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IN THE CHILDREN'S COURT OF VICTORIA

CRIMINAL DIVISION

Court Reference: J12605137

VICTORIA POLICE — Informant

V

KIRK REESE (a pseudonym)[1] — Accused

In the matter of a proceeding under the Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)

JUDGE:	HER HONOUR JUDGE CHAMBERS
DATES OF HEARING:	9 SEPTEMBER, 6 & 22 NOVEMBER, 16 & 19 DECEMBER 2019, 8 JANUARY 2020[2]
DATE OF JUDGEMENT:	6 FEBRUARY 2020
CASE MAY BE CITED AS:	Victoria Police v Kirk Reese (a pseudonym) [2020] VChC 6

REASONS FOR DECISION

CRIMINAL LAW – mental impairment – accused charged with false imprisonment, sexual assault, recklessly causing injury and detention of a person for a sexual purpose – accused found not guilty of two charges following special hearing conducted under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* – whether accused should be subject to a custodial or non-custodial supervision order – profoundly deaf and mentally impaired/disabled accused with significant and complex needs – non-custodial supervision order made for up to six months, until proposed facility at DFATS can be considered by the Court.

APPEARANCES:	Counsel	Solicitors
For the Informant:	Mr Ketts/Mr Higginbotham	Victoria Police Prosecutor
For the Accused:	Ms Brennan	Victoria Legal Aid
For DHHS (Intervening):	Ms Varney	DHHS
For DJCS (Intervening):	Ms Jenkins	DJCS

[1] This decision has been anonymised by the adoption of pseudonyms in place of the names of the offender and victim. The offender is described as "Kirk Reese" or "KR". The victim is described as "Ms Y". Pursuant to s.534(1)(a) of the *Children, Youth and Families Act 2005* (Vic), I have granted permission for the publication of this judgment notwithstanding that the names of the witnesses other than the victim have not been anonymised.

[2] At each hearing, Auslan interpreters were in attendance to assist KR.

Introduction

1. Kirk Reese is now 19 years old. He has significant and complex needs. Profoundly deaf since birth, he has also been assessed with ADHD, autism, mild cerebral palsy and a global intellectual delay, with a full-scale IQ of 50. His IQ falls within the extremely low range. KR is non-verbal and communicates through sign, although he is not Auslan proficient. Ms Jane Lofthouse, neuropsychologist, who assessed KR on 21 December 2018 for the purposes of these proceedings found that his general intelligence fell within the "moderately intellectually disabled" range where he would score better than or equal to less than 1% of peers of the same age.

2. On 13 September 2018, KR was charged with four offences: false imprisonment, sexual assault, recklessly causing injury and detention of a person for a sexual purpose. These charges arose from an incident at KR's residential unit in [location removed] on 18 August 2018 when he was 17 years old[3].

3. On 16 April 2019, having reserved the question of KR's fitness to stand trial, I found him unfit to stand trial on the charges pursuant to s.38K(1) of the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* ('the CMIA'). In making this finding, I had regard to the expert opinion evidence of Ms Jane Lofthouse, Clinical Neuropsychologist contained in her report dated 22 December 2018 and that of Children's Court Clinic consultant forensic psychiatrist, Dr Panduaruangi contained in his report dated 6 March 2019 and to the evidence each gave before me in the fitness investigation.

4. In summary, both experts found that KR's mild intellectual disability and autism spectrum disorder led to "impaired mental processes"[4] that are likely to be permanent and that, because of his cognitive impairment, he was unfit to stand trial on the charges. In Dr Panduarangi's assessment, KR *"did not display any understanding of the nature of the charges he was facing"*, would be unable to *"rationally enter a plea"*, did not *"understand the nature and purpose of a trial"* and would be unable to *"meaningfully instruct his lawyers".* Ms Lofthouse reached the same conclusions.

5. Having found KR unfit to stand trial, and that he was unlikely to become fit into the future, the CMIA requires the Children's Court to hold a special hearing[5], the purpose of which is to determine whether, on the evidence available, KR is either not guilty of the offence or is not

[3] Meeting the definition of a child under s.3(1) of the *Children, Youth and Families Act 2005* (Vic).
[4] See s.38K(1) of the CMIA.
[5] Section 38R(3)(a) of the CMIA.

guilty of the offence because of mental impairment or committed the offence charged (or an alternative offence)[6].

Special hearing

6. On 31 May 2019 I conducted a special hearing into the charges pursuant to Division 3 of Part 5A of the CMIA. I heard evidence from the complainant and the informant.

7. The facts leading to the charges were not disputed. The complainant, Ms Y was employed as a residential support worker. On Friday 10 August 2018 Ms Y was rostered to work at KR's residential unit in [location removed]. In the afternoon, other support workers had left the unit, leaving Ms Y alone with KR in the house. At approximately 4.15pm, KR approached Ms Y in her office. He was holding a length of rope in his hands, with the ends tied in a noose. He motioned for her to place her hands in the noose. She refused and returned to the office. Ms Y then heard KR *"whistle"* to her to get her attention. She walked out of the office into the lounge area. KR jumped off a chair and threw a black dressing gown cord over her head and around her waist, pulling her in close. At this point, KR placed his left arm around her waist and whilst holding her there, used his right hand to grab her left breast and squeeze it. Ms Y then pushed KR forcefully away from her.

8. On 3 June 2019, at the conclusion of the special hearing, I found KR:

   (a) not guilty of charge 3 – recklessly causing injury and charge 4 – detention of a person for a sexual purpose pursuant to s.38X(1)(a) of the CMIA; and

   (b) not guilty of charge 1 – false imprisonment and charge 2 – sexual assault because of mental impairment pursuant to s.38X(1)(b) of the CMIA[7].

9. The effect of these findings is dealt with under s.38Y and s.38ZD of the CMIA.

10. Pursuant to s.38Y(1) of the CMIA, KR is taken for all purposes to have been found not guilty of charges 3 and 4 at a hearing and determination of those charges.

11. Pursuant to s.38ZD(1) of the CMIA, where a child is found not guilty because of mental impairment of an indictable offence[8] heard and determined summarily in the Children's

[6] Section 38V of the CMIA.
[7] As the defence of mental impairment is defined in s.38ZA of the CMIA.
[8] Charge 1 – false imprisonment and charge 2 – sexual assault, are both indictable offences that may be heard and determined summarily in the Children's Court.

Court, the Court must either declare the child liable to supervision or order that the child be released unconditionally.

Liable to Supervision

12. Section 38ZD(2) of the CMIA provides the circumstances in which the Court may find that a child is liable to supervision:

> *"**38ZD Effect of finding of not guilty because of mental impairment***
> *…*
> *(2) The Children's Court must not declare a child liable to supervision unless the court considers that the declaration is necessary in all the circumstances including:*
> *(a) whether adequate supervision is available in the community; and*
> *(b) whether the child has complied with community supervision and the extent of that compliance; and*
> *(c) whether a declaration is required for the protection of the child or the community."*

13. On 6 November 2019, I declared that KR was liable to supervision, having accepted that such a declaration was necessary having regard to the criteria under s.38ZD(2) of the CMIA.

