there aren't any alternatives to gaol if the police or the magistrate don't feel that they can release somebody into the circumstances they were in before, there is no quick response on the service front, usually, to avoid the person going to prison. I think CIDP demonstrated that when they were able to put together services, a lot of people had successful bail applications. So there's a need for a flexible bail service for people with cognitive impairment that can respond quickly so that people don't have to go to gaol in the first place, or be kept in the cells for days.

DR MELLIFONT: I want to come to the last topic, which is the decision to cease funding. As we know, the funding ceased on 30 June 2020. Is it the case that even up until June you were meeting with the Department about seeking to advocate to try and see if funding could continue?

MS COOTES: Is this about CIDP?

DR MELLIFONT: Yes, I'm sorry, CIDP, yes.

MS COOTES: Yes, we were. And that's because --- well, that's because my understanding is that they were trying to be able to keep the service going while the new proposed service was put up for funding. So efforts were made up until the last minute to enable that to happen, as I understand it.

DR MELLIFONT: And your understanding as to who was making those efforts?

MS COOTES: The people in the Department were making those efforts, but I understand supported by the Director.

DR MELLIFONT: Can I take you, please, to just one document, and this goes back to last year, and it is NSW.0033.0003.0002. While that is coming up, Ms Cootes, can I ask you, what were the key reasons you were given for the CIDP not continuing beyond 30 June?

MS COOTES: The key reasons why it couldn't be carried over until the Department put up its new proposal for funding, the key reasons given to us was the tight budgetary situation due to the impact of COVID. And that was in the midst of the worst part of COVID in New South Wales.

DR MELLIFONT: Yes. So did the closure of your program during COVID make it harder for you and your clients?

MS COOTES: Once we knew that the Service was going to close, yes, it made it a lot harder, partly because it was difficult to meet with people, but also because the courts were closed for some period, and the courts were dealing with a lot of matters by long adjournments. So a lot of matters were adjourned beyond when the Service was closing.

But the staff worked extremely hard, against all those odds, to try and get evidence together for section 32 diversion, for pretty much every client, before 30 June. And then because we had JAS, we were able to pass those clients on to the JAS service for support, getting to the court hearing. So supporting them through the court processes.

DR MELLIFONT: Was the level of support that JAS was able to provide the same as CIDP was able to provide?

MS COOTES: No. CIDP had already done all the CIDP specialist work and there would have been more work for them to do, but JAS was able to provide the support to take the person through the court process and further discussions presumably with their legal representatives.

DR MELLIFONT: I want to take you to this document, which is a NSW Government Communities & Justice record that we have been provided with. This records a meeting which was held in the latter half of 2020. I want to take you to a couple of dot points and see if you can assist me with context.

MS COOTES: I just want to note that I haven't read this thoroughly because I got it five minutes before we walked in here.

DR MELLIFONT: That is noted, and maybe you will be able to take this question on notice and come back to us.

If I can take you to the second page, so we're at page 0002, and dot points 4 and 5.

MS COOTES: Yes.

DR MELLIFONT: It says DCJ --- that is the Department of Communities & Justice:

> *DCJ indicated that there may be a possibility of reprioritising funds to augment JAS in the short term while a proposal is put to Government regarding a long term option.*
>
> *IDRS and CID agreed to explore a time limited addition to JAS as an option to supporting existing CIDP clients from July to December 2020.*

Down the page, please, under the heading "Actions and next steps", the first dot point:

> *IDRS and DCJ will assess what 'stop gap' arrangements can be put in place between now and the consideration of the NSW Budget.*

MS COOTES: Yes.

DR MELLIFONT: Tell me, if it is too difficult, just looking at this document now: do you know what this 'stop gap' arrangement was or was intended to be? Was is it something you would like to think about further in the context of the full document?

MS COOTES: Yes, I think I would need to read the full document to comment on that, really.

CHAIR: We might be asking the wrong people, Dr Mellifont, if this is a document emanating from the Department of Communities & Justice.

MS COOTES: I'm not sure whether it's minutes of the meeting or ---

DR MELLIFONT: Yes, it's minutes, or it's dot points, rather. In any event, we will come back to you with that after you finish your evidence, to see if we can get some additional context from that.

Commissioners, that is the end of my questions, please.

CHAIR: Thank you very much. I'll ask Commissioners if they have any questions.

First, Commissioner Mason, do you have any questions?

COMMISSIONER MASON: No, thank you.

CHAIR: Thank you very much. Commissioner Atkinson?

COMMISSIONER ATKINSON: There is just one thing in the document that we need to correct. I understand it is not your document, but since it is now before us, on the first page --- you are familiar with the people from CID, Ms Cootes?

MS COOTES: Yes.

COMMISSIONER ATKINSON: It is Justine O'Neill, not Justice O'Neill.

MS COOTES: Yes.

COMMISSIONER ATKINSON: CID didn't have the advantage of a Judge assisting them in this.

MS COOTES: No, well picked up.

COMMISSIONER ATKINSON: Thank you.

MS COOTES: Every time I type "Justine" my fingers go --- that's what I type most often. But again I didn't type it, so ....

CHAIR: Of course, Commissioner Atkinson is assuming it's an advantage to have a Justice, which is not necessarily a universal view.

Any other questions, Commissioner Atkinson?

COMMISSIONER ATKINSON: No, but I'll take that up with you later.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

QUESTIONS BY THE COMMISSION

CHAIR: Section 32 gets press in New South Wales that rather suggests that it is a mechanism for the well-connected to apply to a court to deal with, usually, offences of domestic violence and so on. Is that something that is shared by the legal community that works within section 32? It seems to be something that is availed of by those who have got the resources to do so.

MS COOTES: They would have to have evidence that they have a cognitive impairment or a mental illness.

CHAIR: It doesn't seem to stop the applications, although perhaps that is based on anecdotal evidence rather than statistical evidence. You can't comment?

MS COOTES: No.

CHAIR: That's the fine. The magistrates in the two courts that you mentioned, did they receive any training about the way this program was going to operate?

MR BAKER: I believe there was some preliminary meeting, and I was involved at Penrith Local Court in a meeting sort of midway through the program, just to see how they felt about it, and that meeting was supported and facilitated by the Department. But as to training, I'm not sure.

CHAIR: All right. Isn't the general difficulty that you and other organisations providing these very important services face, that there's a pool of money, the pool of money is provided in this instance by the New South Wales Government, as far as Legal Aid is concerned another source of funding is of course the Commonwealth and sometimes there are private sources. It is very difficult to evaluate the priorities for services of community legal centres, health and community legal centres joined together. How do you approach that? What's your view about where you fit within a structure where there are a lot of competing demands on what governments will say is a single pot of money?

MS COOTES: Well, we are aligned to people with cognitive impairment so we are going to always be fighting for what they need to get a fair chance --

CHAIR: You will.

MS COOTES: --- and we know that they are very over-represented in the criminal justice system.

CHAIR: I understand. I'm just wondering how we, as an organisation tasked with making recommendations, deal with an issue that involves a particular segment of the community. Of course there should be more resources. The question Dr Mellifont asked you about, would you like more resources, uniformly; you said, not unexpectedly, "Yes."

The question is: how do we deal with your claims that you have got on the public purse, important as they are, with claims made by others, who say, "We have got a community"? It might be CALD communities, it might be people who have been in prison but do not necessarily have cognitive disability and who need support. I'm just wondering if you have thought about how the competing merits are to be assessed. If not, don't worry about it.

MS COOTES: I haven't really compared with all the other groups. But we see one of the biggest areas of injustice for people with cognitive impairment is in the criminal justice system and we see people's lives ruined and we think it's avoidable. And so we think that it's a priority, and that's clearly our bias.

CHAIR: Yes.

MS COOTES: But it's based on many, many years of seeing this happen to people and feeling it's not necessary and it could be changed.

CHAIR: All right, thank you. I assume --- I'll ask Ms Furness whether she has any questions.

MS FURNESS: I do have a question.

CHAIR: You do or don't?

MS FURNESS: I do.

CHAIR: Yes, all right. Thank you. Go ahead.

QUESTIONS BY MS FURNESS

MS FURNESS: (Audio distorted) Dr Mellifont said earlier (audio distorted).

MS COOTES: I'm sorry, that was very hard to hear.

CHAIR: We are finding it very difficult to hear, Ms Furness. I will ask the operators if we can do anything to make the sound have greater clarity.

DR MELLIFONT: I'm sorry to interrupt at this stage, and it may be because of the late development with respect to Mr Coutts-Trotter's statement, but I have not had the opportunity to have a conversation with Ms Furness in accordance with the Practice Guidelines about what questions on topics and areas she might wish to ask, so that we might be able to see whether these matters can be dealt with in another way.

CHAIR: Except that we won't have the witnesses after the adjournment, I assume.

DR MELLIFONT: That is so.

CHAIR: Why don't we find out what Ms Furness' question is and then we can determine how we deal with it.

DR MELLIFONT: Thank you.

MS FURNESS: Thank you, Chair. My question arises very precisely from the evidence that has been given this morning, independently from Mr Coutts-Trotter's statement, so it's not a matter that I could have ---

CHAIR: Please go ahead and ask the question and we will see where we go from there.

MS FURNESS: Do you have a copy of Mr Coutts-Trotter's statement in front of you?

MS COOTES: Yes, I have it here.

MS FURNESS: Can I ask you to turn to paragraph 21, page 5.

MS COOTES: Was that paragraph 21 that you said?

MS FURNESS: Yes, paragraph 21 on page 5.

MS COOTES: I'm still having trouble hearing.

MS FURNESS: I'm not sure if there is anything more I can do at my end.

CHAIR: Ask the question and it comes up on the realtime transcript and if necessary I'll repeat it.

MS FURNESS: Thank you.

You see there that the original model is described as involving a neuropsychologist employed by Justice Health to conduct the screening. Is that right?

MS COOTES: Yes.

