People with Cognitive and Mental Health Impairments

in the Criminal Justice System

Response by the Public Defenders

Introduction

The fitness and diversionary scheme introduced by the Crimes (Mental Disorder) Amendment Act 1983, which took effect in 1986, was a profound re-casting of how accused and defendants with a mental impairment were to be dealt with by the criminal justice system. It has operated in NSW courts essentially unchanged since that time, although there have been some welcome modifications, such as the removal of the decision to release forensic patients who have been found not guilty on the grounds of mental illness ("the special verdict") from the political process.

Overall the scheme has provided an appropriate, and unavoidably complex, blueprint for how the criminal justice system deals with accused and defendants with a mental impairment, but after 24 years of operation, it is timely to review the scheme and other aspects of the impact of mental impairment on the criminal justice system, in light of the experience of its participants.

There are four issues that we wish to raise that are not covered in Consultation Papers 5-8, which are set out below, at the outset of our response to specific issues.

Additional Issues

1. Sentencing of Mentally Impaired Offenders; An Alternative Approach

We submit that it is appropriate for the NSW Law Reform Commission ("the Commission") to consider a significant departure from the current sentencing regime in respect of some offenders with a mental impairment, and that this is justified by research that establishes that there is a disproportionate number of prisoners with a mental impairment compared with the community at large, and that, in a high percentage of cases, the mental impairment was not recognised at the time of these offenders being charged. Such a departure in sentencing practice would be justified from the perspective of both offenders and the protection of the community. The current sentencing legislation does not, in our view, pay due regard to the rehabilitative needs of such offenders, and their reduced appropriateness for punishment generally (and prolonged incarceration in prison in particular).

There are two primary types of mental impairment that have impacted on the criminal justice system, including sentencing: mental illness, and intellectual disability.

Significant advances have been made in the treatment of mental illness in recent decades, although there remain lapses in its early identification in the community, and the delivery of a prompt community treatment response, in the absence of which, criminal behaviour may follow. An example is murder. Between the beginning of 1993 and the end of 2002, there were 1,052 homicides in NSW. At the time of the killings, 93 (8.8%) of the perpetrators had a psychotic illness. A study of 88 of these 93 perpetrators revealed that 54 (61%) carried out the killing during their first episode of psychotic illness ("FEP"); that is, they had not previously been diagnosed, or treated for their illness. The risk of a person with an FEP committing a homicide is as much as 20 times higher than the risk after a period of adequate

treatment.[1] There is no reason to think that the impact of FEP on other categories of crime, both serious and less-so, would not be of a similar order.

Similarly, offenders with an intellectual disability are an increasing proportion of offenders and prison populations, particularly where the offender's disability has not previously been identified, or where services have not been delivered. Professor Eileen Baldry recently carried out a study of some 680 prisoners in NSW prisons who have an IQ of less than 70 (being a person with an intellectual disability). Only 23% (156) were clients of the relevant NSW government agency (the NSW Dept of Ageing, Disability and Home Care: "DADHC"), and of those, 79% (123) were first diagnosed in prison. Therefore only 33 of the 680 prisoners with an intellectual disability had disability services prior to their imprisonment. Those who became ADHC clients after diagnosis in prison reduced offending and contact with the criminal justice system significantly, but prison otherwise did not deter or rehabilitate offenders with an intellectual disability.[2]

However, if the insanity defence is not established, and if the offender does not come within the defence of substantial impairment in respect of murder, there is no structural recognition of the appropriateness of taking a different approach to sentencing. The defence of substantial impairment, as with provocation, is offence-specific. There are no modified forms that apply to attempt murder, or to grievously inflicting grievous bodily harm with intent, let alone to other lesser offences, so as to significantly reduce the public denunciation that accompanies conviction on the primary charge, and to loosen (and perhaps reduce) the available sentencing range. In any event, a substantial impairment manslaughter sentence goes no further than any other sentence in ensuring a tailored post-court rehabilitative process.

There are features of the present sentencing regime in respect of mentally impaired offenders that mitigate against a lesser sentence, with enhanced service delivery and supervision; a combination that would squarely addresses these issues, and ultimately deliver better community protection. These adverse features include the statutory nexus between the non-parole period and the total sentence, and standard non-parole periods. The notion of special circumstances and the mitigatory considerations of section 21A of the Crimes (Sentencing Procedure) Act do not go far enough to provide the flexibility needed, and do nothing at all to ensure a post-sentence supervised service-driven approach to addressing the mental impairment underlying the criminal behaviour.

If there is to be a fundamental re-thinking of how such offenders are sentenced and rehabilitated, the MHRT could be further developed as a supervisory and release authority for some offenders with a mental impairment. Of the existing agencies and organisations, it is best-placed to provide expertise as to the monitoring of service delivery to offenders with a mental impairment, and the quasi-criminal deliberations necessary to the exercise of coercive and release powers.

We are in favour of what might be termed a semi-diversionary scheme; the sentencing court, before which an offender with a mental impairment appears, takes into account a report

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[1] *Homicide during Psychotic Illness in NSW 1993-2002* Nielssen, Westmore, Large & Hayes. MJA Vol 186 No. 6, 19 March 2007.

[2] Paper delivered at the Public Defenders Annual Conference 2010, available on the Public Defenders website at: www.publicdefenders.nsw.gov.au

prepared by or under the auspices of the MHRT in determining the sentence. If a custodial sentence is warranted, the Court fixes a sentence in the normal fashion, namely, where the sentence is in excess of six months, specifying a non-parole period and balance of term. The mental impairment is taken into account in the usual fashion in fixing the sentence.

Subject to the prior approval of the MHRT, the Court may determine to refer the matter to the MHRT for monitoring of the sentence. Thereafter the offender, while within the correctional facilities of the Department of Corrective Services ("the DCS") and, following release to parole into the community, is monitored by the MHRT, which, subject to the overriding responsibility of the DCS, supervises the prisoner. The MHRT may recommend the NSW State Parole Authority approve the offender's release to parole before the expiration of the formal non-parole period ("early parole"), if satisfied that the prisoner does not represent a threat to their, or anyone else's, safety, and that strict conditions (and the availability of relevant services) would be in place, which address the underlying mental impairment and consequent social and treatment/rehabilitative needs. If the prisoner is not released prior to the expiration of the formal non-parole period, the consideration of parole is made in the normal fashion by the NSW State Parole Authority for sentences in excess of three years. Following release on early, the MHRT continues to monitor the offender with a mental impairment until the expiration of the non-parole period, and may continue to do so in appropriate cases until the expiration of the total sentence.

The release to early parole would involve strict conditions, along the lines of those that apply to an intensive corrections order ("an ICO"); in the same way that an ICO is regarded as an alternative to imprisonment, it would be regarded similarly on early parole.

It would be important for this semi-diversionary approach to be identified by the court, when adopted, in a manner that makes publicly clear that there is a demarcation between such offenders and others, because of a relevant mental impairment. One term that warrants consideration is a "forensic offender". This symbolises both the similarity with, and difference from, a "forensic patient", while at the same time marks the offender as coming under the jurisdiction of the MHRT.

We advance this proposal not necessarily as a final proposition, but as a possible alternative for further refinement, as an example of how reform of the current sentencing law might be modified, consistent with basic sentencing principles. For example, the class of offenders with a mental impairment who could be referred to the MHRT as a forensic offender would need to be considered and legislatively defined. There could also be a restriction applied to offence types. For example, Professor Baldry's research has established that 20% of prisoners with an intellectual disability or mental illness had been sentenced as a result of theft and road traffic/motor vehicle regulatory offences. The next most common group were justice offences (10%). In other words there was a very high rate of lower level offences, many of which would have been avoided in her view, had there been more community support for the offenders.[3] This suggests that even if such an alternative approach is confined to prisoners with a mental impairment convicted of relatively minor offences, it could have a significant impact on the current gross over-representation of offenders with a mental impairment in the prison system.

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[3] *supra.*

Importantly, this proposal also avoids an issue similar to current concerns about the limiting term in respect of forensic patients who have received a qualified finding of guilt following a special hearing. The forensic offender is not disadvantaged by the loss of the benefit of a determinate sentence, particularly the loss of a non-parole period. The attraction of this option from the perspective of the community is there is a greater likelihood that the offender will not re-offend, by virtue of the intensive and monitored approach to his or her treatment and "rehabilitation".

Finally, we submit that it is appropriate for the Commission to consider recommending that section 54(a) of the Crimes (Sentencing Procedure) Act be repealed, the effect of which would be to make available the fixing of a non-parole period for a sentence of life imprisonment. We submit that, for the offence of murder in particular, it is conceivable that an offender with a mental impairment may warrant a sentence of life imprisonment as a consequence of considerations of protection of the community, for example where a young offender has committed murder before, but where there may nevertheless be a reasonable basis not to eliminate the reasonable possibility of "rehabilitation" in due course. This could be an option for a sentencing court to consider in a "Veen"-type situation, should it ever arise under the current sentencing legislation.[4]

2. Ethical Issues for Legal Representatives

The successful operation of mental impairment legislation depends on the criminal justice system participants playing their roles appropriately and effectively. The current versions of the NSW Bar Rules and the Law Society Professional Conduct and Practice Rules ("the NSW Solicitors' Rules") do not provide specific guidance to legal representatives dealing with a client in respect of whom a fitness issue is apparent, and related issues. We submit that the Commission should recommend that this be done, and that some indication be provided in your report as to the issues that should be addressed in the ethics review.

Prior to the commencement of the Crimes (Mental Disorder) Amendment Act 1983, it was generally considered that a finding of unfitness, or the special verdict, was contrary to the best interests of any accused, because both resulted in indefinite incarceration, regardless of how trivial the alleged offence was. Accordingly, defence counsel's duty was clear, where the client's instructions were to oppose such findings. After the act was introduced, that view within the legal profession has essentially changed to the opposite view, with reservations. The two primary reservations are, firstly, the indeterminate nature of detention that still results in most cases from a special verdict for an accused, whether fit or unfit, and secondly, the calculation of the length of the *limiting term* that is imposed in lieu of a prison sentence for an unfit accused who is found to have committed the elements of the alleged offence; in particular, that it does not take into account the non-parole period that would be specified in most cases, had it been a sentence following a conviction.

Some specific ethics issues are:

1. What are defence counsel's duties as to raising a fitness issue if the client instructs that it is not to be raised?

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4 *Veen v The Queen* [No. 2] [1988] 164 CLR 465.

2. What are defence counsel's duties in a fitness hearing if the client instructs that he or she opposes a finding of unfitness?

3. In 1 and 2 above, what are counsel's duties as to Part 3.10, Div. 1 of the Evidence Act 1995 (NSW), concerning client legal privilege, particularly if the disclosure of instructions as to the alleged offence or offences (or other sensitive material) to the Court is necessary in order to raise a fitness issue or is relevant to a determination of fitness?

4. A related issue is whether, in anticipation of a fitness hearing, defence counsel should advise their client to be available for clinical assessment by prosecution-retained experts who intend to canvass the circumstances of the alleged offence, and the tendering of expert psychiatric and psychological reports by the Defence which canvass the client's account of the events giving rise to the charges.

5. What are counsel's duties when appearing for a defendant in a committal hearing when counsel is of the view that their client may be unfit? For further development of this issue, see our response to issue 6.12, below.

6. What are the prosecution's ethical duties:

    a. of disclosure in relation to material that may disclose mental illness at the time of the alleged offence, or unfitness?[5]

    b. in a trial, and in a special hearing, as to seeking to tender material, and otherwise put evidence, to the court suggesting that, if the accused did the acts constituting the offence, he or she qualified for the insanity defence?

7. What are defence counsel's duties as to following instructions from a client in a criminal matter which appear to be contrary to their best interests:

    a. Where the client is unfit, during a special hearing?

    b. Where the client is fit to be tried according to the appropriate test but nevertheless the aspect of instructions which are adverse to their interests appear to be as a result of a mental impairment?

8. In particular, what are defence counsel's duties if the client's instructions are not to raise a defence of mental illness on a serious charge such as murder where he or she clearly qualifies, when his or her reasoning appears to be irrational?

As to point 3, how is defence counsel to raise a fitness issue without referring to instructions that are protected by client legal privilege? If the privilege is to be qualified in some fashion in the face of an overriding concern as to the fairness of the trial process, there should be a

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[5] See recommendation of Miles CJ at vol. 1, para 289 of: *Inquiry under s 475 of the Crimes Act 1900 into the matter of the fitness to plead of David Harold Eastman*, published 6 October 2005 in 2 volumes. Available from the ACT Supreme Court website at: http://www.courts.act.gov.au/supreme/content/judgments.asp?textonly=no

legislative prohibition on the use of this material in any subsequent hearing determining the merits of the case.

As to point 4, we are aware that some legal practitioners advise their clients, and the prosecution, that the client should not provide, and should not be asked about, their version of events when interviewed by the forensic psychiatrist or psychologist retained by the prosecution for the purposes of determining fitness. However, an expert may reasonably contend that it is necessary to canvass the accused's version of events in order to form an opinion as to whether the accused is able to instruct their counsel. This being so, we suggest that there be a legislative bar on the prosecution tendering evidence of the history of the events in question, which has been provided to a forensic expert for a fitness issue, at a subsequent normal trial (if the accused is found to be fit) or special hearing (if the accused is found to be unfit).

As to the point 8, it cannot be assumed that a special verdict is unequivocally in an accused's best interests, in spite of recent legislative amendments that remove the release decision-making process from the political arena. There remains a reasonable view that a special verdict may still be more onerous than a conviction, as noted in Consultation Paper 6, although this is likely to be less-so in respect of charges attracting lengthy custodial sentences, such as murder:

> Clearly, however the defence of mental illness is formulated, and whoever is brought within its scope, it is not an easy alternative to a criminal sanction. To the contrary, it may often be just as harsh or an even harsher option for the individual to face.[6]

In *R v Holt* [2009] NSWDC 147, Berman DCJ considered whether an accused charged with an unprovoked stabbing, who otherwise complied with the *Presser* fitness test, was unfit because an experienced forensic psychiatrist was of the view that his decision not to run an insanity defence resulted from a lack of insight that at the relevant time he was mentally ill. His Honour concluded that he was fit, but a factor relevant to his determination was that the Prosecution was aware of the evidence suggesting the accused came within the *M'Naghten* rules, and doubtless would put it before the court; query the situation where this is not so.[7]

Consideration should perhaps be given to involving guardianship in special hearings, which are adversarial and appear to require counsel to act on instructions as if it were a normal trial, but where the unfit client's instructions may not be in their best interest; see our response to issue 6.19, below.

Another alternative is that defence counsel be required to exercise a greater degree of independence; they test the evidence and put up defences for which there is an evidentiary basis, but are not confined by their client's instructions in accordance with their ethical obligations as is presently required, in view of the formal finding that their client is unfit to be tried, an element of which is that they may not be able to provide instructions. A precedent for a legislative requirement that counsel act other than how their ethics would otherwise require is provided by section 12(2) of the MHFPA, which provides that a fitness hearing is to not be conducted in an adversarial manner.

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[6] para 3.11.
[7] paras 29, 30.

Both of these last two alternatives are clearly policy issues for legislation, and are therefore matters for the Commission.

Nor are counsel's duties in the other situations necessarily obvious or agreed. For example, in relation to the first issue, conflicting opinions have been provided by the Chief Justice of the ACT Supreme Court and the Victorian Bar Association.

In his Report on his s. 475 Inquiry into the Fitness of David Eastman ("the *Eastman* Report"),[8] Miles CJ of the ACT Supreme Court noted that counsel who had appeared for Mr. Eastman at his trial at one point had been concerned as to his fitness, but did not inform the Court, on Mr. Eastman instructions. Shortly afterwards counsel's instructions were withdrawn. His counsel did not alert the Court to the fitness issue. In his report, his Honour expressed the view that counsel has a duty to the Court to raise a fitness issue, which continues if their instructions are withdrawn, and that professional rules should be amended to provide guidance for such situations; if this does not occur, legislation should be considered. A photocopy of Miles CJ's general recommendations for reform (Vol. 1: paras 281-295) is appended to our submissions.

In 2007 the Victorian Bar Association issued an Ethics Bulletin titled *Appearances in Criminal Matters-Mental Impairment* (Appendix 2 to this submission), in which it indicated that their Practice Rules would be amended to reflect duties imposed on counsel by statutory fitness principles, and outlined the effect of these provisions. The outline appears to suggest that, while counsel is ethically obliged to inform the Court of a fitness issue, if the client opposes this course, counsel must first seek instructions from their solicitor to do so, and: "allow the maximum opportunity for other counsel to be engaged." Further, the obligation remains only whilst counsel retains the brief.[9] It appears from the Practice Rules on their website that they have not yet been modified. The proposal is at odds with Miles CJ's view of counsel's obligations.

While it happens that we agree with Miles CJ's view of the ethical duties of counsel in such a situation, and support his Honour's recommendation that guidance be included in the Bar and Solicitors' Rules, the fundamental point that this conflict of opinion illustrates is that careful thought needs to be given to these issues, against the background of differing judgements as to whether one course or another is in the interests of an accused, the legislative requirements of counsel and the changing legislative landscape. It would make sense for this ethical review to take place after any fundamental legislative changes prompted by the Commission's report are settled.

3. Fitness at Common Law is Not Confined to Issues of Cognitive Impairment

As noted in *Ngatayi v R per* Gibbs, Mason and Wilson JJ, at [6]-[8], the principles of unfitness are applied at common law to any circumstance that has the effect of the accused being unable to meet the requirements of being fit to be tried. The majority judgement in *Ngatayi* noted examples of unfitness not related to mental impairment, such as if an accused

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[8] *ibid* fn 1.

[9] Ethics Bulletin No 1 of 2007; 13 December 2007. The Bulletin may be downloaded from the Victorian Bar Association's website at: www.vicbar.com.au

is "deaf and dumb", and some instances in code states of aboriginal defendants being discharged because of the non-availability of adequate interpreters.[10]

There are no legislative consequences in NSW (or in other Australian jurisdictions so far as we are aware) to unfitness consequent to causes unrelated to a mental impairment, in the absence of which, where the underlying impediment to fitness is not likely to resolve (so that an adjournment is not an option), the Court is obliged by common law to dismiss the charges. As noted in *Ngatayi*:

> If the incapacity is due to unsoundness of mind the accused will of course be dealt with in accordance with the provisions of the legislation in force on the subject of mental health, but in a case where there is no mental or physical disability, there may be no statutory enactment under which the accused can continue to be detained. In such case no doubt he should be discharged.[11]

In recent decades, instances of unfitness due to physical causes rather than a mental disorder have been a rarity.[12] However, with an ageing population, it is not unrealistic to envisage a case where an accused is unable to satisfy one or more of the *Presser* conditions because of physical frailty due to advanced age, or long-term serious physical illness where death is not imminent, but the stress of a hearing or trial would, in the opinion of appropriate medical experts, expose them to unacceptable medical risks. This category of unfitness might be termed "medical unfitness". Recently there have been some cases in NSW of elderly persons being charged with murder and found unfit, but so far where the basis of the unfitness is a mental impairment deriving from a common advanced age-related physical condition, *vascular dementia*; eg *R v Coleman* [2009] NSWSC 457, where the accused was aged 87. There have also been instances of defendants in their eighties charged with child sex offences, committed many decades before, where physical disabilities have bordered on unfitness, or where physical health risks have prompted a finding of unfitness, but with some contributing elements of associated poor mental function; see for example *R v Murray* NSW DC 9.9.10 (unreported) Woods DCJ (appendix 3).

In this recent case, an 81-year old accused faced five charges of sexual indecency more than forty years after the alleged assaults. He suffered infirmities, including organic brain damage, that impacted his ability to give and follow evidence, but the overriding concern was an unacceptable risk of a heart attack or indeed "sudden cardiac death". His Honour concluded that whereas the accused would be fit for a trial lasting a few days, he would not be fit for the instant trial, which was expected to last some months. Accordingly, he was found unfit, and referred to the Mental Health Review Tribunal ("the MHRT").

Where the sole, or predominant, issue causing unfitness is a physical ailment rather than a mental impairment, the appropriateness of the fitness scheme, to the extent that it requires the

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[10] *Ngatayi v R* [1980] HCA 18; (1980) 147 CLR 1 *per* Gibbs, Mason & Wilson JJ at para 7.

[11] *ibid* pps 7-8. Considered to apply to NSW Local Courts by Adams J in *Mantell v Molyneux* [2006] NSWSC 955: "[28] It is convenient first to deal with the problem arising from the appellant's unfitness for trial. Even though, in the case of a charge being heard in the Local Court, there is no statutory enactment either dealing with determination of the question of fitness to be tried or as to what should occur if a person is found unfit to be tried, it seems to me that, where a defendant is found not fit to be tried, he or she must be discharged."

[12] Although see *Ebatarinja v Deland* 1998 HCA 62 concerning a deaf mute defendant at committal for murder who, it was agreed, could not understand the proceedings. The High Court determined that the committal could not continue.

involvement of the MHRT, may well be inappropriate. Further, a special hearing would not overcome concerns that a court hearing could bring on a stress-related heart attack.

We draw this issue to the Commission's attention, but we do not at this point make any submissions as to how it might be addressed, since it is not presently an issue of significance, unless you wish us to do so. If a case does emerge to be dealt with squarely on the point, where the seriousness of the charges mitigates against a no-bill and the prognosis against an adjournment, it is likely that defence counsel would frame its application for either a dismissal of the charges, or the imposition of a stay, either until such time that the defendant regains sufficiently robust health, or for a permanent stay. Rather, it is an issue that merits monitoring. It is a situation more likely to first emerge as a recurring problem in the Local Court with older defendants with physical health issues charged with less serious offences.

It is a matter that has arisen on occasion in Australia with accused charged with war crimes long after the event; charges have not proceeded because of advanced age-related poor physical health issues of the accused.[13] Likewise in international criminal tribunals with accused charged with war crimes, crimes against humanity or genocide. Such accused are often of senior years in keeping with their military or political standing at the time the alleged offences are committed, and they might not be brought to trial until many years afterwards.[14]

4. Understanding Intellectual Disability

There continues to be a generally patchy level of understanding by participants in the criminal justice system as to the nature, characteristics and relevant consequences of intellectual disability. In part this is due to the terminology used by professionals; borderline, mild, moderate, severe and profound levels of intellectual disability. The general usage of "mild" and "moderate" suggest to many a less than significant degree of disability when applied to that condition, whereas in fact even a mild degree of intellectual disability has profound implications for an under-serviced person. Doubtless the Commission is well aware of the nature of these two levels of intellectual disability.

We suggest that the Commission consider practical measures to better educate the judiciary and magistracy as to what is involved with such degrees of disability, including providing an opportunity for contact and interaction with such individuals. The Intellectual Disability Rights Service could perhaps be approached to collaborate on such a program.