14. The issue I must now determine is whether KR should be subject to a custodial supervision order (**CSO**) or non-custodial supervision order (**NCSO**) pursuant to s.38ZH of the CMIA. In order to analyse this issue, it is first necessary to consider the relevant legislative provisions, context and purpose.

The relevant legislative provisions, context and purpose

15. The CMIA has been in operation since 18 April 1998. However, it was not until 2014 that the Act conferred jurisdiction on the Children's Court to determine a child's fitness to be tried[9]. The CMIA was amended to address that gap by the *Criminal Organisations Control and Other Acts Amendment Act 2014* (Vic) by introducing Part 5A – Proceedings in the Children's Court and Appeals from those Proceedings[10]. In doing so, the legislature created a modified regime[11] for children under the CMIA. In critical aspects, that regime can be distinguished from the regime applicable to adults.

[9] *CL (a minor) v Tim Lee and Ors* [2010] VSC 517 at [77].
[10] With an operative date of 31 October 2014.
[11] See Second Reading Speech, Legislative Assembly, 26 June 2014, at page 2387.

16. Relevantly, the legislative provisions that apply to children and adults found liable to supervision have important differences in their terms, context and purpose.

17. Section 26, appearing in Part 5 of the CMIA, deals with the making of supervision orders for adults declared to be liable to supervision. It has no application to children. Section 38ZH, in Part 5A, governs the making of supervision orders for children. Significantly, s38ZH sets out the *purpose* of a supervision order. Section 26 does not. Section 38ZH(2) states:

> *"(2) The purpose of a supervision order is to ensure that a child receives treatment, support, guidance and assistance for the child's mental impairment or other condition or disability."*

18. The purpose of a custodial supervision order for children is set out in s.38ZH(3):

> *"(3) A custodial supervision order has an additional purpose of protecting the child or the community* ***while*** *the child receives the treatment, support, guidance and assistance referred to in subsection (2)." (emphasis added)*

19. By enacting s.38ZH(2) and (3) of the CMIA, the legislature has expressed its intention that the purpose of any supervision order for a child is to facilitate the child's access to treatment, support, guidance and assistance for their mental impairment or other condition or disability. A CSO has an *additional purpose* of protecting the child or the community, but only *while* the child receives such treatment, support, guidance and assistance. It follows therefore that the legislative purpose of a custodial supervision order will not be met where it only protects the community (or the child) without also providing the requisite treatment, guidance or support for the child's mental impairment or disability. The rules of statutory interpretation require the Children's Court to construe s.38ZH and s.40(1) of the CMIA in a manner consistent with the express purpose for which a supervision order may be made for a child.

20. This construction of the relevant provisions is supported by the Explanatory Memorandum to the *Criminal Organisations and Other Acts Amendment Bill 2014* which at page 57 states:

> *"Section 38ZH(2) and (3) provide the purposes of custodial and non-custodial supervision orders for children. Though a child may be detained in a youth justice facility, the purpose of the detention is not punishment but to protect the child or the community while ensuring the child receives treatment, support, guidance and assistance for his or her mental impairment or other condition or disability"* (emphasis added)

21. Other distinctive features of the legislative scheme for children include the statutory imperative in s.38ZH(4) that a child be subject to a custodial supervision order only for as long as is required for the protection of the child or the community. No equivalent to s.38ZH(4) exists for adults subject to a custodial supervision order.

22. Unlike adults, children may only be subject to a supervision order for a specified period. Section 38ZI provides that the term of a supervision order for a child must not exceed 6 months. If extended, the total period of the order (including CSOs and NCSOs) cannot exceed 24 months in the case of a child aged 15 years or more but under 21 years at the time of the making of the supervision order: s.38ZI(3)(b)). For adults, a supervision order is made for an indefinite term pursuant to s.27 (subject to a nominal term set by the court under s.28).

23. The language and statutory context of Part 5A of the CMIA demonstrates that the legislature has created a distinctive regime for children of time-limited supervision for the purpose of ensuring the child receives treatment, support, guidance and assistance for their mental impairment or disability and, in the case of CSOs, for the additional purpose of protecting the community (or the child) but only for as long as is required to achieve that additional purpose.

24. Under s.38ZH(5)(a) of the CMIA, a CSO commits a child to custody. Section 38H defines "custody" to mean "detention in a youth justice centre or a youth residential centre". If follows that if the Children's Court makes a CSO under s.38ZH(5)(a), that power is limited to committing a child (of the relevant age) to custody in a youth justice centre.

25. Section 38ZH(7) of the CMIA places a limitation on the making of a CSO for children by providing the Court must not make a CSO unless it makes a finding that there is no practicable alternative in the circumstances *and* the order is required for the protection of the child or the community.

26. For adults, the Court must not make a supervision order committing a person to *prison* unless there is no practicable alternative: s.26(4) of the CMIA. However, this limitation does not apply under s.26(3) of the CMIA to a CSO committing an adult to an *appropriate place*, defined by s.3 to mean a designated mental health facility, a residential treatment facility or a residential institution. This case highlights the difficult situation that confronts the Children's

Court in making a supervision order in the absence of any youth-specific equivalent to *an appropriate place* for children[12].

27. Also relevant to my consideration of the question to be answered in this case is the over-arching principle of parsimony to be applied when deciding whether to make a supervision order, including a supervision order under Part 5A. Relevantly, s.39 provides as follows:

> ***39. Principle to be applied***
>
> *(1) In deciding whether to make, vary or revoke a supervision order… the court must apply the principle that restrictions on a person's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community[13].*

28. Finally, the legislature has set out a list of non-exhaustive matters to which the court must have regard in deciding whether to make an order, including an order under Part 5A of the CMIA, at s.40(1):

> ***40. Matters to which the court is to have regard***
>
> *(1) In deciding whether or not to make, vary or revoke an order under Part 3, 4, 5 or 5A in relation to a person… the court must have regard to-*
> *(a) the nature of the person's mental impairment or other condition or disability; and*
> *(b) the relationship between the impairment, condition or disability and the offending conduct; and*
> *(c) whether the person is, or would if released be, likely to endanger themselves, another person, or other people generally because of his or her mental impairment; and*
> *(d) the need to protect people from such danger; and*

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[12] That this is so is contrary to the recommendation of the Victorian Law Reform Commission (VLRC) in its *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* Report tabled in Parliament on 21 August 2014. The VLRC recommendations were adopted in part by the introduction of Part 5A by the *Criminal Organisations Control and other Acts Amendment Act 2014*. However, the VLRC also recommended that a multi-disciplinary youth forensic facility be established in Victoria before the Children's Court was given jurisdiction under the CMIA, stating at [6.244]–[6.245]:

> "*The Commission is of the view that there is a need for a youth forensic unit in Victoria. It is unacceptable that young people with a mental illness, intellectual disability or other cognitive impairment are being detained in custodial facilities that are not appropriate for meeting the needs of this vulnerable group of young people…the Commission emphasises that the development of a youth forensic facility is necessary to provide a secure and therapeutic environment in which assessments can be conducted, and young people can undertake treatment and services to optimise fitness and receive treatment and services while under supervision under the CMIA… The development of a youth forensic facility therefore underpins all of the recommendations made in this chapter*."