MS FURNESS: And that, over the next page, your service is providing support for management, case management? Correct?

MS COOTES: I'm sorry?

CHAIR (Repeating Question from Ms Furness): Over the next page, your service is providing support for management. Is that correct?

MS FURNESS: It's paragraph b, if that helps, on the top of the page.

MS COOTES: Yes.

MS FURNESS: If you go down to paragraph 22, Mr Coutts-Trotter there describes the modified model and has given evidence about the modified model.

MS COOTES: Yes.

MS FURNESS: At the second sentence of that paragraph he refers to the change being that your service would collect the relevant evidence. Do you see that?

MS COOTES: Yes.

MS FURNESS: You understand that was one of the modifications?

MS COOTES: I'm sorry?

CHAIR: You understand that was one of the modifications?

MS COOTES: Yes, that was our understanding.

MS FURNESS: You see the next sentence:

> *This modification was made because of the high cost of having clinical staff undertaking screenings .... timeliness in coordinating clinical assessments and bottlenecks with neuropsychologists ....*

Do you see that?

MS COOTES: Yes.

MS FURNESS: You understood that timeliness and coordinating clinical assessments and the bottlenecks with neuropsychologists was a problem in the first scheme, the original scheme; is that right?

CHAIR (Repeating Question from Ms Furness): You understood the timeliness and the bottlenecks with the neuropsychologists was a problem in the first scheme, the original scheme; is that right?

MS COOTES: Yes, so as the scheme developed it could be a problem. Not all the time, but from time to time.

MS FURNESS: It is the case, isn't it, that the anticipated features of Connect to Divert will continue by not having clinical assessments conducted by neuropsychologists?

MS COOTES: I'm sorry ---

CHAIR (Repeating Question from Ms Furness): It is the case, isn't it, that the anticipated features of Connect to Divert will continue by not having clinical assessments conducted by neuropsychologists?

MS COOTES: I don't really know because I don't know what the proposed model is.

MS FURNESS: In terms of the matters that you were taken to in paragraph 37, subparagraph a:

a service provider with appropriate expertise in working with people with cognitive impairment will be engaged

Do you see that?

MS COOTES: Yes.

MS FURNESS: That fits with the definition of your agency, most certainly, doesn't it?

CHAIR (Repeating Question from Ms Furness): That fits with the definition of your agency most certainly, doesn't it?

MS COOTES: Yes, in my opinion it does.

MS FURNESS: And not with a neuropsychologist employed by Justice Health to conduct an assessment?

MS COOTES: I'm sorry.

DR MELLIFONT: Chair, I'm sorry to interrupt, this is very, very unsatisfactory. The sound is terrible. I would prefer very much if I could have a conversation with Ms Furness over the lunchtime break. It is not fair to the witness, and there are Practice Guidelines that I would like to try and see the spirit of, reflected.

CHAIR: The problem is I think we are going a little longer. I understood at the beginning that Ms Furness wanted to ask at least a question, at least that is what came up on the realtime transcript, and we are going beyond that. I think the sensible thing to do is to adjourn now. I'm very much afraid that we will have to ask Ms Cootes and Mr Baker to hang around for the luncheon adjournment.

Is that possible?

MS COOTES: It's possible for me, but Michael is going to Brisbane to support one of our clients tomorrow who is giving evidence.

CHAIR: You are booked on a plane, are you?

MR BAKER: 4.00 pm.

CHAIR: We will adjourn ---

MS FURNESS: Chair ---

CHAIR: Can I finish what I'm saying. We will adjourn now until 1.45 pm Brisbane time, 2.45 pm Sydney time. In the meantime, if Counsel can sort out what these issues are, I'm sure Mr Baker can stay for a quarter of an hour or so before he heads off to

Sydney Airport or wherever he is going to.

Is there something you want to say about that, Ms Furness?

MS FURNESS: There is. My last question was the last question I had to ask.

CHAIR: Thank you for telling us that. We will adjourn to 1.45 pm Brisbane time and 2.45 pm Sydney time.

ADJOURNED **[1.39 PM]**

RESUMED **[2.45 PM]**

CHAIR: Dr Mellifont.

DR MELLIFONT: Thank you. Ms Furness has indicated she does not require the witnesses back.

THE WITNESSES WITHDREW

DR MELLIFONT: I wish to withdraw my comment with respect to the Practice Guideline because it is now clear to me that the questions sought to be asked were considered to be arising directly out of examination not previously in the statement. The next witness is Mr Walsh. Ms Crawford will be taking that evidence.

CHAIR: Thank you, Dr Mellifont.

Yes, Ms Crawford.

MS CRAWFORD: Thank you, Chair. Can I indicate that you will find Mr Walsh's statement and his CV at Tabs 13 and 14 of Tender Bundle B.1. I ask to tender those documents into evidence and for them to be marked as Exhibits 11.32.1 and 11.32.2 respectively.

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

EXHIBIT #11.32.1 - STATEMENT OF MR JOHN WALSH

EXHIBIT #11.32.2 - CURRICULUM VITAE OF MR JOHN WALSH

MS CRAWFORD: I can also indicate that the attachments to Mr Walsh's statements are at Tabs 25 to 31 of Tender Bundle D.1, and I ask to tender these documents into evidence and for them to be marked as Exhibits 11.32.3 to 11.32.9 respectively.

CHAIR: That too can be done and documents will be given those markings.

EXHIBITS #11.32.3 TO #11.32.9 - ANNEXURES TO STATEMENT OF MR JOHN WALSH

MS CRAWFORD: There is a PowerPoint presentation which the Commission will be taken to during the course of Mr Walsh's oral evidence. That PowerPoint presentation is at Tab 38 of Tender Bundle D.1 and I ask to tender that document into evidence and for it to be marked as Exhibit 11.32.10.

CHAIR: That too can be done. Thank you.

EXHIBIT #11.32.10 - POWERPOINT PRESENTATION BY MR WALSH

MS CRAWFORD: Thank you. I can also indicate that Mr Walsh will take an oath.

CHAIR: Thank you.

Mr Walsh, thank you very much for coming to the Royal Commission to give evidence. Just to explain where everybody is, Ms Crawford is speaking to you from our Brisbane hearing room and in that hearing room there are Commissioners Atkinson and Mason, and Commissioner McEwin is with me in the Sydney hearing room.

If you would be good enough to follow the instructions of my Associate who is in the Sydney hearing room, she will administer the oath to you.

MR JOHN WALSH AM, SWORN

CHAIR: Thank you, Mr Walsh. Ms Crawford will now ask you some questions.

MS CRAWFORD: Thank you, Chair.

EXAMINATION-IN-CHIEF BY MS CRAWFORD

MS CRAWFORD: Mr Walsh, you have provided a statement to the Royal Commission dated 28 January 2021. Is that correct?

MR WALSH: Yes, it is.

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

MR WALSH: I don't think so. I think, apart from the PowerPoint presentation that was added later, I think that evidence stands as it is.

MS CRAWFORD: Thank you. Everything in that statement is true and correct to the best of your knowledge and ability?

MR WALSH: To the best of my knowledge and ability.

MS CRAWFORD: Thank you. You are an actuary by profession, aren't you?

MR WALSH: That's right.

MS CRAWFORD: You have been an actuary since the late 70s, I believe; is that correct?

MR WALSH: I think I finally qualified as a Fellow in 1984, but it was a long process.

MS CRAWFORD: In 2001 you were named as Australia's Actuary of the Year?

MR WALSH: That's right.

MS CRAWFORD: In 2011 you were appointed a Member of the Order of Australia and you received the Prime Minister's Award for Outstanding Service to the Disability Sector, didn't you?

MR WALSH: Yes.

MS CRAWFORD: Among other things, in the past couple of years you were a Principal Member of the NDIS Independent Advisory Council?

MR WALSH: Not for a couple of years. From April 2019 until August 2020, I think.

MS CRAWFORD: And from 2016 to 2020 you were a Board Member of the Australian Commission for Safety and Quality in Healthcare?

MR WALSH: That's right.

MS CRAWFORD: You have your own business, don't you, in actuarial consulting?

MR WALSH: A very small business. I do very little consulting these days. Most of my work is just board work and mentoring.

MS CRAWFORD: Between 2013 and 2020 you were a board member with the National Disability Insurance Agency?

MR WALSH: That's right.

MS CRAWFORD: You have also got experience as an Associate Commissioner with the Productivity Commission?

MR WALSH: Yes.

MS CRAWFORD: Can you tell the Commission what is an actuary?

MR WALSH: There are lots of jokes about what an actuary is, but I'll spare you those. An actuary is a person who is a mathematical expert in the quantification of risk and usually the application of risk in insurance and superannuation-type areas. In more recent years, actuaries have been working far more actively in wider fields, such as health, more recently disability, (audio distorted) science, the environment --- so basically any area where analysis of data and the application of data to understanding of operational risk and data to achieve better outcomes, actuaries would seek to work in those areas. But traditionally they have been regarded --- most statutory actuarial roles are in certifying the financial sustainability of insurance companies or superannuation schemes.

MS CRAWFORD: That would very much come back to what you were talking about a moment ago with respect to the analysis of risk?

MR WALSH: That's right.

MS CRAWFORD: Can I ask for slide 2 of the PowerPoint presentation to be put up. That's EXP.0064.0001.0002.

Mr Walsh, this is the first of your slides that talks to cost benefit analysis. Can I ask you to explain to the Commission what cost benefit analysis is.

MR WALSH: I guess it's an attempt to estimate the extent to which an investment in a particular innovation, service or change is rewarded by benefits that that innovation or change provides to the entity or to the wider system, depending on the definitions that are used in the requirements.

MS CRAWFORD: With respect to performing a cost benefit analysis, is there a minimum amount of information that you would need in order to do that?