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[13] See *Australia's War Crimes Trials: All Pity Choked* Gillian Triggs p.123 at 133-134, in *The Law of War Crimes* ed Timothy LH McCormack & Gerry Simpson, Klewer International, The Hague, 1997 re the cases of in South Australia in 1991-1992 of Berezowsky and Wagner, both abandoned due to physical health issues of the two defendants.

[14] The most famous such case was the trial *Prosecutor v Milosevic* in the UN International Criminal Tribunal for the former Yugoslavia, where the Court accepted evidence that the accused suffered from high blood pressure, such that his life was in jeopardy if he did not take medication, but that when he did, he was unable to adequately concentrate on case preparation and the evidence (a fitness issue). Ultimately the trial slowed to a point that the Court sat every second week, and even then for only a few hours each sitting day, in order to avoid a fitness hearing, which the accused in any event neither sought nor wanted. Similar issues are present in the Cambodia Tribunal (*the Extraordinary Chambers in the Courts of Cambodia: the ECCC*), dealing with crimes against humanity and of genocide, alleged against elderly accused, arising from events in the 1970's.

A separate issue is how the criminal justice system should deal with defendants, accused and offenders who have a borderline intellectual disability. Although precise IQ ranges differ between some agencies and professionals, and in any event an IQ reading is not as precise or as useful as a full psychological profile, a person with a mild intellectual disability is often regarded as having an IQ range of between 69 and 55, and a borderline intellectual disability of between 79 and 70. It would be appropriate in our view if legislative definitions of a cognitive disability included a borderline intellectual disability as well as an intellectual disability.

Public Defenders' Response to Specific Questions

Consultation Paper 5

Ch 4: Legislative Concepts of Cognitive and Mental Health Impairments

5.1 – see page 70

Should a broad umbrella definition of mental health impairment, incorporating mental illness and cognitive impairment, be included in the MHFPA? What practical impact would this have?

An umbrella term should be adopted. This aspect of criminal law legislation has been bedevilled by adverse and largely unnecessary alternative terminology over many decades. Some terms have developed unsavoury meanings in general use, if not at the time they were first deployed in legislation (eg *idiot, lunatic, retarded development*), while other terms, although not pejorative, and technically referring to different conditions, have been sufficiently close as to create unnecessary confusion; eg *developmental disability* and *intellectual disability*. This is, in part, an unavoidable consequence of a plethora of terms used by relevant experts to describe the same mental condition; for example, the DSM IV refers to *mental retardation*, whereas the term for same condition preferred by Australian psychologists is *intellectual disability*.

We submit that the umbrella term should be *mental impairment*. Although we prefer the term *cognitive impairment*, because it more closely describes the symptom common to all pertinent mental conditions that is relevant to the criminal justice system (a significant inadequacy or contortion of cognitive processes), in the interests of uniformity with Commonwealth legislation we consider this slight loss of accuracy is acceptable. We do not think that the term *cognitive impairment* should be used as a sub-class of *mental impairment*, or at all if possible, because this duplication of closely-related terms would again lead to confusion. If the Victorian Law Reform Commission ("the Victorian Commission") definition of cognitive impairment is to be followed to identify conditions other than a mental illness, we suggest that *cognitive disability* be used. Therefore the umbrella term would be *mental impairment*, which would be defined to include a mental illness, personality disorder or a *cognitive disability*, which would be separately defined along the lines of the Victorian Commission definition.

5.2 – see page 71

If an umbrella definition were to be adopted, would it be appropriate to state that mental impairment includes a mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired?

See our response to the previous issue. We query whether it is necessary to add the words, or words to the effect: *however and whenever caused, whether congenital or acquired*, although we do not oppose this inclusion.

5.3 - see page 71

Should the term "mental illness" as used in Part 4 of the MHFPA be replaced with the term "mental impairment"?

Yes. See our response to issue 6.25, below.

5.4 - see page 73

Should the MHFPA continue to refer to the terms "mental condition" and "developmentally disabled"? If so, in what way could the terms be recast?

We agree that the term *cognitive disability* be used, as proposed by us above at our response to issue 5.1. The term *mental condition* is defined in s. 3 of the MHFPA to mean "a condition of disability of mind not including either mental illness or developmental disability of mind". Thereafter it is used in the MHFPA usually in the context of whether there is treatment available in a mental health facility that is nevertheless relevant to that condition.[15]

It is not clear to us whether there is a need to retain a category in the legislation that excludes a mental illness and a cognitive disability (as defined above) at all, given the current state of services and treatment offered. If not, the legislation should be re-drafted accordingly.

5.5 - see page 73

Alternatively, should the MHFPA include a definition of cognitive impairment or disability? If so, should that definition be "a significant disability in comprehension, reason, judgment, learning or memory, that is the result of any damage to, or disorder, developmental delay, impairment or deterioration of, the brain or mind"?

Yes, for the reasons stated in our response to issue 5.1, above.

Ch 5: Identifying the Existence of a Cognitive or Mental Impairment

5.6 - see page 82

Should the MHFPA be amended to create a general power of the court to order an assessment of an offender at any stage during proceedings? If so,

(a) who should conduct the assessment?

(b) what should an assessment report contain?

(c) should any restrictions be placed on how the information contained in an assessment report should be used?

There should be such a power, to be utilised where there is not otherwise a suitable assessment (report) before the court obtained by the defence or prosecution.

As to who prepares it, there are various government agencies and offices that could organise a report, depending on the Local Court area. Possible agencies that might be approached at a policy level (subject to appropriate funding and redirection of funds, etc) are DADOC, the DCS Community Compliance Group or NGOs active in the area in question. However, the

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[15] Sections 16(2)(b), 17(3)(a), 24(2)(b), 27(a), 32(1)(a), 55(4), 56(2) and (3), and 74(a).

report itself, if it is to consider fitness, must be prepared by a suitably qualified expert; a psychiatrist in the case of a suspected mental illness or personality disorder, and a psychologist (preferably) in respect of a cognitive disability, as defined in our response to issue 5.1.

If the report is required by the Court for sentencing purposes, there would be a need for the canvassing of suitable services in the area of the offender's residence, in which case a local umbrella agency (probably DADHC) would be best suited to provide the report. The report would ideally canvass the defendant's disability, his or her current use of services relevant to that disability and what other services might be availed. Particular attention should be paid to any aspects of the disability and resultant lack of services that may have contributed to the type of behaviour that may have led to the charges.

In relation to a report ordered for fitness purposes, it would be helpful if the Court could order that whoever is required to prepare the report has access to the prosecution brief and any DCS Justice Health file, which raises an issue of patient/doctor confidentiality. However, given its relevance to court proceedings, and that, had it been subpoenaed by a party access would probably have been granted, it may be appropriate for the court to order that the entries in the file that are relevant to the issue concerning the court (eg fitness) be provided to the report. Alternatively, that the file be produced to the Court and the court then makes that determination.

If a report canvasses the defendant's account of his or her role in the alleged charge or charges, the assessment should not be admissible, either directly or indirectly (eg used in cross-examination) in any ensuing hearing on the merits of those charges; see Ethical Issue 4 and the commentary to Ethical Issues 1 and 2, discussed under "Additional Issues", above.

Consultation Paper 6

Ch 1: Fitness for Trial

Issue 6.1 - see page 5

Should the MHFPA expressly require the court to consider the issue of fitness whenever it appears that the accused person may be unfit to be tried?

We are not aware of any difficulty with sections 8 and 10 of the MHFPA in respect of the Court appropriately assenting to a fitness hearing when a fitness issue has been raised by counsel.

If the question is directed towards the Court considering the issue of its own accord, as it may pursuant to section 5, our response is as follows:

The two likely circumstances where indicators of possible unfitness are likely to prompt the Court to consider independently exercising its power to direct a fitness hearing are where, in spite of such indicators, defence counsel submits against there being a fitness hearing, or if the accused is unrepresented.

If neither counsel have raised a fitness issue, it is of course appropriate for the Court to receive submissions on the subject from both counsel (or the prosecutor and accused, if the accused is unrepresented) before proceeding to order a fitness hearing. It is unlikely that the Court would not do so in any event, and accordingly we do not propose any amendment expressing such an obligation.

Issue 6.2 - see page 11

Do the Presser standards remain relevant and sufficient criteria for determining a defendant's fitness for trial?

The Presser standards remain relevant, but they are not a sufficient criteria for determining fitness, in one respect; see response to issue 6.3, below. One aspect of the existing *Presser* test is not widely appreciated, and could benefit from recommendations to address this issue; see 6.5, below.

There is a further matter that we are of the view is already covered by the *Presser* test, but which we think is not sufficiently clear, and which could benefit by being legislatively identified, in the same way as the matter referred to at 6.3, below. This is (to quote from the *Presser* test): "... [the accused] must ... have sufficient capacity ... to make his defence and his version of the facts known to the court ...". In our view, this includes a requirement that the accused is a competent witness to give sworn evidence; see s. 13 of the Uniform Evidence Act, 1995 (NSW) ("the Evidence Act").[16] In our view, in order to be fit, a witness must be competent to give sworn evidence; that is, they must have "... the capacity to understand that, in giving evidence, he or she is under an obligation to give truthful evidence" (s. 13(3) of the Evidence Act).

Section 13(4) of the Evidence Act permits a witness who is not competent to give sworn evidence to give unsworn evidence, subject to a lesser test as to the obligation to be truthful, and some other matters, but unsworn evidence does not carry the same weight before the fact-finder as sworn evidence. This is a fundamental issue for the accused to have a fair trial. The accused would be at a disadvantage in a normal trial, due to their mental impairment, if they were unable to obtain the same weight attaching to their evidence as an accused who is competent to give sworn evidence.

The issue does not arise in a special hearing. If an unfit accused is not competent to give sworn evidence, but is competent to give unsworn evidence pursuant to s. 13(4), given the nature and purpose of the special hearing, there could be no reasonable complaint.

Therefore the competence of a witness to give sworn evidence should be broadly understood as an element of the *Presser* test. If it is thought inappropriate to specify this requirement legislatively, and it is agreed that it is an essential element of fitness, it could be included in a recommendation of guidelines to be issued by appropriate bodies to assist forensic experts who are retained to prepare fitness reports; see our response to issue 6.5, below.

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[16] See also English authority on this point: *R v Berry* (1977) 66 Cr. App. R. 156 (Court of Appeal) per Geoffrey Lane L.J. at page 158. at p. 8 " ... nowhere does the learned judge deal with the matters upon which the jury have to base their findings: the ability of the defendant to challenge jurors, the ability of the defendant to instruct counsel, the ability of the defendant to understand the evidence and the ability of the defendant to give evidence himself."

Issue 6.3 - see page 12

Should the test for fitness to stand trial be amended by legislation to incorporate an assessment of the ability of the accused to make rational decisions concerning the proceedings?

If so, should this be achieved by:

(a) the addition of a new standard to the Presser formulation, or

(b) by amendment of relevant standards in the existing formulation?

Yes. We are unclear as to what is meant by each of the two options above. In any event, while the common law (*Presser*) fitness test should remain, there should be an additional element, introduced by legislation, the effect of which is to require the Court to be satisfied, where (and only where) the accused has a mental impairment (however defined), of his or her *capacity* to make sensible decisions affecting the trial; decisions that are, from an objective standpoint, reasonably in his or her best interests. We emphasise that we are concerned exclusively with the accused's decision-making where it is affected by the mental impairment.

In our response we firstly argue that such an element is either not presently part of the *Presser* test, or if it is, its presence is not beyond reasonable argument to the contrary. Secondly, that there is a need for such an element in order to achieve fairness to some mentally impaired accused, and finally, we consider how legislative amendment would best achieve this result.

It is noted in the Consultation Paper that:

> The [*Presser*] standards are articulated in terms that are capable of allowing courts to take into account, in determining the defendant's understanding or capacity, his or her ability to make rational decisions in relation to participation in the trial proceedings.[17]

We presume that the word "rational" is used in this sentence, and in the proposition in the issue above, in its qualitative sense, as well as denoting a logical methodology. Such a qualitative intention is consistent with the definition of "rational" in the Oxford English Dictionary (on line):

> Having the faculty of reasoning; endowed with reason. ... That uses, or is capable of using, the faculty of reasoning; *having sound judgment*; (in extended use) *sensible*, lucid. ... Based on or derived from reason or reasoning, *esp. as opposed to emotion, intuition, instinct*, etc. ... In accordance with reason; reasonable, *sensible; not foolish, absurd, or extreme*. (italics added)

We note that the use of the word *rational* in the formulation of the fitness test taken from the US Supreme Court case *Dusky v United States*, quoted in Consultation Paper 6,[18] is consistent with this broader meaning; in particular, "a rational understanding of the proceedings against him" is expounded to include having: "sufficient intelligence and

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[17] Consultation Paper 6, Para 1.16.

[18] para 1.14.

judgment to listen to the advice of counsel and, based on that advice, appreciate [the] fact that one course of conduct may be more beneficial to him than another."

In our view, there is some doubt that the *Presser* test does in fact permit a court in a fitness hearing to have regard to the capacity of a mentally disordered accused to rationally make trial-related decisions, although we are aware of at least one recent decision that suggests that it is.[19] In *Presser*, Smith J appeared to clearly rule out as a fitness consideration the capacity of an accused with a "mental defect" to make an "able" defence, although he did not elaborate on that term:

> *He … need not have the mental capacity to make an able defence*; but he must, I think, have sufficient capacity to be able to decide what defence he will rely upon and to make his defence and his version of the facts known to the court and to his counsel … . (italics added)

One might infer that the uncontroversial element of the *Presser* test that: "he needs to be able to plead to the charge" implies that it is an informed plea, and similarly that the accused's choice of defence, referred to in the above passage, is also a considered, and *prima facie* reasonable choice. However, this may not be so. Firstly, it is at odds with Smith J's express rejection of this notion. In *Ngatayi v R,* Gibbs, Mason & Wilson JJ referred to this passage and said:[20]

> The view that the accused need not have sufficient capacity to make an able defence, or to act wisely or in his own best interest, is accepted also in English cases such as *Reg. v. Robertson* (1968) 1 WLR 1767; (1968) 3 All ER 557 and *Reg. v. Berry* (1977) 66 Cr App R 156, at p 158, and accords with common sense.

Secondly, in *Eastman v The Queen* [2000] HCA 29, Gleeson CJ noted with approval four propositions as to fitness from a judgement of the Ontario Court of Appeal, one of which was that:

> The fact that a person suffers from a mental disorder which may cause him or her to conduct a defence in a manner which the court considers to be contrary to his or her best interests does not, of itself, lead to the conclusion that the person is unfit to stand trial.

Gleeson considered that: "… each of the above propositions are sound, and they are consistent with the [ACT] statutory test."[21] That statutory test effectively reproduced the *Presser* standard.[22] Miles CJ, in the *Eastman* Report, also was of the view that the ACT statutory test was incompatible with a consideration of whether an accused was capable of "a rational decision to act in his best interests."[23] Although Gleeson CJ's observations were not adopted by the other members of the Bench in *Eastman*, they were cited with approval by the

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[19] *R v JH* [2009] NSWSC 551
[20] *ibid* fn 10, at para 8.
[21] at para 27.
[22] the statutory test is set out at para 23.
[23] *Eastman Report*, Vol. 1, para 248.

NSW CCA in *R v Rivkin* [2004] NSWCCA 7.[24] There is also English authority to the same effect.[25]

In the case of the Ontario Court of Appeal from which Gleeson CJ drew the propositions, *R v Taylor*,[26] the Court considered a submission that an accused who was suffering from paranoid schizophrenia was unfit "... on the basis that the accused ... suffered from delusions so pervasive and irrational that he was 'unable to perceive his own best interests and how those interests should be addressed in the course of a trial'."[27] The Court rejected the submission:

> The adoption of too high a threshold for fitness will result in an increased number of cases in which the accused will be found unfit to stand trial even though the accused is capable of understanding the process and anxious for it to come to completion. In addition, adopting a high threshold of fitness, including a 'best interests' component, derogates from the fundamental principle that an accused is entitled to choose his own defence and to present it as he chooses.[28]

This passage conveniently states the obvious counter-argument to introducing into the *Presser* test a consideration of the capacity of the accused to provide sensible instructions, particularly as to whether to plead, and if not, what defences, if any, are to be run.

Our response is that a finding of unfitness in these circumstances would likely be rare, resulting only where the Court accepts, on the basis of forensic expert evidence, that as a result of a mental illness, intellectual disability or other relevant mental condition, the accused does not have the *capacity* to make necessary court-related decisions in his best interests. In most cases where a mental illness is persisting to some extent after medication, the accused is deemed unfit because of one or more of the accepted elements of the *Presser* test are not established. It would be a rare case where the accused satisfies those elements, but not this one. In our experience, however, it does occasionally happen that a Public Defender is confronted in a murder case with a mentally ill accused who is otherwise fit, but who gives instructions not to run obvious defences such as the insanity defence or substantial impairment, or, in one recent instance, an accused with a personality disorder who insisted that no mitigatory material be put before the Court on a murder conviction, and that no non-parole period be sought.

As to the second point, namely, that such a power derogates from the fundamental principle that an accused should make his or her own decisions, we agree, and share the implicit concern that such a derogation should not lightly be made. The current fitness scheme already involves such derogations; a fitness inquiry is not to be conducted in an adversary manner, regardless of the accused's instructions. At a special hearing the accused is presumed to plead not guilty, even if the accused admits the offence and wishes to plead guilty. Counsel may exercise the accused's right of challenge to jurors, the accused's entitlement to give sworn evidence is subject to his or her competence to do so, and the verdicts available to the Court include the special verdict, regardless of whether the accused wishes to raise that defence. To

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[24] at para 302 of the Court's judgement.

[25] *R v Robertson* [1968] 3 All ER 557. Court of Appeal. The judgement of the court (by Lord Parker CJ) was to the effect that the mere fact that the accused was not capable of making trial-related decisions in his own best interests was not a reason in itself for unfitness.

[26] *R v Taylor* (1992) 77 CCC (3d) 551.

[27] *ibid* page 566.

[28] Pages 566-7.

this list may be added the view that counsel has an obligation to raise an issue of fitness with the Court, regardless of the accused's instructions on that point.

These existing inroads into the accused's independence are justified by the underlying purpose of the fitness test; namely, to identify key basic aspects of the trial process which the Court must be satisfied an accused person is able to perform, in order for the accused to fairly partake in their trial.

Given that some mental conditions may distort, limit or otherwise infect thinking processes to a point outside the normal adult range, and that they may render an accused unfit in respect of the existing *Presser* standards, it seems illogical not to also examine in a fitness hearing whether it is reasonable to hold criminally responsible an accused with such a mental condition for his or her trial-related decisions; in other words, whether the accused also has the capacity to make (as distinct from whether they choose to make) *prima facie* rational decisions as to the course of the trial. If their capacity is not examined, a decision by an accused suffering a mental illness to instruct counsel not to run an obvious defence, or not to raise significant available mitigatory material on sentence, where that decision is consequent to that mental illness, may be as catastrophic to a reliable verdict or appropriate sentence as the inability of an accused to satisfy any of the existing elements of the fitness test.

An alternative approach to using the word "rational" to introduce the issue of the reasonableness of instructions is the term "adequate". An aspect of the statutory test in New Zealand provides that the accused be able: "to communicate *adequately* with counsel for the purposes of conducting a defence." (italics added) In *R v Carrel*[29] the High Court of New Zealand considered this aspect of the test, in particular, whether the word: "'adequately' ... in this particular case has raised the question whether one is required to look at the quality, even perhaps the reasonableness of the communication." The accused, who was charged with murder, had a history of paranoid schizophrenia. Two psychiatrists retained by the defence considered him unfit to be tried. The accused's counsel raised the issue of fitness, over instructions to the contrary. The psychiatrist called by the Crown considered the accused to be fit. His Honour accepted psychiatric evidence to the effect that the accused was obsessed by the notion of a conspiracy against him and a desire to prove as much in his trial, to the point that he perceived the need for instructions on the murder charge as secondary.

His Honour Heron J stated:

> This very unusual situation of course is central to this man's illness, and I have to return to the question as to whether there is an inability to communicate adequately by reason of the mental disorder this man suffers. The introduction of the word 'adequate' suggests a test which is qualitative and not just the ability to communicate in a literal sense. ... Whilst there is on the one hand an undoubtedly articulate man able to communicate the course he wishes to take, and communicate that without difficulty, it is the essential adequacy of that communication for the purposes of conducting a defence which is of concern. There is, on the face of the accused's statement, a material defence; I do not think that the adequacy question can be decided by ignoring that. It is not just a question of the accused electing to plead guilty to avoid a finding of insanity, sometimes the understandable choice of a person charged with murder. The delusional system is preventing instructions to the present time - no one is sure what he will do - he claims to defer

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[29] *R v Carrel* [1992] 1 NZLR 760.

> giving the instruction until he chooses. Furthermore in the course of coming to a decision he will not discuss the critical aspects of the case. I consider all that amounts to a communication but an inadequate one. It is not just a question of being unwise, although it is that as well, but a failure to communicate sufficiently and suitably. There exists a form of communication which in dictionary terms and giving the word its etymological origins is not equal because part of the defence is not addressed by one of the parties to the communication.

However any legislative amendment is expressed, it must unequivocally achieve the objective of assessment of the accused's *capacity* to make sensible decisions. If "rational" is used, it may be appropriate to provide a definition of the term that incorporates notions drawn from its Oxford dictionary definition and *Dusky v United States*, such as *the exercise of judgement* and *the ability to listen to the advice of counsel and, based on that advice, appreciate the fact that one course of conduct may be more beneficial that another.*

Issue 6.4 - see page 12

As an alternative to the proposal in Issue 6.3, should legislation identify the ability of the accused to participate effectively in the trial as the general principle underlying fitness determinations, with the Presser standards being listed as the minimum standards that the accused must meet?

No. The so-called "effective participation test" is too wide. We agree with the concerns expressed at paragraphs 1.19 and 1.20 of Consultation Paper 6.

Issue 6.5 - see page 12

Should the minimum standards identified in Presser be expanded to include deterioration under the stress of trial?

No, because it is already an established part of the common law to take this into account, although some action (and accordingly recommendations by the Commission) is required in relation to this issue. As the report notes, in *Kesavarajah*[30] the High Court made clear that the *Presser* standards are to be applied with regard to the exigencies of the forthcoming trial. However, in our experience, forensic psychologists and psychiatrists sometimes either overlook this aspect or pay insufficient regard to it when preparing their reports, with the consequence that their ultimate opinion may be based on an artificial hypothesis. An accused person suffering from schizophrenia, for example, may impress as functioning reasonably under medication when assessed well before the trial, but their mental functioning may predictably deteriorate under the stress of the trial itself. Similarly, an accused with an intellectual disability may not be able to process the experiences and information emerging during the taking of evidence, and give considered instructions at short notice in response. This consideration particularly applies to the ability of an accused with an intellectual disability or mental illness to give evidence, under the stress of being cross-examined in the witness box.