[13] See also s.21 of the *Charter of Human Rights and Responsibilities Act 2006.*

(e) whether there are adequate resources available for the treatment and support of the person in the community; and

(f) any other matters the court thinks relevant.

Certificate/s of Available Services

29. Section 38ZH(6) of the CMIA provides that the Children's Court must not make a supervision order unless it has received a report under Division 6 as to supervision and a certificate under s.47 stating that the facilities or services necessary for the supervision order are available. For adults, a s.47 certificate must be provided before a court can make a custodial supervision order committing a person to an appropriate place, but not before committing the person to custody in prison: s.26(3) and (4) of the CMIA.

30. In contrast, the obligation to receive a certificate of available facilities or services under s.47 applies before the Children's Court can make either a community based or custodial supervision order. The requirement under the CMIA for the Children's Court to obtain a report and certificate of available services before making a supervision order, including a CSO, is consistent with the purpose of making a supervision order for children; namely, to ensure the child receives the treatment, support, guidance and assistance for their mental impairment or disability.

31. In this case, I have received and had regard to the following reports provided under Division 6 and Certificates of Available Services for KR provided pursuant to s.47 of the CMIA:

(a) Report of Ms Angela Robinson, Manager, Divisional Disability Client Services, East Division, DHHS dated 27 August 2019 recommending a non-custodial supervision order and Certificate of Available Services signed by Keith Smith, Acting Deputy Secretary, East Division, DHHS dated 27 August 2019;

(b) Addendum Report of Ms Angela Robinson, Divisional Disability Client Services, East Division, DHHS dated 29 October 2019 and Certificate of Available Services should a non-custodial supervision order be made signed by Jill Gardiner, Deputy Secretary, East Division, DHHS dated 30 October 2019;

(c) Certificate of Available Services signed by Ms Jodi Henderson, Commissioner Youth Justice, Department of Justice and Community Safety ('DJCS') dated 18 November 2019;

(d) Further Addendum Report of Ms Angela Robinson, Manager, Divisional Disability Client Services, East Division, DHHS dated 21 November 2019;

(e) Updated Certificate of Available Services signed by Ms Jodi Henderson, Commissioner Youth Justice, DJCS dated 11 December 2019; and

(f) Certificate of Available Services signed by Ms Jill Gardiner, Deputy Secretary, East Division, DHHS dated 13 December 2019.

32. In addition, I have taken into account the evidence relating to KR's suitability for admission to the Disability Forensic Assessment & Treatment Services ('DFATS'), DHHS, including the assessment undertaken by Ms Jessica Griffith, Clinician and the report authored by her and Dr Matt Frize, General Manager, DFATS dated 18 October 2019. I have also had regard to the evidence and further letters of Dr Frize dated 1 November 2019 and 10 December 2019 outlining the proposal to accommodate KR in a purpose-built unit within DFATS, to be available from May 2020.

The nature of KR's mental impairment/disability

33. I have had the considerable benefit of expert evidence in assessing the nature and extent of KR's mental impairment and complex disabilities. The oral evidence, supplemented by the assessment reports of the various experts, namely Ms Maxwell, Ms Griffith and Dr Frize and Ms Jane Lofthouse given, were markedly consistent on this issue. I accept that evidence without qualification.

34. Ms Yvonne Maxwell is a clinical consultant and psychologist who was engaged by DHHS to assess KR following the finding at the special hearing. Ms Maxwell has expertise in assessing and treating individuals with complex behaviour and disability. Ms Maxwell's Risk Assessment Report dated 15 August 2019 details the nature of KR's mental impairment and disability, having the benefit of past reports prepared in respect of KR[14] dating back to 2005.

35. In her report, Ms Maxwell states that KR was born premature and in infancy, failed to thrive. At 12 weeks, Child Protection intervened and a diagnosis was made that KR suffered slow transit bowel syndrome. He was hospitalised for significant periods and tube fed. By the age of one he was diagnosed with Cerebral Palsy, and was profoundly deaf. He had slow gross motor development skills, only walking at the age of 36 months.

36. Ms Maxwell states that KR began to demonstrate *"significant behaviours of concern"* at 18 months of age, including head banging behaviour and violence towards caregivers. He wore a helmet to protect his head in his early years, but it is unknown whether he experienced

[14] Report dated 15 August 2019, listed under the heading Sources of Information, page 3 of 42.

brain damage as a result. Ms Maxwell states that KR was assessed in 2006 for an intellectual disability but that a full-scale IQ could not be established as he was unable to follow instruction to complete the test.

37. For the purposes of the fitness investigation, KR was assessed by Ms Lofthouse, clinical neuropsychologist on 21 December 2018. In her report, Ms Lofthouse also states that KR struggled to complete the testing. Nonetheless, on the Wechsler Adult Intelligence Scale his full-scale IQ was able to be assessed at 50 and therefore "*within the extremely low range (below the first percentile)".* Ms Lofthouse states that *"this score is significantly below average, falling in the moderately intellectually disabled range and indicates that [KR's] score is better than or equal to less than only one percent of same age individuals".* Ms Lofthouse also reported that KR had significant executive functioning deficits including "non-sensical" problem solving, behavioural dysregulation, impulsive responses and lack of insight.

38. In addition to his intellectual disability, Ms Maxwell states that KR has also been diagnosed with Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD).

39. KR's diagnosis of slow transit bowel syndrome persists. Ms Maxwell states that KR must adhere to a strict diet and can experience constipation and digestive difficulties, involving hospitalisation at times[15]. She states that his ASD also leads to anxiety and to KR engaging in impulsive behaviours and other behaviours of concern. Ms Maxwell relates this behaviour to the sensory and cognitive deficits associated with ASD.

40. Ms Maxwell states that KR's distress is likely to be impacted by his profound hearing loss and communication deficits. KR has refused to use hearing aids. He is reported to break any given to him. However, his ability to use Auslan is also *"severely diminished",* using idiosyncratic sign language which makes it difficult to understand his requests. For instance, Ms Maxwell states staff report that KR will sign "green cow" when requesting Milo to drink.

41. KR was assessed by a speech pathologist at the Victorian College for the Deaf (author unknown) in June 2018. In addition to being diagnosed with bilateral severe/profound sensorineural deafness, KR was diagnosed with a Severe Language Disorder in Auslan and with a severe pragmatic communication disorder. The report dated 20 June 2018 states that KR has severely restricted expressive and receptive communication skills in Auslan and is *"unable to express his needs and wants, and/or interact with peers at the level expected for*

[15] Ibid [23].

his age". The speech pathologist expressed the opinion that KR will require highly specialised support services throughout the course of his adult life.

The relationship between KR's mental impairment/disability and the offending conduct

42. The uncontradicted expert evidence supports a finding of a direct relationship between KR's mental impairment and co-existing disabilities and his offending conduct.