MR WALSH: There needs to be some way of measuring the benefit and also measuring the cost and that goes to the extent to which the components of the benefit can be accurately measured and the components of the cost can be accurately measured. So it goes to the availability of data. But it is possible to do a cost benefit analysis or a cost-effectiveness analysis with whatever data is available. It just introduces a lot of uncertainties into the value of the exercise.

MS CRAWFORD: If we put up slide 3, in slide 3, that is EXP.0064.0001.0003, you indicate there are some problems with cost benefit analysis in human services. Can you just explain each of those dot points with respect to what those problems really are and how they might manifest when you are looking at a cost benefit analysis with a human service?

MR WALSH: What I mean by "the scope of both benefit and cost are usually unclear", a benefit can be a narrow financial benefit to an operation, a system or a service or it can be a wider benefit, which also includes qualitative benefits to, in the case of human services, there are services to human beings involved, so it can also include wider benefits, which are the improvement in the health, quality of life, employment prospects of the person for which the benefit is intended. So the benefit can be very narrow or it can be very wide.

It can also --- I think I will come to another dot point later --- the cost is also unclear because again there are both direct costs, the narrow costs of the services, but also costs to the person in some cases. So a change which is a negative impact on the person for which the service is intended can actually be a cost which is rarely quantified or included. So I think that dot point introduces a whole lot of uncertainty or a lot of uncertainty into most cost benefit analyses in human services.

MS CRAWFORD: Sorry to interrupt. Did you have something more to add ---

MR WALSH: I was going to go on to the next dot point, but if you have questions on the first one.

MS CRAWFORD: I was going to say with respect to the first dot point, that that would be particularly challenging when we come later in your evidence to talk about the cost benefit analysis that was done with the CIDP, because for example not only the costs that are easily identified can be factored in, but there are so many other variables that need to be taken into account. Is that right?

MR WALSH: I believe that's the case, yes.

MS CRAWFORD: Sorry to interrupt you. Can you go on to the second dot point, thanks, Mr Walsh.

MR WALSH: The second dot point is around the nature of the data. I will take the second and third dot points together. Data in Australian human services is typically -

-- actually, the next three dot points --- have typically been poorly collected and have been, I guess, defined by the silos of the services which deliver them. There are a few examples of that, data in health systems often count episodes of care, for example, the data in the Medicare Benefits Schedule counts visits to doctors. And data in the PBS service counts prescriptions and what those prescriptions look like.

Neither of those attempt to collect data on the impact of the medical service or that pharmaceutical on the patient that it was intended for. Similarly for hospital services, data on hospital services typically counts episodes of care within the hospital service, so basically an admission or --- it is actually called a "separation" in hospital data language. So that again counts just that service and the cost and components of that service, rather than any outcome it provides to the patient.

Neither the MBS nor the hospital service have a holistic longitudinal data set that looks at the health and wellbeing of the person. So to attempt that sort of exercise, it's necessary to undertake a fairly convoluted linkage exercise across all of the data sets and try to match up statistical linkage keys and so on to get some sort of a view. So the point is that the data are not organised in a way that is amenable to benefit analysis or cost analysis at a person level.

The fourth dot point is that they are also delivered in silos. So, for example, a benefit that might be achieved in a successful health outcome might provide a cost savings or a quality outcome in a different service level. For example, it might allow the person to go back to work quicker, so you get a better employment outcome. Because the services are delivered in silos and the units of measurement are counted in silos, those benefits are not counted even if they could have been enumerated in person terms within the health service. So the silo nature of Australian human services definitions makes any cost benefit difficult.

The second-last dot point goes to benefits that may extend to other community members, and classic example is the NDIS, I guess, in which prior to the NDIS the relative percentage of disability support that was provided to Australians with disability was based on some work --- this is work I did previously so I won't tender it in evidence, but just a rough idea --- the rough idea was that the percentage of benefits for services that were provided by family and other community members was about 80 per cent of the total, if you like, burden of support.

The NDIS has, by alleviating some of that burden on the community, freed up the opportunity for families and friends and other members to participate in the broader community and have a better quality of their own lives.

The final dot point complicates everything because of the fact that we have an Australian Government, and State and Territory Governments, means that the silos and --- the separations between silos and services is further complicated, and what might be a benefit for a state system might end up being a cost for a Commonwealth system. Does that answer your question?

MS CRAWFORD: It does.

CHAIR: The last is commonly referred to as "cost shifting", which is the characteristic of the Australian federal system.

MR WALSH: I think that's right, Chair.

CHAIR: I know that your explanation, if I may say so, is very clear and of necessity simplified, but there are all sorts of other complication, aren't there? There are opportunity costs that come into systems that aren't easily measured, there are benefits that are not capable of being transformed into dollar terms such as the benefit that somebody who has a severe disability might receive in the form of a better quality of life but not necessarily translated into a economic benefit that can be measured in dollars. So there are all sorts of complications, aren't there?

MR WALSH: That's right. I believe that latter point of yours can be measured in dollars if the right data is collected. I will come to that later in my evidence, if that's okay.

CHAIR: Yes, I look forward to hearing it.

MS CRAWFORD: Mr Walsh, with those issues with human services being properly assessed by a cost benefit analysis activity, it is the case, isn't it, that it is all of these variances that cause difficulty with measuring what the outcomes or the benefits might be?

MR WALSH: Yes, that's right.

MS CRAWFORD: That then demands that there should be some new approaches to cost benefit analysis, doesn't it?

MR WALSH: Well, I think it demands a whole lot of things. It demands, first of all, the collection and organisation of the data in such a way that outcomes analysis at a person level and a total system level is actually something that governments can start to talk about. Once that data is collected in the appropriate way, then we can have serious conversations about the relative benefits of different types of initiatives. But we are at the moment a long way away from that.

MS CRAWFORD: Would you agree with me that before you come to a cost benefit analysis, when you are in the planning stages of a new project or a new program, that as a component of looking to fund that new program, it is very important to build into that plan what your evaluation data will be and how that data will be collected during the initial phases and throughout every phase of that project?

MR WALSH: Absolutely. And I would go further than that and say that philosophy of defining and collecting data and linking it to an operational innovation should be part of that overall human services. So I would extend that not just to pilot programs

but to the way we design and deliver services.

MS CRAWFORD: Is that something that actuaries are asked to comment on, or are there other expert professionals who look at how to perhaps capture the evaluation data that would be necessary when you come to objectively look at something in hindsight for evaluation purposes?

MR WALSH: Yes. I don't think actuaries have a mandate over this sort of work but certainly it's the sort of thing that actuaries have done as part of the development of Australia's insurance systems, for example. So there's a long history of the development of Australia's accident and compensation schemes.

With respect, Chair, I've referred to your work with the New South Wales Law Commission in the early 1980s.

CHAIR: Funny you should mention that. Richard Cumpston comes to mind.

MR WALSH: That is right. And the implementation of those types of systems, and the Woodhouse recommendations which preceded it, stimulated a quantum change in the way Australian compensation systems were organised from the 1980s until the present. Now, every Australian compensation system requires actuarial monitoring and reporting. And one of my bugbears over the years has been that they also, in my view, should be collecting outcomes, data and reporting on that as well. We haven't quite got there yet but we are on the path, and so I think actuaries might not be the only people that can do this sort of work, but they are probably the profession which has had most experience in understanding the data requirements and the data analyses that are required in a longitudinal outcomes-based set of set of analyses.

CHAIR: There is no getting away, is there, from the proposition that any analysis of this kind ultimately rests upon assumptions that are inherently uncertain? And we see that in relation to the costing of the tails in workers' compensation claims which have been notoriously inaccurate, we saw it in relation to the provision of compensation for people, victims of asbestos, you can see it with discount rates, where a difference of 2 per cent in a discount rate producing a current present value of an income stream in the future can be dramatically altered by a very small change in interest rates and yet we have seen, over the last six years, maybe 4 or 5 per cent differences in interest rates.

So they are the sorts of problems, aren't they, that come in even when you are dealing with dollar figures?

MR WALSH: That's right. I think the interest rate one is an interesting one in relation to this program, coming later. It goes to your earlier comment, Chair, on whether I can qualify the lifetime benefit of this. A lot of work was done in the late 1990s/early 2000s --- actually, a couple of Australians were key to the worldwide firm that did this work, former colleagues of mine, Colin Mathers and Taylor Voss, who worked with Professor Lopez at the World Health Organisation in developing

the Global Burden of Disease Study.

That sought to estimate a global burden of disease, and a way of quantifying it based on a concept called disability-adjusted life years, DALYs. DALYs effectively add together years of life lost and years of life with a disability and quantify the burden, if you like, of disability due to those two dimensions and project it forward.

Now, it is an open question whether or not you discount that projection. If you do, it provides a more realistic quantum of global burden of disease. If it is undiscounted, it just comes up with a hugely scary number. But at the moment, if you used the current --- the sorts of discount rates that are around at the moment, you would still come up with a scary number. But nevertheless, we need a way to quantify that global lifetime cost.

CHAIR: Thank you.

MS CRAWFORD: Mr Walsh, the Chair just really asked you effectively my next question, which was about the assumptions that underpin the inputs in a cost benefit analysis and how they can skew, if you like, the results that you may get.

MR WALSH: Absolutely. The whole point of collecting data and observing experience is to try to minimise the uncertainty. If you haven't collected the data or haven't designed the data to be collected properly, it's literally shooting in the breeze. At least in workers comp schemes, where the data are collected, the implications of the projections are that if this sort of stuff goes wrong, this is what the cost is going to be. I think that's what you are were talking about, Chair, in blow-outs in the tail, where changes in experience flow through into massively underfunded insurance entities, for example.

CHAIR: Yes.

MS CRAWFORD: Mr Walsh, in paragraph 20 you talk about:

> *At a system level, in particular in social policy systems, the question is usually complicated, and strict 'cost benefit' in financial terms may lose sight of the mission of the system ....*

Can you just expand on that a little for me?

MR WALSH: It goes, I suppose, to the narrow cost benefit analysis of the CIDP program, compared to the second goal of the program, which is an estimate of the value of --- I haven't got it in front of me but the second goal is basically quality of life outcomes for the participant.