It would establish a poor precedent to introduce into the legislation matters that are already adequately covered by common law. The issue would be better addressed by the relevant professional bodies being required to issue guidelines for members, as to matters to take into

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[30] *Kesavarajah v R* (1994) 181 CLR 230, *per* Mason CJ, Toohey & Gaudron JJ at pp.246-247.

account when preparing a fitness report. We submit that this be a Commission recommendation.

Issue 6.6 - see page 12

Should the minimum standards identified in Presser be altered in some other way?

They should only be added to, as *per* our response to issue 6.3, above.

Issue 6.7 - see page 19

Should the procedure for determining fitness be changed and, if so, in what way?

See our responses to the specific proposals below.

Issue 6.8 - see page 19

What should be the role of:

(a) the court; and

(b) the MHRT in determining a defendant's fitness to be tried?

Essentially we defer to the proposal for a simplified model for the interaction of the Court and the MHRT on fitness issues, derived from contributions of others with more expertise as to the operation of the MHRT. We express the following concerns with the simplified process, as outlined in Consultation Paper 6 at paragraph 1.38:

As to points (5) and (6), the MHRT should also be obliged to notify the accused's legal representative on the record for the criminal matters as well as the Court and the DPP, so as to facilitate an early consideration by the defence of their position in respect of their instructions on the offence, and whether they have any abiding concerns as to their client's fitness.

As to point (6), if the adjustment period fixed by the Court at (4)(a) is insufficient for the resolution of the mental condition underlying the unfitness, but in the view of the MHRT a further short period may suffice, a power for the MHRT to extend that period may be helpful.

Relevant to this issue as well is the general issue that we have raised under *Additional Issues*, above, of the absence of a legislative scheme for defendants and accused who are unfit for predominantly physical reasons; medical unfitness.

Issue 6.9 - see page 20

Should provision be made for the defence and prosecution to consent to a finding of unfitness?

The finding of Court on a fitness hearing, where both the Crown and Defence experts agree is, in practical terms, a foregone conclusion, and it is therefore tempting to save time and resources by a provision for consent, as proposed. However, in practice such hearings are brief, and the use of resources are minimal. In serious cases such as murder, with the present "open court" procedure, justice is seen to be done from the perspective of an accused who

resists such a finding where the experts are agreed that the accused is unfit, and likewise from that of the alleged victim's family.

In any event, if the proposal of a simplified proceeding is adopted, the Court will still be required to determine a period of detention of an accused who the experts agree is unfit.

Accordingly, we are opposed to this proposition.

Issue 6.10 - see page 21

Should the Criminal Appeal Act 1912 (NSW) be amended to provide for the Court of Criminal Appeal to substitute a "qualified finding of guilt" in cases where a conviction is quashed due to the possible unfitness of the accused person at the time of trial?

While in the past it has been the case that: "... the subsequent retrial in such cases consists of a special hearing which almost invariably reaches the same conclusion as a trial",[31] where the accused has been discovered to be unfit subsequent to the trial, it is not necessarily predictable what might occur on a retrial, where the disability underlying the accused's unfitness was not recognized at that time. In one of the two cases cited in the Consultation Paper as a basis for the above quote, *R v Tuigamala*, [2006] NSWCCA 380, on the retrial ([2007] NSWSC 493), the evidence was necessarily different because of the accused's discovered intellectual disability; in particular, expert evidence was tendered by both parties as to whether, in view of his disability, the accused was likely to have had the requisite intent for murder. It is likely that for similar reasons in many, if not most, cases, additional (or different) evidence will be required, in which case, a "retrial" (a special hearing) will be required, or at least fresh evidence admitted on the appeal to supplement the trial record.

Although we are not in favour of this proposal for these reasons, if it is to be recommended, such a power should be contingent upon the circumstance that the Court determines, following a fitness hearing, that the accused is unfit and is likely to remain so over, say, the following twelve months, so as to eliminate any reasonable possibility of him or her having the benefit of a normal trial.

A less-controversial partial reform is that the Criminal Appeal Act 1912 (NSW) be amended so that, if the CCA makes a finding that the appellant is unfit, the Court will refer the appellant immediately to the MHRT, thereby avoiding the need for a fitness hearing, and expediting the process to a special hearing.

Issue 6.11 - see page 22

Should fitness procedures apply in Local Courts? If so, how should they be framed?

We agree that fitness procedures should be available in the Local Court, and that they should be framed as proposed in Consultation Paper 6 at paragraph 1.48, subject to the following qualifications:

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[31] Consultation Paper 6, para 1.44.

The diversionary provisions of sections 32 and 33 of the MHFPA should remain as an alternative to a fitness hearing, for defendants who qualify by virtue of their mental condition, in respect of whom there is a fitness issue.

The fitness hearing option should only be available to the Court if, following the raising of a fitness issue by either party or the Court, either the defendant does not satisfy the "mental condition" preconditions of s.32(1) or s.33(1) (that is, the possible unfitness is not related to a mental condition or mental illness), or the Court has determined that, although the defendant qualifies in terms of his or her mental state, ss.32 and 33 are nevertheless inappropriate; for example, because the defendant has had the benefit of the sections on multiple previous occasions, and has not complied with conditions.

It is not clear from the proposal what is to occur when the matter is referred to the MHRT, because there is not a proposed legislative basis for the defendant to be detained, or in any way constrained by conditions of liberty in the community. This last stage of the proposal needs to be either developed further, or abandoned for reasons expressed in our introduction above, under the heading: *Fitness at Common Law is Not Confined to Issues of Cognitive Impairment.*

A further development could be that the MHRT operates in respect of serious Local Court matters as it presently does in respect of superior Court matters. This would be justified by the increase in serious matters dealt with in the Local Court since the legislation first introduced sections 32 and 33, in the early 1980's.

Issue 6.12 - see page 25

Should legislation provide for the situation where a committal hearing is to be held in respect of an accused person who is or appears to be unfit to be tried? If so, what should be provided?

The guiding principle in developing a fitness procedure that applies to committals should be, so far as is possible, not to place the unfit defendant in a worse position that a fit defendant.

The practice presently deployed by practitioners of not raising fitness before or during a committal, so that an unfit client does not lose the benefit of one, is a practical measure that achieves this objective, subject to the ethical issue of whether they are obliged to raise the issue, given that there is authority that it is likely that a committal in NSW cannot occur with an unfit defendant.[32]

The Commonwealth scheme purports to address the issue by providing that the Local Court refers a defendant, in respect of whom there is a fitness issue, to the superior court. The superior court then conducts a fitness hearing and, if the defendant is unfit, determines whether there is a *prima facie* case before proceeding further.[33] In this sense the defendant has the benefit of the possibility of an unsustainable prosecution case being dismissed, albeit without the benefit of testing the evidence first, as might happen with a committal.

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[32] *R v Mailes* [2001] NSWCCA 155, *per* Wood CJ at CL (Spigelman CJ and Greg James J agreeing) at para 161, finding that the decision of the High Court in *Ebatarinja v Deland* [1998] HCA 32 had "potential relevance" to a committal in NSW.

[33] *Crimes Act, 1914* (Cth), s.20B(3).

We propose the following:

If a fitness issue is raised in the Local Court before or during a committal, the magistrate conducts a fitness hearing. If the defendant is fit, the committal proceeds normally. If the defendant is unfit, and the underlying condition is not likely to abate so that an adjournment of up to six months has little prospect of overcoming the issue, the unfit defendant is presumed to be incapable of entering a plea, and the magistrate orders that a committal takes place, or continues, if the fitness issue has arisen during a committal. Legislative provisions as to how the legal representative should act should be in similar terms to the provisions that apply presently in respect of special hearings. At the end of the committal, the magistrate exercises his or her powers in respect of whether or not to commit the defendant in the normal fashion.

If the magistrate does not dismiss the charge, or all the charges, he or she commits the unfit defendant for trial to the relevant superior court and at the same time refers the defendant to the MHRT. When the matter comes before the superior court for arraignment, the report of the MHRT is considered as to whether the matter should be further adjourned to allow the possibility of the defendant becoming fit before arraignment, or whether it should be set down for a special hearing. The matter thereafter continues in the normal fashion.

If a defendant wishes to enter a plea before the Local Court to an indictable matter and there are concerns as to his or her fitness, the fitness issue is raised and dealt with as above.

It is important for the court to have an independent power to order a psychiatric or psychological report as to fitness, particularly given that the defendant may be unrepresented.

A further matter that warrants consideration is the situation of a defendant, in respect of whom there is a fitness issue, being called upon to indicate whether he or she wishes an indictable matter to be dealt with summarily, where that is a statutory option. If the Court, or legal representative, detects a fitness issue, what then? In the normal course of events with an unfit defendant before the court on a summary matter, the magistrate would have the option of considering proceeding by way of sections 32 or 33 of the MHFPA. It may be that if the defendant was able to elect for the matter to be dealt with summarily, the magistrate would utilize this option. We propose that there be a legislative provision to enable the legal representative to obtain informed consent from a defendant in respect of whom there is a fitness issue, in the same way as an accused in respect of whom there is a fitness issue was obliged, until recently, to give informed consent to a fitness hearing by judge alone. If the legislation was in similar terms, the case law on how the consent is to be sought and obtained would apply.[34]

Ch 2: Procedure Following a Finding of Unfitness

Issue 6.13 - see page 35

Should the special hearing procedure continue at all, or in its present form? If not, how should an unfit offender be given an opportunity to be acquitted?

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[34] eg *R v Minani* [2005] NSWCCA 226.

We are in favour of retaining the special hearing procedure.

Issue 6.14 - see page 37

Should a procedure be introduced whereby the court, if not satisfied that the prosecution has established a prima facie case against the unfit accused, can acquit the accused at an early stage?

If the Commission adopts our proposal to issue 6.12 above, this would be unnecessary.

If the Commission does not adopt that or a similar proposal, so that there is no assessment of the adequacy of the prosecution case prior to arraignment, then we support the notion of an assessment of the case, *prima facie*, by the superior court, with the broad powers that are available under the Commonwealth fitness legislation in this regard.[35]

Issue 6.15 - see page 39

Should deferral of the determination of fitness be available as an expeditious means of providing the accused with an opportunity of acquittal?

We are opposed to a deferral of the determination of fitness, as presently is the case with both the English and Canadian models. There does not seem to be a great advantage of either model over the current NSW scheme. The English model provides that, when the issue of unfitness is raised, the Court may either determine fitness immediately, or postpone it until a later time, but not later than the opening of the defence case. Whenever it is dealt with, the trial does not re-start. If defence counsel only becomes aware of the fitness issue after the trial has commenced, and even if there is immediately a fitness hearing at which the accused is found to be unfit, there is no opportunity to re-consider the manner in which the defence case has been put through cross-examination of witnesses in particular, thus far. Ultimately, if an accused is found to be unfit, there is no opportunity to put a defence case before the jury. The Canadian model apparently allows for this latter possibility, but the fundamental concern remains as to the trial having proceeded for part of its term on the basis that the accused was fit.

Further, the English scheme provides that the court will determine whether the same jury, or a separate jury, determines fitness.[36] If it is a different jury, it would be a disjunctive trial; adjourned in order for a fresh jury to determine fitness (with ensuing inconvenience to the

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[35] *Crimes Act, 1914* (Cth), s.20B
3) Where a court ... finds the person charged unfit to be tried, the court must determine whether there has been established a prima facie case that the person committed the offence concerned.
...
(7) In proceedings to determine whether, for the purposes of subsection (3), a prima facie case has been established:
(a) the person may give evidence or make an unsworn statement; and
(b) the person may raise any defence that could properly be raised if the proceedings were a trial for that offence; and
(c) the court may seek such other evidence, whether oral or in writing, as it considers likely to assist in determining the matter.

[36] Criminal Procedure (Insanity) Act 1964 (UK) s. 4(5)(b).

first jury while experts are arranged at short notice, and the fitness hearing is held) and then the second jury continuing with the trial. If it is the same jury, having been exposed to just the prosecution evidence at the point that it is called upon to determine fitness could prejudice it against finding the accused unfit. The jury may indeed regard the issue as a defence "ploy" to avoid a strong prosecution case.

In any event, how could the jury deal with the evidence of experts that typically canvass the accused's version of what happened, and then go on with hearing the evidence in the trial, whether the accused is fit or unfit? It would be unrealistic to expect a jury to put out of their mind what they heard in the fitness hearing. The accused then has the double disadvantage of his or her version being put before the court at a time not of their choosing, and any difference between the version recounted to the expert (usually not electronically recorded) and that given to the Court would unfairly count against the accused.

Issue 6.16 - see page 40

Should the special hearing be made more flexible? If so, how?

We agree with the suggestion that the Court have the legislative flexibility to allow the accused to sit elsewhere than in the dock, at a special hearing. Indeed, there should be a legislative presumption that the accused not be placed in the dock, unless there are security reasons for doing so.

We also agree that the Court should be able to permit support persons to assist the accused during the special hearing.

Issue 6.17 - see page 42

Should the MHFPA provide for the defendant to be excused from a special hearing?

We disagree with this proposition. Although it can be confronting for an unfit accused to be present, the consequences of a special hearing for their life can be substantial. Many accused whose unfitness derives from a mental illness are likely to gain insight into their past behaviour at some point after the special hearing, and some of those who have received a qualified finding of guilt, or a special verdict, and who are detained thereafter for many years may later regret that they had not been present. If the unfit accused does not deny the alleged behaviour, in our experience there is often a sense of acceptance by him or her at the time that they had their day in court, no matter how limited. Although we are unaware of any data to support our impression from such cases, it is likely that their presence is ultimately helpful to the accused in "moving on" from that episode in their life.

As well, as imperfect as instructions are from many unfit accused, often they are nevertheless able to provide reliable instructions in some respects, particularly in relation to prosecution exhibits and other tendered material.

Finally, if the alleged crime is serious, such as murder, the absence of an unfit accused may cause some discomfort to a jury; that they are called upon to make a determination in respect of an absent accused that will nevertheless have profound implications for him or her.

An audio video link presence is not an ideal alternative, in our view; it is not a real substitute for an immediate physical consultation by counsel with an unfit accused, or for the jury overcoming any disquiet as to the accused's absence.

Issue 6.18 - see page 43

Should the finding that "on the limited evidence available, the accused person committed the offence charged [or an offence available as an alternative]" be replaced with a finding that "the accused person was unfit to be tried and was not acquitted of the offence charged [or an offence available as an alternative]"?

Although the current formulation is not ideal (nor is "a qualified finding of guilt"), they are preferable to the proposed alternatives, since they contribute to an easier grasp of the theory behind the limiting term, and are less cumbersome.

Issue 6.19 - see page 44

Should a verdict of "not guilty by reason of mental illness" continue to be available at special hearings? Are any additional safeguards necessary?

We submit that the insanity defence should remain as an option in a special hearing. If an unfit accused unrealistically denies that he qualifies for this defence, or for a patently nonsensical reason instructs that he or she does not want it raised, it nevertheless remains an option before the court (if there is an evidentiary basis for its consideration[37]).

As to additional safeguards, in addition to the ethical issues raised at the outset of our submissions, if defence counsel's duties in a special hearing are properly understood as being to follow their client's instructions in respect of not raising the insanity defence in response to a serious charge such as murder, although there is evidence of it, and that evidence is unlikely to come before the court from the prosecution, the question then becomes, should the Public Guardian have a role in providing, or supplementing, instructions? If so, related issues are obvious, such as, who would alert the public guardian to this need?

Further, we submit that the legislative provision that provides that an accused who appeals a special verdict requires revision. Sections 5(2) and 6A of the Criminal Appeal Act 1912 (NSW) relevantly provide:

> 5(2) For the purposes of this Act a person acquitted on the ground of mental illness, where mental illness was not set up as a defence by the person, shall be deemed to be a person convicted, and any order to keep the person in custody shall be deemed to be a sentence.
>
> **Powers of court in relation to certain convictions and sentences concerning mentally ill persons**
> 6A On an appeal under section 5 (1) against a conviction or sentence, being:
> (a) ...
> (b) ... an order under section 39 of that Act in respect of a person, or
> (c) ...
> the court may make any finding, verdict, order or determination which could have been made in relation to the proceedings before the court of trial.

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[37] *R v Gillespie* 6.7.87 NSW SC Hunt J (unreported).

The Court only considers the insanity defence if it is first satisfied beyond reasonable doubt that the elements of the offence are made out. We submit that s. 6A be amended to remove the possibility of an accused who appeals a special verdict on the grounds that the elements of the underlying offence are not made out, instead is convicted either of the offence or an available alternative.

For example, an accused at a normal trial who received the special verdict for murder, who on appeal to the CCA challenges the sufficiency of the evidence that it was he who attacked and killed the victim, and who seeks instead an outright acquittal or a retrial, is exposed by the terms of s.6A to the possibility that the Court will reject his argument but conclude that the evidence as to his mental health was not a proper basis for the jury to return the special verdict, and accordingly enter a conviction for murder or manslaughter (substantial impairment). This is likely to be a more onerous result where the charge is serious, such as murder, than the accused received at trial, and is contrary to the general principle that the accused not be exposed to an appeal against his or her acquittal.

Ch 3: The Defence of Mental Illness

Issue 6.20 - see page 51

Should the defence of mental illness be replaced with an alternative way of excusing defendants from criminal responsibility and directing them into compulsory treatment for mental health problems (where necessary)? For example, should it be replaced with a power to divert a defendant out of criminal proceedings and into treatment?

As we understand it, the proposal is to adopt the process set out at page 51 of Consultation Paper 6:

> One alternative would be to replace the defence of mental illness with a diversionary power that would obviate the need for a defendant to stand trial and allow the court to divert him or her out of criminal proceedings. The same consequences could follow that now apply, in particular, the potential for detention for an indeterminate period subject to regular reviews. This diversionary power could be framed in a way that would require the court to apply a specific test to determine whether a defendant were mentally impaired and so eligible for diversion, in a way similar to the current approach under the defence of mental illness. Alternatively, the power could be framed in a way that would give the court a greater discretion than it currently has under the defence to determine that a defendant should not be held responsible for his or her criminal actions because of mental impairment.

Any alternative should still require that, if the accused denies that he or she committed the objective acts of the alleged offence, this must first be established beyond reasonable doubt. Similarly, if the insanity defence is opposed, or in a special hearing is sought by the prosecution but not by the defence, the relevant issues of fact must be established on the balance of probabilities. The special hearing is a procedure that, in our view, does so in respect of an unfit accused as fairly as it can be done in the circumstances, and it is difficult to conceive of an acceptable alternative, and likewise a normal trial for a fit accused.

Given that usually there is expert forensic evidence in such cases, often the special hearing or trial proceeds faster in a trial before a judge sitting alone ("a trial by judge alone"). We note that there is now a legislative presumption (s. 21A, MHFPA) that a special hearing is before a

judge sitting alone, although an unfit accused may elect to have a jury (s. 21A(1)). In this sense an unfit accused has a choice of fact-finder. However, a fit accused may only have a trial by judge alone if the NSW DPP agrees.[38] This process is currently under review.[39] It is likely that if the legislation governing trial by judge alone is amended so that the trial judge may review a refusal by the DPP to agree to a defence request for one, that many accused who seek a special verdict will avail themselves of this opportunity.

Issue 6.21 - see page 57

Should legislation expressly recognise cognitive impairment as a basis for acquitting a defendant in criminal proceedings?

If yes, should the legislation expressly include cognitive impairment as a condition coming within the scope of the defence of mental illness, or is it preferable that a separate defence of cognitive impairment be formulated as a ground for acquittal?

Although in our experience there is no difficulty in establishing that an intellectual disability is a "disease of the mind" for the purpose of activating the insanity defence pursuant to s. 38 of the MHFPA, we are in favour of a legislative re-branding of the defence so that the title and terms of the defence make clear that it applies to persons with a mental impairment other than a mental illness. For that matter, ideally the titles of the MHFPA and the MHRT should also be re-named, so that the terms are not misleading as to the mental conditions and disorders therein covered. See also our response to issue 7.11, below. We are not in favour of a separate defence for cognitive disabilities.

We suggest the following changes, consistent with our response to issues 5.1 and 5.2. The title of section 38 ("special verdict") should be retained, and the substance of the section be changed as follows (in italics):

> **38 Special verdict**
>
> (1) If, in an indictment or information, an act or omission is charged against a person as an offence and it is given in evidence on the trial of the person for the offence that the person *had a mental impairment*, so as not to be responsible, according to law, for his or her action at the time when the act was done or omission made, then, if it appears to the jury before which the person is tried that the person did the act or made the omission charged, but *had a mental impairment* at the time when the person did or made the same, the jury must return a special verdict that the accused person is not guilty by reason of *mental impairment.*
>
> (2) If a special verdict of not guilty by reason of *mental impairment* is returned at the trial of a person for an offence, the Court may remand the person in custody until the making of an order under section 39 in respect of the person.

References to the an accused being not guilty by reason of mental illness elsewhere in the Act could be changed accordingly. So as to ensure that it is understood that the phrase "the defence of mental impairment, according to law" is intended to import the common law *M'Naghten* test, there could be a statement of this intention in the second reading speech.

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[38] s.132 of the *Criminal Procedure Act* 1986 (NSW).

[39] NSW Legislative Council Standing Committee on Law and Justice is presently conducting an inquiry into s. 132 of the Criminal Procedure Act, 1986 (NSW).

The same definition for *mental impairment* as would apply elsewhere in the revised MHFPA should also apply to section 38; thus a *mental impairment* would include a *cognitive disability*, which in turn would include an *intellectual disability*, as defined; see our responses to 5.1 and 5.2 above.

Issue 6.22 - see page 61

Should the defence of mental illness be available to defendants with a personality disorder, in particular those demonstrating an inability to feel empathy for others?

This is a difficult issue. It is our impression that the psychiatric and psychological understanding of the nature, causes and treatment of personality disorders has not matured, relative to, say, mental illness. There should be legislative latitude to accommodate this dynamic stage. Our preference is that it be included for the purpose of the insanity defence with the qualification that it be a severe form: "severe personality disorder".

Issue 6.23 - see page 63

Should the defence of mental illness be available to defendants who lack the capacity to control their actions?

We submit that an inability to control one's actions should be available under the defence of mental illness, provided it is confined to a connection with an underlying mental impairment, as in s. 7.3(1)(c) of the Commonwealth Criminal Code (see 6.25 below).