43. In broad terms, Ms Maxwell's evidence outlines the impact of KR's intellectual disability, ASD and ADHD on his behaviour, which she says is exacerbated by his severe language disorder and communication deficits. In addition to the functional deficits noted by Ms Lofthouse, Ms Maxwell states that KR's ASD results in sensory processing difficulties and sensitivity, reduced understanding and insight into the emotions and actions of others, and a need for predictability. She says that when KR is anxious or experiencing a "heightened sense of arousal", these neuro-developmental difficulties are heightened. Ms Maxwell's evidence is that KR's ADHD is characterised by difficulty paying attention, hyperactivity, impulsivity. She says that because of these disabilities, KR *"engages in a high level of impulsive behaviour and has difficulty concentrating, particularly in highly stimulating environments".*

44. Ms Maxwell is also of the opinion that KR's exposure to verbal and physical abuse at the hands of his father, in addition to neglect, is likely to have contributed to the development of his inappropriate behaviours. In Ms Maxwell's opinion, this includes both KR's violent and sexually abusive behaviours. This view is also expressed in the DFATS assessment in the report of 18 October 2019[16]. KR lived with his father until he was six years old. Ms Maxwell's report highlights instances of his father dragging and throwing him across the room during that period. KR was also exposed to his father's violence towards other family members, including his mother.

45. It is difficult to separate the impact of KR's experience of childhood abuse on his behaviour from that of his disability. They are each inter-related. This is supported by the findings contained in the DFATS report. In that report, Ms Griffiths and Dr Frize outline KR's background of neglect and abuse (including being relinquished into residential care at the age of 12) and the inter-relationship with his intellectual disability, autism and profound deafness on his behaviour, stating[17]:

[16] Report of DFATS, 18 October 2019, [31].
[17] Ibid [34].

"This combination of [factors] is likely to have predisposed [KR] to severe emotion regulation, problem-solving and communication difficulties resulting in use of maladaptive strategies such as acting aggressively, engaging in property damage and sexually inappropriate behaviour."

46. KR's sexualised conduct and offending behaviour is, on the evidence, at least partly attributable to his mental impairment and disabilities. In Ms Maxwell's opinion it is derived from *"the development of abnormally fixated sexual interest… in the context of poor sexual boundaries, inhibited self-regulation, exposure to pornographic material and the presence of traits associated with Autism Spectrum Disorder".* Similarly, Ms Maxwell considers his property damage and violent offending behaviour to be derived to the same poor self-regulation, easily activated hyper-arousal, related to his experiences of victimisation and his diagnosis of ADHD.

47. Ms Maxwell's expert opinion of the relationship of KR's offending behaviour disability and offending is consistent with the opinion expressed by Ms Griffiths and Dr Frize in the DFATS report:

"[KR's] offending demonstrated extremely limited impulse control and perpetration of reactive violence. If [KR] were to reoffend, his is most likely to offend at a time when he is experiencing frustration and emotional dysregulation, particularly when supported by unfamiliar staff and not engaged in meaningful or fulfilling activities.

Of note, [KR] demonstrates little understanding of the complexities of sexual behaviour, relationships, roles and responsibilities… and is therefore highly unlikely to be experiencing true sexual deviancy. Instead, he is likely experiencing what is sometimes termed 'counterfeit deviance"[18] in which an individual's' normal sexual impulses are diverted into apparently deviant targets".

48. I am satisfied, given the weight of the uncontradicted expert opinion evidence, that there is a direct relationship between KR's offending conduct, being the sexual offending the subject of the special hearing, and his mental impairment and disabilities.

The risk of KR endangering himself or others because of his mental impairment & the need to protect people from such danger

[18] Associated with autism, see DFATS report [36].

49. Ms Maxwell conducted a risk assessment of KR for the purposes of her August 2019 report. In that report, Ms Maxwell assessed KR as being a high risk of sexual offending using J-SOAP-II and the ARMIDILO risk assessment tool, the latter being a professional judgment instrument tool. She also assessed KR as being a high risk of future violent offending using the SAVRY assessment tool. KR's high-risk profile was appropriately conceded by Ms Brennan[19].

50. Ms Maxwell's report identified situations where KR is "least likely to re-offend", including where he is engaged in structured and supported activities with known support persons, during the period in which he is supervised and has a positive rapport with support persons and during periods of regulated emotional states. Ms Maxwell states that predictability is essential for supporting KR to "reduce his experiences of heightened internal arousal" and to "develop more appropriate coping strategies".

51. In the report of DFATS, Ms Griffith and Dr Frize assessed KR's risk for future sexual offending using the Static-99 assessment tool, an actuarial measure of long-term potential risk for sexual offence recidivism in adult male offenders. Using that tool, KR was found to be in the "Low-Risk Category relative to other male sexual offenders. The report states that individuals in that range are, on average, likely to sexually reoffend at a rate of 12% over five years. Dr Frize states that this risk should be seen in the context of KR's considerable level of cognitive disability and that:

> *"… As such, sexual offending per se may be less likely than sexually inappropriate behaviour. The behaviour occurs in the context of significant impairment in social reasoning, a need for stimulation associated with autism, and unmet sexual needs coupled with a poor understanding of social relationships…"*

52. KR's inappropriate sexual behaviours became apparent in April 2016. However, on the evidence before me, his maladaptive behaviours of violence and aggression have been lifelong. Behaviours of concern, such as head banging, were reported at 18 months. Highly concerning instances of violent behaviour are said to have occurred from childhood towards his siblings (including attempting to set his younger brother on fire) and animal cruelty at the age of 12 years (killing his sibling's dog)[20]. He has lived in out of home care since 2011. From September 2011 to November 2019, staff have filed 250 incident reports, the content of which have been analysed by Ms Maxwell[21], although she accepts the inadequacy of the

[19] Submissions on behalf of KR, [33].
[20] Report of Ms Maxwell dated August 2019, [12].
[21] Data Analysis – Incident Reports, 18 November 2019, Exhibit 7.

reporting and the prospect of some incident reports being duplicated. For that reason, Ms Maxwell sensibly recommends more consistent reporting of incidents.

53. Even accounting for a level of inconsistency, the incident reports highlight the risk KR has posed of assaulting staff, residents and engaging in dangerous behaviour over the past eight years. Ms Maxwell's data analysis also indicates an increase in incidents of physical aggression towards staff over the period September 2018 to November 2019 with 166 incidents reported but accepts this trend may also be partially indicative of limitations in the historical data. Nonetheless, having regard to the balance of the evidence, I am satisfied that, consistent with the various risk assessment outcomes, KR is and has long been a high risk of violent offending, particularly towards staff and of ongoing property damage.

54. In Ms Maxwell's updated Addendum Report dated 22 October 2019, she attaches a revised Risk assessment at Appendix A, particularly noting instances of absconding from staff, although noting he will "regulate quicker" with his known, Auslan-proficient care staff. She also notes the risk attached to the stability of his placement with the increase in neighbourhood complaints. This ultimately led to the decision of DHHS to move KR from [location removed] to his current residential unit.

