# THIS IS AN OFFICIAL REPORT OF THE MENTAL HEALTH REVIEW TRIBUNAL PROCEEDINGS IN RELATION TO MR TALBINGO AUTHORISED BY THE PRESIDENT OF THE TRIBUNAL ON 24 FEBRUARY 2016.

Mental Health Review Tribunal

***This is an edited version of the Tribunal's decision. The forensic patient has been allocated a pseudonym for the purposes of this Official Report***

**FORENSIC REVIEW:** **Robert Talbingo**

**s46(1) Review of forensic patients**

***Mental Health (Forensic Provisions) Act 1990***

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| **TRIBUNAL:** | **Daniel Howard SC** | **President** |
| | **Michael Giuffrida** | **Psychiatrist** |
| | **John Haigh** | **Other Member** |
| **DATE OF HEARING:** | **24 September 2015** | |
| **PLACE:** | **MHRT Conference Room by video to xxx** | |
| **APPLICATION:** | **Conditional Release** | |

**DECISION**

1. The Tribunal determines that Mr Talbingo has spent sufficient time in custody for the purposes of section 74(e) of the *Mental Health (Forensic Provisions) Act 1990.*

2. The Tribunal is <u>not</u> satisfied that neither the safety of Robert Talbingo nor any member of the public would be seriously endangered should the application be granted. The Tribunal therefore <u>does not</u> grant Robert Talbingo conditional release.

3. Otherwise, the Tribunal determined that the current arrangements for Robert Talbingo's care, treatment and detention as a forensic patient at Long Bay Hospital , including all previously granted leave, should continue to apply.

4. For the purpose of sections 47(4) and (5) of the *Mental Health (Forensic Provisions) Act 1990,* the Tribunal is satisfied that Mr Talbingo remains unfit to be tried.

Signed

Dan Howard SC
President
Dated this day: 11th December 2015

# REASONS

## BACKGROUND

This is a review pursuant to section 46(1) of the *Mental Health (Forensic Provisions) Act 1990* ("the Act"). Under section 46 the Tribunal is required to review the case of each forensic patient every six months. On such a review the Tribunal may make orders as to the patient's continued detention, care or treatment or the patient's release.

The Act has special evidentiary requirements in relation to leave or release which must be satisfied before the Tribunal can grant leave or release. In view of this, the Tribunal requires notice of applications for leave or release to ensure that the necessary evidence is available. This process also enables the Tribunal to provide notice of such applications to the Minister for Health, the Attorney General, and any registered victims who are entitled to make submissions concerning any proposed leave or release. A notice was provided to the Tribunal prior to this review for an application for conditional release.

## DOCUMENTARY EVIDENCE

The Tribunal considered the documents listed in the Forensic Patient Exhibit List dated 24 September 2015 annexed to these reasons.

## ATTENDEES

Robert Talbingo was excused from attending the hearing but was represented by his counsel Mr Mark Ierace SC instructed by Ms Kwan of the Mental Health Advocacy Service, who were in attendance at the Mental Health Review Tribunal.

Also in attendance at the Mental Health Review Tribunal were:

- Mr David Kell, Counsel for the Attorney General;
- Dr F, Forensic Psychologist and Clinical Neuropsychologist;
- Mr Daha McMullen, Solicitor CSO.

In attendance by videolink from L Hospital were:

- Dr A, Psychogeriatrician;
- Dr G; Geriatrician;
- Ms L, Nursing Unit Manager;
- Ms C, CNC for Specialist Mental Health Services for Older People

## PRESENT CIRCUMSTANCES

### Background

This is the eighth review of Mr Robert Talbingo, aged 73 years, who is currently detained in the Aged Care Rehabilitation Unit at L Hospital on an order of the Mental Health Review Tribunal.

The Notice of Intent filed by the Mental Health Advocacy Service (MHAS) on behalf of Mr Talbingo, applies for Mr Talbingo to be conditionally released to reside at the HNH at Katoomba. That facility is said

to be a secure nursing home with 24 hour nursing staff with a resident profile that includes residents with custodial histories, acquired brain injury and mental health issues.

In an affidavit sworn, and lodged with the Tribunal, Ms Kwan, solicitor with the MHAS, sets out the progress of the inquiries she has made, on behalf of Mr Talbingo, as to whether a place might be made available for him at the HNH. In summary, Ms Kwan states that she was advised in 2014 by letter from the Acting CEO of HNH of a provisional offer of a place there for Mr Talbingo, subject to the outcome of a risk assessment review of the proposed placement. The MHAS then commissioned Dr F, a forensic psychologist, to conduct a risk assessment and prepare a report in relation to Mr Talbingo, in order to meet the requirements of section 74(d) of the Act. Ms Kwan also states in her affidavit that in 2015 Mr Talbingo's Public Guardian consented to accepting a place for Mr Talbingo at HNH.

Ms Kwan further states in her affidavit, that she was informed that the corporate management of HNH had changed. Since that time neither Ms Kwan nor staff from Long Bay Hospital have been able to confirm whether or not a place is available at HNH.

Ms Kwan also makes mention in her affidavit of a number of other possible nursing home placements that could be suitable for Mr Talbingo, but no arrangements are in place in relation to any of these at this time.

It further became apparent during the course of the hearing that more specific detail of how Mr Talbingo would be managed at HNH or any other suitable aged care facility, would be required. For example, would he be accommodated in a separate room, what nursing and other staff would be available, how would his behaviours and any potential for risk be managed, what activities would be available, and similar matters.

Ms L, confirmed at the hearing of this review that, as yet, no community mental health centre, community psychiatrist or case managers have yet been identified for Mr Talbingo, should he be placed in the community. No doubt it would first be necessary to know where Mr Talbingo is to be accommodated, before such arrangements – which would be standard requirements in any order for Mr Talbingo's conditional release – can be put in place.

In view of the above matters, it became apparent at the commencement of the hearing of this review that the application for Mr Talbingo's conditional release could not proceed at this time. However, in accordance with the Tribunal's practice, the Tribunal was nevertheless prepared to consider the threshold question, whether Mr Talbingo has served 'sufficient time in custody' as required by section 74(e) of the Act. Mr Ierace SC, representing Mr Talbingo, and Mr Kell of counsel, representing the Attorney General, were in agreement that the Tribunal should proceed with the determination of that threshold question. The Tribunal notes that this is in accord with the Forensic Guidelines (Version 3, August 2015) issued by the Tribunal (available on the Tribunal's website) at page 13 which states:

***Conditional Release for Patients on a Limiting Term***

*When a patient is subject to a limiting term, the Tribunal must consider whether the patient has spent "sufficient time in custody" before granting a conditional release application: section 74(e) MHFPA. The Tribunal has published an official report of a review in which it considered the interpretation of the phrase "sufficient time in custody": Mr Adams [2013] MHRTNSW 1.*

*If there is any doubt about whether a limiting term patient has served sufficient time in custody, then the Tribunal is prepared to consider two conditional release applications for limiting term patients. The first application will consider only whether the person has served sufficient time in custody, and there may be limited information available about the proposed conditional release arrangements. The second application will consider whether there is any reason to depart from the Tribunal's earlier determination that sufficient time in custody has been served, and then to consider the appropriateness of the conditional release arrangements themselves.*

The policy behind this guideline is to recognise the practical reality that there is a great deal of groundwork that needs to be done in order to prepare a matter such as this for a conditional release application before the Tribunal. An independent expert's risk assessment must be obtained as required by section 74(d) of the Act. Arrangements need to be well advanced for the placement of a forensic patient with severe cognitive impairment, such as Mr Talbingo, in an appropriate facility, because the Tribunal cannot make a final determination of a release application without first receiving evidence, in substantial detail, about the suitability of the particular placement proposed, and the facility's capacity to manage any relevant risk. Before it can order a release (conditional or unconditional) the Tribunal must be satisfied that neither the safety of the forensic patient nor that of any member of the community would be seriously endangered by the forensic patient's release (section 43 of the Act). If a placement is offered by such a facility to a forensic patient, the Tribunal's experience is that it is invariably a 'time limited' offer. There is little point in treating teams, or those representing a forensic patient, going to the vast effort and expense required to establish these requirements, only to be told that the Tribunal is not satisfied that the forensic patient has served 'sufficient time in custody', a matter that the Tribunal must consider pursuant to section 74(e) of the Act. For these reasons the Tribunal's practice, in appropriate cases, is to make a separate determination in relation to the question whether or not the forensic patient has spent 'sufficient time in custody'.

The hearing proceeded accordingly.

Both Mr Ierace SC and Mr Kell agreed that it was appropriate for the matter to proceed in the absence of Mr Talbingo.