As to the concern that it would not be possible to distinguish between an impulse that *could not* be resisted and one that simply *was not* resisted,[40] it is relevant to recall that the onus of establishing the elements of the defence rests on the party seeking to rely upon it.

Issue 6.24 - see page 64

Should the test for the defence of mental illness expressly refer to delusional belief as a condition that can be brought within the scope of the defence? If yes, should the criminal responsibility of a defendant who acts under a delusional belief be measured as if the facts were really as the defendant believed them to be?

Our response to the first question is the same as to 6.23 above; that it be subject to a connection with a mental impairment, as is the case in the Commonwealth Criminal Code at s. 7.3(7).

As to the second question, we disagree. It would be an artificial exercise to "work within" the delusion in order to determine culpability, as expressed in the report of the Canadian Law Reform Commission in 1987, in a passage quoted in Howard and Westmore, *Crime and Mental Health Law in NSW* 2005 at page 172, that responded to a Canadian law in similar terms to the fourth question in *M'Naghten's* case, dealing with insane delusions:

> [The section] has been much criticised and rarely applied. Medical opinion rejects the idea of partial insanity and legal scholarship stresses the injustice and illogicality of applying to the

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[40] Consultation Paper No 6, para 3.44, referring to Discussion Paper *The Criminal Process and Persons Suffering from Mental Disorder* (1987), Western Australia Law Reform Commission.

mentally abnormal a rule requiring normal reactions within their abnormality: a paranoiac killing his persecutor will be acquitted only if the imagined persecution would have justified the killing by way of self defence – the law requires him to be sane in his insanity.

Issue 6.25 – see page 65

Should the current test for determining the application of the defence of mental illness be retained without change?

The "disease of the mind" test should be retained because of the body of common law that has developed around it and which remains relevant, but the test should be imported into legislation in language that overcomes the irrelevance of the original terminology. To a significant extent, s. 38 of the MHFPA already achieves this; the problem is that the section refers only to "mental illness", thereby conveying the impression that the defence applies only to this condition. This is confusing for the accused, victims, juries, and the public generally. This concern could be addressed in the manner suggested in our response to issue 6.21, above.

Another consideration is consistency between Australian jurisdictions, particularly for NSW practitioners between state and federal legislation. We have considered the possible adoption of the formulation in the Criminal Code Act 1995 (Cth):

7.3 Mental impairment
(1) A person is not criminally responsible for an offence if, at the time of carrying out the conduct constituting the offence, the person was suffering from a mental impairment that had the effect that:
(a) the person did not know the nature and quality of the conduct; or
(b) the person did not know that the conduct was wrong (that is, the person could not reason with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong); or
(c) the person was unable to control the conduct.
(2) The question whether the person was suffering from a mental impairment is one of fact.
(3) A person is presumed not to have been suffering from such a mental impairment. The presumption is only displaced if it is proved on the balance of probabilities (by the prosecution or the defence) that the person was suffering from such a mental impairment.
(4) The prosecution can only rely on this section if the court gives leave.
(5) The tribunal of fact must return a special verdict that a person is not guilty of an offence because of mental impairment if and only if it is satisfied that the person is not criminally responsible for the offence only because of a mental impairment.
(6) A person cannot rely on a mental impairment to deny voluntariness or the existence of a fault element but may rely on this section to deny criminal responsibility.
(7) If the tribunal of fact is satisfied that a person carried out conduct as a result of a delusion caused by a mental impairment, the delusion cannot otherwise be relied on as a defence.
(8) In this Code:
"mental impairment" includes senility, intellectual disability, mental illness, brain damage and severe personality disorder.
(9) The reference in subsection (8) to mental illness is a reference to an underlying pathological infirmity of the mind, whether of long or short duration and whether permanent or temporary, but does not include a condition that results from the reaction of a healthy mind to extraordinary external stimuli. However, such a condition may be evidence of a mental illness if it involves some abnormality and is prone to recur.

In many ways the adoption of the Commonwealth provision is an attractive proposition, for the manner in which it deals with the issues that are posed in the Consultation Paper, such as terminology, relevant mental conditions to be included in the insanity defence and its application to a loss of control and delusions. As well, there is the desirability of uniformity between NSW and Commonwealth legislation on this issue.

However, there are some difficulties with an outright adoption of this provision because it codifies the defence, and therefore does not import the common law surrounding the insanity defence. The effect of self-induced intoxication on the application of the insanity defence, for example, is not addressed in the section, although it may be made available in Commonwealth law in a manner similar to the position of common law when s. 8.4(1) of the Commonwealth Criminal Code is applied.[41] If s. 7.3 is to form the basis for a re-drafting of a provision for NSW, it would be important to address this point. As well, the definition of *mental impairment* at 7.3(8) should include *cognitive disability* as defined by the Victorian Commission (see our response to issue 5.1).

Issue 6.26 - see page 67

If the M'Naghten rules were reformulated in legislation, should the legislation define the concept of a disease of the mind? If so, how should it be defined? Should the common law requirement for a "defect of reason" be omitted from the statutory formulation?

If the *M'Naghten* rules were reformulated in legislation, the Commonwealth provision would be a good starting point. As noted in the previous response, self-induced intoxication would need to be codified in a manner that reflected the common law on the point.

Issue 6.27 - see page 68

If the M'Naghten rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge of the nature and quality of the act? If so, should the legislation provide for a lack of actual knowledge, or a lack of capacity to know?

Yes; or *a lack of knowledge of the nature and quality of the conduct*, if the Commonwealth model is followed. The legislation should provide for a lack of actual knowledge, not a lack of capacity to know.

Issue 6.28 - see page 69

If the M'Naghten rules were reformulated in legislation, should the legislation recognise, as one way of satisfying the defence, a lack of knowledge that the criminal conduct was wrong? If so, should the legislation provide any guidance about the meaning of this alternative? For example, should it require that the defendant could not have reasoned with a moderate degree of sense and composure about whether the conduct, as perceived by reasonable people, was wrong? Should the legislation require a lack of capacity to know, rather than a lack of actual knowledge?

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[41] *8.4 Intoxication (relevance to defences) (1) If any part of a defence is based on actual knowledge or belief, evidence of intoxication may be considered in determining whether that knowledge or belief existed.*

The Commonwealth provision, which we favour in this respect, includes such a capacity. If another formulation is adopted, our preference is actual knowledge, rather than capacity.

Issue 6.29 - see page 78

Should the approach for determining the application of the defence of mental illness under the M'Naghten rules be replaced with a different formulation? If so, how should the law determine the circumstances in which a defendant should not be held criminally responsible for his or her actions due to mental illness or other impairment of mental function?

No.

Issue 6.30 - see page 83

Should a defendant's self-induced intoxication or withdrawal from an intoxicant be able to form a basis for claiming that the defendant is not guilty of a charge by reason of mental illness and, if so, in what circumstances?

We agree that, as noted in Consultation Paper 6 at 3.97: "... considerations relating to mental illness and involuntary intoxication are part of a wider issue and go beyond the scope of this paper." We regard this as an issue that warrants closer examination because of its potential for producing outcomes that are arguably unjust.

Issue 6.31 - see page 85

Should the defence of mental illness apply to a defendant's involuntary act if that involuntary act was caused by a disease of the mind? If yes, should legislation provide a test for determining involuntary acts that result from a disease of the mind as opposed to involuntary acts that come within the scope of the defence of automatism, and if so, how should that test be formulated?

We are of the view that the current distinction between sane and insane automatism should not be interfered with for the purposes of this reference. The body of common law that permits the court to distinguish between the two defences, and the different outcomes for each, are *prima facie* appropriate. If changes to the law are to be considered in this regard, it merits a separate reference.

Issue 6.32 - see page 87

Should the MHFPA be amended to allow the prosecution, or the court, to raise the defence of mental illness, with or without the defendant's consent?

We are of the view that the prosecution should be permitted to do so, subject to the leave of the court, as is the case in the Commonwealth provision (see response to issue 6.25, above).

However, we are not in favour of the prosecution being legislatively empowered to require the accused to submit to an examination by a forensic expert. Clearly the prosecution would only seek to raise the insanity defence where defence counsel (or the accused, if unrepresented) had not done so. The logical extension of such a power would be that the accused would be questioned as to his or her version of the events in question, which would then be made available to the prosecution, and could be tendered in evidence against the

accused. In this fashion, the accused's right to silence would be disrespected, and an important aspect of the adversarial trial transgressed.

Rather, where the prosecution raises the defence (and by inference, the defence opposes it), the prosecution is rightly confined to the material that it has access to by other means. It may call a forensic expert to give an expert opinion on whatever material is available to the prosecution (for instance, an ERISP), but it should not be able to presume direct access to the accused in order to build its case for this purpose.

Issue 6.33 - see page 87

Should the MHFPA be amended to allow for a finding of "not guilty by reason of mental illness" to be entered by consent of both parties?

No, for reasons similar to those we advanced as to why there should not be a finding of unfitness entered by consent, in our response to issue 6.9, above.

Issue 6.34 - see page 87

Should the court have the power to order an assessment of the defendant for the purpose of determining whether he or she is entitled to a defence of mental illness?

Yes, only in the circumstance that a court raises the issue of its own volition.

Issue 6.35 - see page 89

Should a process other than an ordinary trial be used to determine whether a defendant is not guilty by reason of mental illness?

No, at least not in terms of the South Australian model, which disadvantages the accused by only considering the prosecution evidence as to whether the elements of the offence are satisfied. More information is required on the operation of the Queensland Mental Health Court, in order to determine whether it has any advantages over the trial/special hearing procedure in NSW.

If the determination of the application of the insanity defence is made by a specialist body rather than a court, and if the insanity defence is not made out, there may be further factual issues to be considered thereafter, in order to finally determine whether guilt is established beyond reasonable doubt; issues that are properly considered by a jury.

In *R v Minani*, Hunt AJA, Spigelman CJ & Howie J agreeing, considered the application of *Hawkins v The Queen* to the sequence in which the insanity defence is considered, where there are alternative issues of whether a mental impairment, short of an insanity defence, deprived an accused of a necessary element of intent:[42]

> Proof of the specific intention which the Crown must prove in such a case is not always an easy one where there is an element of mental illness involved. In *Hawkins v The Queen* (1994) 179 CLR 500 (at 510, 512-514, 517), the High Court held that, contrary to what had previously been thought to be the law in this State, evidence of mental illness is relevant to the question as to

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[42] R v Minani [2005] NSWCCA 226, considering *Hawkins v The Queen* (1994) 179 CLR 500, at para 32.

whether the accused's act was done with the specific intent charged. The High Court held that the order in which the issues should be determined in a case where there is evidence of mental illness is: (1) Was it the act of the accused which, in this case, caused the malicious wounding? (2) Was he criminally responsible for doing that act? (3) Was that act done with the specific intention required? The second question is resolved by a finding that mental illness had been established. The third question arises only if the second question is answered adversely to the accused and, in those circumstances, the evidence of mental illness (even though insufficient to make out the defence) is relevant to the issue of specific intent. That evidence is not, however, relevant to the issue as to whether the act of the accused was a deliberate one. The High Court said (at 515) that there was no necessary inconsistency between mental abnormality and the existence of a specific intent, but nevertheless the evidence of mental illness must be taken into account in determining whether there was that specific intent.

Therefore it would make sense for the jury to retain responsibility of the matter throughout.

Issue 6.36 - see page 90

Should the defence of mental illness be available generally in the Local Court and, if so, should it be available in all cases?

Yes, and for both summary matters and indictable matters dealt with summarily.

Ch 4: The Partial Defence of Substantial Impairment

Issue 6.37 - see page 105

If the umbrella definition of cognitive and mental impairment suggested in Consultation Paper 5, Issue 5.2 were to be adopted, should it also apply to the partial defence of substantial impairment?

Yes. The defence could then be termed *the partial defence of mental impairment*, as opposed to the *complete defence of mental impairment* (presently the insanity defence). The language would then reflect the logic behind the two defences when the accused is charged with murder; one mitigating the offence and thereby delivering manslaughter, and the other absolving the accused completely of criminal responsibility, both as a consequence of one or more conditions from the same set, and the end result being determined by the extent to which the behaviour is explained by the condition.

Self-induced intoxication and the defence of substantial impairment

In the material in the Consultation Paper leading up to this issue, mention is made of the current legislative requirement that self-induced intoxication is to be disregarded for the purposes of the defence, although no specific proposal is formulated, nor is it identified as an issue for debate. In our view this legislative provision (s. 23A(3)) should be repealed. Rather, the issue of the effects of intoxication should be treated in the same way as it applies to the insanity defence, which is conveniently summarised by Judge Berman in *R v McMahon* [2006] NSWDC 81 at paragraphs [14]-[30].

We are not aware of a persuasive philosophical or policy reason as to why self-induced intoxication should be treated differently to the manner in which it applies to the insanity defence. For example, if an accused with an intellectual disability consumes alcohol with no intention of committing a crime, in circumstances where there is no reason why he or she should have anticipated that the effects of alcohol in conjunction with the mental impairment would compromise his or her ability to act lawfully in a stressful situation, and it is more likely than not that the accused's criminal acts were a consequence of a combination of his disability and the alcohol, it seems unfair that the jury is required to disregard the effects of the alcohol in its deliberations, particularly in the circumstance that if the defendant had advanced the insanity defence it would not be an impediment to that defence.

Further, at a practical level, it is an exercise in hypothesis that is difficult, if not impossible, for the jury to carry out; to make their determination by imagining the same circumstances without the element of intoxication.

Issue 6.38 - see page 106

As an alternative to an umbrella definition of cognitive and mental impairment, should the mental state required by s 23A be revised? If so, how?

We agree with the proposal at paragraph 4.33,[43] subject to *a cognitive impairment* being termed *a cognitive disability*; see our responses to issues 5.1 and 5.2.

Issue 6.39 - see page 107

Is the requirement in s 23A of the Crimes Act that the impairment be "so substantial as to warrant liability for murder being reduced to manslaughter" sufficiently clear? If not, how should it be modified?

We are of the opinion that this requirement is not clear, and that it should be removed, in any event.

Before the current formulation of the defence was adopted, which introduced the legislative requirement of s.23A(1)(b), it was arguably part of the common law that had developed around the statutory defence in any event. In *R v Ignjatic* (1993) 68 A Crim R 333, Hunt CJ at CL, Finlay & James JJ agreeing, noted, in relation to the legislative requirement that the jury determine whether the abnormality of mind "substantially impaired his responsibility" that: "It is often put to the jury as amounting to an impairment which warrants the reduction of the crime from murder to manslaughter."[44]

In this sense the thrust of the defence in NSW, once the threshold matters are established, has long been to leave the matter to the jury as a moral, or at least community standards,

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[43] *4.33 We suggest that mental impairment could be defined as a "mental illness, cognitive impairment, or personality disorder, however and whenever caused, whether congenital or acquired". We also suggest that mental illness should have the same meaning as in the Mental Health Act 1990 (NSW), and cognitive impairment could be separately defined. Note that this definition would cover senility, brain injury, and drug/alcohol abuse to the extent that it has caused a mental illness, personality disorder or cognitive impairment.*

[44] page 346.

determination; whether: "*the impairment was so substantial as to warrant liability for murder being reduced to manslaughter*" (s.23A (1)(b)). From this perspective, it is difficult to formulate an alternative quantification, since on one view the jury is required to weigh both the degree of impact of the impairment on the accused's functional ability at the relevant time (the degree of criminal culpability) and the relative wickedness of the killing. Ultimately the jury cannot be provided with legislative assistance in its task, if this philosophical structure of the defence is maintained.

This approach is at odds with the defence being the distance on a continuum between, at one end, the insanity defence, and at the other, a point "substantially" short of a conviction. There is no logical reason as to why this stage of that continuum should exclusively involve these considerations at all, particularly in an ultimately determinative sense. The jury's task under s.23A in its present form in this respect is more akin to a task otherwise undertaken in a sentencing exercise, where a court has regard to the objective seriousness of an offence, as well as to subjective matters.

Our preferred option is to delete s.23A(1)(b) altogether, so that the jury is only called upon to identify by verdict whether the degree of criminal culpability, as a consequence of the mental impairment, falls short of the insanity defence, but remains sufficiently relevant to an understanding of the commission of the offence that the accused could not be regarded as criminally culpable of murder.

A recent revision of the English version of the defence of diminished responsibility is worthy of consideration in so far as it deals with the notion of substantial impairment, and causation:

(1) A person ("D") who kills or is a party to the killing of another is not to be convicted of murder if D was suffering from an abnormality of mental functioning which –
(a) arose from a recognised medical condition,
(b) substantially impaired D's ability to do one or more of the things mentioned in subsection (1A), and
(c) provided an explanation for D's acts and omissions in doing or being a party to the killing.

(1A) Those things are –
(a) to understand the nature of D's conduct;
(b) to form a rational judgement;
(c) to exercise self-control.

(1B) For the purposes of subsection (1)(c), an abnormality of mental functioning provides an explanation for D's conduct if it causes, or is a significant contributory factor in causing, D to carry our that conduct.

This approach is similar to s.23A(1)(a) of the NSW legislation, without the further requirement of s.23A(1)(b). Indeed, Professor Stanley Yeo has noted that it appears that the Law Commission, which drafted the provision, developed it from s. 23A of the NSW Crimes Act,[45] in which case it seems that the Commission chose to leave out the requirement at s.23A(1)(b), and that self-induced intoxication also be disregarded.

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[45] Prof Stanley Yeo *English Reform of Partial Defences to Murder: Lessons for New South Wales* published in *Current Issues in Criminal Justice* July 2010 Vol 22, No 1, page 1, at page 3.

Issue 6.40 - see page 117

Should the defence of substantial impairment be retained or abolished? Why or why not?

Whether the defence is re-shaped as we suggest, or essentially retained in it present form, we are in favour of its retention. If, however, the Commission is inclined to recommend its abolition, we respectfully submit that its advantages be preserved in some other fashion.

There are two advantages of a substantial impairment-manslaughter conviction, over murder: the offender with a substantial mental impairment avoids the stigma that accompanies a murder (rather than manslaughter) conviction, and as to the sentence, life imprisonment as a possibility, and receives the benefit of a more flexible sentencing range; in particular the avoidance of the standard non-parole period for murder of 20 years, subject to *R v Way* considerations.[46]

We consider that both of these advantages are reasonable in respect of an offender and the community when the defence is appropriately made out, and therefore both must be addressed before the defence could be abolished. To some extent both advantages could be addressed by the adoption of a general mental impairment sentencing model such as we propose at the outset of our response.[47] If this model were to be adopted, there would still be a need for public recognition that the criminality falls significantly short of murder; otherwise it is difficult to imagine public acceptance of, in many cases, low manslaughter-type sentences for what is still termed murder. Further, if the prosecution does not accept a "substantial impairment" plea, or the appropriateness of a more flexible sentencing range however it is termed, how is the issue of to be determined; by judge, or jury?

Accordingly, we are of the view that, even if the defence is abolished in light of, say, the adoption of our proposed sentencing model, where the elements of the defence as it presently exists are made out in a sentencing exercise on murder, the sentencing judge should find, as part of that exercise, that the offence is reduced to manslaughter. Alternatively, if the determination of manslaughter or murder is to remain a matter for the jury where the prosecution does not accept an offer of substantial impairment manslaughter, the defence should remain, in the form that we propose in our response above, at issue 6.39.

Ch 5: Infanticide

Issue 6.41 - see page 133

Is there a continuing need for infanticide to operate, either as an offence in itself, or as a partial defence to murder?

While we appreciate the arguments for its abolition, on balance we favour its retention, because of the sentencing pattern that has developed in respect of it. If section 22A of the Crimes Act is to be abolished, we suggest that it be recommended that the 2nd reading speech to the Bill introducing its abolition make clear that there is no intention to cause an impact on

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[46] *R v Way* [2004] NSWCCA 131.

[47] see "Sentencing Reform of Mentally Impaired Offenders; An Alternative Approach" at Additional Issues, above.

the sentencing pattern that applies to manslaughter where the elements of infanticide, as it presently exists, are made out.

Issue 6.42 - see page 133

Should the continued operation of the infanticide provisions be conditional on the retention of the partial defence of substantial impairment?

Either its retention, or abolition in the circumstances set out in our response to issue 6.40, above.

Issue 6.43 - see page 133

If infanticide is to be retained, should it be recast? If so, how?

No.

Ch 6: Powers of the Court following a UNA or NGMI

Issue 6.44 - see page 144

Should the MHFPA be amended to provide a mechanism and/or requirement for the court to notify the MHRT of the terms of its order under s 27 of the MHFPA?

Yes, given that it appears to be a legislative oversight.

Issue 6.45 - see page 148

To what extent (if any) should sentencing principles continue to apply to the court's decision whether to detain or release a person who is UNA?

The principle behind the fixing of a limiting term is an assurance that the forensic patient is not detained for longer than he or she would have been, had there been a conviction in a normal trial. We are of the view that this objective remains appropriate, although we acknowledge the problems, some of which are insurmountable, in a precise application of it.

In his second reading speech in 1982 of the Crimes (Mental Disorder) Amendment Bill, the Minister for Health said:

> … where [the unfit accused] is found to have committed the offence alleged, the court must state the sentence or disposition it would have considered appropriate had the special inquiry been a normal criminal trial and the person been found guilty. It is intended by this provision that a person should not be detained for an offence because of his unfitness for any period in excess of that which he would have been detained had he been of sound mind and found guilty of a similar offence.[48]

The manner in which the limiting term is calculated does not achieve this objective. It reflects the total sentence; no non-parole period is set, or specified. Where a non-parole period is fixed by a sentencing court for a fit offender, most prisoners are released to parole before the total sentence expires. Accordingly, the limiting term as presently calculated all but ensures

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[48] Hansard, Legislative Assembly, 24.11.82 at page 3006.

that forensic patients will be exposed to the possibility of a longer period of detention than had they been sentenced following a normal trial.

There are other problems with the calculation of the limiting term, as well. For example, since the unfit accused is presumed to plead not guilty at a special hearing, there is no benefit of a plea, let alone an early plea, being taken into account in fixing the limiting term, regardless of whether the unfit accused accepts their responsibility, within the limits of their mental impairment, for the elements of the offence.

Accordingly we submit that the court should nominate a non-parole period and total sentence, calculated on the presumption of the likely sentence that would have been handed down at a sentence hearing, had the accused pleaded guilty at the earliest instance, and that the accused's detention should cease on the expiration of the non-parole period, at the latest. The court should also be required to take into account as many of the usual sentencing factors that are applicable, both aggravating and mitigatory. Although there will be many aspects that still cannot be properly assessed in such an exercise, the overriding principle is to deliver the best assessment possible, in the circumstances.