55. There is no doubt on the evidence before me that KR poses a risk to safety of the staff who care for him when he is dysregulated and exhibiting aggressive behaviour towards them. I accept that this situation places the long-term sustainability of his community-based placements and the stability of his care support team at significant risk.

56. A summary of the pending charges was provided[22] and is in evidence. There are 70 outstanding charges, all laid in 2019. This include 32 charges of criminal damage, 16 charges of unlawful assault, two charges of sexual exposure in a public place and another two charges of behaving in an indecent manner in a public place.

57. The most serious charge is that of sexual assault. It is alleged that on 6 July 2019 KR absconded from support workers and went to a nearby park. He is alleged to have approached a woman, given her a hug and touched her genitals over her clothing. Ms Maxwell said KR told her he did this because he wants a girlfriend.

58. A further charge of stalking and another of sexual exposure arose from KR attending the home of a girl, knocking on the door and turning off the electricity and gas supply to the

[22] The summary of the police allegations is in evidence – Exhibit 9.

house. It is alleged he sent her letters of a sexual nature and that he exposed his genitals to her family from the garden of the house.

59. It is unclear from the material before me whether the precise charges will be proved. However, I accept that the allegations are consistent with the risk assessments undertaken by Ms Maxwell and Dr Frize.

60. I have also had regard to the gravity of the offending behaviour that was the subject of the special hearing. In that regard, it is unlikely that KR, with no priors, would have received a custodial sentence for that offending or indeed, a conviction disposition, if he had been found fit to be sentenced under the *Children, Youth and Families Act 2005* (Vic). This was fairly accepted by the prosecution in submissions. Moreover, I accept Ms Brennan's submission that the sexual offending behaviour the subject of the further allegations is at the lower end of the range of seriousness for sexual offending. I make that observation without in any way diminishing the serious impact of the offending on the victims. On 12 December 2019 KR is alleged to have sent another note to neighbours, reading *"Girl Kiss Yes, No Boy Kiss Yes No"* with tick boxes. Whilst concerning, this is likely to fall short of criminal behaviour. I accept that much of KR's sexualised behaviour is, as assessed by Dr Frize, more likely to result in sexually inappropriate behaviour "*than sexual offending, per se".*

The adequacy of the resources available for the treatment and support of KR in the community

61. In August 2019 DHHS recommended that KR be placed on a NCSO by the Children's Court. The DHHS report dated 27 August 2019 authored by Ms Robinson states that such an order "will allow [KR] to continue receiving intensive support and therapeutic interventions in the community that are tailored to his complex disability support needs". In making this recommendation, the DHHS report outlined the availability of the services and supports available in the community at that time to support KR's complex needs, including:

- the availability of sole tenant accommodation for KR in [location removed], with modifications to the property having been completed prior to his move there in May 2019, including reinforced walls, safety glass in the windows and importantly, a fire sprinkler system *"that was suitable for [KR] and deaf staff";*

- the availability of OnCall staff to provide accommodation support, with *"a strong commitment to supporting [KR] and building capacity for staff to communicate with him in AUSLAN"*; reporting that his NDIS plan includes funding for staff to access Auslan training;

- the availability of a day program through the GROW program and Kevin Heinze three times per week with the support of two staff, supported by *"familiar AUSLAN speaking workers"* when he does so;

- the ongoing availability of *"three regular, familiar AUSLAN skilled workers to access day activities between eight am and four pm each day"*;

- the availability of Mr Andy Moore, psychologist to continue to provide behavioural support for KR, including assisting staff to implement appropriate behavioural strategies;

- access to the Community Forensic Dual Disability Service for psychiatric review and monitoring;

- the involvement of the Office of the Senior Practitioner, DHHS to provide active support to KR's care team, and assist with an application for a Supervised Treatment Order and oversight of his progress on a treatment plan; and

- access to *"high levels of support through the National Disability Insurance Scheme, which includes Supported Independent Living, specialist support coordination, assistance with community access and access to allied health and behavioural supports"* coordinated, by Ms Cath Dwyer, Expression Australia who has worked with KR since he left care, and can sign and communicate with KR directly and has *"strong knowledge of his complex disability support needs".* The report states that the NDIS plan provides *"high levels of access to behaviour support and other therapeutic services such as speech pathology".*

62. However, when the matter returned before me on 9 September 2019, counsel appearing for both DHHS and KR jointly applied for the proceedings to be adjourned to examine whether a confined therapeutic environment may be available for KR and specifically, whether KR was eligible for placement in a residential treatment facility under the auspices of the DFATS. On that date, the Court was also advised of the existence of multiple charges pending against KR in the Magistrates' Court. The matter was adjourned to 6 November 2019 for the option of a therapeutic treatment facility to be explored.

63. When the matter resumed on 6 November 2019, the position of DHHS had been revised and a CSO was sought. In part, this was due to the assessment of Dr Frize that KR is unsuitable for the therapeutic treatment model offered within the Intensive Residential Treatment Program (the IRTP) run by DFATS due to the nature and extent of his disability. According to Dr Frize, this is because the IRTP model "*is based upon a cognitive behavioural*

relapse prevention program using the self-regulation model of relapse prevention" and requires a *"significant cognitive load and good communication"* that is beyond KR's cognitive and communication ability.

64. The DFATS assessment report concluded that KR would *"benefit most from an intensive ecologically driven behaviour modification program within the community which is tailored to his very specific complex support needs"* and recommended that a community-based containment model be explored that is suitable to KR's risks, needs, strengths and goals. Dr Frize had regard to "the least restrictive option" suited to addressing KR's behaviour whilst also meeting his disability needs consistent with principles, purposes and framework of the CMIA, stating:

> *"The severe nature of [KR's] behaviour and his limited ability to self-regulate suggests that the least restrictive option suited to addressing [his] behaviour and meeting his needs is one that provides a high degree of security to prevent absconding and a reinforced structure to ensure the safety of clients and staff. Whilst there are a range of disability focused models that have not been tried, there is currently no alternative model to DFATS that provides this level of security."*[23]

65. DHHS' revised position was also informed by the receipt of further information about KR's subsequent police charges and an increase in complaints it had received from local residents concerned about KR's behaviour. These were outlined in evidence before me given by Ms Robinson on 6 November 2019 and her further report dated 29 October 2019 and a revised risk assessment report of Ms Maxwell dated 22 October 2019. In a further Certificate of Available services dated 30 October 2019, DHHS stated it is unable to provide an immediate placement that can safely accommodate KR and manage community risk. DHHS' position since that date has been that a CSO is required to manage the risk presented by KR's behaviours, in the absence of any practical alternative.

66. Ms Robinson's evidence on 6 November 2019 also outlining difficulties in maintaining stable accommodation and service provision for KR, with the withdrawal of service provision by Care Choice and then Expressions Australia, leading to OnCall's inability to staff KR's accommodation in residential care with anything other than a high rotation of largely one-off or casual disability support workers. Indeed, this was also referred to in the earlier August report, as indeed were the fact of outstanding charges, at the time DHHS supported the making of a NCSO.

