MENTAL HEALTH COURT

CITATION:	*In the matter of HYX* [2018] QMHC 13
PROCEEDING:	Reference
DELIVERED ON:	20 November 2018
DELIVERED AT:	Brisbane
HEARING DATE:	31 October 2018
JUDGE:	Dalton J
ASSISTING PSYCHIATRISTS:	Dr S J Harden and Dr A S B Davison
DETERMINATIONS:	**1. The Court cannot determine the questions of unsoundness of mind at the time of the alleged offences because of s 268 of the Mental Health Act 2000.** **2. The defendant is fit for trial.** **3. All charges before this Court should continue according to law.**
COUNSEL:	A E Loode for the defendant S Robb for the Chief Psychiatrist M B Lehane for the Director of Public Prosecutions
SOLICITORS:	Legal Aid Queensland for the defendant The Office of the Chief Psychiatrist The Director of Public Prosecutions (Qld)

[1] This is a reference in relation to HYX [redacted]. He is before this Court on 39 charges. All but one of the charges relate to indecent treatment, rape or sexual assault of children said to have been committed between 1965 and 1989. [Redacted]. I heard and determined the reference on 31 October 2018, reserving my reasons, which I now outline.

Material before the Court

[2] The reference was filed on 22 May 2015 and was accompanied by a report of Dr Reddan dated 4 October 2014. Dr Reddan is now an assisting psychiatrist to this Court. She did not give evidence in the matter and it was accepted that the matter would proceed on the basis that I would not have regard to the contents of her report.

[3] The reference was also accompanied by a short letter from Dr Penny King, who was, and is, the defendant's treating doctor. She is a psychiatrist and psychogeriatrician. Dr King's letter is dated 22 May 2014 and says:

> "Further to our discussion I would like to confirm that [HYX] is a patient of mine and has recently been assessed at our memory clinic. He suffers from a memory disorder of Alzheimer's type, with a moderate degree of impairment confirmed on imaging studies and memory testing. I believe that he lacks the capacity to instruct counsel in that his complex decision making and complex cognitive capacities are significantly impaired. I have attached this assessment at his consent."

[4] Attached to the letter is a memory clinic assessment summary [redacted], which does not seem to be complete and does not seem to be dated. It gives the results of an assessment on 21 November 2013 and seems to be addressed to a general practitioner. As the copy which the Court has is incomplete, I cannot determine who provided the assessment. It contains almost no useful information and I disregard it in making my decision on this reference.

[5] Lastly in the list of material to which I do not have regard in deciding this reference, I refer to a report from Dr Graham Senior, dated 21 April 2015. Dr Senior has become an assisting clinician to the Mental Health Court. He was not called or cross-examined. Again I think in the circumstances I should not have regard to his report in deciding this reference.

[6] The material before the Court to which I do have regard on the reference can be summarised as follows:

- reports of the psychologist, Dr Haydn Till, dated 18 August 2015, 29 May 2016, 22 October 2017, 10 January 2018 and 27 September 2018, together with his oral evidence;
- the report of Dr Pamela van de Hoef, psychiatrist, dated 13 December 2015, together with her oral evidence;
- the report of Professor Gerard Byrne, dated 19 September 2017, a letter from him dated 27 September 2018, together with his oral evidence, and
- the letter from Dr Penny King dated 22 May 2014 as described above, together with a report from her dated 30 July 2018, and her oral evidence.

Scope of Controversy

[7] There was no support from any witness for a finding of unsoundness in relation to any of the charges before the Court. To everybody who examined him the defendant denied the offending. It was the submission of defence counsel that there was a dispute of fact in relation to the offending and I think that is right, so the first finding which I made on

31 October 2018 was that by reason of s 268 of the *Mental Health Act 2000,* I was precluded from making any finding about unsoundness at the time of the offending.

[8] The second determination which I made on 31 October 2018 was that the defendant was fit for trial. There was a dispute on the evidence before me as to that, and my finding involved preferring the evidence of Professor Byrne and Dr van de Hoef to that of Dr King and Dr Till. That preference was my own, but it was supported by the advice of my assisting psychiatrists. The remainder of these reasons are to explain my decision on fitness.