**Some Relevant Statutory Provisions**

Section 43 of the Act provides as follows:

***43 Criteria for release and matters to be considered by Tribunal***

*The Tribunal must not make an order for the release of a forensic patient unless it is satisfied, on the evidence available to it, that:*

*(a) the safety of the patient or any member of the public will not be seriously endangered by the patient's release, and*

*(b) other care of a less restrictive kind, that is consistent with safe and effective care, is appropriate and reasonably available to the patient or that the patient does not require care.*

Section 74 of the Act provides:

***74 Matters for consideration***

*Without limiting any other matters the Tribunal may consider, the Tribunal must have regard to the following matters when determining what order to make about a person under this Part:*

*(a) whether the person is suffering from a mental illness or other mental condition,*

*(b) whether there are reasonable grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious harm or the protection of others from serious harm,*

*(c) the continuing condition of the person, including any likely deterioration in the person's condition, and the likely effects of any such deterioration,*

*(d) in the case of a proposed release, a report by a forensic psychiatrist or other person of a class prescribed by the regulations, who is not currently involved in treating the person, as to the condition of the person and whether the safety of the person or any member of the public will be seriously endangered by the person's release,*

*(e) in the case of the proposed release of a forensic patient subject to a limiting term, whether or not the patient has spent sufficient time in custody.*

Section 75 of the Act provides:

***75 Conditions that may be imposed by Tribunal on release or leave of absence***

*(1) The Tribunal may impose conditions relating to the following matters on orders for release or granting leave of absence made by it in relation to a forensic patient under this Part:*

*(a) the appointment of a case manager, psychiatrist or other health care professional to assist in the care and treatment of the patient,*

*(b) the care, treatment and review of the patient by persons referred to in paragraph (a), including home visits to the patient,*

*(c) medication,*

*(d) accommodation and living conditions,*

*(e) enrolment and participation in educational, training, rehabilitation, recreational, therapeutic or other programs,*

*(f) the use or non-use of alcohol and other drugs,*

*(g) drug testing and other medical tests,*

*(h) agreements as to conduct,*

*(i) association or non association with victims or members of victims' families,*

*(j) prohibitions or restrictions on frequenting or visiting places,*

*(k) overseas or interstate travel.*

*(2) This section does not limit the matters in relation to which a condition may be imposed.*

In addition the Tribunal must have regard to the Objects contained in section 40 of the Act and such of the Principles of Care and Treatment referred to in section 68 of the Mental Health Act 2007 (Mental Health Act) that may also be applicable to these proceedings by reason of section 76B(1) of the Act.

**Mr Talbingo's background as a forensic patient**

Mr Talbingo's index offence of murder was found to have been committed by Mr Talbingo on the limited evidence available at a special hearing before a judge and a jury in the Supreme Court of NSW.

Mr Talbingo had been found unfit for trial in 2011 and Justice H imposed a limiting term of 15 years. The Tribunal has had regard to his Honour's remarks upon fixing the limiting term.

At [28] of those remarks, his Honour stated at [39]:

> *I accept that the killing of Mr X was not the product of any premeditation. It appears to have been something that occurred suddenly, as the culmination of ill-feeling by Mr Talbingo towards the deceased that had been brewing for some weeks. The fatal assault, however, involved extreme ferocity and brutality; the deceased received a great many blows to his head and torso with a heavy metal stake. The final blows were inflicted when he was lying face down on the ground with Mr Talbingo's foot on the small of his back. I am satisfied beyond reasonable doubt that at least when the final blows were delivered Mr Talbingo had formed an intention to kill the deceased.*

At [42] his Honour stated:

> *Victim impact statements by five members of Mr X's family were tendered by the Crown. They make abundantly clear that the sadness involved in this case centres upon the effect that this most dreadful crime has had upon them. Each of the statements eloquently describe the extreme loss and grief they have experienced. It is no overstatement to say that the lives of many people have been irreparably changed for the worse because Robert Talbingo took their loved one from them.*

At [28] his Honour noted that Mr Talbingo had no previous criminal convictions in New South Wales but he did have convictions in Western Australia. In 2007 he was fined for an offence of common assault. In the mid to late 1990's he was dealt with by way of fines for unlawful wounding, assault occasioning actual bodily harm and common assault, and received a suspended sentence of 4 months imprisonment for the breach of a violence restraining order. In 1984 there were two offences of assault occasioning actual bodily harm for which he received fines. The record contains a number of other entries for traffic and dishonesty matters which, for present purposes, are of no significance. His Honour stated that, overall, Mr Talbingo's record disentitled him to the leniency that could be extended to a person with prior good character.

The salient feature of this matter is that although Mr Talbingo was a prime suspect for the murder and had been interviewed a number of times by the police, he had not yet been charged when, in 2009, Mr Talbingo was severely injured in a car accident in which the vehicle he was driving crossed onto the wrong side of the road and collided with a large oncoming truck. As a result of this Mr Talbingo suffered catastrophic brain damage. His injuries had rendered him unfit for trial.

Justice H clearly had regard to the evidence before him in relation to the extent of Mr Talbingo's injuries. His Honour states at [29] – [32] of his remarks:

> 29 *A number of reports relating to the effects of Mr Talbingo's brain injury were tendered subsequent to the jury's verdict at the special hearing. The latest dated 2012 is authored by Dr G, a specialist in geriatric medicine. Mr Talbingo has been an inpatient in the Aged Care and Rehabilitation Unit (ACRU) of the L Hospital since 2010. He is held there as a forensic patient. He previously spent almost a year in M Hospital.*
>
> 30. *Dr G reports that the severity of Mr Talbingo's brain injury has caused significant cognitive impairment and although there has been some recovery, most of the deficits now appear to be permanent. Dr G reports that, "full recovery is not expected". Two neuropsychiatric assessments in M Hospital confirmed Mr Talbingo's cognitive deficits.*
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> 31. *Dr G's report continues:*
>
> *Currently, he requires prompting and occasional supervision with his activities of daily living. He is able to understand simple instructions but has difficulty following more complex instructions. He has limited insight into his situation and does not understand why he is being kept in the current facility. He would not have the capacity to make lifestyle decisions, medical decisions and to manage his financial affairs. A public guardian has been appointed to manage his affairs.*
>
> *Other than his cognitive deficits, he also suffers from pain in his right shoulder due to rotator cuff injury and osteoarthritis, hypercholesterolaemia, reduced vision in his right eye and mild bilateral hearing impairment.*
>
> *Since his admission to ACRU, he remains medically stable and has not exhibit [sic] any challenging behaviour. He has never been psychotic or suffers from depression. He did suffer a bout of pneumonia in 2011 and was admitted to the Prince of Wales Hospital for treatment. He remains well since discharge.*
>
> *My opinion is that physically Mr Talbingo remains well and requires minimal assistance (mainly in the form of prompting for his activities of daily living). Cognitively however, he requires a supervised and secured environment to continue to function, especially if he is to be released into the community. A facility such as a secured nursing home would be*

*appropriate for him and [a] potential facility has been identified. He has already been approved from the local Aged Care Assessment Team (ACAT) for high level care.*

32. *In an earlier report of 2011, Dr G noted that Mr Talbingo had no recollection of the motor vehicle accident or of the crime that he had committed.*

His Honour clearly took Mr Talbingo's condition into account in assessing the limiting term. His Honour stated at [40]:

> *Mr Talbingo's age and his severe intellectual impairment as a result of brain damage provide reasons for assessing a sentence that would be significantly less than otherwise would have been imposed. The authorities are clear that advanced age is a relevant factor to be taken into account on sentence, albeit within limits. They are also clear as to how the question of Mr Talbingo's intellectual impairment should be taken into account. I accept the submission by Mr Y that it is relevant in this case in two respects. The first is that it justifies no weight being given to either general or personal deterrence. The second is that time in custody will be more onerous for Mr Talbingo because of his impairment, coupled with his age, than it would be for the average inmate of a correctional centre. The Crown Prosecutor, most fairly, did not take issue with any of Mr Y's submissions on these matters.*

At [36] His Honour adopted Adamson J's summary from *R v Goodridge (No 2)* [2012] NSWSC 1180 at [24] – [28] as to the requirements for nominating a limiting term, where her Honour stated:

> *[24] A verdict that the Forensic Patient committed the offence charged (s 22(1)(c)) is a "qualified finding of guilt" made in the absence of a conviction (s 22(3)(a)). Accordingly, by reason of section 23(1)(a), the Court must indicate whether, if the special hearing had been a normal trial, it would have imposed a sentence of imprisonment.*
>
> *[25] Section 23(1)(b) of the Act defines limiting term as:*
>
> *"... the best estimate of the sentence the Court would have considered appropriate if the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for that offence and the person had been found guilty of that offence."*
>
> *[26] The effect of s 23(1)(b) of the Act is that the Court is obliged, when determining a limiting term, to adopt and apply all the statutory and common law principles of sentencing that apply to the sentencing of a person convicted of that offence: R v AN [2005] NSWCCA 239 at [13]. A limiting term is the period beyond which a person cannot be detained for the offence which was the subject of the special hearing: R v Mitchell [1999] NSWCCA 120; 108 A Crim R 85 at [30].*
>
> *[27] In R v Mailes [2004] NSWCCA 394; 62 NSWLR 181 (Mailes), Dunford J, with whom Adams and Howie JJ agreed, said, at [32] that the purpose of a limiting term:*
>
> *"... is not to punish the person who has not been convicted of any crime, but to ensure that he or she is not detained in custody longer than the maximum the person could have been detained if so convicted following a proper trial..."*

*[28] Section 54D(1)(b) of the Crimes (Sentencing Procedure) Act 1999 provides that the standard non-parole period statutory scheme does not apply to the sentencing of a Forensic Patient to detention. Accordingly the "sentence" referred to in s 23 of the Act must be a reference to the total sentence and not to the non-parole period since there is no power to fix a non-parole period less than the total term: Mailes at [29].*

**Mr Talbingo's Current Condition**

Evidence of Dr A

The Tribunal was provided with a report dated, 2015 by Dr A, a senior Visiting Medical Officer, and an Aged Care Psychiatrist and Neuropsychiatrist, who has been providing consultation to Mr Talbingo at the Aged Care Rehabilitation Unit at L Hospital since 2015.