The narrow cost benefit analysis counts basically the widgets, the cost of the inputs to the program, and in terms of benefits it says, what does the CIDP program provide us in terms of less days of custodial sentence and less days of community based

monitoring, and what is the average dollar per day, and that's our benefit. That's a very narrow financial benefit definition of a much broader potential benefit. It's easy to be wise after the event, I suppose, and I'm not being critical of either the designer of the program or the cost benefit analysis of the consultants, but had the program been set up in a different way and data been collected in a different way, it would have been - and run for a longer time, it would have been possible to surmise, I suppose, at a much bigger social benefit, which is the actual potential welfare of the participants. There are measures that can do that and one of them I noticed was included in the second stage of the project, the personal wellbeing index.

MS CRAWFORD: Yes.

MR WALSH: There are others, the EuroQol, the Short-Form 12, and all of these seek to rate a person's quality of life on a scale, and an improvement of that scale represents an improvement of quality of life, which can then feed into a disability-adjusted year, disability-adjusted life year calculation and give a financial benefit, potential financial benefit.

So it is possible to do that in this project, but of course the data weren't collected, but that's the way I would have been happier to see it. And even that doesn't collect all of the wellbeing benefit, it just collects the direct reported wellbeing benefit of the participants. It doesn't get the benefits to the broader community or family or the broader system in terms of potential employment productivity.

COMMISSIONER ATKINSON: Ms Crawford, can I ask a question.

MS CRAWFORD: Thank you, Commissioner.

COMMISSIONER ATKINSON: Can I ask you about this, Mr Walsh. When it comes to crime, there are other costs apart from --- other costs and benefits other than the participant. For example, if people are not victims of crime because recidivism has been reduced, then there is both a financial benefit and a wellbeing benefit, not only to the participant but to that wider community of all the people who do not become the victims of crime that there would have been. Is that not relevant to the cost benefit analysis of a program like this?

MR WALSH: It's a great point and it's one I have never seen sought to be measured. I'm sure someone has done it somewhere but that's a really good point.

COMMISSIONER ATKINSON: The other thing I often saw as a criminal judge is the cost to the families of offenders, the fact that they will be thrown on to social security, the children may go to out-of-home care, with the effect on their lives, so there is both the economic cost and the wellbeing cost to the members of families of offenders if they are not put into a program which reduces the chance of future offending.

MR WALSH: Yes.

COMMISSIONER ATKINSON: The third thing I think is the cost to the community, economic cost to community, of post-prison release, that once someone has been in prison, the prospects of them gaining employment, needing accommodation, actually requiring government support, becomes much greater. So that's another --- apart from wellbeing costs, that's an actual economic cost.

MR WALSH: That is correct.

COMMISSIONER ATKINSON: So even if we don't just look at the participant, I can immediately think of economic costs that haven't been included in any cost benefit analysis, when you are looking at reduction of crime.

MR WALSH: I think that was one of the weaknesses that I named towards the end of my evidence about this evaluation, because it does --- the second goal of the process evaluation talks about connecting participants with the NDIS and other services, and there is no attempt in the evaluation that I could find to assess the extent to which investment by other services has assisted those participants who were not eligible for NDIS or even those who were eligible for NDIS.

I think that - as you say, there are lots of them, homeless people need support, employability, all of that sort of stuff.

CHAIR: I don't want to get too philosophical about this, but don't we reach a point, having regard to the sorts of issues that Commissioner Atkinson has raised --- and there are many of that kind --- that the process of attempting to put costs and benefits in dollar terms is often misconceived, and what comes out of it is something that is, with the best will in the world, inherently unreliable and is really there for a political purpose; that is to say, if somebody can come up with a calculation that demonstrates that there's going to be a benefit to some particular program, whether it's for the tourism industry or something else, the community is going to benefit because we are going to have savings here and people are going to be better off.

I'm conscious of that because we have had that debate in relation to the legal system. The former Chief Justice of New South Wales, James Spigelman, wrote an article criticising the Productivity Commission's attempt to quantify the costs and benefits of certain changes to the legal system, which neatly avoids of the question of what is justice and how efficient can justice be.

I did a case once that ran for 120 hearing days and it took eight and a half months to write the judgment, so my productivity for a year was one case, but it doesn't tell you very much about whether I was or wasn't productive, and it works the other way as well. So we have to be very careful I think, and maybe this is where you are heading, about assuming that what comes out as a neat package really tells us very much about the phenomenon being assessed at all.

MR WALSH: I think that is a really good point. The world is full of consultant

reports that, if you added them altogether, you would come up with a benefit of the global burden of disease which is 10 times the world's total GDP. So I understand where you are going with that.

The other side is that cost benefit analysis can also be used for arguments to make decisions that are not really based on all of the available benefits, and so there's --- hence my point that a discrete analysis like this is not always the best way to go. Maybe it's to build systems which collect data and link it into operational services and outcomes.

CHAIR: You had better get a question in quickly, Ms Crawford, otherwise you might be diverted again.

MS CRAWFORD: Mr Walsh, at paragraph 22 of your statement you talk about another distortion arising from the expected duration of the benefit. Is this just another indication of some of these underlying assumptions that get built into the formula when you are analysing or evaluating a particular program?

MR WALSH: I think that question goes to a lifetime benefit-type duration. So a good example might be recidivism. So the benefit that is claimed in this analysis is the benefit of one year of reducing offending, and I think probably a more comprehensive, I guess, taking the Chair's previous comment into account that you don't want to boil the ocean, but recidivism doesn't --- sorry, the reduction of recidivism doesn't stop, in my view. I did some work many years ago with Juvenile Justice where early intervention among childhood offenders reduced recidivism over their lifetime, and it is well established in some international work.

I think again the quantification of the duration of the benefit to recidivism would have provided a greater benefit. Similarly, the quantification of the NDIS benefit, leveraged benefit --- not that I think that's the best way to quantify the benefit, but it doesn't finish after one year. So getting someone onto an NDIS package is a longer term benefit and that --- there's no attempt to quantify that longer term benefit.

MS CRAWFORD: That comes out in your slide number 4, which is EXP.0064.0001.0004, where you talk about uncertainty and direct benefits. The things we were talking about earlier were the undirect benefits but these are more quantifiable benefits, at least with respect to the cost benefit analysis that was done of the CIDP.

There are differences between the draft report and the final report. But if I have understood your statement correctly --- and please correct me if I'm wrong --- you're not saying that there was any particular issue between the draft report and the final report that gives you great concern; you think that both of those analytical findings were open on the material that was available to the evaluator; is that right?

MR WALSH: That's right. I mean, my understanding is that the consultant was appointed in a fair and reasonable tender process and made assumptions that could be

justified by investigation. After consultation with the Department and probably others, the assumptions were changed in the final report.

In my view, both sets of assumptions have problems where their --- credibility is the wrong word --- their accuracy, and in each case the final or the best estimate probably lies somewhere in between. No, I'm not suggesting any inappropriate changes in the report, just that there are uncertainties and discussion between drafts of reports which results in changes in assumptions.

MS CRAWFORD: It is those underlying assumptions and the changes to those underlying assumptions that give you these different results even in these quite blunt benefit components that are listed on that slide? That's right, isn't it?

MR WALSH: That's right. And I guess the purpose of highlighting these differences is it just demonstrates the different ways in which a quantification of a human service, in the absence of the right data and the right set of assumptions, can produce different results.

Going to the Chair's earlier point, the first one, the custodial sentence diverted, really goes to the likelihood of the quantity of the sentence, and that's something that could go into either direction, I imagine, based on the particular magistrate or judge. It's beyond my level of expertise to say which of those is correct. But reading the reports and other material, it seemed to me that it is likely to fall somewhere in the middle. Do you want me to go on to the others?

MS CRAWFORD: No, I don't think that's necessary, Mr Walsh. We can come back to that if we have to.

MR WALSH: Okay.

MS CRAWFORD: You say that the difficulty --- at paragraph 25 of your statement you say that programs:

> *.... new services or programs for people with disability can be viewed as simple changes in the financial enterprise .... [or] they can be viewed more widely.*

Is that just harking back to what you were alluding to earlier with the difference between a very blunt cost benefit analysis versus the cost effectiveness of the program that we were looking at earlier, and how to factor in those less tangible, perhaps, variables into the calculation?

MR WALSH: Are we still talking about this particular slide?

MS CRAWFORD: No, we weren't, no.

MR WALSH: Okay.

Yes, that's right. So there are all sorts of ways in which a service or government can provide benefits. We have talked about most of those during the discussion, but I'm happy to expand them if you wish.

MS CRAWFORD: It's really just --- if I can put it this way --- is it just that attempting to add a dollar value and a quantification value to things that are not readily open to do that make it much more difficult to come to a cost benefit analysis result that is robust enough for people to rely upon it? Is that really what we're naming at here?

MR WALSH: That's not what I'm saying. I'm saying that there are lots of components to a cost benefit analysis and an attempt should be made to quantify all of them, both for the sake of Government funds but also for the ability to monitor the quality outcomes for the (inaudible) at the end and the efficiency of the service systems. And all of those require a level of investment in the collection of information, and one of those cases is that information currently exists.

Again, harking back to the NDIS, it was one of the attempts to establish a longitudinal database for the NDIS, and apart from all of the other issues in implementation of the NDIS, one thing it has done quite well is established a longitudinal database which didn't exist previously.

MS CRAWFORD: The hope would be from that, obviously, that the data that is captured will be sufficiently sophisticated and able to be disaggregated so that you can actually make use of it that you need in order to focus on what needs to be done for particular subgroups within the participant cohort?

MR WALSH: Exactly. That's the whole idea. And that doesn't necessarily mean having endless evaluations, it means using the data and the learning from the data to influence operational investments in a real time. So I think that goes to the earlier discussions we had around there's always going to be uncertainty. If you don't attempt to quantify the big picture, you can use the data to achieve realtime outcomes in an operational way.