[9] I should make it clear that if Dr King and Dr Till were correct in their assessments of the defendant's cognitive abilities, there is no doubt he would be unfit for trial.[1] The question was whether their assessments of his cognitive abilities were correct. Professor Byrne and Dr van de Hoef thought that the assessments of the defendant by Drs King and Till were based on unreliable presentations by him. Dr van de Hoef allowed that the defendant had a mild cognitive impairment, but thought him fit for trial, even with that.[2] Dr Till agreed that with a mild dementia the defendant would be fit for trial.[3] So did Professor Byrne.[4]

Psychological Testing by Dr Till

[10] Dr Till was an independent doctor performing Court-ordered examinations. He first saw the defendant on 21, 28 and 30 July 2015. The defendant was able to give Dr Till quite a detailed family and life history – see pp 5-6 of the report. [Redacted]. He reported that he receives a total and permanent impairment pension [redacted]. It appears that this is in relation to a diagnosis of post-traumatic stress disorder. That diagnosis was made by someone who did not report to this Court.[5] The defendant described his current functioning as poor; that he just wanted to sit and read, that he was easily frustrated and that people and noise irritated him. He said he had difficulty concentrating on what he was doing, completing things he started, and learning and remembering things. He said he struggled to make decisions and left it all to his (second) wife.

[11] The defendant told Dr Till that he could not recall how many charges he faced and could not recall what the exact titles of the alleged offences were. He said that he was well aware of how the legal system worked because he had worked in it and because "they explained it to me". However, he was apparently unable to explain it to Dr Till. He said that he would rely upon "information from the civil suit"[6] in his defence, and said that his sister would say that the charges were untrue. Dr Till records that, "Irrespective of the questions asked, HYX stated that he could not recall detail from that time."

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1 This was conceded by the Prosecutor – t 1-24.
2 See [48] below.
3 t 1-15, ll 10-15 and ll 25-30.
4 t 1-34, l 5.
5 There was no evidence that the diagnosis was correct. There was some doubt about it. See Dr van de Hoef at tt 1-47-48 and Dr Harden at t 1-79.
6 There was a civil suit at least mooted by some of the complainants which preceded criminal charges being brought.

[12] The defendant's wife told Dr Till that she noticed intellectual and functional changes in the defendant from 2011 which have worsened. She said he had experienced a decline in his memory and functioning so that he was now very forgetful. He will disengage from conversation; he will ask the same question several times, and he had difficulty understanding situations and explanations. She said that he was very dependent upon her; unable to independently shop or take the grandchildren out, or conduct basic activities, such as washing up. She reported that he simply sat in front of the TV most of the time. She said he required prompting to attend to his personal cares and that he had poor judgment.

[13] The defendant's wife also told Dr Till that he was agitated, aggressive, depressed and dysphoric, anxious, apathetic, indifferent, irritable and experienced lability of emotions and unusual motor behaviours.

[14] Dr Till administered quite a battery of testing to the defendant. The tests were appropriate and there was no criticism of Dr Till's testing from anyone.[7] Some of the tests Dr Till administered were purely designed to test whether or not the subject was making proper effort. Other tests which he administered had measures of effort built into them.[8] There was no criticism that Dr Till had not administered appropriate testing to see if the defendant was making an effort. As well, I thought Dr Till gave thorough evidence in which he explained very well how he had thought about the defendant's effort and the scores which had been obtained on testing for effort. It was obvious that he was well-informed as to these matters, and had given them considerable thought.

[15] There is no doubt that on all the measures of effort the defendant's results were abnormal.[9] That is, the testing did not show that he was making normal effort. Unfortunately, results of the type which the testing showed are displayed by people who have dementia, as well as people who are not making proper effort.[10] These difficulties were discussed by Dr Till at page 13 of his report. I will not set out the entirety of that page of his report but will set out the first three paragraphs to give an indication of the dilemma:

> "The Test of Memory Malingering is a stand-alone measure of effort. [HYX's] performance on this task rated within the range characterised as chance responding for both the first and second trials. His performance also fell well below that typically observed in the dementia subgroup of the test validation sample. The lower bound of chance responding was calculated. [HYX's] performance was above that calculated lower bound characteristic of blatant suboptimal effort. This measure has been criticised in relation to its variable reliability to accurately differentiate sub-optimal effort from the effects of dementia.
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> The Word Choice Effort task is another stand-alone measure of effort. [HYX] performed at an unusually low level compared to the comparison

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7 To the contrary, see Dr van de Hoef's report p 18, and Professor Byrne's oral evidence at t 1-31, ll 30-34.

8 t 1-21.

9 t 1-11, l 19 and t 1-21.

10 Dr Till explained in his oral evidence that the tests were never designed to be used for Alzheimer's patients and that they thus produce a higher rate of such people being misidentified as malingering – t 1-3, l 45 – t 1-4, l 7. Dr Harden's questioning produced more specific information about this – t 1-26, l 45 – t 1-27, l 10.