The presumption that the unfit accused would have pleaded guilty, had it been a sentence hearing for a fit offender, is consistent with the existing legislative requirement that the unfit accused is taken to plead not guilty at a special hearing, since both presumptions are made in the interests of the accused; the first to reflect the presumption of innocence and to provide him or her with the opportunity of acquittal if the evidence would be insufficient for a conviction, and the second to operate so as to provide him or her with the least exposure to incarceration, given that he or she would not be able to properly partake in the sentence proceeding. To put it another way, it is inconsistent to provide an unfit accused with a maximum chance of acquittal in the circumstances by requiring him or her to plead not guilty, and then, if there is a qualified finding of guilt, to "sentence" him or her (calculate a maximum period of detention) based on the most unfavourable assumptions.

The significance of this issue cannot be overestimated; it is the most important contributing factor to a reasonable view held by many practitioners and unfit accused that it remains in an accused's best interests not to raise fitness. To the extent that it does so, it undermines the interests of justice, by encouraging accused who may be unfit to participate in a process that presumes (and is based on) their fitness.

Issue 6.46 - see page 150

Should the MHFPA be amended to provide additional guidance to the court in deciding whether to order detention or release of persons found NGMI?

The safety issue is already addressed at s. 39(2). We do not think any guidance is necessary.

Issue 6.47 - see page 151

Should the MHFPA be amended to provide guidance to the court in relation to the conditions that may be attached to an order for conditional release?

Having regard to the factors listed at page 150 of the Consultation Paper that have been considered by courts in past cases, there may be no need to provide legislative guidance, since the factors listed appear quite appropriate, and have been made with no such guidance.

Issue 6.48 - see page 153

Is there any reason to retain a distinction between the orders available to the court in cases where the person is UNA or NGMI?

There is no reason.

Issue 6.49 - see page 155

If the present frameworks are to be retained:
(a) should the definition of "forensic patient" be amended to include a person who is UNA and in respect of whom a non-custodial order is made?
(b) should the MHFPA be amended to provide a power for the court to order conditional release if it does not make an order for detention under s 27?

Yes, for the reasons offered in the Consultation Paper.

Issue 6.50 - see page 157

What orders should be available to the court?

See 6.52 response.

Issue 6.51 - see page 157

Should the same orders be available both for persons who are UNA and for those who are found NGMI?

See 6.52 response.

Issue 6.52 - see page 157

What orders should result in a person becomes a "forensic patient"?

In relation to this and the previous three issues, we consider that, of the four options discussed in the Consultation Paper, Option D is preferred, with the power of the Court to make interim orders until such time as the MHRT hears the matter.

However, this is subject to the retention of the limiting term for accused who are UNA. It is not clear to us if the abolition of the limiting term is proposed in the Consultation Paper, or not. If it is proposed, we disagree that the notion of a limiting term should be abandoned, because its absence will discourage accused persons from raising a fitness issue, since they will be anxious to avoid the possibility of indefinite detention. In our experience, the issue of a limiting term that does not recognise a non-parole period troubles many accused persons with a fitness issue considerably, and the removal of any limiting term at all will significantly exacerbate this problem. This is already an issue in advising clients to seek the insanity defence, even in respect of serious charges such as murder.

Issue 6.53 - see page 159

To what extent (if any) should the court take into account a risk of harm to the person him- or herself, as distinct from the risk (if any) to other members of the community?

This is a legitimate concern for the Court. See our response to the next issue as to how the Court should respond.

Issue 6.54 - see page 159

Should the court be provided with a power to refer a person to the civil jurisdiction of the MHRT, or to another appropriate agency, if the person poses a risk of harm to no-one but him or herself?

We agree with the statement of principle to the effect that the civil law system should prevail, and that if this is the only remaining concern, there should be a transfer from the forensic process to the civil law system. However, this must be subject to an overriding concern that the transitional procedures do not place the accused at risk of self-harm.

Issue 6.55 - see page 161

What kind of possible "harm" should be relevant to decisions by the court to detain or release persons who are UNA or NGMI?

Physical or psychological self-harm or harm which is criminal in nature.

Issue 6.56 - see page 161

Should "harm" be defined in the MHFPA?

Yes, being physical or long-lasting psychological harm.

Issue 6.57 - see page 163

How should the relevant degree of risk of harm be expressed in the MHFPA? Should it be defined?

We prefer the Canadian approach of a "significant threat to the safety of the public".

Issue 6.58 - see page 164

Should a presumption in favour of detention continue to apply when courts are making decisions about persons who are UNA or NGMI?

No, the presumption should be reversed.

Issue 6.59 - see page 164

When deciding what order to make in respect of a person who is UNA or NGMI, should the court be required to apply a principle of least restriction consistent with:
(a) the safety of the community?
(b) the safety of the person concerned? and/or
(c) some other object(s)?

We submit that factors (a) and (b) are appropriate.

Issue 6.60 - see page 166

In relation to court proceedings involving people who are UNA or NGMI, are the current provisions concerning notification to, and participation by:
(a) victims; and
(b) carers
adequate and appropriate?

We are in favour of "victims" receiving notification of the forensic patient's progress after a UNA or NGMI, but not participation, unless the MHRT is of the view that there is a contribution that the victim can make to the relevant issues for determination. This may be the case if, for example, there is a pre-existing personal or other relationship between the forensic patient and victim, or some other form of contact, that may continue after release. We are in favour of carers being notified, and participating, because of their unique interests and knowledge.

Issue 6.61 - see page 168

What principles should apply when courts are making decisions about persons who are UNA or NGMI?

In broad terms, we submit that the relevant principle is the current assessment of serious risk to others and him or herself.

Issue 6.62 - see page 168

What factors should courts be allowed and/or required to take into account when making decisions about persons who are UNA or NGMI?

In applying this principle, the Court should take into account the state of the accused's post-alleged offence mental impairment and available relevant services, and the seriousness of the alleged criminal behaviour (the strength of the prosecution case in an UNA). We have no objection to factors permitting the court to require regular reviews of fitness where there is a reasonable basis to expect that the accused will become fit.

Issue 6.63 - see page 169

In cases where the person is UNA, should the possibility that the person will become fit to be tried be a sufficient basis for the court to make an order of some kind?

Yes; see our response to the last issue.

Issue 6.64 - see page 170

Should legislation specify what standard of proof applies to facts which form the basis of the court's decision as to what order to make in respect of a person who is UNA or who has been found NGMI? If so, what standard of proof should be specified?

Yes. The balance of probabilities.

Issue 6.65 - see page 173

What powers or procedures (if any) should be provided to assist the court in determining the appropriate order in cases where the person is UNA or NGMI?

We are of the view that the MHRT is better placed to make orders in this regard, and that the legislative mechanism should require that the matter be referred to the MHRT.

Issue 6.66 - see page 173

Should legislation provide a mechanism for the court to notify the MHRT of its final order in cases where the person is UNA or NGMI?

Yes.

Issue 6.67 - see page 177

In what circumstances (if any) should the Criminal Appeal Act provide for the person the subject of the proceedings to appeal against:
(a) a verdict of NGMI;
(b) orders by the court in cases where the person is NGMI;
(c) non-acquittal at a special hearing?
(d) orders by the court in cases where the person is UNA?

The accused should be able to appeal against all four outcomes.

Issue 6.68 - see page 178

In what circumstances (if any) should the Criminal Appeal Act allow the prosecution to appeal against:
(a) a verdict of NGMI?
(b) orders by the court in cases where the person is NGMI?
(c) orders by the court in cases where the person is UNA?

The prosecution should not be able to appeal a verdict of NGMI, but should be able to appeal orders made by the court consequent to both that finding and a finding of UNA.

Issue 6.69 - see page 178

Should the Criminal Appeal Act be amended to require the Court of Criminal Appeal to consider the safety of the person and/or the community prior to making an order for release?

Yes, for the reasons expressed in the Consultation Paper.

Issue 6.70 - see page 178

What manner of appeal is most appropriate for reviewing:
(a) findings; and

(b) consequent orders in cases where the person is UNA or NGMI?

As submitted above, the prosecution should not be able to appeal the findings made in the form of UNA or NGMI, but may appeal any consequent orders made by the Court. The manner of any appeal to a UNA or NGMI by the accused should be to the court that would otherwise hear a conviction appeal by an accused. Similarly, an appeal against orders by the accused or prosecution should be to the court that would normally hear an appeal against sentence.

Issue 6.71 - see page 178

Should any ancillary powers be provided to assist the Court of Criminal Appeal in deciding such cases?

Yes, for the reasons set out in the Consultation Paper.

Issue 6.72 - see page 180

Is there any reason why Local Court magistrates should not have power to make orders in respect of persons who are UNA or NGMI?

No. We are in favour of such a power.

Issue 6.73 - see page 180

If the Local Court should have powers for cases involving persons who are UNA or NGMI, should they be the same as the powers of the District and Supreme Courts? If not, what should be provided?

Yes, the Local Court should have the same powers.

Ch 7: Management of Forensic Patients following Court Proceedings

Issues 6.74 to 6.103

Generally we consider that the issues raised in response to Chapter 7 are not within our expertise as Public Defenders, with some exceptions.

Issue 6.83 - see page 194

Should a person cease to be a forensic patient if he or she becomes fit to be tried and the Director of Public Prosecutions decides that no further proceedings are to be taken?

Yes.

Issue 6.85 - see page 195

Should the requirement that the MHRT have regard to whether a forensic patient who was UNA has spent "sufficient" time in custody be abrogated?

Yes. It is contrary to the underlying philosophy of unfitness and the insanity defence.

Ch 8: Sentencing: Principles and Options

Our responses to specific issues in this chapter should be read in conjunction with our observations above, under "*Additional Issues: Sentencing of Mentally Impaired Offenders; an Alternative Approach*".

Issue 6.104 - see page 241

Should s 21A of the CSPA be amended to include "cognitive and mental health impairment" as a factor in sentencing?

Yes, for the reasons expressed in the Consultation Paper. However, we prefer that rather than "cognitive and mental health impairment", any amendment instead refer to "mental impairment" so as to achieve consistency of terminology in criminal law legislation. In this regard, see our response to Issues 5.1, 5.2.

Issue 6.105 - see page 241

Further, should the CSPA contain a more general statement directing the court's attention to the special considerations that arise when sentencing an offender with cognitive or mental impairments? If so, how should that statement be framed?

Yes. Ideally the statement should require a different approach to the sentencing exercise where the offender has a mental impairment, along the lines of our observations above, under "*Additional Issues: sentencing of Mentally Impaired Offenders; an Alternative Approach*".

If our proposal is not accepted, then the statement should refer to the significantly greater weight to be given to rehabilitation, in the interests of both the offender and the community.

Issue 6.106 - see page 242

Should the purposes of sentencing as set out in s 3(1)(a) of the CSPA be modified in terms of their relevance to offenders with cognitive and mental health impairments? If so, how?

See our response to the previous issue.

Issue 6.107 - see page 248

Should the CSPA be amended to make it mandatory for a court to order a pre-sentence report when considering sentencing offenders with cognitive or mental health impairments to prison? If so:
(a) what should the report contain?
(b) should the contents be prescribed in the relevant legislation?

We are in favour of a mandatory report that canvasses community-based programs for which the offender qualifies in more detail than presently is the case, so that the Court is better informed of non-custodial options. Such reports may involve the probation and parole service being more fully acquainted with what their local community has to offer in this regard.

Issue 6.108 - see page 250

Should the CSPA be amended to give courts the power to order that offenders with cognitive or mental health impairments be detained in facilities other than prison? If so, how should such a power be framed?

Yes. The legislative power should require the Court to first obtain a pre-sentence report which canvasses the availability and suitability of possible facilities.

Issue 6.109 - see page 252

Should the CSPA provide a mechanism for courts to notify other agencies and tribunals of the needs of offenders with cognitive and mental health impairments who are sentenced to imprisonment? If so, should the legislation state that the sentencing court:

(a) may make recommendations on the warrant of commitment concerning the need for psychiatric evaluation, or other assessment of an offender's mental condition as soon as practicable after reception into a correctional centre; and/or

(b) may forward copies of any reports concerning an offender's impairment-related needs to the correctional centre, Justice Health, the MHRT, or the Disability Services Unit within DCS, if appropriate?

Yes. In relation to (b), there have been many practical problems with the transfer of reports from the Court to the DCS and Justice Health in particular. These issues need to be addressed by an agreed protocol between the DCS and the Courts.

Issue 6.110 - see page 253

Should the CSPA be amended to empower the court, when considering imposing a sentence of imprisonment on an offender with a mental illness, to request that the MHRT assess the offender with a view to making a community treatment order pursuant to s 67(1)(d) of the MFPA?

Yes.

Issue 6.111 - see page 253

What similar powers, if any, should the court have with regard to offenders with other mental conditions or cognitive impairments?

The powers should also apply to any mental impairment; see our response to issue 5.1 and 5.2. The MHRT should be able to deal with an offender with an intellectual disability, as well as it does with an offender with a mental illness.

Issue 6.112 - see page 257

Should provisions regarding parole be amended to refer specifically to offenders with cognitive and mental health impairments? In particular, should the relevant legislation require specific consideration of an offender's cognitive or mental impairment:
(a) by the Probation and Parole Service when preparing reports for the Parole Authority;
(b) by the court when setting parole conditions; or

(c) by the Parole Authority when determining whether to grant or revoke parole, and when determining parole conditions.

Yes, in relation to all three issues.

Issue 6.113 - see page 266

Should the relevant legislation dealing with periodic detention, home detention, community service orders and good behaviour bonds be amended to increase the relevance and appropriateness of these sentencing options for offenders with cognitive or mental impairments?

Yes, although periodic detention will be replaced with Intensive Corrections Orders ("ICO's") from 1 October 2010. The same should apply to ICO's.

Issue 6.114 - see page 267

In particular, how could:
(a) the eligibility and suitability requirements applicable to each type of order; and
(b) the conditions that may attach to each semi or non-custodial option be adapted to meet the requirements of offenders with cognitive or mental impairments.

We agree with the concern expressed in Consultation Paper 6 (paras 8.104, 8.105) that mitigate against offenders with a mental impairment being considered suitable for such orders, or being able to fully satisfy conditions. The eligibility criteria and conditions have to be modified accordingly for such offenders.

Issue 6.115 - see page 268

Should s 11 of the CSPA concerning deferral of sentencing be amended to refer expressly to rehabilitation or intervention programs for offenders with cognitive or mental health impairments?

Yes, for the reasons expressed in the Consultation Paper.

Consultation Paper 7

Ch 2: Pre-Court Diversion

Issue 7.1 - see page 11

(1) Should a legislative scheme be established for police to deal with offenders with a cognitive impairment or mental illness by way of a caution or a warning, in certain circumstances?

(2) If so, what circumstances should attract the application of a scheme like this? For example, should the scheme only apply to certain types of offences or only to offenders with certain defined forms of mental illness or cognitive impairment?

We agree that there should be a legislative scheme, and it should apply to all forms of mental impairment, as defined in our response to 5.1 and 5.2, above. However, realistically, police cannot be expected to always identify a suspected offender as having a mental illness or intellectual disability. This should be addressed in two ways: by better police training as to indicators of an intellectual disability in particular, and by the ability to remove a charge where, following the decision to charge, police accept that the suspected offender has a mental impairment and would have qualified for a caution or warning, had they known before-hand. The system should apply to relatively minor offences.

Issue 7.2 - see page 11

Could a formalised scheme for cautions and warnings to deal with offenders with a cognitive impairment or mental illness operate effectively in practice? For example, how would the police identify whether an offender was eligible for the scheme?

See our response to the previous issue.

Issue 7.3 - see page 12

Does s 22 of the MHA work well in practice?

Our experience does not extend to us being able to make a response to this issue.

Issue 7.4 - see page 12

Should the police have an express, legislative power to take a person to a hospital and/or an appropriate social service if that person appears to have a cognitive impairment, just as they can refer a mentally ill or mentally disturbed person to a mental health facility according to s 22 of the MHA?

Our experience does not extend to us being able to make a response to this issue.

Issue 7.5 - see page 12

Do the existing practices and policies of the Police and the DPP give enough emphasis to the importance of diverting people with a mental illness or cognitive impairment away from the criminal justice system when exercising the discretion to prosecute or charge an alleged offender?

Our experience does not extend to us being able to make a response to this issue.

Issue 7.6 - see page 14

Do provisions in the Bail Act 1978 (NSW) setting out the conditions for the grant of bail make it harder for a person with a mental illness or cognitive impairment to be granted bail than other alleged offenders?

Yes.

Issue 7.7 - see page 14

Should the Bail Act 1978 (NSW) include an express provision requiring the police or the court to take account of a person's mental illness or cognitive impairment when deciding whether or not to grant bail?

Yes.

Issue 7.8 - see page 15

What education and training would assist the police in using their powers to divert offenders with a mental illness or cognitive impairment away from the criminal justice system?

Some of us have participated in the training of police officers in this regard in the past. It is our experience that it is most effective when there are persons experienced in the area of mental illness and intellectual disability and the criminal justice system involved in short, simple face-to-face training sessions. It is also critically important that, in each police area, if not each police station, there is a designated officer who has undergone training in this regard.

Ch 3: Diversion under Section 32

Generally we consider that this Chapter, and Chapter 4, are outside our area of expertise, since Public Defenders rarely appear in the Local Court in respect of summary matters, or indictable matters dealt with summarily. However, we have responded to some issues, on the basis of past experience, matters of general principle and matters that have an overlap with issues raised in earlier Consultation Papers.

One such general principle is that we are in favour of sections 32 and 33 remaining as a diversionary measure in respect of both a defendant in respect of whom there is suspected to be a fitness issue, and also, separately, where the defendant is thought to have had a mental impairment either at the time of the alleged offence, or at the time of the court appearance, or both.

Issue 7.9 - see page 23

(1) Should the term, "developmentally disabled", in s 32(1)(a)(i) of the MHFPA be defined? (2) Should "developmentally disabled" include people with an intellectual disability, as well as people with a cognitive impairment acquired in adulthood and people with disabilities affecting behaviour, such as autism and ADHD? Should the legislation use distinct terms to refer to these groups separately?

This issue appears to overlap with issues 5.3 and 5.4. We refer to our responses to those issues. In essence, we suggest that for the purposes of s. 32, as with the balance of the MHFPA, the term *cognitive disability* be used, with the Victorian Commission definition.

Issue 7.10 - see page 24

Is it preferable for s 32 of the MHFPA to refer to a defendant "with a developmental disability" rather than to a defendant who is "developmentally disabled"?

As a rule in respect of all mental conditions, it is preferable to avoid the adjectival use of such qualifying terms. That is, the appropriate structure is: a person with an intellectual disability, with a mental illness, with a mental impairment, with a cognitive disability, etc. The reason is that this format best respects the notion that the individual is not to be defined by their disability. It is a policy that, as we understand it, is strongly endorsed by umbrella organisations for various mental conditions, and it is important that legislation respects the policy.

Issue 7.11 - see page 25

Should the term, "mental illness" in s 32(1)(a)(ii) of the MHFPA be defined in the legislation?

We are of the view that the definition of "mental illness" in the MHFPA be the same as is used in the Mental Health Act. It is confusing to have potentially different meanings for mental illness denoted by the terms in the MHCPA of "mental illness" and "mentally ill person".

We agree with the Intellectual Disability Rights Service that the MHFPA should be re-named to avoid the impression that it applies only to mental illness. The title should reflect whatever umbrella term is adopted, So, for example, if *mental impairment* is adopted, the Act could be titled: the Mental Impairment (Forensic Procedure) Act.

Originally the provisions of the MHFPA were introduced as separate Parts of the Crimes Act, 1900 (NSW).[49] This recognised that fitness, the insanity defence and diversionary options were primarily criminal law provisions. Unfortunately, some 20 years ago, the provisions were removed into "Mental Health" legislation without any public consultation, or opportunity for public comment.

Issue 7.12 - see page 26

Should the term, "mental condition" in s 32(1)(a)(iii) of the MHFPA be defined in the legislation?

We agree with the proposal at 3.20 of the Consultation Paper, that the term "mental condition" be defined to refer to a condition "for which treatment is available". However, it also makes sense to deal with this issue in a manner consistent with other references in the MHCPA to "mental condition", and to first question whether the policy requirements have changed, since the various references were first drafted in the early 1980's. See our response to issue 5.4, above.

Issue 7.13 - see page 27

(1) Should the requirement in s 32(1)(a)(iii) of the MHFPA for a mental condition "for which treatment is available in a mental health facility" be changed to "for which treatment is available in the community" or alternatively, "for which treatment is available"?

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[49] Parts XIA and XIB.

(2) Should the legislation make it clear that treatment is not limited to services aimed at curing a condition, but can include social services programs aimed at providing various life skills and support?

Yes; see our response to the previous issue.

Issue 7.14 - see page 29

Should the existing categories of developmental disability, mental condition, and mental illness in s 32(1)(a) of the MHFPA be removed and replaced by a general term used to determine a defendant's eligibility for a s 32 order?

Yes. We submit that the terms *mental impairment* should be used, consistently with our responses to the issues in Chapter 5, above.

Issue 7.15 - see page 29

What would be a suitable general term to determine eligibility for a s 32 order under the MHFPA? For example, should s 32 apply to a person who suffers from a "mental impairment"? How would a term such as "mental impairment" be defined? For example, should it be defined according to an inclusive or exhaustive list of conditions?

We agree that the term *mental impairment* should be used, defined as we suggest in our response to issues 5.1 and 5.2.

Issue 7.16 - see page 29

Are there specific conditions that should be expressly excluded from the definition of "mental impairment", or any other term that is preferred as a general term to determine eligibility under s32 of the MHFPA? For example, should conditions related to drug or alcohol use or abuse be excluded? Should personality disorders be excluded?

Section 32 should apply to the same set of mental conditions that qualify an accused for the insanity defence and the defence of substantial impairment; in other words, the definition of *mental impairment* should be consistent for all these purposes. The relationship between these conditions and self-induced intoxication is different between the insanity defence and the defence of substantial impairment; see our response to issue 6.37. We submit that a similar test should apply to section 32 as is the case with the insanity defence.

Issue 7.17 - see page 33

Should a magistrate take account of the seriousness of the offence when deciding whether or not to divert a defendant according to s 32 of the MHFPA? Why or why not?

Our responses in relation to how the discretion is exercised under s. 32 generally depends to some extent on whether a fitness regime is adopted for the Local Court as a consequence of a recommendation by the Commission to that affect, and what procedures are introduced by legislation to deal with defendants found to be unfit. The relevance of this issue is that, under the current regime the Local Court has no alternative in respect of an unfit defendant but to either dismiss a summary charge or impose conditions pursuant to sections 32 or 33.