MS CRAWFORD: Perhaps we might go to slide 5 of your PowerPoint presentation, which is EXP.0064.0001.0005. This is where you talk about the results of the CIDP report, so the analysis, and the difference between the final report and the draft report with respect to the value, the final value, of the program in dollar terms. Can you just explain --- for the benefit of those watching at home, but can you just explain how these calculations are done and what this benefit of $1 to the 23 cents is about and what the benefits of the $1 to the $1.11 or $1.40 to $1.60 is about in the report?

MR WALSH: What this is saying --- and this slide needs to be considered in the context of the previous slide, the top paragraph, the 23 cents per $1 spent is the final report. If you apply the benefit assumed in the final report of days of custodial sentence diverted, multiplied by the assumed daily cost of custodial service plus the assumed rate of diversion of community support and monitoring times the daily cost

of that, plus the impact of recidivism, all of those are assumed in the final report, you get to a number of 23 cents per dollar, which means that every dollar spent on the CIDP, in terms of the actual dollars and cents spent by the New South Wales Government, for every dollar that was spent there's a direct benefit to the New South Wales Department of Justice of only 23 cents. So that's a poor outcome. So for every dollar spent you only get 23 cents' value.

The second paragraph is using the assumptions that were in the draft report, and if you use all of those assumptions in the draft report, that says that for every dollar spent on CIDP there is a direct cost benefit to the New South Wales Department of Justice of $1.11. That's a good result. And further, if the service were longer and had cost efficiencies, it potentially could provide a benefit of $1.40 to $1.60, which is quite a good result.

So the message of that slide is just that the variability in those assumptions on the previous slide lead to quite big differences in the outcome of the direct cost benefit.

This slide, and the bottom line there, those direct costs have no inclusion of recidivism beyond the first year. So there's a further potential benefit, direct benefit. There's no inclusion on this slide of the indirect benefits of better outcomes for the participants.

CHAIR: Is the point we're heading to that neither analysis is worth the paper it's not written on or one of them is not worth the paper it's not written on, or what?

MR WALSH: I think the point we're heading to is that, reading the process evaluation --- leave aside the cost benefit analysis, the cost benefit evaluation, reading the process evaluation of the CIDP finds the program has very good quality --- I forget the numbers, but something like 87 per cent diversion rate and of those people, those who were assessed for NDIS, something like 60 per cent had packages. So a good outcome, in terms of how was the process. There were lots of recommendations to improve the program but overall the finding was it's a good program in the process evaluation.

What this says to me is that it seems counterintuitive to me to not invest in a program that's got a manifestly good outcome on the basis of a cost benefit evaluation which is subject to big differences in the assumptions, the assumptions made by the same consultant in the draft report and the final report.

MS CRAWFORD: Mr Walsh, is that really --- the issue that you have got there is really saying that these simplified cost benefit analysis results, when you don't take into account the information that is included in the process evaluation report sufficiently, that you are actually failing to answer the second question of the evaluation questions that you were asked to answer?

MR WALSH: I think that's right. There is an attempt to use a proxy measure of the second question, which is what the consultants call --- I don't remember if I put it in

this slide pack --- yeah, it's on the last slide.

MS CRAWFORD: It's on the last slide. We might go to slide 6.

MR WALSH: Yes. The second part of the evaluation is a direct cost benefit analysis, which goes to the second evaluation question, what are the early health and welfare and re-offending outcomes for participants against cost to government? As I said, the process evaluation finds that there are many, but they make no attempt to directly quantify them by applying the sorts of measures I suggested earlier, like a personal wellbeing index like EuroQol or a Short-Form 12, whatever is most appropriate for this population, and they seek to quantify this second evaluation question by what they call leveraged NDIS benefits per participant.

So they assume that the value of the benefit is the increase in the package size of those participants who have been able to get into the NDIS or increase their package in the NDIS.

My point is that trying to quantify an outcome measure by the cost of a support package is at best a proxy measure and potentially not a measure at all because there is no guarantee that a bunch of dollars from the NDIS is going to lead to a good outcome. It might and hopefully it does, but it's not an evaluation of this program directly, in my view.

MS CRAWFORD: Mr Walsh, is the take-away message here that the evaluation that was done of the program was done with insufficient and perhaps unsophisticated data that would have allowed a cost benefit analysis to be done more robustly, but also that the number of perhaps indirect benefits that were apparent within the program and recorded in the other report --- not the cost benefit analysis report but the process evaluation report --- that they ought to have been informing the cost benefit analysis in a way that they apparently weren't?

MR WALSH: If they could have been quantified. And that's the problem. I don't believe the data were available to quantify those benefits that were identified in the process evaluation. I think one of the recommendations in the process evaluation is the establishment of a data set that would capture these sort of data.

CHAIR: Isn't the message that sometimes there is no substitute for making a judgment? An evaluation based upon all sorts of factors? I don't want to come back to lawyers all the time, but that's what judgments in courts do, all the time. You can't evaluate every decision that has to be made by reference to quantification of dollar alternatives. Sometimes you are weighing up imponderables and they have to be, in a sense, balanced but they are not of the same order and there is no substitute in the end for judgments. That's what happens when politicians make decisions about policies as to what should be done. Introducing an NDIS is not a judgment based simply --- I'm not suggesting you are suggesting this --- but it's not based simply on costs, it's fundamentally a value judgment about the worth and dignity of human beings and what should be done in order to support people who have complex needs

in a civilised society.

MR WALSH: Hopefully it is also an opportunity to change the imponderables into ponderables, by collecting the source of information that allows you to reduce the number of judgments you have to make and to provide more evidence to make better decisions.

CHAIR: Maybe the difference between us is that you are more optimistic about that than I am.

MR WALSH: Possibly.

COMMISSIONER ATKINSON: Would it be fair to say, Mr Walsh, that your criticism of the cost benefit analysis here is that it's a flawed cost benefit analysis with insufficient information put into it?

MR WALSH: I don't want to say it's flawed, because this is an endemic problem in the human services sector. I think what I'm trying to say is it's a flaw in the way the human services sector collects and uses data.

COMMISSIONER ATKINSON: Thanks.

MS CRAWFORD: Chair, I have no further questions for Mr Walsh.

MS CRAWFORD: Thank you very much, Ms Crawford.

Commissioner Atkinson, do you have any further questions of Mr Walsh?

COMMISSIONER ATKINSON: No, thank you.

CHAIR: Commissioner Mason?

COMMISSIONER MASON: No, thank you.

CHAIR: Commissioner McEwin?

COMMISSIONER McEWIN: No, thank you.

CHAIR: I don't have any more questions but I will ask Ms Furness, who represents the State of New South Wales, if she has any questions to ask you.

MS FURNESS: I don't have any questions, thank you.

CHAIR: In that case, Mr Walsh, thank you very much indeed. I for one have found this to be an interesting and stimulating session. Having said that, I'm not entirely sure it will set the Twitter-sphere alight, but it is of great value to the work we have to do. So thank you very much for your report and for the evidence you have

provided today.

MR WALSH: Thank you. Twitter is not the world that actuaries live in.

THE WITNESS WITHDREW

CHAIR: Where do we go from here, Ms Crawford?

MS CRAWFORD: Thank you, Chair. I'm going to swap over with Mr Power to introduce the last witness.

MR POWER: Chair, the last witness today is Taylor Budin. Her evidence is in the form of a pre-recorded oral statement. Commissioners, you will find that pre-recorded oral statement in the form of a transcript at tabs 10 to 15 of Tender Bundle A. I ask that these documents be tendered into evidence and for them to be marked Exhibits 11.29.1 to 11.29.6.

CHAIR: Yes, that can be done.

EXHIBITS #11.29.1 to #11.29.6 - PRE-RECORDED EVIDENCE OF MS TAYLOR BUDIN

MR POWER: Thank you. I will ask that the pre-recorded video statement of Ms Taylor Budin be played.

[VIDEO RECORDING PLAYED]

MR FOGARTY: Good afternoon, Taylor, thanks for coming in today to do a pre-recording for the Royal Commission.

MS BUDIN: That's okay.

MR FOGARTY: Thank you for your patience. Can I start with the formalities? Can I get you to tell the Royal Commission your full name?

MS BUDIN: My name's Taylor Budin.

MR FOGARTY: How old are you at the moment?

MS BUDIN: I am 26.

MR FOGARTY: You prepared a statement for the Royal Commission?

MS BUDIN: Yes, that's correct.

MR FOGARTY: And you signed that today?

MS BUDIN: Yes.

MR FOGARTY: And you've got a copy with you today?

MS BUDIN: Yes, that's correct.

MR FOGARTY: And it's that document, and what you have put in there, is it true and correct to the best of your knowledge and belief?

MS BUDIN: Yes, that's correct.

MR FOGARTY: Also today we've got Michael and Josh with us in the room as your supports. Brilliant. All right.

I have read your statement. Excellent statement. Today is an opportunity for you and I just to walk through that, talk about it; there might be parts you want to talk more about.

MS BUDIN: Yeah.

MR FOGARTY: --- might be things you want to emphasise. It's totally up to you. If you want a break, let me know.

MS BUDIN: Yep.

MR FOGARTY: Starting --- the subheading in your statement is "About me", some of your experiences and talking about your disability. You say in your statement that you knew you had autism before 2019 when you got the diagnosis.

MS BUDIN: Yeah.

MR FOGARTY: What made you feel like you knew that?

MS BUDIN: I guess I've always thought something was wrong. All people --- and my parents have also thought so. Growing up, we've always tried to find something and we found out, not long ago, that one of my sisters had --- was fully diagnosed with autism, doesn't speak or talk, so she's non-verbal --

MR FOGARTY: Right.

MS BUDIN: --- so we looked into it a bit further with Michael, my case manager at

the time, and he ended up getting in contact with --- oh, God, I can't remember ---

MR FOGARTY: That's okay.