[23] DFATS report dated 18 October 2019, [67].

67. In August 2019, Ms Maxwell made a series of recommendations to manage KR's behaviour in the community[24]. These included a secure base with a strong structure or routine, consistency or supports, relationships and treatment, personal space, a safe environment, relational and program stability, choice of vocational and leisure supports, a therapeutic program and ability for "sufficient" communication[25]. Additionally, Ms Maxwell recommended opportunities for inclusion and belonging and appropriate matching of disability support staff within an accommodation model. She states that ideally all staff would have some Auslan ability. She also recommended "an environment that supports self-determination". Ms Maxwell said that KR requires reliable, continuous supervision and assistance with the benefit of a restrictive behaviour support plan and functional behaviour assessment.

68. In her subsequent assessment in October 2019, Ms Maxwell says she reconsidered the risk KR posed by reference to the details of his offending charges provided by Victoria Police[26] and the DFATS assessment, finding that KR's accommodation at this time is not suitable for his needs.

69. At the hearing on 6 November 2019, a letter authored by Dr Frize dated 1 November 2019 was tendered and Dr Frize gave evidence outlining a proposal for DFATS to undertake clinical and capital works to *"develop a model of treatment and care that will be appropriate for and specific to [KR's] disability and criminogenic needs"*, including:

- Significant building works at the DFATS site in Fairfield to ensure it is sufficiently durable and safe as well as separate from other offenders accommodated at the service;
- Development of a clinical model of treatment that includes skills training, an intensive positive reinforcement program and reactive strategies;
- Recruitment of sufficient and appropriate pool of staff;
- Training of staff in Auslan, alternative communication and the clinical model of treatment.

70. Dr Frize estimated that, as at 1 November 2019, that this work would take between 4-6 months to complete. Dr Frize's opinion is that this work is necessary for KR to receive a bespoke model of care involving a *"secure and intensive model of long-term*

[24] Risk Assessment Report, Ms Maxwell dated 15 August 2019 at [44] – [72].
[25] Ibid [44].
[26] Outlined in Ms Maxwell's Addendum report dated 22 August 2019 at [7].

treatment…under the Disability Act (2006) that currently does not exist in the Victorian service system." In the most recent Certificate of Available Services dated 13 December 2019, DHHS confirmed that the repurposed DFATS unit will be available for KR by May 2020.

71. Ms Maxwell has now developed a comprehensive treatment plan for KR[27]. In that plan, Ms Maxwell recommends the development of a Positive Behaviour Support Framework. She says that for this to occur, the Treatment Plan has been developed to address the *"underpinning support needs and functions of [KR's] behaviours".* The purpose of the plan is to provide KR with a consistent and supportive environment, with consistent response strategies and clear, firm boundaries. Ms Maxwell also discusses the need to implement an incentive model daily and for staff to be trained in the use of visual aids.

72. Ms Maxwell's evidence on 8 January 2020 is that she now spends every second day speaking with staff to train in the use of visual aids and to implement the incentive model. She says she has observed two of the OnCall staff become more familiar with KR and with whom he is responding well. She says KR takes time to build rapport with staff, herself included. She says she will move to more formal training in February 2020. She says she will be meeting with the speech and occupational therapist in January 2020 to review the visual aids. The occupational therapist will assess the sensory component of the incentive model.

73. Ms Maxwell says the NDIS funds 60 hours of behavioural support under the current plan through to the end of March 2020. Ms Maxwell said she is yet to finalise the Behavioural Support Plan for KR, but that this was likely to be completed by the end of January 2020. Ms Maxwell said she is also in the process of developing a full functional behavioural assessment for KR, a process that can only commence once the risk assessment and behavioural support plan are in place. Additionally, arrangements have been made for KR to be assessed for treatment by a forensic psychiatrist, Dr David Thomas, Forensicare in February 2020.

74. It is unfortunate that KR's transition to the NDIS was not approved until mid-January 2019. It is clear from Ms Maxwell's evidence that further services and supports are yet to be realised but are available to KR to implement the strategies and supports she has carefully considered, including the referral to Dr Thomas, and the implementation of the Positive Behaviour Support Framework and a full functional behavioural assessment. It remains her

[27] Exhibit 8.

view however, that an ability to lock KR in a room in his accommodation setting is necessary during periods of escalating behaviour.

Other relevant considerations

75. One further relevant consideration when considering whether a CSO should be made is the degree to which a CSO would afford protection to the community whilst also "*ensuring*"[28] KR receives the treatment, support, guidance and assistance for his mental impairment and disabilities. In my view, the Parkville youth detention centre is fundamentally ill-equipped to do so. As stated succinctly by Ms Henderson, Commissioner Youth Justice, DJCS, *"this is not a forensic disability service, it is a youth justice centre".*

76. In making this finding, I have had regard to the evidence of Ms Henderson and Dr Gemma Russell, Director of Clinical Oversight and Rehabilitation, DJCS and the DJCS Certificates of Available Services if KR were to be subject to a CSO dated 11 and 18 December 2019.

77. The DJCS Certificates confirm the availability of a secure individual placement for KR in the Parkville unit within the Parkville Youth Justice centre. However, whilst this is a secure custodial placement, the Certificates state that the *"custodial facilities are not purpose built for [KR's] profound forensic disability support needs".* Dr Russell's evidence is that for the unit would require reinforced internal doors and frames, and importantly, assistive technology to alert him in the event of fire, cages over utility pipes and rectifying removable cladding/brickwork from the outside yard. Rectification works would be required to the unit for KR to be safely accommodated there. This has not occurred.

78. Moreover, Ms Henderson states there is no guarantee of the Parkville unit remaining a single occupancy unit if demand rises at Parkville[29]. In that event, KR would be subject to a *"restrictive regime"* meaning long periods of isolation in his cell to prevent mixing with other young people in the unit. Ms Henderson says that Parkville Unit is the only unit in the facility suitable for KR given the cohort of youth in the other units. I accept this is the case and that this factor alone significantly limits the options available to the Youth Justice Centre to accommodate KR.

[28] See s.38ZH(2) and (3).
[29] For instance, by email dated 4 February 2020 the Court was advised that *"…following a peak in remand numbers, Parkville Unit is currently being used to accommodate young women. While Youth Justice would endeavour to accommodate [KR] separately from others, noting his specific needs, remand numbers are subject to rapid fluctuation, and this may not always be possible".*

79. In all other respects (save for being able to manage KR's restrictive diet[30]), the evidence of Ms Henderson and Dr Russell is that Parkville is unable to provide services directed towards the treatment, support, guidance and assistance required for KR's significant and complex disabilities. In particular, the services which the DJCS *could not* provide in youth detention as at November 2019[31], include:

- capability within its current unit staff or contracted service providers to provide deaf and Auslan interpreters to participate in activities and interact effectively with others*;*
- the ability to roster any staff that have forensic disability training and can effectively accommodate KR in his day to day support needs;
- sufficient lead time to establish staff capability or proficiency in providing for KR's most basic day-to-day support needs, including toileting (encopresis and soiling), self-care, augmented communication and the management of attempts by KR to seek out physical touch and affection from staff that is inappropriate or uninvited;
- any guarantee of consistent staffing in the unit, requiring DJCS to procure specific clinical supervision of staff given that unit staff are both unqualified and untrained in disability support work;
- disability expertise to provide an appropriate level of support for KR, including early intervention to regulate and de-escalate behaviours and triggers;
- an ability to manage KR's complex needs and to guarantee his safety in the context of a custodial environment involving 8pm lockdown/8am unlock, frequent and unpredictable lockdowns due to inadequate staffing levels and incident management, and the use of restraint;
- education programs through Parkville College[32] to provide a specialist education program for KR's appropriate to his disability needs, and the requirement to source an external education specialist;
- limited or no access to other programs, eg, activities involving tools, such as carpentry, cooking etc.