Either way, the seriousness of the alleged offence should continue to be one of the matters that a court takes into account. However, it is more justifiable for the court to do so if there is a legislative scheme that accommodates consideration of any issue of unfitness, and an accommodation of a defendant found to be unfit.

Issue 7.18 - see page 34

Should the decision to divert a defendant according to s 32 of the MHFPA depend upon a direct causal connection between the offence and the defendant's developmental disability, mental illness, or mental condition?

If a causal connection is required, a consequence is that, where a defendant develops a fitness issue between the date of the alleged offence and the hearing and becomes unfit, s. 32 would not be available as an alternative to an outright dismissal of summary charges of a conditional discharge. It could only operate where the mental impairment existed at the time of the offence. Therefore we reiterate our view that there should be a fitness scheme in the Local Court, and note that if a causal connection is required, there will be some cases where the section cannot operate as a diversionary option to a fitness hearing.

If the Commission is of the view that there should be a causal connection, we submit that it not be necessary to establish a "direct" causal connection. In many instances it is not possible to find a direct connection between a mental impairment and the alleged offence, but equally it could be said that the alleged offence can be better understood, or explained, in the context of the mental impairment.

Issue 7.19 - see page 35

Should the decision whether or not to divert a defendant according to s 32 of the MHFPA take into account the sentence that is likely to be imposed on the defendant if he or she is convicted?

For matters dealt with in the Local Court, certainly summary matters, we are of the view that the likely penalty should not be excluded from the court's consideration. There may well be circumstances where, having regard to the circumstances of the offence, the likely penalty and the nature of the mental impairment and current services and treatment being received in the community that the Court reasonable concludes that it is not in the community's interests for the matter to proceed, but rather to conditionally dismiss the matter.

Ch 4: Diversion under Section 33

See our introductory comments to our responses to the previous chapter of this Consultation Paper.

Issue 7.36 - see page 60

Should s 33 of the MHFPA require a causal connection between the defendant's mental illness and the alleged commission of the offence?

We refer to our response to 7.18, above.

Ch 6: Enhancing Diversion in the Superior Courts

Issue 7.40 - see page 68

Does 10(4) of the MHFPA provide the superior courts with an adequate power to divert defendants with a mental illness or cognitive impairment?

We are of the view that it does not. Having regard to *Newman v R* [2007] NSWCCA 103, section 10(4) empowers a court to divert the defendant in circumstances where, in anticipation of a finding of guilt, no conviction would have been recorded, had the matter proceeded; that is, that a s.10 bond dismissal was the inevitable outcome of a finding of guilt.[50]

In *Newman v R* the Court considered the general legislative dismissal power at the time of the introduction of s.10(4), being section 556A of the Crimes Act, and its modern equivalent, a dismissal pursuant to s.10 of the Crimes (Sentencing Procedure) Act. Accordingly, it appears that, given the terms of s. 10(2)(a) of the Crimes (Sentencing Procedure) Act 1999, if the trial judge anticipated that the s.10 bond would have conditions attached, this also would preclude the accused from the benefit of s.10(4).

In matters coming before a superior court, a s.10 dismissal is a rare occurrence. For example, for one of the least serious offences that comes before the District Court, common assault, the number of s.10 dismissals handed down between July 2002 and June 2009 was 3 out of 112 offenders.[51]

We submit that this is too narrow a gateway for removing an accused from the criminal trial process in respect of whom there is a fitness issue. An incremental improvement would be to adopt the terms of the Commonwealth legislation (s.20BA(2): *any punishment other than a nominal punishment*). Given the reference to "nominal" in s. 10(2)(a) of the Crimes (Sentencing Procedure) Act 1999, this would ensure that anticipation of a bond with conditions would permit the court to consider a dismissal of the charge. This would only be a slight relaxing of the strictures against release; in the same period as noted above, for common assault offenders there were 13 s.10 bonds handed down; a combined percentage of 15% of all offenders. For a slightly more serious category, assault occasioning actual bodily harm, in the same period there were 496 offenders, of whom 13 received a s.10 bond or dismissal, being 3%.

However, it is difficult to justify a more liberal gateway than what we propose, unless the court also has power to ensure that conditions are in place so as to address any abiding concerns as to future related behaviour that might lead to charges. We therefore propose that s.10(4) be amended as we suggest, and that there be a further power to impose conditions of release.

The Court's exercise in determining whether charges against the accused are to be dismissed is a retrospective exercise; the Court has regard to the circumstances of the offence and related matters. A diversionary exercise, on the other hand, should also take into account the

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[50] *Newman v R* [2007] NSWCCA 103 *per* Spigelman CJ (Bell and Price JJ agreeing) at paras 41-46.

[51] JIRS sentencing statistics.

accused's present and likely future situation, in order to determine whether the accused's interests, and those of the community, are better served by an alternative approach to the criminal justice system.

We suggest that section 10 of the MHFPA be amended to incorporate this two-stage approach; the first stage is that which we have proposed for a modest extension of the powers to dismiss the charge, having regard to the features of the alleged criminal behaviour and the accused's disability at the time.

The second stage arises for consideration if the Court does not dismiss the charge at the first stage. At this second stage, the court considers additional matters to those considered in the first stage; the accused's current situation, the availability (and the accused's use) of appropriate services, and the proposed regime for the accused into the future.

Issue 7.41 - see page 68

Should s 32 and 33 of the MHFPA apply to proceedings for indictable offences in the Supreme and District Courts as well as proceedings in the Local Court?

An adoption of our proposal put forward in response to the preceding issue would also deal with this issue.

Issue 7.42 - see page 68

(1) Should there be a statement of principles included in legislation to assist in the interpretation and application of diversionary powers concerning offenders with a mental illness or cognitive impairment?
(2) If so, what should this statement of principles include?

We do not consider that this is necessary.

Consultation Paper 8

Issue 8.1 - see page 6

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a diversionary order under s 32 or s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW), or should the legislation be amended in some other way referable to the particular order made?

We submit that it is appropriate for forensic material not to be destroyed until after the expiration of any conditions imposed by the local Court consequent to an order made pursuant to sections 32 or 33, because this best approximates the situation that applies when a court hands down an order pursuant to s. 10 of the *Crimes (Sentencing Procedure) Act*.

Issue 8.2 - see page 8

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following a verdict of not guilty on the ground of mental illness?

We are of the view that there is an argument that forensic material should be retained where there has been such a finding, because there has been a finding that the accused did the acts that otherwise would have constituted a conviction, had it not been for the absence of criminality. We prefer the Victorian option, since that would best resolve the competing concerns; that is, that the police may apply to a court to retain the relevant forensic material.

Issue 8.3 - see page 14

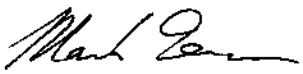
Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the destruction as soon as practicable of forensic material taken from a suspect following:
(a) a decision by the Director of Public Prosecutions not to continue with the proceedings, or
(b) a finding at a special hearing that, on the limited evidence available, the defendant has committed an offence? If so, in what way?

In relation to (a), Yes. In relation to (b), yes, in the manner proposed at para 1.44 of the Consultation Paper.

Issue 8.4 - see page 16

Should the Crimes (Forensic Procedures) Act 2000 (NSW) be amended to require the compulsory retention of forensic material in any of the following cases, namely:
(a) persons who, because of cognitive or mental health impairment, are diverted from the criminal justice system under s 32 or s 33 of the Mental Health (Forensic Provisions) Act 1990 (NSW);
(b) persons found not guilty by reason of mental illness;
(c) persons, having been found unfit to be tried, are found, on the limited evidence available at a special hearing, to have committed an offence? If so, in what way should the legislation be amended?

In relation to all issues, no.



Mark Ierace SC
22 September 2010

Senior Public Defender
Carl Shannon Chambers

Appendix 1: *Eastman Report*, Vol. 1, Recommendations

Section 11: Recommendations

278. As it has not been shown that Mr Eastman was unfit to plead during the whole of his trial or during any part of it, or that an unresolved question as to his fitness resulted in a miscarriage of justice, I do not recommend that the Executive take any action to set aside Mr Eastman's conviction.

279. At the risk of repetition it needs to be understood, however, that if the trial judge had been made aware on the morning of 22 May 1995 of the opinions of Mr Eastman's previous counsel, Mr Williams and Mr O'Donnell, and of the reports of Dr Hocking and Dr Milton, which were in the possession of the prosecution, it is highly likely that the trial judge would have determined that there was a question as to Mr Eastman's fitness to plead. That determination would have required an order which would have resulted in a determination of the Mental Health Tribunal whether Mr Eastman was or was not fit to plead. Furthermore, if in the appeal to the Federal Court, that Court had been made aware of what is now known to have been evidence available then as to Mr Eastman's unfitness, it is likely that that Court would have allowed the appeal, set aside the conviction and ordered a new trial. It is now put on Mr Eastman's behalf that he should not suffer that loss of the opportunity of a new trial. I reject that submission on the ground that on all the material now available there was no actual miscarriage of justice in what occurred. In my view, Mr Eastman was fit to plead throughout his trial. If there was a question as to his fitness to plead on the morning of 22 May, that question was resolved by his demonstrated fitness thereafter.

280. If the Executive was of the view, contrary to my own, that the fact that the issue of fitness to plead was not raised with the trial judge or in or by the Federal Court has resulted in a miscarriage of justice, then it should consider whether the conviction ought be set aside and a new trial take place. If that were the Executive's assessment, it would be necessary to

introduce legislation into the Legislative Assembly in order to bring about the desired effect. Alternatively, the Executive might introduce legislation to treat this report as a report under Part 20 of the Crimes Act as it now stands and to confer power on the Full Court of the Supreme Court to decide whether to confirm or quash the conviction and order a new trial accordingly under present s 430. I do not recommend either of those courses.

281. Kirby J in the High Court described the situation that led to the inquiry as unsatisfactory. It is possible to identify some of the unsatisfactory features of the case and to make suggestions how they may be avoided in the future.

282. At the heart of the matter is the role of counsel in relation to the issue of fitness to plead. Traditionally counsel in a criminal trial, whether for the prosecution or for the defence, have been reluctant to raise the issue of fitness to plead because of the perception that it may result in "throwing away the key", that is to say, detention in a mental asylum indefinitely and without rights for the person detained.

283. Whilst a decision to inform the court or opposing counsel of what one has learned about an accused person's mental capacity in the confidence of preparing a defence (or preparing the prosecution case against the accused) is not to be taken lightly, it needs to be taken in the full and accurate understanding of the consequences in the current medico-legal setting. The mental health legislation in the ACT provides a comprehensive regime for disposition, treatment and review of persons found unfit to plead, which is a far cry from the old days of "throwing away the key".

284. The recognition of the anomalous nature of fitness to plead as something for the court and for counsel to consider outside the adversary system, and of the obligation on counsel who raises an issue of incapacity to indicate the nature of the facts which go to support the view that the accused is unfit carries the clear implication that there is no impropriety in counsel (whether

for the defence or for the prosecution) raising the issue with the court. It suggests indeed that there is a duty to do so.

285. The ethical situation facing a lawyer who believes that his or her client is or may be unfit to plead should also be spelt out. This should be initially a matter for the professional associations themselves to formulate appropriate rules of conduct, and only in the failure of such formulation, need it be a matter for legislation. The possibility of legislation, however, should not be overlooked. I express the strong view that there is no impropriety in a lawyer appearing or acting in a criminal trial who has a well-founded belief that the accused person is unfit to plead informing the opposing lawyer and the court. The law as to how the issue is to be dealt with clearly implies that the continuing duty to the court over-rides any perceived duty to the client to keep the matter secret.

286. Once this is recognized, it follows that where the very question as to the client's capacity to give instructions is at issue, then the lawyer may not be bound by the express direction of the client that the matter of fitness is not to be raised.

287. A decision to raise unfitness by a lawyer acting for an accused person should be made in the light of an understanding of the possible ramifications for the retainer of the lawyer. Where the court determines that despite what counsel has raised, there is no question as to fitness, or where there is a finding of fitness (or even of unfitness) the lawyer may have to consider whether it is appropriate to continue to act or appear on behalf of the person. I refer in Appendix 6 to the salutary practice of ceasing to act for a client for whom the lawyer has acted unsuccessfully to resist a determination of unfitness to plead. Professional rules of conduct would be useful in this regard.

288. The duty to the Court should be regarded as surviving the termination of the lawyer/client relationship. The position of a lawyer as an officer of the court should usually be sufficient to secure a hearing in the courtroom. A lawyer who has been dismissed and who no longer has a

right of audience in a trial will need to be tactful and possibly persistent in seeking to be heard on a matter concerning a former client. A request to prosecuting counsel to make or join in the application may be appropriate and effective.

289. The position of prosecuting counsel needs particular consideration. The over-riding duty of the prosecution to assist in securing a fair trial has come to mean that the prosecution is under a duty to disclose to the defence all relevant material including any credible material that could conceivably go to assist the accused to make a defence. In my view, this duty of disclosure extends beyond matters concerned with issues relating to the ingredients of the alleged offence charged. The duty, in my view, clearly extends to disclosure of matters relevant to whether the accused was mentally ill at the time of the alleged offence and thus entitled to a verdict of not guilty on the ground of mental illness. In a trial for murder it extends to matters relevant to whether the accused acted in a state of diminished responsibility which would reduce the offence from murder to manslaughter. I see no reason why the duty of disclosure should not extend to matters which go to raise the issue of fitness to plead. I recommend that the ACT Director of Public Prosecutions be invited to revise the guidelines to prosecutors with these suggestions in mind.

290. Had these principles been recognised and applied at Mr Eastman's trial, the need for this inquiry might have been avoided. In the absence of conflicting opinions from the professional associations about whether it was proper to raise the issue of Mr Eastman's fitness to plead contrary to his directions, counsel for the defence, whose retainer had been withdrawn, might have been more persistent about raising the issue with the trial judge. Had the defence been furnished with the reports of Dr Milton and Dr Hocking, both Mr Williams and Mr O'Donnell might have been firmer in their assessments of Mr Eastman's unfitness. Had the prosecution paused to consider the Milton and Hocking reports and the opinions of

Dr McDonald in the light of a duty of disclosure, the concerns of defence counsel might not have been dismissed so easily.

291. It is a fact that legal practitioners generally are not well acquainted with mental health law and practice. The professional associations, the ACT Law Society and ACT Bar Association, should be encouraged by the Attorney-General to provide continuing education programs in this field.

292. More so than in any other jurisdiction in Australia, lawyers, mainly barristers, whose principal place of practice is outside the jurisdiction, commonly appear in ACT courts. Before Mr Eastman's trial these interstate counsel had to be admitted to practice in the ACT before they had the right of audience. This requirement provided a reminder that they should familiarise themselves with ACT laws and the practices of ACT courts. It was perhaps not as obvious that they were also bound by rules of professional conduct that might not be identical with those applying elsewhere and that if they needed advice on ethical matters it was to senior ACT practitioners or to the ACT Bar Association that they might have turned with benefit rather than to their fellows in their home cities. Unfortunately the tendency of interstate lawyers to overlook the differences between ACT laws and practices and those of their home jurisdictions was exacerbated by the Mutual Recognition Act 1992 which assumes that Australian lawyers are equally familiar with the situation on any one State or Territory as they are with that in any other. This tendency might be countered in the ACT by encouraging visiting interstate lawyers to join local professional associations or at least participate in their activities including continuing education programs.

293. There is something to be said for what appears to be the practice in the United States and Canada regarding a deliberately disruptive accused. In those jurisdictions leave of the court is required before the accused may appear unrepresented and the court has power to appoint "standby" counsel in the event of leave being granted. The practice is founded upon

constitutional considerations not applicable in Australia and any recommendation is outside the scope of the inquiry.

294. Likewise any recommendation as to clarifying the criteria for unfitness to plead, although touched on briefly in Appendix 3, lies outside the scope of the inquiry.

295. The recommendations made are not intended to be a precise formulation of appropriate rules that may be adopted but rather a basis for consideration by the Executive.

Appendix 2: Victorian Bar Association Ethics Bulletin No 1 of 2007

ETHICS BULLETIN

APPEARANCES IN CRIMINAL MATTERS - MENTAL IMPAIRMENT

An issue has arisen concerning barristers practising in the criminal jurisdiction as to the course to follow where an accused is unable to give instructions.

There may be many reasons why there is a lack of instructions. A client may refuse to instruct without disclosing a reason, or because of a lack of trust that a confidence will be respected, or out of an irrational fear of the consequences, and so on. Where this occurs, counsel is obliged to retain and act in accordance with the brief subject only to the application of Rule 98(b) which may authorise the return of the brief. Where resort is had to Rule 98 to justify a return of the brief, counsel must comply also with the statutory requirements for judicial leave to withdraw, which if within 7 days of the trial, is granted only if reasonable – see s.27 (2) *Crimes (Criminal Trials) Act 1999*. Rule 98(b) does not negate or diminish this judicial discretion. The duty counsel owes to a court requires, further, that return of the brief be done in sufficient time to allow the client to inform the court at the initial directions hearing whether or not he or she is represented – see s.5(4)(c) *Crimes (Criminal Trials) Act 1999*.

Some occasions have arisen where counsel has formed the opinion that the client's mental processes are disordered or impaired, with the consequence that there is a lack of understanding of the charge, or of the significance of a plea, or of the nature of the trial and the evidence to be or being led, or an inability to give any or any proper instructions. Rule 152 requires a barrister to take special care in these circumstances to ensure that the disordered or impaired mental processes do not work to the client's prejudice. The return of a brief by the application of Rule 98 is subject to Rule 152, and also subject to the application of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997*.

A statutory presumption of fitness to stand trial (and thereby give instructions) is raised by s.7 of that Act. It binds counsel as it does all others concerned with the trial. It is rebuttable, but only by a judicial order made following investigation.

Until that occurs, counsel is not entitled to refuse or return a brief on the ground of an inability to obtain instructions by reason of mental disorder or impairment.

Where counsel forms an opinion that there is a mental disorder or impairment with a consequent inability to give instructions, counsel, if he or she retains the brief, is obliged, to disclose that inability to the trial judge in accord with the duty owed by counsel to the court. This arises because an inability to give instructions directly affects the proper administration of criminal justice. That a client may fear the consequences of a determination of unfitness does not negate or lessen this duty.

Before disclosing the matter, however, counsel must inform the client and the instructing solicitor as soon as such an opinion is formed, and seek instructions from the instructing solicitor to follow that course. Counsel must allow the maximum opportunity possible for other opinions to be obtained and for other counsel to be engaged. This may not always be possible, where for example the mental disorder or impairment first becomes apparent close to or at the commencement of a trial, or after the trial has commenced. If the instructing solicitor declines to give such instructions, counsel, having obtained the permission of the court, should return the brief. If the court refuses permission, counsel must continue to act, however difficult that may be.

If following the statutory investigation the court determines that the client is fit to stand trial, counsel must accept that finding, retain the brief, and conduct the trial as best can be done. Where it is determined that an accused is unfit to stand trial, the statutory 'special hearing' of the criminal charge will take place with the jury informed by the court of the mental disorder or impairment. Even though counsel may not be able to obtain proper or any instructions, the duty requires retention of the brief and conduct of the trial. There will be severe restrictions on what can be done by counsel and they need to be accommodated.

In due course the Practice Rules will be modified to reflect explicitly the duties imposed on counsel by reason of these statutory provisions.

Appendix 3: *R v Murray* NSW DC 9.9.10 (unreported) Woods DCJ

IN THE DISTRICT COURT
OF NEW SOUTH WALES
DOWNING CENTRE
CRIMINAL JURISDICTION

Matter No 2009/00063315

9 September 2010

CORAM: GD WOODS DCJ

In The Matter Of R v HUGH EDWARD MURRAY

Judgment As To Fitness To Be Tried

A question arises as to the fitness of Hugh Murray to be tried on 5 counts of sexual assault set out in an indictment dated 1 April 2010. The indictment alleges 5 counts of several sexual indecencies committed between 1966 and 1978.

It is common ground that an indictment has been presented and that under section 5 of the Mental Health (Forensic Provisions) Act 1990, the question of the fitness of the accused had been properly raised, in fact by Notice of Motion. I have determined, under section 8, that an inquiry into fitness should be conducted. It appears to me that the question has been raised in good faith (section 10(2)).

Accordingly I have as soon as possible after that determination (as section 10(1) requires) conducted such an inquiry.

Bail has been allowed to the accused during the period between when the issue was initially raised before me (12th August 2010) and now, September 9th.

Relevance of Delay To The Charges

There is no statute of limitations against the bringing forward of charges such as these.

In recent decades the law and the community have recognised that many genuine victims of sexual assault do not immediately come forward and complain. There are very legitimate and understandable reasons why this should be so. Feelings of embarrassment and shame may freeze them into silence. They may wish, for a long time, merely to suppress or ignore particular events.

It is understandable that cases such as the present one may surface ten years, twenty years or even, as here, more than forty years after the event. Complainants have a right to raise such matters, and the mere effluxion of time is no legal impediment to the bringing of a charge or charges.

Yet realistically, where decades slip by, the chances of justice being served become more remote. The alleged offender may in fact have died, so that he cannot be tried. Judgment of the allegations is then not a matter for the courts.

While the complainant who delays has the right to a fair trial of the charges he instigates, however many years have elapsed, so does the accused – a fair trial is only possible if the accused is in such a condition that he is "fit to be tried". This is

not a very demanding requirement - he is not required to be in peak health or at the top of his mental condition – but it is a requirement. If the accused is not fit for trial, there cannot be a trial according to law. Other legal processes then are followed.

The relevance of delay is not that it is a bar to bringing charges, but that as decades go by, the possibility that a potential accused may have passed the point of being fit for trial will increase.

This is the issue which confronts the court here.

Unfitness Not A Means To Avoid The Law

The mere fact that a criminal trial may impose stress upon an accused person does not of itself mean that he or she will be unfit to be tried. Generally speaking, a criminal trial is not optional. The legal system operates to apprehend and punish offenders, and a criminal trial is a necessary part of this process. It would be against good public policy if accused persons could escape trial by a pretence of illness or by suffering from many of the common kinds of disadvantage which human beings variously suffer. If an accused has a broken leg, he can be brought into court in a wheelchair. If he or she is depressed or upset, arrangements can be made so that appropriate medication can be prescribed and the accused put before the court. It is exceptional that a person will be so mentally defective that he or she is incapable of participating in the trial so that even the modest standards set by the Presser test are not met.

This is as it should be. Members of the public are well aware of the desire by some guilty people to go to any lengths to avoid trial and punishment. There was a notorious episode some years since, when a prominent Australian businessman, facing fraud charges, put forward evidence and claimed to a court a loss of memory so profound that he could not adequately defend himself and was therefore unfit for trial. This claim was rejected. Some years later, after the trial and some years in prison, this prominent businessman re-emerged into the world of commerce and apparently resuscitated his financial affairs to the point where he is once again in charge of a large corporate group.