MS BUDIN: --- his name, and he ended up getting this diagnosis of autism stage 2.

MR FOGARTY: So when you talk about "Michael", this is the CIDP program ---

MS BUDIN: Yes, the CIDP Program.

MR FOGARTY: --- that we are going to come on and talk a little bit more about that. And Michael is supporting you today. In your statement, you also talk about you've had a lot of different labels.

MS BUDIN: Yes.

MR FOGARTY: What do you mean by that or what were they?

MS BUDIN: So I had an intellectual functioning disorder, I have been told I might have bipolar, ADHD, and stuff like that.

MR FOGARTY: But the primary diagnosis is stage 2 autism?

MS BUDIN: Yes.

MR FOGARTY: In your statement you talk about growing up and school, and you remember, I think you talk in it about in primary school, having people obsessive with behaviour issues?

MS BUDIN: Yes.

MR FOGARTY: Is that when you started noticing --- (overspeaking) ---

MS BUDIN: Yes, my family started to notice that at a young age, when I was probably like year 3 or 4.

MR FOGARTY: Did you go through mainstream primary school?

MS BUDIN: Yes, I did, all the primary school was mainstream, but when I got to high school and they started to see that I was actually struggling in year 7, they put me into the ---

INTERVIEWER: The support unit.

MS BUDIN: Yes.

MR FOGARTY: Did that help you?

MS BUDIN: Yeah, it did. It helped me a lot.

MR FOGARTY: When you were, I think, 17 ---

MS BUDIN: Yep.

MR FOGARTY: --- you finished school and started working with a disability service?

MS BUDIN: Correct.

MR FOGARTY: From what I read, it sounds like something you loved and love.

MS BUDIN: Yes, it's my favourite thing to do.

MR FOGARTY: Why is that?

MS BUDIN: Because my best friend, Reece, had cerebral palsy. And growing up with me --- I met him at singing and dancing in primary school. And I used to go to his house every weekend and he used to come to my soccer games and stuff like that. And he went --- when we got older, he went to Nepean High School, the special -

MR FOGARTY: It's a performing arts school as well.

MS BUDIN: Yes, performing arts school. And he's a really good singer, so he could be in that. And unfortunately he died on his way home from school one day and got hit by a truck through the red light then. So ever since then, I wanted to work with disability, so I went out and got that job and I studied at TAFE for about five years it took me to finish that.

INTERVIEWER: So you got your cert?

MS BUDIN: Yes, got my Certificate IV ---

MR FOGARTY: I don't think that's in your statement.

MS BUDIN: No. But I got my Certificate IV in disability. And I got my HSC. I got my HSC ---

MR FOGARTY: You did that --- (overspeaking) ---

MS BUDIN: I didn't do the HR --- no, I did it at school --

MR FOGARTY: --- (overspeaking) ---

MS BUDIN: --- with the learning setup, so if it wasn't for that, I wouldn't have got

my HSC.

MR FOGARTY: So there was a real difference to your outcomes at school with the right supports?

MS BUDIN: Yes.

MR FOGARTY: But even --- at that age you didn't have a formal diagnosis?

MS BUDIN: No.

MR FOGARTY: Okay. All right. I want to talk about your experiences with police, and again if you need a break ---

MS BUDIN: Yep.

MR FOGARTY: --- or something you don't want to talk about, it's fine because I think you present it quite well in your written statement.

I think you say you first started having trouble with the police when you were 20, at a pub with a friend.

MS BUDIN: Yep, that's correct.

MR FOGARTY: You don't have to go into the ins and outs of what happened, if you do, it's fine, but I guess what I'm wondering about is how you found the interaction with the police, whether you struggled, whether they got you, whether it was all a blur, I mean, whether they offered support ---

MS BUDIN: Struggled.

MR FOGARTY: Yeah.

MS BUDIN: Yeah.

MR FOGARTY: So they arrested you?

MS BUDIN: Well, after the incident when I assaulted the girl at the pub, I ran off. I ended up going home. The next day the police came to the house, and that's when they wanted to talk to me about it and stuff like that, and then they took me to the police station, and my parents stayed home, so I just went, and then ---

MR FOGARTY: By yourself?

MS BUDIN: Yep. And then they asked me questions and stuff like that.

MR FOGARTY: Did you have a support person while you were doing that?

MS BUDIN: No.

MR FOGARTY: Did they offer you a support person?

MS BUDIN: No. The program wasn't around then.

MR FOGARTY: Yep.

MS BUDIN: There was nothing, so I had to deal with it really. Go to Legal Aid on my own.

MR FOGARTY: Yeah. So did they give you bail that day from the cop shop?

MS BUDIN: Yes.

MR FOGARTY: They gave you a date to go to court?

MS BUDIN: Yes.

MR FOGARTY: You had to get there on your own?

MS BUDIN: Yes, my grandfather took me.

MR FOGARTY: Yes, and then you had to find Legal Aid?

MS BUDIN: Yeah.

MR FOGARTY: Was it [REDACTED]?

MS BUDIN: Yeah.

MR FOGARTY: So you got a --- did you get a --- so you got a good lawyer --

MS BUDIN: Yes, a good one. That was good.

MR FOGARTY: Can I ask you this, you mightn't talk about this in here but it seems to be a theme coming up on this topic with the Royal Commission: did that lawyer stay with you throughout or did you have different lawyers?

MS BUDIN: When she got busy, like it was a real bad day in court for her, then I would get a replacement, but the replacement was [REDACTED], and [REDACTED], he's great, so it was okay.

MR FOGARTY: Were there difficulties because you had to tell the story again to ---

MS BUDIN: Yes, yes, that is one thing that's hard, when you have to keep telling

different lawyers the story, and they don't know where you're at in the case, like ---

MR FOGARTY: Sometimes in the programs ---

MS BUDIN: Sometimes that can be a disadvantage too, I find, like, if you get a new lawyer all the time, like, they are not bothered, you know ---

MR FOGARTY: I see, they don't have the passion the earlier one had for you ---

MS BUDIN: Yeah.

MR FOGARTY: --- they don't really know ---

MS BUDIN: Yes, there's no passion there or they don't really care.

MR FOGARTY: Can I take you to the program, the CIDP program ---

MS BUDIN: Yep.

MR FOGARTY: --- is part of what they do is supporting you in court?

MS BUDIN: Yes.

MR FOGARTY: And so, that support, does that help? I mean, that helps you with your direction with the court?

MS BUDIN: The court, the police, anything really and ---

MR FOGARTY: And then Legal Aid as well.

MS BUDIN: Yes.

MR FOGARTY: You got a good behaviour bond, I think, for that first matter.

MS BUDIN: Yes.

MR FOGARTY: But in your statement you talk about some of the long-term consequences of that process and one was you ---

MS BUDIN: I lost my job ---

MR FOGARTY: --- lost your job ---

MS BUDIN: --- can't work with Disability any more.

MR FOGARTY: And then sent you on a bit of a spiral?

MS BUDIN: Yes.

MR FOGARTY: Got upset and angry about stuff?

MS BUDIN: Yes.

MR FOGARTY: So, really negative outcome.

MS BUDIN: Very.

MR FOGARTY: And you get a bond but ---

MS BUDIN: Yes.

MR FOGARTY: --- there's all those other consequences for you that don't help you, you were in a worse place probably than before you walked through the door of the court. In your statement you talk about looking back and feeling ashamed about some of the things you did with the crowd you are were hanging out with.

MS BUDIN: Yep.

MR FOGARTY: And I think you had problems with drugs for a bit at a time --

MS BUDIN: Yes.

MR FOGARTY: --- all that sort of stuff. In terms of that time in your life, is there anything particular that you think the Royal Commission needs to hear about, or is it more, "Look, my first interaction with police and the courts proved to have negative consequences for me" ---

MS BUDIN: Yes.

MR FOGARTY: --- "rather than maybe going off to a supported environment and learning skills or getting diverted in a way that supports me, I was kind of just left to go off and be of good behaviour, and that didn't help" --

MS BUDIN: Yes.

MR FOGARTY: --- is that a fair assessment?

MS BUDIN: Yes.

MR FOGARTY: Was part of your bond to be engaged with probation and parole, or community corrections, as they call it?

MS BUDIN: At that point um ---

MR FOGARTY: "Yes" or "no"?

MS BUDIN: No. Nothing.

MR FOGARTY: Just "Off you go and be good"?

MS BUDIN: Yes, be good.

MR FOGARTY: In 2018 is where you got contact with Cognitive Impairment Diversion Program, CIDP. That's what we might call it here. We have talked a bit about that, about how they support you in court. But does that program help you in other ways? How else does it help you?

MS BUDIN: Yes, they helped me get my diagnosis, anything relative for court that needed, like supporting documents and stuff like that ---

MR FOGARTY: Yes.

MS BUDIN: --- they help you with; they help you with like services that you might need, whether OT, or anything like that, doctors, anything.

MR FOGARTY: Does that help go past the kind of --- well, in any sense, "It's done, see ya later", is it more holistic?

MS BUDIN: Yes, it more of a --- continues, sort of, like helpful.

MR FOGARTY: Yes, but that was the last time you were linked up when that service started to exist?

MS BUDIN: Yes.

MR FOGARTY: It might be a really stupid question to ask, but if that service had been around when you walked into the door of the local court with your grandfather ---

MS BUDIN: It would have been a whole different story.

MR FOGARTY: Right.

MS BUDIN: I probably would have got a section 32 or something and then ---

MR FOGARTY: And actually got constructive --

MS BUDIN: Yeah.

MR FOGARTY: --- stuff going on ---

MS BUDIN: Yeah, that didn't --- (overspeaking) ---

MR FOGARTY: You might not have lost your job ---

MS BUDIN: Yeah ---

MR FOGARTY: --- you might have got someone to assist you to talk to them about your job?

MS BUDIN: Yes. 100 per cent.

