IN THE SUPREME COURT

OF THE STATE OF VICTORIA

(COURT OF APPEAL -

CRIMINAL DIVISION)

AT MELBOURNE

IN THE MATTER of the

CRIMES ACT 1958

-and-

IN THE MATTER of the

Criminal Appeals and Procedure Rules 1998.

-and-

IN THE MATTER of an Appeal against Sentence by MICHAEL DAVID JONES

MICHAEL DAVID JONES

Appellant

-and-

THE QUEEN

Respondent

APPELLANT'S SUPPLEMENTARY OUTLINE OF ARGUMENT (SENTENCE)

Introduction

1. It will have been noted that the Court has been provided with a Forensicare report of Dr Debra Wood dated 12 June 2006 when leave was granted in this matter. The Appellant has sought to rely on this report either as fresh evidence or as evidence that can be taken into account in the event of re-sentence: see the Appellant's Outline of Argument at paras 8-9.

2. Since the provision of Dr Wood's report, the Appellant has come into possession of further evidence that is similarly relevant, it is submitted,

either upon re-sentencing the Appellant or as fresh evidence (that is evidence that further bears upon the true significance of facts that were in existence at the time of sentence: *R v Babic* [1998] 2 VR 79 at 82) or both. (Evidence of a relevant, pre-existing, state of affairs may be admissible on appeal in order to avoid a miscarriage of justice and this includes even where the Appellant (and the Appellant's legal advisers) knew of the state's existence but did not raise it on the plea: see *R v Maniades* [1997] 1 Qd R 593 at 597 (cited with apparent approval in *R v Wilshaw & Lowe* [2001] VSCA 35 at [38]) and *Knights* (1993) 70 A Crim R 105 at 11)

3. As is clear, the manner in which prison inmates who suffer from a mental illness are treated while in custody was a matter of great concern to the sentencing judge. The materials that are now submitted relate to this issue. The material is exhibited to the affidavit of Peter Rankin dated 17 October 2006 ("the Rankin Affidavit"). For ease of reference, and to save time, the salient parts of this material will be identified and summarised in these submissions.

Materials

Forensicare Submissions to the Senate Select Committee on Mental Health (May 2005): **Exhibit "PCR-4" to the Rankin Affidavit**

4. The Thomas Embling Hospital is Forensicare's (The Victorian Institute of Forensic Mental Health) secure inpatient facility that houses and treats mentally ill people who come into contact with the criminal justice system and, in particular, prisoners.

5. By 30 April 2005, of the 100 beds on offer at Forensicare, 55 were occupied by Forensic Patients, namely, long-term patients detained

under the mental impairment legislation. Each long-term patient takes a bed from an ill prisoner (people whom Forensicare has a charter to treat):

> "Pressure on inpatient admissions is great. Seriously mentally ill people wait in prison for admission where conditions are not conducive to well being and recovery": (pp 4-5)

6. Forensicare's submission continues:

> "People with psychotic illness who go to prison are not always recognised, often not provided the care and treatment they require, and released without adequate provisions for their subsequent management. Imprisonment is often damaging to those with schizophrenia, but if it is to occur, then at least a reasonable effort should be made to provide care and treatment… Currently in Australia the provision of care to mentally ill prisoners is rudimentary at best. Rarely are proper provisions made… ": (p 20)
>
> "(I)t is not uncommon for a mentally ill prisoner displaying acute and disturbing psychiatric symptoms to be placed in a management and observation cell (known as a 'Muirhead cell') This placement is not a mental health decision, but one made by correctional administrators when there is no other accommodation available to guarantee the safety of the prisoner displaying disturbing psychiatric symptoms…
>
> The fact that Muirhead cells, which were designed to be used by correctional administrators to safely accommodate prisoners displaying difficult and often violent behaviours, are also used for mental health reasons, is often difficult to reconcile. At the most extreme, this can lead to psychiatric care being seen as punitive within the prison environment.": (p 21)

Evidence of Professor Mullen to the Senate Select Committee on Mental Health: **Exhibit "PCR-3" to the Rankin Affidavit**

7. Professor Mullen gave evidence on 6 June 2005 to the Senate Select Committee. His evidence concerned the treatment of the mentally ill in Victoria's prisons.