The public is aware of such episodes of attempted abuse and so are the courts. The courts need to be careful to guard against any public perception that allegations of criminal conduct, however distant in time, can be avoided by ruse or artifice. I am conscious of this consideration and bear it strongly in mind in my scrutiny of the evidence.

Conduct of the Inquiry

This exercise is in the nature of an inquiry: it is not an adversarial legal dispute where one party asserts and the other denies (section 12(2)). The onus of proof on the question of a person's unfitness to be tried does not rest on any particular party to the proceedings (section 12(3)) and the determination is to be made by the judge alone (section 11(1)) rather than – as was the case at common law and under the original version of the legislation in 1983 (by the Crimes (Mental Disorder) Amendment Act, 1983) by a jury.

I note that, as section 12(1) requires, the accused has at all times during the course of the inquiry been legally represented. I note also that, as section 6

provides, the question of unfitness is to be determined on the balance of probabilities.

A trial would be expected to last for at least a month. No plea has yet been taken, as the defence has raised the issue of fitness on a notice of motion supported by material contained in Exhibits A1 & A2.

The Crown has responded with several medical reports which are Exhibits B1, B2 and B3.

The accused is an 81 year old retired Catholic priest who was for some years a teacher at a rural secondary college in New South Wales, a school attended by most of the various complainants.

The question is whether the accused is fit under the terms of the Mental Health (Forensic Provisions) Act 1990 and principles particularly as set out in **R v Presser** (1958) VR 45 and in the High Court decision of **Kesavarajah v The Queen** (1994) 181 CLR 230.

The Evidence

During this inquiry, reports and oral evidence has been received from:

- Dr. John Roberts 13.8.10 (tt. 4-37) and 6.9.10 (tt. 237-254);
- Dr. Elizabeth McCusker 16.8.10 (tt. 3-18);
- Prof. D.M. Greenberg 17.8.10 (tt. 21-61) and 18.8.10 (tt. 35-107);
- Dr. Susan Pulman 17.8.10 (tt. 62-82);
- Dr. Olav Nielssen 18.8.10 (tt. 106-122);
- Dr. Michael Kennedy 18.8.10 (tt. 123-146);
- Prof. Hosen Kiat 25.8.10 (tt. 150-181); and
- Dr. Wendy Goh (Exhibit A2, Tab 7, presented but witness not required cross-examination)

Non-medical evidence was given by:

- Mr Gregory Walsh 26.8.10 (tt 187-223).

I have considered all this evidence and the other evidence before me.

Medical Conditions Affecting the Accused

It is common ground that the accused is 81 years old and suffers from a number of medical conditions, briefly as set out in Exhibit A8, summarising the accused's medical history since 1930, and as spelled out in Dr Kennedy's report, Exhibit B2, by Dr Roberts in Exhibit A2 (Tab 5, p.4), by Doctor Wendy Goh (Tab7), Dr McCusker (Tab 8), Dr Neilssen (Tab 15, p.3) and Professor Kiat in his report of 12 August 2010 contained in Exhibit A2. The lists as attached to Dr Goh's report (Exhibit A2, Tab 7) are as follows:

Active Medical History

- Severe Ischaemic Cardiomyopathy – dyspnoeic on minimal exertion AF (Atrial fibrillation) – on Warfarin

- Unstable angina – previous large inferior and inferolateral myocardial infarct and distal LAD infarct.
- Biventricular Pacemaker - 6th to date.
- July 2001 – Cardiac Arrest during a stenting procedure to his circumflex artery.
- Obstructive Sleep Apnoea – on CPAP machine
- Right Deep Venous Thromboses
- Cerebro-Vascular Accident, confusion, cognitive impairment.
- recurrent skin cancers – requires frequent surgical excisions, diathermy and cryotherapy treatments.
- Carotid Artery disease
- Renal Impairment
- Bowel Polyps has regular surveillance colonoscopies.

Inactive Medical History

- Subtotal right thyroidectomy in 1971.
- Cholecystectomy 1978.
- Prostatectomy 1989
- Right hemicolectomy for carcinoma ascending colon and repair of abdominal hernia 1992.
- Diabetes Mellitus 1993.
- Bilateral total hip replacement.
- 1st pacemaker 1987 due to bifascicular block.
- Angioplasty 1994
- Coronary artery Bypass Graft x 2 1994 (Adelaide)
- Myocardial Infarct 1999
- Total Thyroidectomy – left lobe 2008 and left vocal cord palsy
- Renal Calculi 2008
- Acute Renal failure 2007 and a need for one dialysis treatment following an angiogram in 2007.
- Arthroscopies and Menisectomies to both knees.
- Degenerative lumbar spine.
- Large Incisional hernia.

What is in dispute is not so much the actual medical history but whether, with the frailties and illnesses afflicting him at the age of 81, the offender is fit for the proposed trial.

The "Presser Tests"

In R v Presser, the court set out the following criteria for fitness or otherwise:

> *"[The accused] needs, I think, to be able to understand what it is that he is charged with. He needs to be able to plead to the charge and to exercise his right of challenge. He needs to understand generally the nature of the proceeding, namely, that it is an inquiry as to whether he did what he is charged with. He needs to be able to follow the course of the proceedings so as to understand what is going on in court in a general sense, though he need not, of course, understand the purpose of all the various court formalities. He needs to be able to understand, I think, the substantial effect of any evidence that may be given against him; and he needs to be able to make his defence or answer to the charge. Where he has counsel he needs to be able to do this through his counsel and by giving any necessary instructions and by letting his counsel know what his version of the facts is and, if necessary, telling the court what it is. He need not, of course, be conversant with court procedure and he need not have the mental capacity to make an able defence; but he must, I think, have sufficient capacity to be able to decide what defence he will rely upon and to make his defence and his version of the facts known to the court and to his counsel, if any."*

I add that the law says that mere failure of memory for the alleged events does not of itself amount to unfitness.

The Central Conflict

The essential issue in this case can be identified by quoting some extracts from the evidence of Dr Roberts, on the one hand, and Professor Greenberg on the other.

Dr Roberts reported and maintained that the accused is not fit to be tried, saying:

> [13 Aug p. 7] Q. And then did you come to a view that he suffered from or likely to suffer from impaired cognitive function?
>
> A. Well there's irrefutable evidence on the scan of brain damage and there's irrefutable evidence of brain shrinkage, the CT scan is a more crude assessment of brain damage than for example an MRI but when it's clear and obvious on a CT that the fact that there's damage is unarguable.
>
> Q. And in time did you have access to a psycho, a Neuro-psychologist's report from Pulman?
>
> A. Yes I did.
>
> ...
>
> [p. 7] I relied on the presence of the clinical examination and on the material provided which showed irrefutable evidence of brain damage and the clinical account given by Father Murray at the time of his attendance.
>
> ...

[p. 8] Q. Can I take you then to page 7 of your report. Father Murray indicated to you he was terrified of cross-examination and felt that he would not cope but crumble?

A. That is correct.

Dr Roberts was asked directly about an important aspect of fitness:

[p. 8] Q. Did you then give an opinion as to his capacity to give evidence?

...

A. I consider that it was my opinion that on reasonable psychiatric grounds due both to presence of the efflux of time, the presence of infirmities including organic brain damage, that Father Murray could not be relied upon to give evidence. He could not be relied upon to give an accurate account of matters of fact that occurred 30 to 40 years ago.

[p. 8-9] Q. And given your expertise, do I understand that you - did you take into account any of his physical ailments in expressing your opinion?

A. Yes because the physical ailments are an indisputable part of the whole. It's the physical ailments, Father Murray's cardiac state and the other diseases which are responsible for the vascular damage, which in turn gives rise to his brain damage. It's a continuum of cause and effect.

...

[p. 9] Q. I won't take you to that but on the assumption that the events of this trial cover for a period of 50 years from 61 - events from 1961 through to 78. Given Father Murray's psychiatric and physical capacities, what do you say about his abilities to give evidence and to withstand trial?

A. In my view, on psychiatric grounds, I do not think that the evidence that Father Murray would give due to his age, infirmity and other medical conditions, will be forensically reliable. He could not be relied upon to give consistent - to give evidence in regard to matters of fact and a further concern is that his - the stress of giving evidence in a court would be a circumstance where, due to his state of health, both physical and mental, he would not be able to be relied upon to give consistent evidence, even on a day to day basis.

Dr Roberts was shown other medical reports:

[p. 11] Q. And did you take note of Dr McCusker's report to make your own opinion?

A. That is correct. Dr McCusker commented, in essence, on areas of disease that have been commented upon by myself, including the cardiac history, pacemaker replacement, cardiac arrest, coronary artery angioplasty and bypass grafting, notes the history of diabetes, and I comment all of these diseases are associated with organic brain damage, and I reiterate that that has been conclusively and unarguably demonstrated, and I reaffirm my opinion that Father Murray is a physically unwell man with brain damage, who could not, in my view, be capable of giving an account in regard to matters of fact by virtue of the presence of degenerative brain disease.

...

Q. He would not fulfil the criteria of dementia, but the changes, on examination, would be consistent with mild cognitive impairment?

A. ..(not transcribable).. It's not so mild as was later shown by Dr Pulman's report but certainly clinically that would be the case, but she cognates again, as I have done, the presence of multiple disease states, including vascular disease with the brain damage that has been demonstrated.

Q. And she suggested that the greatest difficulty was a test of executive function, executive functions likely to be impaired in an infarct involving the frontal region?

A. Exactly.

...

[p. 16] Q. Compromised cognitive function?

A. Well that's demonstrated by Dr Pulman and both in her report and it's demonstrated clinically.

Dr Roberts said, as to whether the accused could follow the course of the trial:

[p. 16] Q. And reasonable psychiatric grounds to state that his level of impairment, having regard to your understanding of the Presser criteria, that as the trial proceeds Father Murray would be unable to follow what is going on in Court in the general sense?

A. That is correct and I believe that his slow processing speed as demonstrated by Dr Pulman, will present difficulties for Father Murray on following the course of proceedings during a trial.

Q. And you made a diagnosis of "cognitive disorder not otherwise specified"?

A. Yes there's been a change in labels over the years. In earlier times Father Murray would have been labelled a chronic organic brain syndrome but because we now know that organic changes also occur in patients who do not have a physical illness such as in schizophrenia or mood disorders where you can demonstrate brain changes on scanning, that label has fallen into disrepute and it's now called "cognitive disorder not otherwise specified" and I've quoted from the text of the DSM-IV which says that this category is for disorders that are characterised by cognitive dysfunction presumed to be due to the direct physiological effects of a general medical condition that do not meet the criteria for any of the specific deliriums, dementias or amnestic disorders listed in that section.

Professor Greenberg, by contrast, took the opposing view:

[17 Aug. p. 26] Q. With respect to each of the three complainants did you ask Mr Murray as to whether he understood what the allegations were?

A. Yes.

Q. Was he able to relate to you anything about the allegations?

A. Yes, he was. In other words it wasn't as far as I was concerned it wasn't my task to determine what the truth was. That's for the courts to decide. I was just trying to determine whether he was, whether he met the Presser criteria, namely whether he could give his version of the facts and understand what he was accused of and respond appropriately by giving instructions to his legal counsel.

Q. At the time that you were obtaining this information how did he appear in relation to his clarity or his ability to recall and recount?

A. Well considering that these allegations are some 30, 40 years old I would regard his recall as exceptional.

...

[p. 32] Q. In relation to Mr Murray's status as to whether or not you say he fits the diagnosis of dementia what is your opinion?

A. I think my opinion is he does not have a dementia and I think that's accepted by all the experts, yes.

...

[p. 33] Q. At the time that you saw him you said that it was possible that there was evidence of mild cognitive defect?

A. Yes.

...

Q. And you've indicated it's your opinion his level of functioning is therefore well above the threshold and that in your opinion Mr Murray's currently fit to plead and fit to stand trial at this time?

A. Yes.

...

[p.36] Q. However, his processing speed index is at 86 being the low average, the 18th percentile?

A. Yes.

Q. Given those results, did that affect your opinion in any way as to whether or not Mr Murray is fit to be tried?

A. No, I still feel he's still fit to be tried. He does have, as I said, cognitive impairments but because he functions at a relatively higher level than the average he, he doesn't meet the criteria, the fitness, the Presser fitness criteria to be unfit. The issue of processing speeds, many people who I see in daily practice have low processing speeds, for example, people with schizophrenia have low processing speeds. I work in the, part of my work is that I do, I run the Courts Liaison Service with the New South Wales Health Service and that means that dozens and dozens of people with, for instance, schizophrenia have low processing speeds, but very, very few of them are found unfit.

When cross-examined, Professor Greenberg said:

> [p. 51] A. Not that's not what I'm saying. First of all it's an unfair description to say that I did a four minute test to assess his cognitive function. I did a full comprehensive psychiatric assessment. In that assessment I assessed his, the fact that he was neatly dressed, well manicured, that tells me a lot - if I may finish
>
> ...
>
> A. It tells me a lot about a person's cognitive function. A person who has got dementia will have dirty nails, may be unkempt hair or dirty hair because they cannot look after their health. I also assessed his general interaction. He's good eye contact, he's coherent, speech, his eloquent speech. That tells me a lot about his cognitive functions. I observed his mood status. I observed, you know, the fact that he was orientated for time, place and person. Mr Murray, Father Murray was able to tell me that he was on the 8th floor at 235 Macquarie Street.

Professor Greenberg conceded that he had not been shown Professor Kiat's report of 26 July.

> [p. 87] Q. You would not gainsay Dr Kiat's opinion?
>
> A. I would say that if Dr Kiat, as I said I'm not a physician, but if Dr Kiat feels that he is physically unable to stand trial I concede to that. I'm saying from a mental capacity he is Presser fit. Dr Kiat is saying, and I'll turn to the last part of his report on 26 July 2010.
>
> Q. That's his first report?
>
> A. Yes, page 5. He's saying that he obviously has lots of illness and he may require hospitalisation, that he has general vascular disease but not a dementia, although his memory's far from perfect, and with the combination of his cerebral and his cardiac problems he doubts whether he could concentrate.
>
> Q. Yes?
>
> A. And then he goes on further to say, as you've pointed out in the letter to Mr Walsh dated 30 July 2010, that he probably would be unable to concentrate for longer periods of time. What I'm saying is that physically I concede that he is of high probability to have further physical problems with the stress, that is what the physician is saying and I concede to that, but in terms of certainty he does not know that.

Some Agreement of the Cardiologists

Whereas Dr Roberts and Professor Greenberg broadly addressed themselves to what I might call the "Presser issues", the two cardiologists focussed on their specialisations. Two distinguished heart specialists, Dr Kennedy and Professor Kiat, reached broadly similar conclusions about Father Murray's cardiac history with some possible difference as to its current impact on him.

Dr Kennedy gave this evidence, after going through the accused's history of heart operations:

> [p. 129] A. Well, he presented as an elderly gentleman who walked into the room with some difficulty because he has troubles with his back, and was able to give a history but was obviously a little forgetful. He was clearly in the obese range. He's not just overweight, he definitely was obese and he had swelling in both ankles. It was to a degree where I could not feel the pulses in the feet. It is an index of your peripheral arterial system, and that's why I went up and felt the pulses above that just behind - halfway up behind the knees, popliteal pulses, which meant there was at least good blood flow going down that far. The next thing, I listened to his neck to hear if I could hear noises in his neck which is often a clinical indication of blocks in the arteries. This is standard clinical examination. I measured his blood pressure and that is basically close enough to the normal range. It is taken as a systolic of 130 to 140. Above 140 is taken as hypertension. He has diabetes, and with diabetes you should try and have it below 130. But in this case I thought that was satisfactory.
>
> ...
>
> [p.129] His heart sounds normal. In other words, he didn't have extra sounds, a galloping beat. In other words, he wasn't in acute failure at the time. His lungs were clear, meaning I couldn't hear any water in the bottom of his lungs. He had a fat abdomen. He had a lot of scars for someone who was - it's unusual to require that many pacemakers. Something I haven't seen for many years. Most people have one or two. He had a laparotomy scar, that's a cut within the abdomen. That was when he had had his bowel cancer removed, an additional illness. He had a scar in his neck, his thyroid had been completely removed.
>
> ...
>
> [p.129-130] He had a spontaneous beat arising from the cardiogram. He had a test similar to what pregnant ladies have where you bounce sound waves off the heart. It's a simple non-invasive test to get a lot of information about the heart in a very short period of time. This showed that his ventricular ability - his pumping ability, when he's at rest, is low. 30 to 35 is bad. Everyone here is probably 55 or above. On top of that when his heart beats, instead of all the blood going out to the circulation through the aorta, every section of it goes back into the top section of the heart. In fact, the mitral valve is not working properly and that would be as a result of the fact he's had a myocardial infarct. And there's further evidence of this problem here because that pressure of the regurgitant - the back-flow jet going in the wrong direction is sending pressure all the way over to the other side of the heart. It's going back through the lungs and I could measure on the other side of his heart where the pressure should be 15, he has 47. He has mild pulmonary tension. I have no doubt about that. Because it was a legal requested examination I thought I'd better do the standard Mini-Mental test, which is a very simple test, and he did very well on that, but I don't claim to be a neuropsychologist. But most people, unless they have dementia, do pretty well on it and he was a gentleman who obviously performed at a high intellect function in the past.

Dr Kennedy continued:

[p. 130-131] Q. And looking at page 4 of your report it's mentioned there there's a finding of carotid stenosis of 50 to 69 per cent. Was that a significant view from a cardiac point of view?

A. The most significant factor about finding 50 to 69 per cent stenosis is that it would increase his risk of a major cerebral event if he was having by-pass surgery. And there's an index that he has polysystem disease.

Q. Polysystem being?

A. Multiple areas being affected, got the heart affected, carotid artery affected, he is an elderly patient with poly system disease.

Q. Doctor, you go on, in relation to your conclusions, where you do say, of course, he suffers from complex polysystem disease, which led to the various problems he has. You indicate there that he remains in a high-risk group for sudden cardiac death, heart failure is very serious condition once diagnosed even in modern - 30 to 45 per cent die within one year and 60 to 70 per cent are dead within five years, and you give the citation. From Mr Murray's history, when would he have qualified for the diagnosis in heart failure?

A. Well, heart failure is a clinical diagnosis. I couldn't say exactly when he first had cardiac failure.

...

[p. 132] Q. Doctor, are there such things as I think what's called outliers?

A. Outliers?

Q. Not, "outlier"'s not a term, people who despite the facts that statistically they should be dead they're not?

A. Well, I have to admit in my practice, I have a cardiology practice which I think comprises all outliers, if that was the definition, but it's part of, really, how well patients are looked after and you can do all the right things and if you, see, the means by which the clinical trials judge the efficacy of medications is usually, the criteria is usually hospital admission or sudden cardiac death.

Q. And if he was in a clinical trial or been in a review of patients being treated by, he may well be in the register for a coronary bypass surgery?

A. He could well be at risk of a sudden cardiac death on maximal treatment.

On cross-examination Dr Kennedy was asked:

[p. 133-134] Q. Doctor, would you regard him as medically fit enough to attend a trial?

A. I would have thought that was a legal question. I put it this way, if he was, if he was a patient of mine and for some reason he had decided to take extensive legal proceedings against some individual for some case which was obviously going to involve him being in court for a period of time and being aggressively cross-examined in relationship to some matter or other, financial or something, I would have said, I think, "I don't think that is good for you". That would have been my advice, that's what I would have advised him, I would have said "the decision's up to you".

Where Dr Kennedy was shown Dr Kiat's report, he said:

[p.136] Q. Yes; now, would you agree with Professor Kiat's description of a moderately weakened cardiac function and dilated heart?

A. Yes. That's a rather non technical way of expressing it.

...

[p.136-137] Q. So he's got half a heart, half normal, according to

A. His ventricular function is down and he has severely impaired left ventricular function at rest.

Q. And he has a 30 per cent ejection fraction which you've put as very low?

A. At rest he has a low ejection fraction, yes.

Q. Therefore does that mean he's at risk of sudden death?

A. There is a relationship between patients who have had myocardia and sudden death, yes.

Q. There is a strong relationship between impaired left ventricular function and sudden cardiac death?

Q. And he's breathless on minimum exertion?

A. Yeah.

Q. He's in that bottom rung, I think it's in here, NYHA class 3 at best, you see that on page 2?

A. It's on page 1.

Q. Yes, okay, so, do those two components together mean anything?

A. Yes, it means he has very severe cardiac failure.

Q. And his prognosis, then, could be unpredictable?

A. I'm not sure what you mean by unpredictable.

Q. He's a candidate for sudden death?

A. Yes.

As to whether the accused could sit in a trial for a shortened day, Dr Kennedy said:

[p. 138-139] Q. And when you were asked whether he could withstand a trial you said, well, one hour, two hours?

A. In terms of giving, in terms of being aggressively cross examined or even not aggressively cross examined or being asked to perform, to take detailed history and so forth, I would have thought one hour would be about the most he would be able to give meaningful information on.

Q. Or even sit in court, is that right, don't you agree?

A. If he was required to maximally concentrate on proceedings

Q. Yes?

A. I think after an hour he would be getting probably a bit tired.

Q. Yes?

A. And his ability to concentrate, I think, would be impaired.

Q. One of the authorities that you've helpfully given the prosecution that's now in evidence is the link between arrhythmias and a sudden cardiac death?

A. Yes.

Q. And I do I take it that sitting in court in the normal set of events would be an acutely stressful event?

A. I think so.

Q. Yes?

A. Yes.

Q. Especially if it involved as the observation was steadily pointing to basically humiliation?

A. Yes.

Q. And so the mere sitting in court, albeit an hour a day or two hours a day, would be a very stressful pressure on Father Murray?

A. Yes.

...

[p. 141-142] Q. Having done all of that, we go back to Professor Kiat who thought that there was a risk of an adverse event should he be exposed to

court proceedings for the hours a day, several hours a day for four or more weeks. That's a context which I was asking?

A. Sure. It is a stressful situation, which is certainly unfavourable for people with severe cardiac conditions.

...

[p. 142-143] Q. You have to advise patients every day of the week, don't you, as to the risks they have at an elderly age such as this in respect for having for example surgery?

A. Yes. I am particularly consulted. At times I refer ...

HIS HONOUR

Q. You would generally talk to other doctors, wouldn't you, rather than the patient?

A. It's an interesting situation, your Honour. They are sent to me, say an orthopaedic surgeon, they send me the patient because they want to have an elective hip or something of that kind. I go through it and I finally say to the patient, your chance of a peri operative risk around the operation will be 5 per cent, 10 per cent, 20 per cent. I finally say, you know, you're the only one who can say yes I can have it. The surgeon can definitely say no. So the patient says yes or no. But the patient is the only one who finally says they want to keep going on with the procedure.