MR FOGARTY: You also spent time in prison, in custody, your bail refused in 2019, with some fresh offences when you were bail. What was your experience of being in prison?

MS BUDIN: Horrible. Absolutely horrible.

MR FOGARTY: So how old were you then?

MS BUDIN: About --- 24.

MR FOGARTY: Okay.

MS BUDIN: Yep.

MR FOGARTY: A young woman.

MS BUDIN: Yep.

MR FOGARTY: With a disability. Still --- had it been diagnosed?

MS BUDIN: No --- yes, it had.

MR FOGARTY: Yes. So I think you talk about going to [REDACTED].

MS BUDIN: Yes.

MR FOGARTY: [REDACTED]?

MS BUDIN: Yes.

MR FOGARTY: You know, it's pretty --- your description in the statement about --- I really got a sense when I read it of a young woman who is like, "What happened to me? I'm in this truck" ---

MS BUDIN: That was it!

MS BUDIN: --- "[REDACTED] has gone past. I used to go there to enjoy myself, now where the hell am I going?"

MS BUDIN: Yes.

MR FOGARTY: That day in court when you didn't have supports, I think it was --- you kind of just didn't know what was going on.

MS BUDIN: I had no idea.

MR FOGARTY: Yeah.

MS BUDIN: So I was brought downstairs.

MR FOGARTY: Yes. After court.

MS BUDIN: After court I was brought downstairs, and it was like, nearly 5 o'clock ---

MR FOGARTY: Yeah.

MS BUDIN: --- and I'm thinking to myself, court closes now, so what is happening? Am I waiting till the next day or something?

And then next minute I'm being put on a bus --- a truck, and the next minute it pulls up at [REDACTED], dropping someone off, then the next minute going past [REDACTED] and the people in the back of the truck and they said "We're going to [REDACTED]." That's when I broke down and that was it.

MR FOGARTY: Yeah.

MS BUDIN: Because I --- no one had told me. I didn't know ---

MR FOGARTY: Had you even gone up in front of the court that day?

MS BUDIN: Yeah, I did, but I still didn't understand ---

MR FOGARTY: You didn't know what was going on?

MS BUDIN: --- what was going on. No.

MR FOGARTY: Taking a step back, [REDACTED] police, at that time?

MS BUDIN: Yes, but it was [REDACTED] that was dealing with the matter.

MR FOGARTY: You have talked about your experience in the police station cells there.

MS BUDIN: Oh. [REDACTED] was horrible.

MR FOGARTY: That was [REDACTED], was it?

MS BUDIN: Yes.

MR FOGARTY: Just horrendous.

MS BUDIN: Horrendous.

MR FOGARTY: No supports, nothing.

MS BUDIN: No supports, nothing.

MR FOGARTY: As a woman, as a person with disability, as the lot.

MS BUDIN: Yes, especially when a girl needs things like --- and it's not given.

MR FOGARTY: Yeah, basic human.

MS BUDIN: Yes.

MR FOGARTY: You talk about that in your statement. I think too you said they didn't let you call your family.

MS BUDIN: Nope. I got one call, and that was to the lawyer.

MR FOGARTY: Yeah.

MS BUDIN: The lawyer told me not to say nothing at all, but then next --- I went back to my cell after I spoke to the lawyer, the lawyer speaks to them and says, "You are not to say", but then once you're off the phone, it's a totally different story, isn't it? They came up to my cell, made up a lie saying such and such, "If you don't do this, we are going to take this."

MR FOGARTY: Right. Did you do anything in the end?

MS BUDIN: Yes, sure did.

MR FOGARTY: Right.

MS BUDIN: That's where they got me.

MR FOGARTY: Even after they'd done --- you'd called a good lawyer?

MS BUDIN: Yes.

MR FOGARTY: All right. Do you think having a service like CIDP in those sorts of situations might assist --

MS BUDIN: Yes.

MR FOGARTY: --- because I understand part of their role --- correct me if I'm wrong, is organising lawyers who understand cognitive disability --

MS BUDIN: Yes.

MR FOGARTY: --- and being very sure with police and keeping records of conversations with police about, "This is not an interview per se."

MS BUDIN: Yes.

MR FOGARTY: That would have helped?

MS BUDIN: Yes, it would have.

MR FOGARTY: Roughly how long did you spend in the [REDACTED] unit?

MS BUDIN: Two months.

MR FOGARTY: Two months. Did it get harder, did it get easier?

MS BUDIN: Well, first day I got there, I nearly got bashed.

MR FOGARTY: Yep. For probably no apparent reason?

MS BUDIN: Pretty much, yeah. I couldn't make phone --- the one thing that got me was that no one told me when I first got there that I couldn't make a phone call or anything like that, like to my partner. So like I'm stressing out, I don't what's going on, I don't know how to do anything. So when I finally can get a hold of my partner, it was the biggest weight lifted.

MR FOGARTY: How long ---

MS BUDIN: I think it took ---

MR FOGARTY: --- would that have been?

MS BUDIN: --- a couple of days.

MR FOGARTY: All right. Meanwhile, you're wondering what he's thinking and your family are thinking?

MS BUDIN: Yeah.

MR FOGARTY: "Where is my partner?" "Where has my child gone?"

I just want to ask you a little bit about the staff that were there. I think in your statement you say none of the staff had any idea at all what to do with people with disability.

MS BUDIN: Pretty much, yeah.

MR FOGARTY: Was that unit one that was meant to be --- is designed for people with disability or with mental health issues?

MS BUDIN: Well, actually, [REDACTED] is, yes. There's [REDACTED], which is higher up, then there's [REDACTED], and then there's another one. But most of the people who were in my section was more mental health. The only other person that had a disability was a dwarf that I was with at the time.

MR FOGARTY: So, a physical disability?

MS BUDIN: Yeah.

MR FOGARTY: Okay. But otherwise it was people with --- were they fairly unwell.

MS BUDIN: Fairly unwell, yes.

MR FOGARTY: And what about conditions in there?

MS BUDIN: Horrible conditions.

MR FOGARTY: Yeah. What about, how much time did you spend in --- (overspeaking) --- cells?

MS BUDIN: Okay. So mainstream get out, like, early as and don't get locked back in until, like, 10 o'clock at night, they can stay in there, port open, for however long. For me, I was out at, I think it was, 8.00 am until 8.30, locked back in at 11.00 until 12.00 or something and then back out until 2.00. I was only about for about eight hours, not even, and I was locked in my cell for 18 and a half hours. I know that for a fact.

MR FOGARTY: And you talk about you were almost assaulted.

MS BUDIN: Sexually assaulted twice, yes.

MR FOGARTY: And what about responses to ---

MS BUDIN: Not good.

MR FOGARTY: --- emergencies or ---

MS BUDIN: Not good, not good. I mean, even when I was sexually assaulted and I tried to press charges on the people that did so, the police, when they did show up, turned around and said to me, "There's no point, she's going to plead mental health." How's that?

MR FOGARTY: Didn't follow it up?

MS BUDIN: Didn't follow it up at all. That's it. There's heaps of things that aren't right in there, like at times you can't have certain things, because other people self-harm.

MR FOGARTY: You talk about senior guards and junior guards and your experiences with them.

MS BUDIN: Yep.

MR FOGARTY: Is it fair to say --- you experienced it, not me --- some of the senior guards are a bit set in their ways.

MS BUDIN: Yes.

MR FOGARTY: And probably your experiences with some of the other younger guards were better ---

MS BUDIN: Yep.

MR FOGARTY: --- because they were a bit more open-minded and empathetic.

MS BUDIN: Yeah. There was a couple of them that used to be ex-disability workers, which I found funny, I didn't know they did this. The older ones, especially the ones that had most things on their shoulders, that was it.

MR FOGARTY: Right. They just weren't ---

MS BUDIN: It was black and white. They didn't care if you had a disability, mental health, they didn't care about the colour of your skin, didn't care, you are nothing but scum to them.

INTERVIEWER: One of the younger guards got you a headset, I think ---

MS BUDIN: Yes, she did.

MR FOGARTY: --- which was nice to help you out.

MS BUDIN: Yeah, that was good. But then the older guard, when she would be on, would take my headset and say, "You can't have that because it's got a piece of metal in it." Do you see what I'm saying?

MR FOGARTY: Yes. You didn't feel that was the real reason why it was being taken off you?

MS BUDIN: Yes. When the governor approved something, but then if the senior member of staff in my section who is on that day doesn't want it, it got taken away from me.

INTERVIEWER: While you were in prison the court case was going on and I read about how all of it was done by video link.

MS BUDIN: Yes.

MR FOGARTY: How did you find that?

MS BUDIN: Horrible. You can't hear anything, because when you're in those pods --- you guys don't understand --- I've got inmates just outside the door, yelling and yelling at each other, in between the cells, trying to prepare each other's statements about what they're going to say. I've got guards banging on my door, telling me I have to hurry up because it needs to be used. The worst thing is I've got disability, I can't hear what's being said and then I'm not told what even was going on. That's the worst part. Or when I did finish, my lawyer would call and not explain anything and I'm left ---

MR FOGARTY: Just tell you the next day.

MS BUDIN: "Oh, you were refused bail." That's all I know. That's not good enough.

MR FOGARTY: Again, does the CIDP help bridge that gap, in your experience?

MS BUDIN: Yes, yes. But the issue with that was what I didn't have any connection to anyone on the outside, apart from my partner, at first, and I did not get to see my support worker, Michael, for like three weeks into my thing. That's good into enough. He struggled to get in. It took that long because they make it difficult.

MR FOGARTY: Almost halfway through the time you spent in there.

MS BUDIN: Yes.

MR FOGARTY: It took about another six months for the whole thinking, after two months you got bail.

MS BUDIN: Yes.

MR FOGARTY: And then the court case obviously continued and CIDP were involved when you got bail.

MS BUDIN: Yes.