Dr A carried out some cognitive testing on Mr Talbingo in 2015. An interpreter assisted Mr Talbingo, whose English is limited. Dr A noted that Mr Talbingo was disoriented to time. He could not state his age.

Dr A used the Roland Universal Dementia Assessment Scale (RUDAS), which is a screening test for cognitive impairment in people with a non-English speaking background. Mr Talbingo scored 14 out of a maximum of 30, indicating a moderately severe dementia. There were deficits in short term memory, judgment, praxis (the ability to plan and execute co-ordinated movement) and category fluency. He demonstrated difficulties with planning and could not place the hands of the clock correctly on the Clock Drawing test.

Dr A states in her report that, overall, Mr Talbingo demonstrated cognitive impairments in a number of domains, particularly executive function. She notes that Mr Talbingo scored 21/30 on the Mini-Mental State Examination (MMSE) conducted by Dr G on 21 January, 2011, and scored 22/30 on the RUDAS. Dr A states that Mr Talbingo's scores have declined, indicating that his deficits are related to dementia superimposed on his traumatic brain injury.

Dr A also assessed Mr Talbingo as to his fitness for trial. She states in her report that he was moderately severely cognitively impaired. He could not recall his charges, said he could not recall conducting any offences, did not indicate that he knew how to plead to the charge and did not appear to understand when asked about the court processes or the functions of the officers of the court. She states that his cognitive impairments precluded him from following any evidence that might be presented, and were of sufficient severity that he would not be able to comprehend any evidence presented, even with memory aids or with a tutor. The cognitive deficits precluded him from instructing legal representatives. Dr A considers that he is unfit to plead and unfit to stand trial and would remain so indefinitely. She assesses Mr Talbingo's brain injury and dementia as permanent, and that it is unlikely that he will become fit in the future.

Dr A diagnoses Mr Talbingo as having cognitive impairment secondary to Traumatic Brain Injury, Dementia, and Behavioural and Psychological Symptoms of Dementia (BPSD). He has a dementing process.

Dr A notes from the Justice Health files that there was evidence in the notes of some sexual dis-inhibition, manifested by incidents of indecent exposure, by Mr Talbingo. This is associated with his BPSD, and he has been prescribed Risperidone to assist in management of this behaviour, with some benefit, although he continues to inappropriately touch other inmates in a non-sexual manner. There have been no reports of violence or aggression since his last Tribunal review (16 July, 2015).

Dr A assessed Mr Talbingo's mental state. There was no evidence of depression, mania or psychosis and he does not suffer from a mental illness as defined in the MHA. His affect was reactive. There was a paucity of spontaneous speech, and little elaboration in his answers. His replies tended to be perseverative and concrete. He denied experiencing any perceptual abnormalities, and denied experiencing any persecutory or referential ideas. He denied any thoughts of harm to himself or others. He appeared unaware as to the circumstances of his detention and had no insight into his cognitive deficits or behaviours. His judgment was influenced by his cognitive deficits.

Dr A notes that Mr Talbingo is reported by staff to manage activities of daily living with prompting, and was compliant with his medications.

Dr A states in her report that a medium to long term plan for Mr Talbingo may include placement in a nursing home capable of managing the consequences of his brain injury and dementing process, and able to manage any risks that Mr Talbingo may pose to others. In the meantime she recommends his current placement in the Aged Care Unit continue.

Dr A told the Tribunal that she considers more needs to be done to clarify the situation with HNH or any other community aged care facility that may be proposed as an appropriate placement for Mr Talbingo. She notes that Mr Talbingo is a still very fit and 'quite young' elderly man. If placed in a high dependency dementia specific ward with other patients with dementia and behavioural disturbance, there could be some risks arising from potentially provocative interactions with others. She is not sure how he would manage in a shared room, for example. She was aware that when in M Hospital, Mr Talbingo had twice removed the handle from a 'big lifter' lifting machine, and this was taken from him by staff and left at the nurses' station. Dr A states in her report that "According to police, while he was at M Hospital, he was abusive to staff, and threatened another patient with a metal pole." The Hospital notes do not mention that Mr Talbingo threatened anyone with the handle of the lifter.

The Tribunal notes that there is an entry in the M Hospital notes in 2010 indicating that Mr Talbingo was loudly verbally abusive toward another patient in the patient's lounge, but was convinced by staff to leave the room.

An entry made in 2010 refers to an incident when a nurse asked Mr Talbingo whether he had loaned money to another patient, he said he could not remember if it was $110 or $120; the nurse told Mr Talbingo he was not going to get the money back and Mr Talbingo is said to have replied that he would "kill the bastard" if the other patient does not return the money.

Another entry in the hospital notes indicates that Mr Talbingo 'absconded from the gym today' at 2.45 pm but returned on his own at 4.00 pm that day. Another entry indicates that Mr Talbingo absconded from the unit again. It appears that he made his way, with some assistance, from a stranger, to the airport for a flight to Perth, but was soon extradited back to New South Wales as he was in breach of his bail conditions.

All of these above incidents occurred over five years ago and in the context of Mr Talbingo's lengthy admission to Hospital.

In her evidence to the Tribunal, Dr A said that a community aged care placement would have access to diversional therapy useful to a person with behavioural disturbance. The main deficiencies in the Aged Care Ward at L Hospital is that they don't really have enough access to these kinds of diversional activities, so their strategies for managing behavioural disturbances are limited to nursing and pharmacological interventions. The patients in the Aged Care Ward are locked in their rooms for a considerable part of the day, from the afternoon, without diversional opportunity.

According to Dr A, Mr Talbingo is generally quite placid. His touching behaviour and sexual dis-inhibition can be reduced by diversional therapy, but can also be adequately managed by redirection by staff. One of the advantages of his current placement is that the other patients are more physically frail, rather than suffering from severe dementia, so he is not as likely to be exposed to difficult interactions.

**Other Evidence from the Treating Team**

The Tribunal asked Ms L what Mr Talbingo's day-to-day level of functioning was like. She said that he was independent but required prompting at times. His attention span is quite short. He is able to bathe himself, feed himself and move around independently, but sometimes needs prompting.

Dr G, who is a geriatrician and the Clinical Director for the Unit, agreed that it would be important to find out more about the profile of the patients at HNH or any other proposed community aged care facility.

The Tribunal asked Dr G about Mr Talbingo's awareness of why he is incarcerated, and whether he was aware of his index offence. Dr G said that, early on, Mr Talbingo was able to tell staff something about what he had done, but he has since told Dr G he doesn't know why he is there. Dr G could not say whether or not Mr Talbingo thought he was being punished. Dr A agreed with Dr G on this matter.

Dr G said he thought Mr Talbingo was becoming bored and frustrated. He has been more sexually disinhibited, including dropping his pants and fondling his genitals, especially when there is a new nurse on the unit, but they haven't seen this for the past two or three months. However, there appears to be a trend over time that he is more behaviourally disturbed.

Dr A and Dr G were asked whether, since 20/10/12, when Mr Talbingo's limiting term had been set, Mr Talbingo's condition has changed or whether any behaviour has emerged that wasn't known at that time.

Dr G said Mr Talbingo's cognition has become worse as a result of his dementia. Over the past 12 -15 months there has been a dementing process.

Dr A said that Mr Talbingo's dementia seems to have progressed in line with the natural progression of dementia. She said that it is unlikely he would be able to plan anything. He's quite euthymic and happy in his current placement. His capacity to engage in a socially appropriate manner is diminishing – he's not able to gauge the emotional reaction of people when he prods them physically and doesn't understand why they avoid him. He has trouble 'putting it all together'. Dr A said that, otherwise, Mr Talbingo's physical health is stable now.

Ms L confirmed that patients on the Aged Care Unit are in their rooms from 2.30 pm until the following morning. Their evening meals are in their rooms and Mr Talbingo has his own room. They have a total of some 6 hours a day outside of their rooms to mix with other people. The total number of hours mixing with others in a community facility would be considerably greater. She stated that Mr Talbingo has a limited attention span for activities. He does like to walk. He watches the television a lot. He has access to the yard area and the day room.

Dr G stated that Mr Talbingo may have access to art or music therapy, exercise classes and outings at an aged care facility in the community. None of these are provided in the Aged Care Rehabilitation Unit.