8. He said that there is always a waiting list to get into Thomas Embling of people who would be suitable for admission if and when a bed became available. These people wait at the Acute Assessment Unit ("AAU") at the Melbourne Assessment Prison ("MAP"). The number of beds sets the criteria for admission: p 40.

9. In the men's prison, a number of people will be managed in MAP and then returned to the main prison: p 41.

10. In Professor Mullen's view, Victoria should provide more hospital services to offenders with schizophrenia. He said that:

> "this is not just for the sake of the patients – although this is obviously the most important thing – but also for the sake of the community. It is the failure to manage the problems that arise from their mental illness which is so often important in driving re-offending when these people return to the community." (p 42).

11. Patients housed under the mental impairment legislation and who stay in Thomas Embling for long periods will deprive psychotic prisoners of hospital beds: p 43.

12. On the subject of Muirhead cells and prisoners with mental health problems who pose a suicide risk, Professor Mullen said:

> "There is always a problem with providing mental health care within the context of a prison, The culture of prisons inevitably is a culture of observation and control. The culture of therapy for mental disorder is a culture – or should be – of communication and enablement of people to begin to stretch their capacities and begin to move. You see it very clearly when you come across a suicide risk. The response of a prison to a suicide risk is to restrict the possibilities of suicide. At the grossest end, you put people in a plastic bubble, take all their clothes away and watch them. That does prevent suicide but it also, in my view, produces enormous destruction to the psychological and human aspects of that individual, and it is not the way to go. So whenever you are trying to provide mental health care to severely distressed and disabled people within a prison, you are running up against a

> clash of cultures, the result of which can lead to abuse. The only solution is not to try to treat severely mentally ill people and acutely suicidal people in prison. They should not be there. But that does mean a radical rethinking of priorities. Also, it is not just that we do not have the beds and the resources. Sometimes the beds and resources are there but they are not available to our patients." (pp 48-49)

The Senate Select Committee Reports: **Exhibits "PCR-1" and "PCR-2" to the Rankin Affidavit**

13. It is sufficient to note for present purposes that the Committee accepted and adopted the Forensicare's recommendations and the evidence of Professor Mullen. It noted that the evidence was that treatment of mental illnesses in Australian prisons was inadequate and said that although corrections authorities throughout Australia generally had developed and established relatively enlightened policies for the care of prisoners with mental illness, it seemed that the practice may often be different from the theory: First Report, March 2006 at [13.98]-[13.102], [13.121].

FOI Documents that relate to the Appellant's incarceration: **Exhibit "PCR-7" to the Rankin Affidavit**

14. Documents released to the Appellant under the *Freedom of Information Act* 1982 (Vic) reveal the nature of some of the Appellant's experiences in prison since his incarceration in October 2004. The relevant incidents are summarised in an 'Index to FOI Documents' that appears at the commencement of this particular exhibit.

15. It must be recalled, at this stage, that the sentencing judge found that the Applicant was a chronic paranoid schizophrenic: see the Applicant's Outline of Argument at para [8] As can be seen, the Index

reveals that between October 2004 and May 2006, the Appellant experienced a significant number of difficulties in prison.

16. The Index and documents speak for themselves. In summary, however, there are numerous instances of threatened self-harm either by "slashing up" or setting fire to his cell. The Appellant was often seen by a psychologist. At times he was grandiose and delusional etc, reporting that he was the Son of God etc. He would hear voices, namely, the Devil telling him to kill himself and others. He "stared blankly" throughout interviews. He wanted to be taken to Thomas Embling Hospital. Importantly, the Index and documents reveal numerous placements in a Muirhead cell.