MR FOGARTY: I think you talk about how surprised and relieved and ---

MS BUDIN: I was very surprised, I didn't think I was getting it.

MR FOGARTY: You wouldn't get bail, yes. Did the program also work with your Legal Aid lawyers and helped you ---

MS BUDIN: Yes. They stayed in connection really well, actually.

MR FOGARTY: On the final day of court, when the sentence came, again was that a time when you had a support person, you had Michael?

MS BUDIN: Yes.

MR FOGARTY: And what role did Michael play for you?

MS BUDIN: That day, just to really be a support, really.

MR FOGARTY: Explained what was going on as well?

MS BUDIN: Yeah.

MR FOGARTY: Or explained at the end what had happened?

MS BUDIN: Yeah, explained everything at the end, what had happened, what we had to go through from then on.

MR FOGARTY: Part of the effect of your disability, at times stuff just goes past, like when you're stressed?

MS BUDIN: Yes, when I'm overwhelmed.

MR FOGARTY: You are on the NDIS?

MS BUDIN: Yes.

MR FOGARTY: How has that assisted you? How do they assist you at the moment? Enough or not enough? Work in progress.

MS BUDIN: Yes. Let's go with that.

MR FOGARTY: Be as diplomatic as you like.

MS BUDIN: Could be better.

MR FOGARTY: Okay. In terms of understanding how CIDP works --- (overspeaking) CIDP, is that part of their role to assist with NDIS at this stage?

MS BUDIN: Yes. They're trying. We're trying.

MR FOGARTY: What I'm trying to get at is I'm trying to understand how the CIDP thing works in terms of how broad that assistance is.

MS BUDIN: Yeah, they help me with that. They keep in contact, like if I have any issues, I tend to pass it on to Michael, instead of my NDIS workers, and he follows it up ---

MR FOGARTY: He advocates for you.

MS BUDIN: Yeah, that's better for me. I find it's better if I do it that way.

MR FOGARTY: That's because you have built a rapport with that person at CIDP.

MS BUDIN: Really good, yes.

MR FOGARTY: It's always the one person?

MS BUDIN: Yes. You can't change that person on me.

MR FOGARTY: Have you more recently --- so you have worked with the disability support service or disability service after leaving school but have you done some more short-term work in that space since?

MS BUDIN: Yes.

MR FOGARTY: Is that something ---

MS BUDIN: That I want to continue to do? Yes, it is.

MR FOGARTY: I'm building up to the part where you did some work with IDRS in Making Rights Real.

MS BUDIN: Yes.

MR FOGARTY: Can you let the Royal Commission know what that's about?

MS BUDIN: Yes. So I've just started really.

MR FOGARTY: Yeah, that's okay.

MS BUDIN: It's all about really, there's like five of us and we all have different disabilities and impairments and we all sit in a group and we discuss ways on how to train police and other organisations on how to actually deal with someone with a disability who needs to be spoken to by the police or needs to go to court or anything like that. We also are trying to build programs and stuff around ---

MR FOGARTY: If you can't remember, that's fine.

MS BUDIN: I can't remember it.

MR FOGARTY: Is it the plan for you guys to do some training with those people?

MS BUDIN: Yes.

MR FOGARTY: Have you done that yet?

MS BUDIN: The most I've done so far, I actually --- can I speak about it? I don't know. I'll just speak about it. So about a month ago I went to [REDACTED] and I met with a bunch of security guards.

MR FOGARTY: Guards?

MS BUDIN: Yes. And there was about 50-odd and I stood up and I told my story. And it was really powerful because when I was telling my story, actually, one of the guards that was in [REDACTED], who was no longer there when I was there, he got left, he got moved on, he was there. And as I was telling my story, before I noticed him, I was actually explaining how much this person helped me get things that needed to be addressed. And he was there.

MR FOGARTY: You saw him.

MS BUDIN: Yes, then he started to cry. It was like a really good type of thing because I helped him in the situation he was in. So it was like, yeah, it was good. Everyone that day said I made a huge impact on how they are going to approach things, because [REDACTED] has a special unit there for the men, which is really great. I heard a lot of good things are happening there, so I'm happy to hear about that.

MR FOGARTY: How did that session make you feel?

MS BUDIN: Really good.

MR FOGARTY: Were you nervous beforehand?

MS BUDIN: No, I wasn't nervous that day. That day I was fine.

MR FOGARTY: Awesome.

MS BUDIN: It was good.

MR FOGARTY: I suppose that feeling you got and that feeling of achievement but also one for both sides, the person telling it, is something you want to do more of?

MS BUDIN: Yes, it is. Like, my story --- I don't know if you know, my story is being published in a criminology textbook?

MR FOGARTY: I heard on the grapevine about that. I think that's something that's going to go in with your statement.

MS BUDIN: Yes.

MR FOGARTY: As is something else I'm going to come to as my last topic, which is your art. I want to ask you about that. I want to understand the person, other than all this stuff about police, courts and prisons we're talking about.

Before I ask you about that, at the end of this statement you talk about views and recommendations, and how you would like to see things change and improve in the criminal justice system. What recommendations are the most important for you?

MS BUDIN: The big issues?

MR FOGARTY: Yes, like education.

MS BUDIN: Yes, education is a huge one that they need to be ---

MR FOGARTY: Probably what you ---

MS BUDIN: Yeah ---

MR FOGARTY: --- started doing.

MS BUDIN: More educated and stuff like that, because the way I was treated is not right. Like just because I can't have certain food types does not mean you don't have the right to say, "I don't give a f.... if your food touch your peas touch your corn." Like, it's things like that. All we ask for is to be spoken to a little bit more nice. You don't have to treat us like crap ---

MR FOGARTY: Yes.

MS BUDIN: --- it's not the right thing. We're in here doing what we have to do, we're in here doing our time, you don't need to make it any worse than it already is.

MR FOGARTY: Yes, that example you gave ---

MS BUDIN: Yeah.

MR FOGARTY: --- because of your disability, you have difficulty eating when things are mixed together --

MS BUDIN: Yes.

MR FOGARTY: --- and you give an example in your statement about how you intentionally kept being given food that was mixed --

MS BUDIN: Yeah, mixed.

MR FOGARTY: --- and you said, "Look, I can't deal with this, I can't eat" --- (overspeaking) ---

MS BUDIN: Yes, for days I couldn't eat.

MR FOGARTY: --- basically they turned around and said, "Shove it, not my problem."

MS BUDIN: Look, there were points I had even to call up my partner and family and get them to try and speak on my behalf to the Ombudsman and stuff like that, just to get my needs met.

MR FOGARTY: Yeah.

MS BUDIN: And that's not right.

MR FOGARTY: Fundamental.

Any other recommendations that you can think of now? I think there were a couple more in your statement. It's not a test. Do you feel, when I ask you about --- you talk about educating them, is your feeling that the best person to educate, like a police officer or a prison guard, about what you are talking about, is a person with lived experience?

MS BUDIN: Yes.

MR FOGARTY: Is a person with disability?

MS BUDIN: Yes.

MR FOGARTY: Yeah. But otherwise they just don't get it?

MS BUDIN: Well, you have no training, you have no knowledge ---

MR FOGARTY: No knowledge.

MS BUDIN: --- about it. How can you help someone if you don't ---

MR FOGARTY: Don't understand.

MS BUDIN: --- understand it?

MR FOGARTY: All right, I'm going to come to the last --- I have seen these pictures and I need to be corrected, but you obviously have a very creative side ---

MS BUDIN: Yes.

MR FOGARTY: --- in art. And currently ---

MS BUDIN: I learnt wood burning at rehab at [REDACTED].

MR FOGARTY: Oh, right, okay.

MS BUDIN: And I just kept doing it.

MR FOGARTY: When is your exhibition coming up?

MS BUDIN: I don't know. I thought that --- I like my art ---

MR FOGARTY: Yeah.

MS BUDIN: --- but I don't feel like it's good enough for anything like that, so I'm not that ---

MR FOGARTY: You do it for art's sake?

MS BUDIN: Yeah, I would love to make like a real business of my own but I don't think it's good enough for that.

MR FOGARTY: Well, I think it's pretty impressive, what I have seen.

The last thing I want to say as a wrap-up question is whether there's anything else you don't think you have covered from your statement or something you want to emphasise to the Royal Commission?

MS BUDIN: Yes, that we need the program back, please!

MR FOGARTY: CIDP?

MS BUDIN: Yes.

MR FOGARTY: You want it to be ---

MS BUDIN: Keep the funding, please! Well, we need something in the court systems, because I don't --- where I (inaudible) --- sorry, what I can't comprehend is why you get rid of something that was going so well.

MR FOGARTY: Yeah.

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

MR FOGARTY: Yeah.

MS BUDIN: And that worries me. Because how many other people are still in there that need to be on the program.

MR FOGARTY: Yeah.

MS BUDIN: They could be out, not in.

MR FOGARTY: And they just don't know about it --- (overspeaking) ---

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

MR FOGARTY: Yeah.

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

MR FOGARTY: Who just don't have the support.

MS BUDIN: Who just don't have the support or the advocacy. They're just getting pushed under the rug ---

MR FOGARTY: Yeah.

MS BUDIN: --- another number.

MR FOGARTY: All right. Thank you.

MS BUDIN: Thank you.

[VIDEO RECORDING ENDS]

MR POWER: Thank you, Chair. That concludes the evidence for today. Could we ask that the Commission be adjourned until tomorrow morning at 9.30 am Brisbane time, 10.30 am Sydney time.

CHAIR: Yes, we can do that. I rather thought Ms Budin's evidence was a fairly good cost benefit analysis.

MR POWER: Indeed.

CHAIR: We will adjourn until 10.30 Sydney time, 9.30 Brisbane time tomorrow. Thank you very much.

MR POWER: Thank you, Chair.

HEARING ADJOURNED AT 4.12 PM UNTIL 10.30 AM ON THURSDAY, 25 FEBRUARY 2021

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