Mr Kell questioned Dr A who confirmed that she had recently commenced Mr Talbingo on the medication 'Aricept' which is designed to help slow down cognitive decline and can help with behavioural disturbance. She would hope that any improvements would be apparent in three months from commencement. Dr A said that it would not be usual for a 73 year old to have dementia. From age 65 the prevalence of dementia is less than 5% and that percentage doubles every 5 years. She said that something less than 10% of 73 year olds would have dementia. Both Dr A and Dr G agreed that Mr Talbingo's brain injury would have greatly increased the chances of him developing dementia.

In response to a question from the Tribunal, Dr G confirmed that it was rare for a sentenced prisoner with dementia to be released before their release date, even on compassionate grounds. They would generally remain in the Aged Care Unit until their sentence was complete.

In response to a question from the Tribunal, Ms C, with the NSW Ministry of Health's Specialist Mental Health Services for Older People (SMHSOP), agreed that sentenced prisoners would be able to be re-classified under the classification system, which was not available to persons on a limiting term.

**Dr F's Evidence**

A report was provided to the Tribunal by Dr F, who is a forensic psychologist and clinical neuropsychologist. Dr F is well qualified in her field and her report and evidence fulfils the requirement, pursuant to section 74(d) of the Act that requires the Tribunal, in any application for release of a forensic patient (whether conditional or unconditional), to consider the report of an expert who is appropriately qualified, and who is not currently involved in the patient's treatment, as to the condition of the person and whether the safety of the person or any member of the public will be seriously endangered by the person's release. Dr F also provided to a previous Tribunal review a report.

In her report Dr F set out a considerable amount of material relating to Mr Talbingo's background, and his medical condition and treatment since he suffered his traumatic brain injury. She notes in that report that she administered a number of neuropsychological tests. In her opinion as stated in that report, Mr Talbingo sustained an extremely severe traumatic brain injury. He had post traumatic amnesia for approximately 108 days indicating that the brain injury was extremely severe. She stated that assessments of Mr Talbingo's cognitive capacity continue to reveal significant and widespread cognitive impairments in attention, memory, judgment, problem solving, insight and decision making. She states that his cognitive impairments are permanent and he will require accommodation in a secure high level care facility with access to 24 hour nursing staff, and would need close supervision. She expressed the opinion in that report that, if he were accommodated in HNH, with the support of Dr G, a geriatrician who knows his history, together with a visiting psychiatrist and GP's to HNH, and 24 hour staff, this would be the least restrictive care consistent with safe and effective care for Mr Talbingo, and his safety and that of any member of the public would not be seriously endangered if he were conditionally released to that placement.

Dr F's report was prepared prior to the change of management of HNH, and as noted above, it is common ground between the parties to this present application that further clarification will be required as to the ability of HNH, or any alternative community aged care facility that may be proposed, to manage Mr Talbingo.

In her report, Dr F included a segment headed 'Risk Assessment' in which she indicated that she utilised the HCR-20 Version III risk assessment tool. In relation to historical items, she notes a number of protective factors including stability of Mr Talbingo's long term relationship of 40 years of marriage until shortly before the index offence; apparently stable employment history; no information to suggest substance misuse; she notes that the quality of his peer relationships with work colleagues is an unknown; there is no history of major psychotic or mood disorder; there are no known adverse childhood experiences. Dr F notes Mr Talbingo's prior offending history in Western Australia including acts of

violence as well as the index offence, which resulted in his first time in custody. Dr F states that therefore the presence of antisocial personality traits and violent behaviour is indicated in Mr Talbingo's criminal history. However, she notes that it is well established in the literature that personality and behaviour are known factors which can change following severe traumatic brain injuries. She notes that since his injury, Mr Talbingo has lacked capacity due to that injury and more recently to his dementia. She states that Mr Talbingo's mental and physical capacity has deteriorated substantially since the index offence and therefore his risk of re-offending is low.

In relation to current clinical risk items, Dr F notes in her report that Mr Talbingo's insight is severely impaired as a result of his traumatic brain injury. He is unable to explain the reasons for his being detained in L Hospital or why he requires supervision. He has not been diagnosed with any mental disorder. He has not displayed any violent ideation, intent to commit violence or negative attitudes towards staff or other patients. Dr F notes that Mr Talbingo has displayed inappropriate sexual behaviour towards staff and other patients however these behaviours have been managed without incident. She notes that such behaviour can be symptomatic of both traumatic brain injury and dementia, and that Mr Talbingo has been diagnosed with extremely severe traumatic brain injury and dementia which results in him requiring 24 hour supervision in a secure facility.

In relation to risk management items, Dr F notes that Mr Talbingo has been cooperative with his treatment regime and routine. He requires prompting for personal hygiene such as showering. He has no family or personal support as he is estranged now from his family.

Dr F also notes that Mr Talbingo breached his bail when he absconded from Hospital to travel to Perth after asking a person to assist him to make a phone call to a family member and to purchase a plane ticket to Perth, and that he caught a train to the airport and boarded the flight. He was subsequently extradited from Perth to Sydney. Dr F states that she concurs with the opinion of Dr G that it is highly unlikely that Mr Talbingo would be able to achieve even a small part of this journey with his present presentation. She notes that absconding attempts and wandering are not unusual events in patients who have sustained a traumatic brain injury or have dementia and that strategies can be put in place to manage such behaviours.

Dr F does not consider that Mr Talbingo has attempted to exaggerate his cognitive capacity or to be selective in his responses to her questions.

In relation to Mr Talbingo's sexually disinhibited behaviour, Dr F notes that this has occurred since late 2014, and that nursing staff have observed Mr Talbingo expose himself to both male and female staff and on occasion he had attempted to masturbate on the ward. She notes that the Nursing Unit Manager, Ms L, has indicated that this behaviour is often directed at seeking attention and can occur with boredom. She notes that staff can predict and re-direct this behaviour. The introduction of Risperidone medication has reduced these incidents by about 30%. Dr F also notes that there have been some occasions where

Mr Talbingo has poked or prodded other patients, but he has been able to be re-directed and there have been no incidents involving aggression arising from this.

Under the heading 'Diagnosis', Dr F states:

> *Mr Talbingo has dementia and cognitive impairment as a result of a traumatic brain injury. There will be no improvement in his cognitive capacity. There is a risk with any dementia or brain injured patient of the presence of challenging behaviour including agitation, aggression, frustration and sexually inappropriate behaviour.*

**Dr F's oral evidence at this review**

Dr F was asked by the Tribunal panel about Mr Talbingo's awareness, of why he is where he is, and whether or not he was capable of understanding his situation.

Dr F said that she has seen Mr Talbingo twice over a ten month period. She agreed that there has been ongoing deterioration in his cognitive functioning that was clear on the RUDAS scale, which indicates he has a diminished level of insight. When this is added to an extremely severe traumatic brain injury (ESTBI) such as he sustained, she would be surprised if he had sufficient level of insight on these matters even before she met him. She stated that he falls within the category of ESTBI based on the length of the period of ongoing post-traumatic dementia that he has experienced. Dr F said that the behaviours of such persons can change dramatically. Over a period of time, Mr Talbingo had a period of some recovery from his brain injury, but in the meantime, the dementia process has now been superimposed on his functioning. Dr F stated that she would not expect Mr Talbingo now to have the necessary degree of insight to understand the ramifications of, or the meaning of, his index offence. She thinks it more than likely that he doesn't have the necessary degree of insight to understand that he is serving time for something that he has done in the past, or that he should be demonstrating remorse. She does not think he has the level of awareness to understand why he is incarcerated. On the occasions that she has seen him, he wasn't able to articulate what his crime had involved.

Dr F stated that when dementia happens on top of a brain injury, the person starts to lose components of their past memory. This would explain why, at an earlier stage, Mr Talbingo had given some account of the offence, but is not able to do so now.

When asked by the Tribunal panel whether Mr Talbingo was capable of deriving any benefit from being punished, feeling remorse, and expiating his guilt, Dr F stated that Mr Talbingo is past being capable of having an appreciation of these matters.

Dr F was asked about the appropriate placement for Mr Talbingo. She agreed with the treating team's view that it is difficult to know what will be best for him at the moment (in view of the uncertainty of whether an appropriate placement will become available). She noted that Mr Talbingo has a good treating team at present that is familiar with him. She agreed there were limited diversionary therapies available to

him in his current placement. She said that it may be that Mr Talbingo's medications will manage his disinhibited behaviour but this remains to be seen. She expressed the view that if there was a suitable facility in the community with diversional therapy programs and techniques available, that could be a very positive factor in managing challenging behaviours and potential escalations of such behaviours. Dr F said that it may be that Mr Talbingo would become more apathetic over time and not engage in such programs, but that remains to be seen. She said that HNH has experience in managing people with brain injury and dementia and such a facility could be a good one for Mr Talbingo. She agreed that being placed on a ward with persons with severe dementia may be problematic, and it would be important to know the mix of patients in the facility, and she shared Dr A's concerns about this. Dr F stated that there is a 'settling in' period that would require an individual room for Mr Talbingo and this period would need to be closely monitored. The staff would need to be fully appraised of Mr Talbingo's circumstances and would need to assess him.

In relation to whether such a placement would give rise to any serious endangerment to Mr Talbingo or to any member of the public, Dr F stated that she would reserve her opinion, pending further clarification about the arrangements that would be in place at any proposed aged care placement. She said that, in relation to Mr Talbingo, we are "dealing with a very different brain than that which was involved in the index offence."