Report of Dr Mark Ryan dated 17 October 2006: **Exhibit "PCR-8" to the Rankin Affidavit**

17. The Report of Dr Ryan confirms the diagnoses of Dr Jager and Dr Sullivan. Dr Ryan states that the Appellant has a "longstanding diagnosis of a chronic psychotic illness, paranoid schizophrenia". Dr Ryan confirms the Appellant's recent stay in Thomas Embling and subsequent discharge to the AAU. Importantly, Dr Ryan maintains a diagnosis of paranoid schizophrenia notwithstanding the Appellant's tendency of feigning symptoms.

Argument

Common Law

18. As was noted in the Appellant's Outline of Submissions at paragraph 9, the fact that the Appellant suffers from a serious psychiatric illness is

relevant to sentence because, *inter alia*, of how burdensome that illness makes the service of a prison sentence.

19. The materials referred to above give content to that submission. It is recognised, it seems, by the very authority that is charged with the care and treatment of people such as the Appellant that it does not have the resources to properly carry out its charter of responsibilities. The result of this is that the mentally ill are often treated inappropriately in prison. The Appellant's experience in custody bears a striking resemblance to the treatment that is described by Professor Mullen as sometimes being inappropriately accorded to the mentally ill while in prison. The transcript of the plea reveals that the Appellant himself considered that he ought to have been receiving expert care when in fact he was forced to remain in the mainstream prison environment.

International Law

20. It must be noted that the common law of sentencing in this State as it applies to offenders who are mentally ill closely resembles the content of the various international legal covenants to which Australia is a party and which bear upon this issue. This Court has invited submissions on international law to the extent that it will assist in the determination of cases: see *Royal Women's Hospital v Medical Practitioners Board of Victoria* [2006] VSCA 85 at [70] per Maxwell P. Indeed, it has expressed the view that the Court should be mindful of the international rights guarantees which exist in relation to the treatment of prisoners: *Re Rigoli* [2005] VSCA 325 at [5]. The various obligations arising from international law will, therefore, be briefly summarised below.

21. In short, international law mandates that a person imprisoned for committing a criminal offence should not suffer punishment over and above the deprivation of liberty which imprisonment entails. A prisoner whose rights have been breached should be entitled to an effective remedy (article 2(3) of the ICCPR and General Comment No 9 of the ICESCR).

22. Article 10 of the International Covenant on Civil and Political Rights ("ICCPR") to which Australia is a party provides that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person. It also states that the essential aim of the treatment of prisoners in the penitentiary system shall be their reformation and social rehabilitation. In its General Comment on article 10, the Human Rights Committee has said:

> "Thus, not only may persons deprived of their liberty not be subjected to treatment that is contrary to article 7 [relating to torture and cruel, inhuman or degrading treatment], including medical or scientific experimentation, but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a close environment": General Comment No 21, 10 April 1992 at [3].

23. A similar statement is found in Rule 57 of the United Nations Standard Minimum Rules for the Treatment of Prisoners ("UN Minimum Rules"), namely, that the prison system "shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation." The UN Minimum Rules should be taken into account in determining the content of the obligation found in article 10 of the ICCPR.

24. More particularly, principle 9 of the Basic Principles for the Treatment of Prisoners (adopted by General Assembly Resolution 45/111 of 14 December 1990) states that prisoners shall have access to the health services available in their country without discrimination on the grounds of their legal situation. The Principles for the protection of persons with mental illness and the improvement of mental health care (Adopted by General Assembly Resolution 46/119 of 17 December 1991) ("UN Mental Health Principles") set out basic rights in respect of mental health care. Principle 20 provides that persons serving sentences of imprisonment for criminal offences should receive the best available mental health care as provided in Principle 1, which sets out the general right of all persons to mental health care. Principle 20 explains that the UN Mental Health Principles apply to prisoners to the fullest extent possible, with only such limited modifications and exceptions as are necessary in the circumstances.