[30] Necessary for the management of his slow transit bowel syndrome.
[31] Outlined in the DJCS Certificates of Available Services dated 11 and 18 November 2019.
[32] Parkville College is not a designated special school for young people.

- offender/behaviour moderation programs in the absence of expertise within Caraniche, the youth offender program service provider at Parkville, to provide treatment for KR's offending behaviours given his profound disability; and

- an emergency response model or guidance on the use of force, referred to as *"tactical options"* in the Certificate dated 18 November 2019, or restraint techniques that could safely restrain KR given his cerebral palsy and significant communication barriers.

80. It is important to consider these service and treatment limitations in the context of the existing constraints and challenges that currently impact on the operations of the Parkville Youth Justice Centre. Ms Henderson's considered evidence on this issue was not challenged.

81. At the time of giving her evidence in November 2019, Ms Henderson said there were 85 young people detained at the Parkville Youth Justice Centre.

82. Units at Parkville are staffed by youth justice custody officers. There is no qualification prerequisite to be appointed to this role and custody staff have no disability qualifications or experience prior to their employment. The only training custody staff receive is a 7-week induction program. Ms Henderson says there is one allocated specialist disability worker whose role must meet the variable disability needs of around 200 children and young people across both the Parkville and Malmsbury youth detention centres. Ms Henderson agreed that although the disability worker plays a role in the induction program, custody staff receive no detailed training, and have no experience of dealing with youth presenting with complex intellectual disability, ADHD, ASD or the skills associated with augmented communication.

83. Moreover, Ms Henderson states that Parkville's staffing capacity is already under stress with fluctuating staff numbers. She says there are significant challenges in ensuring Parkville has adequate staffing levels. To manage this situation, Parkville is heavily reliant on casual/agency custodial staff. In the absence of adequate permanent or agency staff, Ms Henderson says that units and at times, the entire facility is placed in lock down, sometimes for extended periods. These lockdowns may also occur due to other incidents in the precinct. Lockdowns in these circumstances can occur at any time and are unpredictable in timing and duration. During these periods, *"a restricted regime"* operates, meaning young people *"are not allowed out of their rooms"*[33]. Ms Henderson says she would anticipate that KR "*would be in a very restrictive environment at Parkville"* in the current environment.

[33] Ms Henderson's evidence on 6 November 2019.

84. Dr Russell's evidence expanded on the operational requirements under a restrictive regime. She says that in lockdown, a child is placed alone in their room behind a secure door where the only means of communication with staff is through an A4 sized trapdoor or through a steno phone, through which the young person can speak with staff in a central office. At the 8pm lockdown, all detainees are placed in their rooms behind the secure door, without exception. Three custody staff must be present for operational reasons to open the trapdoor or, as a last resort, to open the door. An operations manager (who is not on the unit) must approve any decision to open the door to the room. When the door is closed, the trap door must be closed. Dr Russell says that, without necessary modifications, unit staff would not be able to see or speak to KR between 8pm and 8am.

85. In the absence of Auslan interpreters during the hours of 8pm and 8am, KR would be unable to communicate with staff. Dr Russell says that *"it is unclear how staff will know if [KR] is safe or requires some response"* during those hours and would hold *"grave concerns for his safety"* in that situation. Ms Maxwell also agreed she would hold concerns for KR's safety in these circumstances and that lockdowns would be a "frightening experience" for him. Dr Russell's evidence is that lockdowns occur in the precinct *"every single day".* Given KR's history, in Dr Russell's view KR would struggle to manage alone in his room over long periods and would be at risk of self-harm. I accept Dr Russell's evidence in respect of the impact on KR's likely experience of isolation during periods of lockdown. It is consistent with other expert evidence received, including that of Ms Maxwell and Dr Frize, of KR's limited ability to self-regulate. In my view, the physical inability of staff to have line of sight of KR or any effective means of communicating with him would pose significant risks to his safety and wellbeing in the current custodial setting.

86. Dr Russell's evidence is that if a young person's behaviour begins to escalate in the common areas, protocol requires custody officers to seek to de-escalate verbally before moving to a more restrictive response. However, Dr Russell says that in her experience, custody officers have *"a low tolerance"* in the current environment to behaviours of concern. In practice this can promptly lead to an emergency response, commonly through the Special Emergency Response Team (SERT), who are able to use force to manage a situation including the use of handcuffs and physical restraint. In KR's case, he would have no way of communicating with the SERT team when force was used.

87. In its submissions, DHHS accepts that detaining KR in a youth justice centre for a period *"is not an ideal outcome given the reduced opportunity for disability-focused support and treatment"*[34]*.* However, it maintains its recommendation that the Court make a CSO for KR

[34] Submissions on behalf of the Secretary, DHHS dated 6 January 2020, [101].

to spend *"the minimum period necessary"* for it to develop the purpose-built unit and treatment program specific to KR's needs at the IRTP within DFATS. As an interim measure, the DHHS proposal is to supplement the services that can be provided in Parkville by the following measures:

- the provision of three Auslan proficient support workers between the hours of 8am to 4pm Monday to Sunday, with the first month funded by the NDIS. In periods where they are absent (eg on leave) DHHS will provide other support workers however they are unlikely to be Auslan fluent[35];
- the availability of Ms Maxwell to deliver training to Parkville staff for up to four hours per week[36];
- Ongoing speech pathology and occupational therapy, funded by the NDIS for 20 hours each over the life of the current NDIS plan which, whilst expiring in March 2020, is expected to be available via the next package[37];
- A DFATS clinician would begin to visit KR towards the end of his time in youth detention to assist in his transition to the IRTP within DFATS.

88. DHHS emphasise Ms Maxwell's availability to train custody staff for up to four hours per week and to assist in the implementation of an abbreviated Behavioural Support Plan (BSP) for KR that could be followed by custody staff. Further, that an incentive model of behaviour, recently introduced for KR in his residential unit, could be used in the custodial setting, again through training to be provided by Ms Maxwell.