Dr F agreed that there are aspects of personality traits that can be exaggerated after a traumatic brain injury. She does not consider that there has been an exacerbation of such traits. In relation to Mr Talbingo's observed sexual dis-inhibition, and his 'prodding' of others that might lead to interpersonal aggression, it was Dr F's view that this kind of behaviour can coincide with the dementing process and damage to the frontal area of the brain. These behaviours were not exhibited by Mr Talbingo during the many months that he was in M Hospital, and she believes they are related to his dementia.

The Tribunal panel's psychiatrist asked Dr F a number of questions about her risk assessment of Mr Talbingo which she carried out using the HCR 20 Version III risk assessment tool. She agreed that one of the difficulties that she had in her assessment was in obtaining a history from Mr Talbingo. She also noted that not a lot is known about his past history. She agreed that the 'historical items' component of the HCR – 20 was difficult to assess on present information.

There was some discussion at the hearing that the Crown submission, made to the Supreme Court in the proceedings in which Justice H nominated Mr Talbingo's limiting term, suggested that Mr Talbingo's wife had indicated that Mr Talbingo had a significant gambling problem and resultant relationship difficulties. Dr F agreed that there is presently no detailed information available about his employment history, substance use history, quality of relationship history, or childhood experiences. She noted that she did point out in her report that he had some antisocial traits.

Dr F was asked about the period of days (referred to above) when Mr Talbingo appeared to display some aggressive behaviour whilst at Hospital. Dr F stated that she did not have all the details about this at the time she prepared her report. She stated that Mr Talbingo's history of tendency to violence is a concern, but noted that this was some time ago and now, with dementia, he is deteriorating. She stated that if Mr Talbingo didn't have dementia, she would be very concerned. However, she noted that there have been no further incidents of aggression since he has been at L Hospital. Dr F noted that Mr Talbingo has three previous occasions of assault in his criminal record. She agreed that the strongest predictor of future violence is past violence, but observed "we don't know how much that has been impacted upon by the considerable changes in his mental processes since his injury." Dr F agreed that the issue is highly unpredictable and she agreed that, with the dementing process, you can get violence coming through, and she agreed that Mr Talbingo's sexual inhibition had arisen from this process. Dr F also agreed that the impairment of Mr Talbingo's insight itself is a significant risk factor.

Dr F said it has been a difficult assessment to do in the circumstances and she has been reserving her judgment about the risk that Mr Talbingo presents. She said that she sees Mr Talbingo's presentation now as being consistent with other individuals she has seen in a hospital setting with potentially explosive and difficult behaviours, and she noted that there are facilities that can manage these behaviours, but it is a matter of finding one. Dr F stated that she bases her opinion on how Mr Talbingo has been over the past five years. She remains optimistic that such a placement could be found, but at this stage there is not a sufficient level of confidence about whether HNH can provide adequate and appropriate supervision and risk management.

The Tribunal panel asked Dr F whether the fact that Mr Talbingo is blind in one eye and has bilateral deafness may have contaminated any results of any of her tests that relied on pencil & paper tasks and tasks involving verbal instructions. Dr F said she was aware of Mr Talbingo's impairments and that these could have impaired his ability with some tasks (such as, possibly, the clock drawing test). However he had the same problem when earlier testing was done and there has been a decline in his performance between tests. She also acknowledged that there was possibly a language issue in determining the results, although his English at times could be clear. She acknowledged that assessing the 'impoverished verbal functioning' test through an interpreter can give rise to difficulties, but overall in the questioning she found him to have impoverished concrete thinking.

Mr Ierace SC asked Dr F whether, if Mr Talbingo were released to a community placement, it would be possible to fashion a condition such that any change in Mr Talbingo's behaviour, that might be an early warning sign of change, could result in him being returned to a more secure environment. Dr F responded that it would be important for there to be a behavioural management plan in place with awareness of escalating behaviours (for example, if his touching behaviour went past 'prodding').

Dr F stated that it would be essential that Mr Talbingo have a room to himself, and she stated that the first three months in a suitable nursing home placement would be a 'testing period' as to whether or not the

placement would be successful. She stated that there would need to be a review within the facility. She said that it is still unclear how his illness would progress.

**Legal argument**

Both Mr Ierace SC and Mr Kell acknowledged that it was common ground that Mr Talbingo's risk ultimately cannot be adequately assessed until the position regarding HNH (or some other suitable facility) becomes clear. This clearly is also the present view of Mr Talbingo's treating team and of Dr F. Therefore, the primary matter that remained for legal argument and determination by the Tribunal, is whether or not Mr Talbingo has spent 'sufficient time in custody'. As noted above, this is a matter that the Tribunal must consider when making an order for release (conditional or unconditional) of a forensic patient.

Both Mr Ierace SC and Mr Kell provided helpful written submissions and supplementary submissions.

Mr Ierace SC submitted that the Tribunal should not equate a limiting term with punishment. He points to the legislative history whereby the power to release forensic patients was formerly vested in the Executive, and the Attorney General previously had a discretion to, in effect, veto the release of a forensic patient by objecting to such release on the ground that *'the person has served insufficient time in custody or under detention'* – see s 117(6)(a) of the now repealed *Mental Health Act, 1983.*

Mr Ierace SC submits that the meaning of the words in that section were deliberately 'unexplained' because they were intended to vest a broad discretion in the Executive. Mr Ierace SC notes that this discretion applied not only to forensic patients serving a limiting term, but also to forensic patients who had been found not guilty on the grounds of mental illness. However, Mr Ierace SC notes, when the release power was devolved from the Executive to the Tribunal as a consequence of the *Mental Health Legislation Amendment (Forensic Provisions) Act, 2008*, the 'sufficient time in custody' consideration was retained, in the present form of words contained in section 74(e) of the current *Mental Health (Forensic Provisions) Act, 1990* (but only in relation to forensic patients serving a limiting term).

Mr Ierace SC submits that, in the absence of any clear expression by Parliament and in the absence of elaboration in the case law as to the meaning of those words, section 74(e) as it now stands remains a broad discretion, albeit to be exercised by the Tribunal, rather than the Executive, with no further qualification than the ordinary meaning of the words themselves as understood in light of the relevant parts of the Act, most particularly the objects of the Act (section 40) the criteria for release (section 43) and matters to be taken into account (section 74, most particularly section 74(d)). Mr Ierace SC submits that the thrust of the Act's objectives, under which this aspect of the Tribunal's functions are carried out, is the safety of the public and the proper care, treatment and control of the forensic patient, and he notes that no reference is made to punishment.

Mr Ierace SC takes issue with the submission put on behalf of the Attorney General that the Tribunal might at least have regard to what the non-parole period would have been, had Mr Talbingo been sentenced after a normal trial, as a 'signpost' to assist the Tribunal in its consideration of whether Mr Talbingo has spent sufficient time in custody. Mr Ierace SC submits that there is no legislative basis for such an approach. Indeed, he submits that there are provisions in the current Act that are quite inconsistent with such an approach, for example, section 23(6). He also submits that such an interpretation is at odds with the reasoning of the Court of Criminal Appeal in *R v Mitchell* [1999] NSWCCA 120. Mr Ierace SC submits that, in any event, the Tribunal is inappropriately qualified to perform the function of determining what the non-parole period would have been, with all of the notorious complexities of sentencing law.

Mr Ierace SC submitted that it is without precedent that a body other than a court could make a determination that results in a person being detained in custody due to the notion of punishment. He submitted that the competing argument on behalf of the Attorney is that the Tribunal (a quasi-judicial body) might require Mr Talbingo to be kept in prison for purposes of punishment, without sworn evidence & without the benefit of the material available to the sentencing court. Mr Ierace SC submits that this suggests that Tribunal should interpret a limiting term as not containing any element of punishment.