25. Australia is also a party to the International Covenant on Economic Social and Cultural Rights ("ICESCR"). Article 12 of the ICESCR provides that the parties to it recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. It requires that State Parties take steps to achieve the full realisation of this right, including those steps necessary for the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

26. Article 2(2) of the ICESCR contains an undertaking from State Parties to guarantee that the rights enunciated in the Covenant will be exercised without discrimination of any kind as to race, colour, sex etc or "other status". In commenting on article 12 the Committee on Economic Social and Cultural Rights has said that health facilities, goods and services have to be accessible to all, especially the most

vulnerable and marginalised sections of the population in law and fact, without discrimination on any prohibited grounds. Discrimination on the basis of civil, political, social or other status, which has the intention or the effect of nullifying or impairing the equal enjoyment or exercise of the right to health, was said to be proscribed. In particular, the Committee has pointed out that States are under an obligation to respect the right to health by refraining from denying or limiting equal access to health facilities by prisoners or detainees.

27. Breaches of international standards which result in a prisoner suffering more than usual hardship in prison or being punished while in jail beyond that entailed by the deprivation of liberty should be taken into account in the exercise of the sentencing discretion.

28. The proposed Australian National Statement of Principles for Forensic Mental Health 2002 (the "National Statement") was drawn up by the Forensic Expert Reference Group of the National Mental Health Working Group of the Australian Health Ministers' Advisory Council, and endorsed by the National Mental Health Working Group. The Senate Select Committee on Mental Health also endorsed the National Statement in its final Report, which recommended that the Australian Health Ministers agree to establish a timeline and implementation plan for the National Statement.

29. The National Statement explains in its preamble that the principles contained in the statement have been developed in the context of, and are underpinned by, international and national policy frameworks including the UN Mental Health Principles and the ICCPR. Principle 1 in the National Statement provides that prisoners and detainees have the same rights to the availability, access and quality of mental health care as the general population. It states that the "Principle of

Equivalence" applies to both primary and specialist mental health care. Similarly, in principle 4 the National Statement provides that the range of treatments and interventions available to prisoners and the qualifications and experience of mental health staff "should be at least congruent with that available in the general community."

30. Furthermore, the Standard Guidelines for Corrections in Australia, Revised 2004, (the "Corrections Guidelines") provide that every prisoner is to have access to evidence-based health services provided by a competent, registered health professional who will provide a standard of health services comparable to that of the general community. Every prisoner is to have access to psychiatric health services, with referral to such services being required to take account of community standards of health care: (Principles 2.26 and 2.27)

Conclusion

31. The common law does not expressly set standards of mental health care, or if it does, it does so in a negative sense by stating that if service of a term of imprisonment is made more burdensome when compared to the experience of others by virtue of the prisoner's illness then that burden ought be taken into account as a matter in mitigation. On the other hand, International law and the National Statement and Corrections Guidelines expressly set minimum standards and define a failure to meet these as a form of punishment over and above the sentence imposed.

32. If Forensicare's submissions to the Senate Select Committee, Professor Mullen's evidence and the findings of the Committee itself are taken at face value, then there is, it appears, a gap between theory and practice.

33. Although the diagnoses of the various professionals who have treated the Appellant are not entirely consistent (see Dr Wood's opinion on the one hand, and the opinions of Dr Jager, Dr Sullivan and, most importantly, Dr Ryan on the other) it must be stated that the preponderance of evidence states that the Appellant suffers from chronic paranoid schizophrenia. There is no doubt, therefore, that the Appellant suffers from a serious psychiatric illness and that service of his prison term has been made more burdensome as a consequence. If there was any doubt about this, the Appellant appeals to the striking congruence between the Appellant's own experience in mainstream prison and the observations of Forensicare and Dr Mullen.

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R v Wilshaw & Lowe [2001] VSCA 35