89. Dr Russell was questioned about the impact of these measures in supporting KR in a custodial setting. Whilst Dr Russell agreed that BSPs are developed for youth in Parkville, particularly around management of a range of triggers for violent behaviour, Dr Russell's evidence is that these differ to disability BSPs. Moreover, she says implementation of BSPs at Parkville is inconsistent at best, due to poor staff skill sets, training and a lack of consistent staffing. She says key reminders, repetitions required to successfully implement BSPs as they exist at Parkville are *"not implemented, not even on the simplest level".* Furthermore, the heavy reliance on agency staff in the current environment means it is likely there is unlikely to be consistent custody staff on the unit to benefit from Ms Maxwell's training as *"every day may have different staff on the unit".*

[35] Certificate of Available Services (DHHS) dated 13 December 2019.
[36] Ibid, and evidence of Ms Angela Robinson on 6 November 2019.
[37] Evidence of Ms Maxwell on 8 January 2020.

90. I accept Dr Russell's evidence that even in *"mainstream"* units the low skill base of staff in implementing BSPs, combined with inconsistent staffing, makes it very difficult to deploy consistent behavioural management strategies. Dr Russell's evidence of the practical reality at Parkville is that custody staff are currently ill-equipped to respond to escalations in behaviour, despite the provision of BSPs, leading to an increased reliance on emergency responses to manage behaviour. Notwithstanding Ms Maxwell's undoubted expertise in the developing a BSP for KR and her willingness to provide training to staff, I am not satisfied that four hours of custody staff training – noting the staffing challenges referred to in the evidence of DJCS – and the provision of a modified BSP will provide the necessary support, structure and guidance needed to moderate KR's behaviour in the context of his complex disabilities. For the same reasons, I do not consider the incentive program, only recently introduced by Ms Maxwell, will mitigate the impact of a significantly restrictive custodial setting on KR given his mental impairment and disability.

91. I accept that the presence of Auslan-proficient support staff with whom KR is familiar, funded by DHHS 7 days a week between 8am and 4pm is a significant improvement on the initial proposal that NDIS would fund this service in detention for only four weeks. However, whilst this service ensures KR is able to communicate with his support staff and to facilitate communication with custody staff between those hours, it is clear from Dr Russell's evidence that during periods of lockdown, the support workers will be prohibited from assisting KR. No staff are permitted in the secured room during periods of lockdown. During these periods KR would be out of view and unable to communicate with any staff, including the Auslan-proficient staff.

92. In its submissions, DHHS accepts that the delivery of disability and behavioural support services outside these hours and during lockdown periods will be *"carried out in a more limited way than the delivery of that support in a therapeutic custodial setting or in the community".*[38] In my view this submission understates the position. In such circumstances, KR would be without any form of disability appropriate supports, treatment or guidance. Indeed, I accept the evidence of Ms Maxwell that this form of isolation would be highly prejudicial to KR and on the evidence of Dr Russell, would pose a genuine risk to his safety, including a risk of self-harm.

93. DHHS submits that the limitations on services outlined in the Certificates of DJCS are, in critical respects, the same limitations as exist in the providing services in the community, such as lack of a consistent staffing group, risk of danger to staff and the lack of a fully robust

[38] Submissions on behalf of the Secretary, DHHS dated 6 January 2020 at [108].

infrastructure. Whilst this is true in some respects, it is not an answer to the question I am required to answer.

94. The critical task for me is to assess whether, in the context of the statutory provisions, the CSO proposed by DHHS will ensure the safety of members of the community whilst also *ensuring* that KR receives the treatment, support, guidance and assistance for his mental impairment and disabilities. Having regard to the evidence of DJCS, when considered in the context of Ms Maxwell's recommendations, I am not satisfied that a CSO would achieve that statutory purpose.

95. Firstly, the custodial environment at Parkville would be far more restrictive than that recommended by Ms Maxwell to manage KR's behaviours, recalling that her recommendation is for the ability to lock doors within his accommodation setting during periods of heightened behaviour. I accept the evidence of Ms Henderson under a CSO, KR would be subject to a significantly restricted environment at Parkville, including unpredictable and at times, extended periods of isolation. I accept the evidence of Dr Russell that whilst isolated in his room, there are significant and "grave" risks for his safety. Contrary to the recommendation of Ms Maxwell, it would not be possible that KR remain in line of sight of staff during periods of lockdown.

96. The principle of parsimony expressed in s.39 remains relevant to this consideration, in that the least restrictive alternative to a custodial supervision order should be pursued[39], particularly for a child. As stated by the Court of Appeal in *NOM v Director of Public Prosecutions* (2012) 38 VR 618; [2012] VSCA 198 at [68], *"a supervision order is not a sentence or punishment but treatment".* There is no legislative justification for the imposition of a CSO for a child that will operate as a punishment, even if it operates to confine the child for the protection of the community.

97. Secondly, whilst detained under a CSO, I am not satisfied that the services proposed, even as supplemented by DHHS, would ensure KR receives the treatment, support, guidance and assistance he requires for his mental impairment and other disability. The majority of staff responsible for KR in custody are custodial staff (with a large component of agency staff) who are untrained, unqualified and inexperienced in working with complex disability and forensic behavioural support that would be required for KR.

98. Notwithstanding the availability of Ms Maxwell to provide training to custodial staff for up to four hours a week, I accept Dr Russell's evidence that this will have limited effect. This is for

[39] See also *Richards (a pseudonym) v The Queen [No.2]* [2017] VSCA 174 at [30].

two reasons. Firstly, the high turnover of largely agency staff, with no consistency of staff in units, means it is unlikely the training hours will be sufficient to adequately train all custody staff on the unit. Secondly, the lack of capability in those staff to implement models of therapeutic behavioural intervention means they are unlikely to be effective, particularly for someone with KR's complex needs and behaviours. Whilst the presence of the Auslan-proficient staff will mitigate this situation, this will only be the case between the hours of 7am to 4pm and then, only when KR is not subject to inevitable, and daily, lockdown.

99. Moreover, the environment at Parkville would not ensure that KR is provided with a sense of predictability and consistency, key recommendations of Ms Maxwell in the treatment of KR's disability.

100. Thirdly, whilst I accept that the risk of KR continuing to engage in maladaptive behaviours is significant, there are some key additional services that have been introduced over the past 12 months through the NDIS funding to assist in the management of KR's behaviours. These include, critically, the role now played by Ms Maxwell, including the assessment and comprehensive treatment plan she has developed. Work in training staff in this plan, including the implementation of the incentive model, has only commenced relatively recently. Ms Maxwell is developing a Positive Behaviour Support Framework and will undertake a full functional behavioural assessment to assist in the management of KR's behaviours. Additionally, a referral has been made for February 2020 to Dr Thomas, psychiatrist at Forensicare, for further evaluation and potential treatment.

101. For these reasons, I am satisfied that a NCSO should be made for a defined period up to six months and until the proposed facility at DFATS can be considered by the Court[40]. I consider the DFATS facility and therapeutic treatment proposed by Dr Frize is most likely to be achieve the dual purposes of a CSO for KR. In the meantime, I direct that the matter be brought back for review in late April, early May 2020, on a date to be fixed.

102. I will hear from the parties on the conditions to be imposed on the NCSO.

Judge A Chambers
President
Children's Court of Victoria

[40] Or the proceedings be transferred to the County Court for review; s.38ZQ.