Mr Ierace SC refers to the Tribunal's decision in *Mr Adams* at p 22 where the Tribunal stated:

> *Having considered the legislation and its history and the relevant case law, and having considered the very helpful submissions by Mr Ierace SC and Mr Kell, the Tribunal is persuaded that the imposition of a limiting term does carry with it an element of 'punishment' in the broader sense of that word, and this in turn supports the view that the purposes of a limiting term should be equated, to some degree, with the purposes of sentencing. That it is a 'punishment' in the broad sense is strongly supported by the reasoning of Spigelman CJ (with Bell and Price JJ concurring) in Newman v R (2007) referred to above; the approach taken by the Court in Newman's case is consistent with the approach taken by Handley JA (with whom Sheller JA agreed) in DPP v Mills. This view also derives support from the passages referred to above from Subramanian and from the language of the Act, especially section 10(4) and section 23.*
>
> *It is difficult to see any other work that section 74(e) has to do, apart from giving expression to the need for sufficient 'punishment' (using that word in its broad sense) which the Tribunal considers is properly equated to the purposes of sentencing in section 3A of the Crimes (Sentencing Procedure) Act 1999 referred to above. If a person is otherwise not posing any serious danger to himself or herself or to others, continued incarceration can serve no other purpose.*

Mr Ierace SC also referred to the following passage from page 27 of that decision:

> *It is clear that section 23(1)(b) of the Act requires the court, when nominating a limiting term, to make the term "the best estimate of the sentence the court would have considered appropriate if the special hearing had been a normal trial of criminal proceedings against a person who was fit to*

*be tried for that offence and the person had been found guilty of that offence." It is clear that, in performing that task, a court setting a limiting term would need to have regard to section 3A of the Crimes (Sentencing Procedure) Act 1999. It seems entirely appropriate that the Tribunal should also have regard to that section when considering whether or not sufficient time has been spent in custody. Of course, by the time the Tribunal is having regard to that question under section 74(e), it will be vital to have regard to the patient's history as a forensic patient whilst serving the limiting term. By also having regard to the length of the limiting term, the remarks of the court when setting the limiting term, as well as, in the case of a conditional release, any conditions that the Tribunal may consider it appropriate to impose, the Tribunal will be appropriately guided on the issue of whether sufficient time has been spent in custody.*

In relation to the purposes of sentencing in section 3A of the *Crimes (Sentencing Procedure) Act, 1999,* Mr Ierace SC reminded the Tribunal of the relevant case law regarding the sentencing of persons with a mental or cognitive impairment, including the helpful summary of principles referred to in the judgment of McClellan CJ at CL in *DPP (Cth) v De La Rosa* [2010] NSWCCA 19. Mr Ierace SC also referred the Tribunal to the decision of Mathews J in the case of *R v Malcolm Anthony Boyle* (unreported) 18/9/92.

In *Boyle's Case*, her Honour imposed a limiting term upon Mr Boyle who had become unfit for trial after he suffered severe brain damage subsequent to committing the offences he was charged with (which included sexual assaults upon a minor) as a result of attempting suicide by carbon monoxide poisoning. Her Honour noted the difficulty and a level of artificiality involved in nominating a term in such circumstances, when the offender has effectively become a 'different person' as a result of his severe brain damage. The case was particularly notable in that, although she nominated a limiting term of four years, her Honour declined to make any order in relation to Mr Boyle's custody pursuant to section 24(1)(b) of the *Mental Health (Forensic Provisions) Act, 1990*. It is clear that her Honour considered that the making of an order under section 24(1)(b) was discretionary, and that she did not think that any useful purpose would be served by a period of imprisonment, given that, inter alia, Mr Boyle was grossly disabled in memory and cognitive function and was entirely dependent on his wife (see p 7 of her Honour's judgment). The Tribunal notes that *Boyle* was decided prior to the Court of Criminal Appeal's decision in *DPP v Khoury* [2014] NSWCA 15, which has clarified the nature of the trial Court's functions upon nominating a limiting term, and the constraints upon a court when exercising its powers pursuant to section 27 of the Act.

Mr Ierace SC submitted that, in view of Mr Talbingo's inability to appreciate why he is being detained, specific deterrence has no relevance. He submits further that general deterrence has little or no relevance (although noting that Mr Talbingo's mental condition was not causally connected to his offence). Mr Ierace SC also submitted that the community is placed in little danger by Mr Talbingo in view of the risk assessment evidence before the Tribunal. He also made the following submission (at [38] of his submissions) in relation to the purposes of sentencing referred to in section 3A (d) – (g) of the *Crimes (Sentencing Procedure) Act 1999:*

*It seems that his rehabilitation (section 3A(d)) has peaked, in the sense that he is in a declining state of physical and mental health. For reasons similar to those applicable to section 3A(a), holding him 'accountable' (section 3A(e)) is pointless when he has no or little awareness of why he is being detained against his will. The factors stated at sections 3A(f) and (g) are akin to the common law sentencing purpose of retribution but, as Mathews J noted in Boyle, it also has little relevance.*

Mr Ierace SC submitted that having regard to section 3A suggests that an "absolutely minimal time is 'sufficient time'" in the circumstances of Mr Talbingo's case. He submitted that five years of incarceration is a long time for someone with Mr Talbingo's impairments. He noted that the limiting term set by Justice H was three quarters of the standard non-parole period for murder at that time, and thus the period had been significantly reduced.

In relation to Mr Talbingo's history as a forensic patient, Mr Ierace SC submits that he has not presented himself as a danger to himself or others, and that his sexually inappropriate behaviour, which has only emerged in recent times, is not of a degree of seriousness that would constitute dangerousness, and it can be appropriately managed.

Mr Ierace SC notes in his submission that Justice H, in nominating the limiting term, broadly accepted that the objective seriousness of the offence was approaching, but still less than, the middle range. Whilst there was an intention to kill, there was no premeditation.

Mr Ierace SC notes that the Tribunal can impose appropriate conditions of release. He further submits that the experience of Mr Talbingo's detention in a suitable aged care facility is unlikely to be different, in essence, from his current detention. In both cases he will be in a secure care setting.

Mr Kell emphasised in his written submissions that the 'sufficient time in custody' consideration in section 74(e) of the Act is clearly intended by Parliament to have particular work to do beyond the matters to which regard may be had in section 43(a) and (b) of the Act, as well as the matters referred to in section 74(a) – (d). Thus, he submits, the concept of 'sufficient time in custody' cannot be equated with whether a forensic patient poses a danger to the community.

Mr Kell submits that, in determining whether or not a person has spent 'sufficient time in custody', regard may properly be had to the purposes of sentencing and to ordinary sentencing principles, including the objective seriousness of the index event and whether the time spent in custody to date would sufficiently recognise the harm done to the victim of the crime and the community and would sufficiently denounce the relevant conduct engaged in by the forensic patient.

Mr Kell submits that section 74(e) does not involve the Tribunal (not being a court) in imposing or determining any mandatory period of detention. Rather, he submits, as one of the factors to be

considered when determining release of a forensic patient, the Tribunal is to have regard to whether the person has spent 'sufficient time in custody', a task the Tribunal is well equipped to undertake.

Mr Kell notes in his submissions the gravity of the objective seriousness of the index event. Nevertheless, he notes, Justice H had appropriate regard to the subjective features including Mr Talbingo's age and severe intellectual impairment as a result of his brain damage. His Honour gave no weight to any need for personal or general deterrence when setting the limiting term, and noted that custody would be more onerous for Mr Talbingo than a normal prisoner. Mr Kell submits that there has been little change in Mr Talbingo's condition since the limiting term was imposed.

Mr Kell submits that the Tribunal will find guidance in its previous decision in *Mr Adams*, in which the Tribunal accepted that a limiting term does carry with it an element of 'punishment' in the broader sense and that the purposes of a limiting term should be equated, to some degree, with the purposes of sentencing.

Mr Kell formally advanced the submission on behalf of the Attorney General that guidance on the question of 'sufficient time in custody' may be provided by the statutory ratio provided by section 44 of the *Crimes (Sentencing Procedure) Act, 1999,* although he quite properly, and correctly, acknowledged that the Tribunal would adhere to its rejection of the same submission in *Mr Adams*.

Mr Kell submitted that Mr Talbingo's history as a forensic patient is not such as to impact significantly on the question of sufficient time in custody. He notes that, consistent with his intellectual impairment, Mr Talbingo has not demonstrated any degree of remorse or contrition, nor gained any insight into his offending behaviour. He submits that the documentary material before the Tribunal indicates that, to a significant extent, Mr Talbingo has not progressed in any meaningful sense during his period in custody. His progress has essentially been static.

Mr Kell acknowledges that Mr Talbingo now reportedly has dementia, but submits this is not unexpected for someone of his age and in his circumstances.

In relation to Mr Talbingo's attempts to abscond, Mr Kell, very fairly, accepts that it appears that these were a reflection of Mr Talbingo's limited ability to comprehend his circumstances and an intention to return to his family rather than being wilful instances of non-compliance.

Mr Kell submits that the Tribunal would be justified in concluding that Mr Talbingo has not spent sufficient time in custody.

Mr Kell submitted that section 3A (e) - (g) of the *Crimes (Sentencing Procedure) Act, 1999* relating to accountability, denunciation and recognising the harm done to the victim and the community, still have 'resonance' in Mr Talbingo's case, unrelated to his awareness or capacity.

**CONSIDERATION**

It is clear that, although Justice H has adopted the view (at [36]) that a limiting term is not a punishment, nevertheless his Honour accepted that the calculation of the limiting term required him to *apply all the statutory and common law principles of sentencing that apply to the sentencing of a person convicted of that offence*, and that *the "sentence" referred to in section 23 of the Act must be a reference to the total sentence and not to the non-parole period since there is no power to fix a non-parole period less than the total term.*

Whether a limiting term in fact is a form of punishment is a matter that is not entirely free from controversy and about which there are conflicting views in the judgments of the courts, including appellate courts. The Tribunal considered this matter and the relevant authorities, including appellate authorities, in some detail in *Mr Adams* [2013] NSWMHRT 1, and, in the context of that case (in which both Mr Ierace SC and Mr Kell also appeared as counsel), concluded that a limiting term does contain an element of punishment, (see the paragraph at page 22 of Mr Adams previously quoted above).