Q. Do you know of any research that's ever been done anywhere that is equivalent in terms of assessing the risk for a person with cardiac problems of court appearance?

A. No, I don't. There are anecdotal comments.

...

[p. 143] These come as anecdotes.

...

But in relation to your specific question I don't know if anyone has ever done a study on it. It seems commonsense from the data that emotional stress will precipitate cardiac arrhythmias.

A. Yes.

After Dr Kennedy, Professor Kiat gave evidence, He went through the cardiac history and continued:

[p. 152-153] A. He has got a medical term wise left ventricular ejection fraction which means that ejection fraction is the proportion of blood being pumped out of his heart. When a heart squeezes not every bit of it is squeezed out of the pump, out of the heart, only a proportion is. Usually it's about 55 to 60 percent of the blood in the cardiac main chamber is pumped out with every heart beat. In his situation his ejection fraction instead of 60

percent is about 30 percent and therefore he has approximately 50 percent less heart function and that will make him less able to perform his physical activity such as trying to exercise and that will slow down his metabolism in the body because the body will not receive an adequate distribution of blood flow and therefore his kidney function would start to suffer. And also essentially most of his skeletal muscles which are muscles required for physical activity will be reduced in its ability to function.

...

[p. 153] In addition Father Hugh Murray has a condition called atrial fibrillation and this condition means that one of the chambers which is in fact two of the chambers which is the left and the right atria or left atrium and right atrium do not pump.

...

[p. 154] Q. Just concentrating on the sheer ejection fraction low figure, is he at risk of sudden death?

A. Yes. I would like to clarify that. I can only answer every question based on available evidence.

Q. Yes?

A. Not specifically to any particular patient because no one can tell about any specific individual. I could drop now, for example.

Professor Kiat further said:

[p. 155] We know from the general population epidemiologic and observational data widely available in the medical literature, such as following earthquakes in Athens, in Los Angeles, in Japan, following three days, Iraq missile attacks to Israel, et cetera, the background cardiac death rate increased by up to 3 times, 300 per cent. This is just in general population, not in specific cohort of population.

...

[p. 155-156] Q. These are medical research papers based on catastrophic events?

A. These are medical journal peer review publications looking at the epidemiologic data following acute stress to a general population. Therefore these are low risk group people. Even in that group of people acute emotional stress results in a very rapid rise of cardiac death.

So that if I were to extrapolate, even conservatively Father Murray who I imagine would be subject to emotional stress which we in experimental situations would not even give this type of people for more than 10 minutes that would increase his risk of death, you know, by say 5 by 3, to 15 to 20 per cent.

That's just cardiac death of sudden nature. I'm not even talking about acute events which result him to have to go to hospital, for example, from acute heart failure, what we call pulmonary oedema because his heart function reduces acutely during emotional stress or mental stress.

Professor Kiat continued:

There is a lot of data that I can elaborate on. And therefore overall I feel that a 20 per cent increase in the risk of death acutely is not reasonable.

Q. That's not allowing, as you say, for an acute non-fatal event?

A. That doesn't allow for non-fatal heart attacks, pulmonary oedema or acute heart failure or more rapid atrial fibrillation due to increased adrenalin level. Those are conditions which will result in hospitalisation but not necessarily result in death.

Q. So the figure would be much higher?

A. The figure would be approximately 60 per cent based on evidence, which I will be happy to elaborate.

Professor Kiat described certain research at Cedars-Sinai Medical Centre in New York when he had worked and studied there, the general effect of which was that even mild stress can be dangerous for cardiac-vulnerable patients. He was asked about Dr Kennedy's view relating to possible shortened court hours:

[p. 158-159] Q. You became aware in your preparing to write your reports in this matter of Dr Kennedy's suggestion that perhaps one or two hours a day might be a way to deal with his difficulties. What do you say about that in court?

A. The only evidence is that within ten minutes of mental stress we would see significant deterioration in heart function. We have never and probably will never be approved to test a patient with heart disease with a mental stress of lasting one to two hours. That probably would not be humane enough for an ethic committee to approve and because that may pose unacceptable or unreasonable risk. Therefore we confine our test to 10 minutes.

Q. Is your comment of unacceptable risk to his cardiovascular health, that is Father Murray, includes a rejection of even a couple of hours a day in court?

A. Correct. Yes, I don't see how he can attend Court for 10 minutes.

Q. Without some significant risk?

A. That's the only evidence we have is that we did it for 10 minutes and it would already result in a significant deterioration of the heart function which continues all through the day.

Q. I ask you to assume that this case is a case where allegations of sexual impropriety are made by at least three persons, perhaps up to ten persons, do you understand, I ask you to assume that, that that's the allegation. Those allegations relate to activities alleged to have happened 45 years ago to 30 years ago involving either three complainants and seven eyewitnesses. The case would evolve and would mean that Father Murray would be sitting in Court listening to the witnesses give their evidence and seek to give instructions to his counsel during the course of however long it went. It could go for weeks and then Father Murray may be called upon to give evidence in the box, the very box you are sitting in and give an account. Making all of those assumptions, are they risks that you find medically unacceptable?

A. Yes. I'm stressed even just answering your questions. And I'm perfectly healthy. I think it is absolutely unreasonable to subject a patient with a significant cardiac disability in New York Heart Association Class 3 with an ejection fraction half normal with evidence proven increased risk of between 20 to 50, 60 per cent risk of adverse cardiac events including cardiac death to mental stress.

If I have a patient in that cohort, that I have just described, that needs a hip surgery and we come to a conclusion that stress could be about 20 per cent risk even under controlled environment of a surgery, that's means the anaesthetist is watching everything, the ECG is watched, the defibrillator is there, everything is there, if the risk the 20 per cent I would say probably you don't need the hip surgery.

It's unreasonable to put yourself through a 20 per cent risk for even a useful procedure. Therefore, I feel if it is unreasonable for a patient in this cohort to be subject to mental stress if he can avoid it.

Q. If per chance he was to suffer a hypoglycaemic event while he was here or to suffer an adverse cardiac incident while he was in this courtroom, is there a predictability about his survival based on the complex problem that he has?

A. Yep. Again based on available evidence if his cardiac arrest is due to cessation of heart beat, statistically the survival rate is between 0 to 2 per cent successful resuscitation.

In cross-examination, Professor Kiat was asked about Father Murray's medications:

[p. 166] Q. Professor, if I can refer you to your report of 12 August, page 2. You speak in the last paragraph about the sentence commencing "Even minor mishaps such as missing his cardiac medications, minor over hydration or under hydration" that aspect there as an increasing risk to him, with Mr Murray with medications that have been prescribed for him is he likely to suffer ill effects if he fails to take any of his medications?

A. Yes, the answer is absolutely resoundingly yes. I haven't got a list of his medications but I'm happy to be given the list to be reminded on but people

with ejection fraction of 30 percent will be on a slew of cardiovascular medications and a lot of them are going to be very finely hydrated over a period of time.

As to the various medications he said:

[p. 168-169] This is what we call poly pharmacy. Most of these patients have a lot of medications. But the reason why I did come back to furosemide is because diuretically, particularly it can rapidly dry you up or missing it can rapidly make you fluid overload going into pulmonary oedema.

WITNESS: So there are a lot of medications that patients with left ventricular ejection fraction of less than 30 take, which if they are sort of screwed up would result in hospitalisation.

Professor Kiat was cross-examined:

[p. 169] Q. Doctor, if Mr Murray has not had any adverse events within the past 21 months, would that indicate that his medication regime has been adhered to?

A. I presume so, yep. Certainly that is the benefit of having a very good GP, who keeps the patient under good surveillance, who reviews the patient diligently, who check his blood tests for electrolytes imbalance and so on carefully and therefore, yes, we do as I said rely on the GP to keep an eye on their patients very carefully.

...

[p. 171-172] Q. But as far as Mr Murray, do you say or do you disagree with Dr Kennedy's statement "it is possible he may require hospital admission at any time during the proceedings"?

A. I don't disagree at all, but it doesn't mean that possible is the highest probability we could use. I generally use very likely if I feel that the probabilities of an event is more than 10 per cent. Because a 10 per cent risk of a significant event is high risk.

Q. Sorry, you would have described it as "very likely" if the risk is 10 per cent?

A. Correct.

10 per cent risk is what we call high risk. If a patient has got a 10 per cent risk of a stroke from atrial fibrillation that is high risk. If a patient has a 10 per cent of dying from cardiac arrest that is high risk.

We do not go ahead with an elective surgery if the surgeon says you have got a 10 per cent risk of dying on the table. That's high risk. Most coronary bypass surgery is point 5 per cent risk. We are now talking about 20 per cent risk of sudden cardiac death and 50 per cent risk of adverse events requiring hospitalisation based on statistical evidence published in medical literature.

...

[p. 174] Q. Professor, the fact that you can study these groups, as you have said a number of studies have been done on this sudden cardiac death following these acutely stressful events, you have not referred to any studies that show the increased death rate for people with ischaemic cardiomyopathy with these extremely stressful events. You have only got general population studies?

A. That's right. Those studies did not, in my memory none of them, whether it was Los Angeles Earth Quake Publication, the Japanese, the Athens one was the most famous one, sub analyse the population into various heart function groups. But from the data of people with heart failure we do know that mental stress subjects them to increased incidence of arrhythmia which is irregular heart beat of a fatal nature.

There are several very eloquent studies which have been conducted. Because in the last few years we have been able to implant a defibrillator inside the patient's chest which will detect if a patient goes into ventricular fibrillation. We have found that approximately 20 to 50 per cent of what we call defibrillation activation. That means that the patient goes (witness indicated) like that because the defibrillator fired in the sense that if he doesn't walk around with a defibrillator he would be dead if it increased by 20 to 60 per cent following or during mental stress. That we have the data of.

Evidence of Dr Neilssen

The evidence of Dr Neilssen is important. In a nutshell, his view appears to lie half-way between the decisive but opposed positions adopted by Dr Roberts, on one hand, and Professor Greenberg, on the other.

Dr Neilssen diagnosed early dementia, a progressive condition.

In his report and in evidence in chief he said:

[p. 111] Q. And you came to the view on the final page that he was "unfit for trial on the basis of his impairment of short term memory...on instructions based on his recollection of what was said in court and be able to give evidence on his own account and be able to respond to cross examination."

A. Yes.

Q. And you go on to say he's unlikely to remain fit for the duration of a difficult trial

A. Yes.

Q. Given his multi system deficits.

In cross-examination he agreed that Father Murray did not have dementia as such under the DSM 4 guidelines, but qualified his answer:

[p. 113] Q. Is it a situation that, on the diagnostic features for the DSM IV he would not meet with a diagnosis of dementia?

A. Well, I think that's arguable, and it's a grey area. He definitely has impairment in the domains that make up the definition of dementia and in my opinion he has a mild form of dementia or cognitive impairment, whatever you like to call it. It's a permanent and irreversible impairment in intellectual function.

Q. But cognitive impairment, while a person with that will very often go on to develop dementia, they may not.

A. Yes, they may not. But another factor that has to be taken into account with Father Murray is that there was premorbid intelligence in a superior range and it does represent a significant decline.

He agreed with the cross-examiner that the accused met some of the Presser tests:

[p. 113] Q. Doctor, could I take you to page 2 of your report, the second last paragraph before the psychiatric history? You went through, basically, with Father Murray to establish the various factors of the Presser criteria?

A. Yes.

Q. And as you've said, he was able to give an understanding of the adversarial trial including the very eloquent description of a judge?

A. It's the best description I've ever heard, actually, in all my career of asking this question.

Q. You said he was able to name specific charges and to give an account of the evidence in the case, so did you actually ask him about the nature of the allegations that had been made against him?

A. Yes, in general terms. And in the sense that I asked an open ended question about it and he was able to name the charges and give a description of what had been said about him.

Q. By the various

A. Complainants, yes.

...

[p. 115-116] Q. If I can refer you to that, there you went through the various allegations and Mr Murray told you what the allegations were?

A. Yes.

Q. And effectively told you what his position was in relation to whether he accepted those offences?

A. Yes.

Q. Which would indicate he has an understanding of what the allegations are and an ability, in my submission, to give a version of his own in relation to those offences?

A. Yes, and, and that's the part of the Presser, that test, which I agree meant, you know, that he does understand the charges and the evidence in the case.

Q. And he has a capacity to give a version of the event?

A. Well, in general terms, yes, I mean, I haven't checked but, I mean, I was provided with the reports but I'd have to go through them in detail to give the purpose of the assessment.

Q. Given that he's been diagnosed with a mild cognitive impairment and given his results on Dr Pulman's testing in relation to memory, in particular, it's stressed that he would have the capacity to answer questions in the trial, had you taken into account particularly his high IQ level?

...

[p. 116] A. Yes, I mean, he could, could answer questions but there is a high chance that he would become confused on persistent questioning and his capacity to concentrate, I believe, would be impaired, and similarly his physical condition would affect his capacity in the course of the day.

He was asked about the possibility that short court days in court might assist the accused's capacity for trial. Dr Nielssen said:

[p. 116-117] A. I mean, again, that's a hard thing for me to predict as to exactly what course the trial might take and how difficult it would be for him, but it is my opinion that he's got some intellectual impairment and he's physically very ill and that would affect his intellectual function over a trial.

Q. But he can be assisted if his Honour applied various steps to be put in place such as frequent breaks?

A. Yes.

Q. If he was able to have access to transcript of the evidence or summaries of the evidence?

A. Well, that might assist, yes.

Dr Neilssen was asked to nominate how the accused could be assisted in a trial:

[p. 120-121] Q. Well, if we can just try to focus on the psychiatric or mental capacity that he has, if his Honour was to find him fit is there anything that you could suggest that should be put in place that would assist him?

A. I think if, if, if, if, only thing I can think of is that he's checked on during the course of the day on his capacity to stay awake, his capacity, you know, whether he's free from breathlessness, free from pain, free from anything that might be distracting him from listening, I, he has a condition which is likely to

fluctuate during the day, I can't say when or what period of time, but I think regularly checking on him whether he is okay is the obvious measure that I could think of.

...

Q. That would assist particularly with his medical issues. In relation to his cognitive functioning, would it assist if he was given documents, pieces of transcript and summaries of material?

A. Well it might assist, but I think he does have impairment in his capacity to read and concentrate and absorb written material as well as verbal material.

As to his possibly giving evidence:

[p. 121] Q. Given adequate time to consider questions, is it possible he could give reliable evidence in the trial?

A. Well again I find it hard to predict how his state will hold up over the course of the trial, but he is a very sick man and I think there would be a considerable risk that he wouldn't be able to give reliable evidence on his own behalf.

Dr Neilssen's conclusion when asked the critical question is important:

[p. 121-122] Q. I suggest that Mr Murray is actually fit to be tried?

A. Look I think he's fit enough according to the Presser criteria. It's just his capacity to withstand a trial and the likely effect of the problems that he does have on his capacity to perform adequately during a trial.

Q. On the Presser criteria you would say he is fit?

A. Well, fit enough compared to many other accused. It's really in the Kesavarajah test of being able to maintain his abilities during the course of the trial, I believe that there is a significant risk that he will become ill and have problems with his intellectual function over the course of the trial.

Q. When you say that I assume you take into account shortened court days to assist him?

A. Yes.

Q. Given shortened court days we would be running for a much longer period of time, a two-week may turn into a four to six week trial?

A. Yes.

Q. Given the shorter days, but given additional time off would it be possible for him to remain fit to take into account that Kesavarajah element?

A. Yes, well you raised it there. You put the term possible, of course it's possible. But you know the combination of physical and intellectual problems are pretty severe.

Likely Length of Trial

In **Kesavarajah v The Queen** (1994) 181 CLR 230, the High Court emphasised "...the need for a trial judge at the commencement of a trial to pay very careful attention to the question, once it arises, whether an accused is fit to be tried and to ensure that the question is determined in the light of the estimated duration of the trial."

Here the trial would be at least one month in length, complicated by the possibility, on the evidence of Dr Kennedy, that stress upon the accused would be less if the court only sat for an hour or two each day. The length of the trial is to some extent imponderable, but in my view it would take at least a month however conducted, very likely two and possibly three, as the Crown conceded.

In my view, the **Kesavarajah** component assumes, in this case as great a significance as the **Presser** component, if I can so describe it. It is a general requirement of a trial that the accused actually be present in court every day of hearing. It would be necessary for the accused to concentrate on the evidence of scores of witnesses, and even with the assistance of counsel this would be demanding and stressful.

Conclusions

I acknowledge that there are in this case contending opinions by very able medical practitioners. It falls to me, however, to determine the issue and I do so after deliberation.

The accused is a frail 81 year old man suffering from a complex set of medical ailments.

He has had a number of heart attacks and his current cardiac pacemaker is the sixth which has been implanted in his body.

His heart functions at a much reduced capacity compared with a healthy person of his age. This brings with it a serious risk of an adverse cardiac event or even death.

Various other ailments combine with his compromised heart functioning to increase the risk of adverse outcomes for him.

He has been an intelligent man in the course of his past life and he retains the capacity to converse in day to day conversation of the ordinary kind. He is not mentally ill or retarded.

Upon interview and examination he impressed Professor Greenberg as being generally fit for trial, and he impressed Dr Neilssen as able to fulfil the main Presser criteria, at least in the short term.

Upon interview and examination he impressed Dr Roberts as being unfit for trial.

In the course of giving instructions to Mr Walsh, he impressed Mr Walsh as often confused.

His treating doctors Dr Goh and Professor Kiat, without focussing on the Presser criteria, were strongly concerned that the stress of a major criminal trial would involve an unreasonable and unacceptable risk of sudden death or adverse cardiac event.

In my view it is likely that the accused would present very differently to different interviews on different days. He is on multiple medications for a variety of conditions. Failure of medication regime from time to time is likely, and various of the medications are finely balanced. I generally accept Mr Walsh's evidence as to what instructions he was and was not able to obtain, and regard it as evidence indicating fluctuations in the accused's capacities.

A trial as proposed would last between one and three months, and would involve dozens of witnesses. The Crown list alone is a possible forty three witnesses.

It is likely that, in a trial lasting several or a few days, the accused would meet the Presser criteria and could be fit for trial.

However in a trial lasting one, two or three months, and involving very many Crown witnesses, not to mention defence witnesses, I am satisfied on the balance of probabilities that there would almost inevitably be many times and occasions when the accused's capacity would fall below the minimum Presser standards whatever arrangements the court makes about court sittings.

The trial would involve multiple factual issues, in contrast with a short trial focussed on a brief event, such as the hold-up of a service station or store.

Such times and occasions would be likely to coincide with episodes of greatest stress in the course of the trial, particularly in the presentation of a defence case. Forensic realities, this being a "word against word" case, dictate that the accused would practically have to give evidence.

In this trial, such times and occasions when the capacity of the accused would fail to meet one or more of the Presser criteria would include times when he might be affected by, as Professor Kiat said at transcript p. 156, "non-fatal heart attacks, pulmonary oedema or acute heart failure or more rapid atrial fibulation due to increased adrenalin level."

Consciousness by the accused of the possibility of one of these events occurring would almost inevitably, in my view, cause him such anxiety during the course of a long trial that he would not satisfactorily be able to concentrate on the evidence so as to have a fair trial.

This would be so in my view even if the court sat for only one or two hours per day, as hypothesised. In this respect, I accept the evidence of Professor Kiat at tt. 159:

> Q. Is your comment of unacceptable risk to his cardiovascular health, that is Father Murray, includes a rejection of even a couple of hours a day in court?
>
> A. Correct. Yes, I don't see how he can attend Court for 10 minutes.
>
> Q. Without some significant risk?
>
> A. That's the only evidence we have is that we did it for 10 minutes and it would already result in a significant deterioration of the heart function which continues all through the day.

The Presser criteria which would in my view be at some point or points in the hypothesised trial the accused could not meet would include:

- the capacity to follow the course of the proceedings;

- the capacity to understand the substantial effect of any evidence that may be given against him;
- the capacity to make a defence or answer the charge;
- the capacity to give counsel necessary instructions;
- the capacity to give his version of the facts.

I accept the thrust of Dr Neilssen's evidence that in the initial stages the accused would be capable of pleading to the charge and exercising his rights to challenge, and of generally understanding the nature of the proceedings.

These are considerations which would operate at the beginning of a trial. As I say, if the trial were quite short, he might well be fit to be tried, although I am not certain about that. But the proposed trial is not short. What the Crown presents in the one indictment is three separate cases relating to three separate alleged victims, for trial at the same time. As well, the prosecution proposes to lead evidence from possible "tendency and coincidence" witnesses. The possible Crown witnesses alone may total forty three.

This case is, it seems to me, classically a scenario which the High Court in **Kesavarajah** saw as a possibility: where a person might be fit for trial in a short and uncomplicated trial, but would be unfit for a long, complex and inevitably stressful trial.

This is what I see to be the situation here, even where the possibility of actual sudden death during the trial – the ultimate "unfitness" – is disregarded. I make it clear that my determination is not made on this latter basis. Whether the significant possibility of such an outcome, being less than probability "on the balance", would itself amount to unfitness for trial, I do not decide. It arguably could, but arguably it may be legally irrelevant. It is unnecessary to decide this and I do not reach any conclusion on this basis.

I am satisfied, as I have said, to assume that the accused would at least survive for the duration of the proposed trial. His fluctuating condition over the anticipated period of trial would probably – indeed almost inevitably – involve times and occasions when the accused's capacity would fall below the minimum **Presser** standards.

I reach this conclusion conscious that the practical requirement of fair trial do not demand perfection, merely a modest achievement of minimum standards.

I am satisfied on the balance of probabilities that this accused is unfit for this proposed trial.

Let me make plain my view that this is a regrettable and frustrating outcome. It is, nonetheless an outcome which the evidence and the law requires.

It is not part of this court's function in this case to explore how or why these claims were not raised earlier – decades earlier. However I note from some of the material before me that there have been numerous transfers and movements of the accused as a priest during the course of his career. Perhaps this factor plays some part in the overall picture – I cannot say.

I emphasise however that nothing in this judgment is a criticism of the complainants in relation to the long delay. Nonetheless, whether or not the

Catholic Church and those who have directed father Murray's movements over the years bear some responsibility for this frustrating impasse, the fact is that at this point, the opportunity to conduct a fair trial of these allegations has passed, and on the evidence before me as I interpret it, a trial conducted in his present condition would not be a fair trial according to law.

The accused is unfit to be tried on this indictment.

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This and the preceding 25 **pages**
are a true copy of the reasons for
judgment given by His Honour
Judge G.D. Woods given on 9 September 2010.

.....
G Findlay
Associate.