Having considered the legal submissions put on behalf of Mr Talbingo and on behalf of the Attorney General in the present proceedings the Tribunal considers that it is appropriate in the present matter to follow the approach it took in *Mr Adams*. Further, the Tribunal makes the observation that the determination by the Tribunal of the 'sufficient time in custody' issue in the present matter is quite a different exercise to that with which Justice H was concerned, namely, the fixing of the limiting term. In this regard, his Honour's view as to whether or not the purpose of a limiting term includes punishment is not germane to the task that the Tribunal is required to undertake.

In its decision in *Mr Adams* the Tribunal stated (at page 26-7):

> *The Tribunal has come to the view that it would be appropriate to have regard to the following when assessing whether sufficient time has been spent in custody:-*
>
> > *1. The length of the limiting term set by the court.*
> > *2. The sentencing remarks made by the court when setting the limiting term.*
> > *3. The patient's history as a forensic patient whilst serving the limiting term to date, including any progress or lack thereof made in matters such as insight into their offending behaviour at the time of the index offence, the degree of the patient's remorse and contrition, their current physical and mental condition and such other relevant matters that may arise from a consideration of that history, so that an assessment can be made whether or not it remains appropriate to continue to detain the patient for the purposes of sentencing referred to in Section 3A of the Crimes (Sentencing Procedure) Act 1999 (set out above).*
>
> *It is clear that section 23(1)(b) of the Act requires the court, when nominating a limiting term, to make the term "the best estimate of the sentence the court would have considered appropriate if*

*the special hearing had been a normal trial of criminal proceedings against a person who was fit to be tried for that offence and the person had been found guilty of that offence. "It is clear that, in performing that task, a court setting a limiting term would need to have regard to section 3A of the Crimes (Sentencing Procedure) Act 1999. It seems entirely appropriate that the Tribunal should also have regard to that section when considering whether or not sufficient time has been spent in custody. Of course, by the time the Tribunal is having regard to that question under section 74(e), it will be vital to have regard to the patient's history as a forensic patient whilst serving the limiting term. By also having regard to the length of the limiting term, the remarks of the court when setting the limiting term, as well as, in the case of a conditional release, any conditions that the Tribunal may consider it appropriate to impose, the Tribunal will be appropriately guided on the issue of whether sufficient time has been spent in custody.*

Section 3A of the Crimes (Sentencing Procedure) Act 1999 provides as follows:

***3A Purposes of sentencing***

*The purposes for which a court may impose a sentence on an offender are as follows:*

*(a) to ensure that the offender is adequately punished for the offence,*

*(b) to prevent crime by deterring the offender and other persons from committing similar offences,*

*(c) to protect the community from the offender,*

*(d) to promote the rehabilitation of the offender,*

*(e) to make the offender accountable for his or her actions,*

*(f) to denounce the conduct of the offender,*

*(g) to recognise the harm done to the victim of the crime and the community*

The purposes of sentencing referred to in section 3A will be considered in turn. In doing so the Tribunal notes the following statement by Mason CJ, Brennan, Dawson and Toohey JJ in *Veen v R (No 2)* (1988) 164 CLR 456:

*The purposes of criminal punishment are various: protection of society, deterrence of the offender and of others who might be tempted to offend, retribution and reform. The purposes overlap and none of them can be considered in isolation from the others when determining what is an appropriate sentence in a particular case. They are guideposts to the appropriate sentence but sometimes point in different directions.*

In relation to 3A(a), the Tribunal has regard to the evidence before the Tribunal at this review, and is satisfied that Mr Talbingo is, by reason of both his extremely severe traumatic brain injury and now overlaying dementia, severely limited in his capacity to understand the reason for or the circumstances of his present incarceration. When asked by the Tribunal panel whether Mr Talbingo was capable of deriving any benefit from being punished, feeling remorse, and expiating his guilt, Dr F stated that Mr Talbingo is past being capable of having an appreciation of these matters. The Tribunal finds this to be the case.

In relation to 3A(b), his Honour Justice H acknowledged in his remarks on fixing the limiting term at [40] that, due to Mr Talbingo's intellectual impairment, he should give no weight to either general or specific deterrence. The Tribunal respectfully agrees.

In relation to 3A(c), his Honour did not articulate, in his remarks on fixing the limiting term, any particularly heightened need to protect the community from Mr Talbingo. There is nothing in the remarks that indicates that his Honour regarded Mr Talbingo as posing a significant risk of future offending or dangerousness. Nevertheless, any risk that Mr Talbingo may pose is an important matter for the Tribunal to consider, pursuant to section 43 of the *Mental Health (Forensic Provisions) Act 1990* and the Tribunal cannot order his release unless, inter alia, it is satisfied that neither the safety of Mr Talbingo, nor the safety of any member of the public would not be seriously endangered. This is further discussed later in these reasons.

In relation to 3A(d), there are compelling reasons, given the continuing progression of Mr Talbingo's dementia arising from his traumatic brain injury and his resultant lack of capacity to appreciate the reasons why he is incarcerated, for the Tribunal to consider that 'rehabilitation' (in the sense of Mr Talbingo regaining his place in society by reforming his character and gaining any meaningful appreciation of the criminality of his conduct) is not a realistic expectation.

In relation to 3A(e), the evidence before the Tribunal leads the Tribunal to the conclusion that Mr Talbingo is never likely to regain the capacity to understand what happened in his index offence or why he is incarcerated. The notion of 'accountability' therefore has no meaningful relevance in so far as Mr Talbingo is subjectively concerned.

Both 3A(f) and (g) remain pertinent factors to consider. In relation to (f), Justice H (at [38]) was inclined to regard Mr Talbingo's index offence as approaching, but still less than the middle of the range for murder. He was satisfied beyond reasonable doubt that Mr Talbingo had formed an intention to kill the deceased. He found that the fatal assault involved extreme ferocity and brutality (at [39]). In relation to (g), his Honour at [42] had regard to the impact of the offence, noting that "the lives of many people have been irreparably changed for the worse because [Mr Talbingo] took their loved one from them". As for the deceased victim, his Honour (at [10]) was satisfied beyond reasonable doubt that Mr X's death was occasioned by a savage, brutal and sustained beating by Mr Talbingo with the use of a heavy metal stake. The Tribunal notes that Mr Talbingo has now served five years and four months of his limiting term of fifteen years. The only circumstance that has changed notably for Mr Talbingo since the limiting term was fixed by Justice H is the onset of Mr Talbingo's dementia. However, this is a significant matter. Dr A's evidence is that Mr Talbingo's scores have declined when his 2015 cognitive testing is compared with testing done in 2011, indicating that his deficits are related to dementia superimposed on his traumatic brain injury. As noted above, Dr A diagnoses Mr Talbingo as having cognitive impairment secondary to Traumatic Brain Injury, Dementia, and Behavioural and Psychological Symptoms of Dementia (BPSD). His more recent onset of sexual dis-inhibition is associated with his BPSD, and he has been prescribed

Risperidone to assist in management of this behaviour, with some benefit, although he continues to inappropriately touch other inmates in a non-sexual manner. As noted above, Dr A said that Mr Talbingo's dementia seems to have progressed in line with the natural progression of dementia. She said that it is unlikely he would be able to plan anything. Although he is quite euthymic and happy in his current placement, his capacity to engage in a socially appropriate manner is diminishing – he's not able to gage the emotional reaction of people when he prods them physically and doesn't understand why they avoid him. He has trouble 'putting it all together'.

As noted above, Dr F noted in her report that Mr Talbingo has displayed inappropriate sexual behaviour towards staff and other patients. However, these have been managed without incident. She notes that such behaviour can be symptomatic of both traumatic brain injury and dementia, and that Mr Talbingo has been diagnosed with extremely severe traumatic brain injury and dementia which results in him requiring 24 hour supervision in a secure facility. In her evidence before the Tribunal, Dr F agreed that there has been ongoing deterioration in Mr Talbingo's cognitive functioning that was clear on the RUDAS scale, which indicates he has a diminished level of insight. She stated that Mr Talbingo falls within the category of ESTBI based on the length of the period of ongoing post-traumatic dementia that he has experienced. Dr F said that the behaviours of such persons can change dramatically. Over a period of time, Mr Talbingo had a period of some recovery from his brain injury, but in the meantime, the dementia process has now been superimposed on his functioning.

Although his Honour Justice H took into consideration Mr Talbingo's age and cognitive impairment, and the additional hardship that Mr Talbingo would thereby experience in prison, his Honour of course makes no mention of dementia in his remarks when fixing the limiting term because it had not yet occurred. The onset of Mr Talbingo's dementia, and its extent, has only become apparent to clinicians subsequent to the fixing of the limiting term by Justice H.

It appears from the history of Mr Talbingo's previous Tribunal reviews as summarised in Annexure 'A' that Mr Talbingo's dementia was first brought to the Tribunal's attention at the review held in 2015, and the Tribunal notes that in her report Dr F (at page 6) refers to an entry in the Justice Health records made that recorded "last two weeks observed by nursing staff to be more sexually disinhibited, making suggestive gestures, attempted to masturbate in public". She also refers to a further entry made stating "Recent cognitive decline may suggest onset of dementing illness." In her report Dr F states (at page 9):

> *However, there is notable changes in his behaviour in the form of sexually inappropriate behaviour. It is likely that these behavioural changes represent a dementing process, possibly fronto-temporal dementia, secondary to traumatic brain injury. Severe brain trauma has been found to be associated with a threefold increase in the risk for fronto-temporal dementia. It is also noted that he has ischemic disease which is also a possibly contributing factor.*

Dr A's evidence was that it is not usual for a 73 year old to have dementia. She said that something less than 10% of 73 year olds would have dementia. Both Dr A and Dr G agreed that Mr Talbingo's brain injury would have greatly increased the chances of him developing dementia.

Mr Talbingo's development of dementia is a significant change in his circumstances since the limiting term was fixed.

In considering whether Mr Talbingo has served 'sufficient time in custody', the Tribunal, as indicated above, accepts that there is an element of punishment in the limiting term, and that it should adopt the same approach as it did in *Mr Adams.* The Tribunal also accepts Mr Ierace SC's submission that the *Mental Health (Forensic Provisions) Act, 1990* does not provide any definitional guidance as to what constitutes 'sufficient time in custody'. The Tribunal agrees with his submission that it must be taken that the Tribunal has a broad discretion, when determining the sufficiency of time in custody, to have regard to a variety of factors relating to the particular circumstances of the forensic patient in question, that may vary from case to case and may have a relevance to the question of 'sufficient time in custody'. The Tribunal does not consider the category of relevant matters to be closed, and it would be impossible to delineate exhaustively what such considerations might be, so varied will be the circumstances that might arise. Nevertheless, the Tribunal's discretion is not unrestrained, and it is the punitive element in a limiting term that restrains that discretion to a degree by necessitating that the Tribunal also have regard to the factors identified by the Tribunal in *Mr Adams.*

After giving consideration to these factors, the Tribunal is of the view that Mr Talbingo's extremely severe traumatic brain injury, his resultant cognitive impairment, combined with his current progressing dementia, have rendered him incapable of appreciating why he is incarcerated. Considerations of punishment, denunciation and accountability for his offence do not have any meaningful resonance with him so far as he is subjectively aware. However, the Tribunal agrees with Mr Kell's submission that those considerations have some resonance, at least from the objective viewpoint of the community, and so does the recognition of the harm done to the victim of the crime and the community.

Neither Mr Kell nor Mr Ierace SC submitted that specific or general deterrence were significant factors in Mr Talbingo's case, and the Tribunal notes that Justice H did not consider these to be relevant factors when fixing the limiting term.

To speak of the rehabilitation of Mr Talbingo is to confront the same artificiality identified by Matthew J in *Boyles' Case*. Given that Mr Talbingo lacks any meaningful appreciation of what he has done or why he is incarcerated, rehabilitation is not a meaningful consideration in the circumstances of this case. In relation to Mr Talbingo's continued detention in the Aged Care Unit at L Hospital, the evidence before the Tribunal has identified real limitations to the availability in that place of diversional programs and therapies that would be more available to Mr Talbingo in an appropriate nursing home placement in the community. Whilst it remains unclear to what extent Mr Talbingo would avail himself of such programs and therapies,

the Tribunal considers that the absence of such arrangements is a significant additional hardship for Mr Talbingo in view of his progressing dementia (overlaying his extremely severe traumatic brain injury), that could not have been foreseen by Justice H when he set the limiting term. Such programs and therapies ought to be available to Mr Talbingo, particularly in view of the severe limitations that he has. Further, the Tribunal accepts the evidence of Dr F that diversionary therapies and programs can be a very positive factor in managing challenging behaviours and potential escalation of such behaviours.

The Tribunal accepts Mr Ierace SC's submission that the need to protect the community from Mr Talbingo is a factor that is relevantly covered by the provisions of section 43 of the Act, which has been set out above, and which forbids the Tribunal from making any order for his release unless the Tribunal is satisfied that his safety, or the safety of any member of the public, will not be seriously endangered by his release. As noted above, the Tribunal cannot be satisfied on the evidence presently before it, that this requirement has been met. The current situation regarding HNH is unclear and much more work needs to be done to find a suitable Aged Care Facility for Mr Talbingo, and the safety and nature of any such facility, including its organisation and staffing, its programs and risk management protocols would need to be closely examined by the Tribunal before the Tribunal could give adequate consideration to the requirements of section 43. There would also need to be in place a much more structured proposal regarding ongoing clinical responsibility for Mr Talbingo by identified appropriate specialists, and arrangements for his case management by a suitably qualified community case manager, with responsibility to report to the Tribunal at regular reviews of Mr Talbingo and to ensure compliance with the Health Department's Guidelines for the management of forensic patients.

In addition, the Tribunal notes that Dr F's assessment of Mr Talbingo's potential risks became somewhat less sanguine and more guarded when she was questioned about some of the views she expressed in her report about his risk. In relation to whether a placement in a suitable community aged care facility would give rise to any serious endangerment to Mr Talbingo or to any member of the public, Dr F stated that she would reserve her opinion, pending further clarification about the arrangements that would be in place at any proposed nursing home placement. Accordingly, the issue of any risk that Mr Talbingo may present to himself or to any member of the community, and therefore the need to protect the community, will need to be re-visited at a future review hearing before the Tribunal when the necessary information is to hand.

Further, the Tribunal notes that any release of Mr Talbingo would inevitably be a conditional release only. As noted in *Mr Adams*:

> *The Tribunal has the power to release a person conditionally or unconditionally. When making a conditional release, the Tribunal can impose very stringent conditions as to a variety of factors, including (but not limited to) the conditions referred to in section 75* [this is set out above].
>
> *Conditional release orders can be structured so as to keep very firm control and supervision over a forensic patient who is subject to a conditional release. The Tribunal may also review the case of any such patient at any time the Tribunal considers it appropriate to do so (section 46(1)). Thus a*

*conditional release may still retain an element of punishment and, at the same time, may ultimately promote the safety of the community as well as the rehabilitation of the patient. It is also important to bear in mind that the Tribunal may, at a review under section 68 of the Act, order a forensic patient back into detention, effectively revoking the conditional release, in the event that the forensic patient has breached any release condition, or has suffered a deterioration of their mental condition so as to be at risk of causing serious harm to themselves or to another member of the public because of their mental condition. It is accordingly proper for the Tribunal to have regard to its capacity to make such orders, and any orders so made, when assessing whether the forensic patient has spent "sufficient time in custody".*

If in due course at a future review it was established, to the Tribunal's satisfaction, that the requirements of section 43 of the Act were made out so that consideration might be given to Mr Talbingo's release, it is inevitable, given Mr Talbingo's permanent need for constant care (as has been made very clear by the evidence before the Tribunal), that any such release would be a conditional release only. Any conditions imposed by the Tribunal would need to be stringent and in place for a considerable length of time - possibly even until the expiration of his limiting term. As noted by the Tribunal in *Mr Adams*, ongoing conditional release carries with it a significant element of punishment.

The Tribunal accepts Mr Ierace SC's submission that, given Mr Talbingo's condition, his experience of detention in a suitable aged care facility is unlikely to be different, in essence, from his current detention, as in both cases he will be in a secure setting. Given Mr Talbingo's present circumstances of progressing dementia overlaying his extremely severe traumatic brain injury, a conditional release, in addition to the actual time that Mr Talbingo has served of his limiting term to date would, in the Tribunal's view, give adequate recognition to the purposes of sentencing that relate to ensuring that an offender is adequately punished (section 3A(a) of the Crimes (Sentencing Procedure) Act, 1999); making him accountable for his actions (section 3A(e)); denouncing his conduct (section 3A(f)) and recognising the harm done to the victim of the crime and the community (section 3A(g)). As noted above, the remaining purposes of sentencing referred to in section 3A have no meaningful application to Mr Talbingo given his present circumstances.

**DETERMINATION**

Mr Talbingo has now spent five years and four months in detention as a forensic patient. Having considered the evidence and the various factors relevant to the Tribunal's consideration of 'sufficient time in custody', the Tribunal is satisfied that Mr Talbingo has now spent sufficient time in custody for the purpose of section 74(e) of the Act. In accordance with the Tribunal's Forensic Guidelines in relation to the Conditional Release for Patients on a Limiting Term, set out above, there will need to be a further Tribunal review at an appropriate time, when the necessary material and evidence is available, for the Tribunal to consider whether there is any reason to depart from the Tribunal's present determination that sufficient time in custody has been served, and then to consider the appropriateness of the conditional release arrangements themselves. As noted above, that will involve further detailed information as to

what arrangements are proposed and a detailed assessment of the risks that any proposed conditional release might give rise to, so that an assessment can be made by the Tribunal, pursuant to section 43 of the Act, as to whether there would be any serious endangerment of the safety of Mr Talbingo or any member of the public.

In relation to the matter of Mr Talbingo's fitness for trial, for the purpose of section 47(4) and (5) of the Act, the Tribunal is satisfied on the evidence presented at this review, that Mr Talbingo remains unfit to be tried.

Signed

Dan Howard SC
President
**Dated this day: 11th December 2015**