> sample on this task. While his performance rated as unusual it was above the theoretical guess level considered to represent blatant suboptimal effort. The comparison sample for this measure consisted of non-dementia clinical populations. Therefore, even though this is a common measure of effort, the validity of comparing [HYX's] performance to the comparison sample is difficult to support.
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> [HYX] performed at an unusually low level on one of two embedded measures of effort. That measure was the verbal learning recognition task and his performance was ≤5% of the comparison sample. As that task is a based in functional memory, it is likely susceptible to dementia and therefore may not have adequate sensitivity to sub-optimal effort. As with the Word Choice Effort task, the comparison sample did not contain individuals with confirmed or suspected dementia. Therefore, the reliability of the measure for differentiating between the dementia and effort (specificity) is unknown."

[16] Dr Till accepted in his oral evidence that in reporting he accepted that the defendant did have dementia and analysed the test results on that basis.[11] This further complicated the matter and I think that can be seen, for example, in the last lines of each of the three paragraphs in the extract from his report at [15] above. That is, while the tests indicated suboptimal effort, Dr Till thought that was accounted for by the fact that the defendant had dementia.[12] This Court must decide whether or not the defendant does have dementia and, if so, whether or not it is having anything other than a mild effect on him. I thought that Dr Harden, one of my assisting psychiatrists, put this well in his advice to me.

> "I think the other thing that has come out is that the state of science in regard to testing when combining the issues of dementia, perhaps moderate – let's say moderate dementia and possible feigning, slash malingering, slash exaggeration of symptoms. The state of science and testing, as Dr Tills has really, I think, acknowledged, is that the testing is not very helpful in that combination of circumstances because you can look at the data from this direction and say, 'It shows moderate to severe dementia.' Or you look at it from this direction and say, 'It shows feigning' with roughly the same dataset. And I have an interest in cognitive testing, although I'm not an old age psychiatrist." – t 1-79.

[17] In fairness, it must be said that there were aspects of Dr Till's testing which he thought did show that the defendant was making an effort but was impeded by dementia. One was his performance on the digit span effort measure.[13] Another one was his performance on recognition memory tasks for verbal information. In that test the defendant did recognise more of the information which had been presented earlier in the test for learning. Dr Till's view was that if the defendant had been trying to present poorly, he was likely to have performed just as poorly on that previously learned information as he did for the rest of the test.[14] Also in performing this test, the

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[11] t 1-6, l 15 and t 1-14, ll 20-30.
[12] This conundrum was nicely illustrated in oral evidence at t 1-13, ll 20-30.
[13] p 13 of his report, 18 August 2015.
[14] t 1-25.

defendant confabulated, which Dr Till said was a "common enough feature in moderate Alzheimer's disease".[15]

[18] Dr Till's conclusion was that, "[HYX] displayed considerable cognitive impairment branching across the cognitive domains of intellectual processing speed, non-verbal intellectual function, memory, language, and executive functioning".[16] Indeed, his evidence was that the defendant had severe Alzheimer's disease.[17]

[19] In assessing fitness for trial, other than simply reporting the results of his testing, Dr Till thought it was of concern that the defendant could not explain how he would mount his defence against the charges either from a strategic or factual basis. Also he thought it was of concern that he had an "apparent inability to recall facts to a level consistent with the detail available to him in November 2014".

[20] By the time of this second report Dr Till had received Dr van de Hoef's report (below). Dr van de Hoef thought that depression might be affecting the defendant's ability to perform cognitively. Dr Till was open to this idea, and the idea that further testing might show that the defendant's depression had been alleviated with a consequent improvement in his cognitive function. He thought the only way to explore that was to test in the future.

[21] Dr Till's third report, 22 October 2017, was a specific response to Professor Byrne's report and I will deal with it in the context of considering Professor Byrne's evidence below.

[22] On 10 January 2018 Dr Till wrote another major report which reported the results of examining the defendant for a second time on 12 December 2017. He reported that the defendant had difficulty answering some of the questions he was asked. That his interview manner was at times vague, and that he appeared prone to losing his train of thought. He provided less detail about his early history and work history than he had at the first interview. He appeared to have considerable difficulty recalling the details of his current marriage. When asked specifically about the charges he faced, the defendant responded in a disjointed manner and was hard to follow. He complained about the slow progress of his Court case and his bail conditions. He still denied doing the acts complained of. He still attributed a financial motive to the complainants which he had done, so far as the material reveals, ever since the complaints were made.

[23] Dr Till reported that [the defendant's wife] reported that her husband required support 24 hours a day and that his ability to perform the basic activities of daily living had declined. He needed prompting to shower, but he could dress independently. He had difficulty recognising different food products by their cartons. He was unable to reliably take his medications.

[24] Dr Till re-administered testing. Once again the defendant's scores on measures of effort were not normal. Dr Till reported, "As discussed in my previous reports, individual

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[15] t 1-25. Dr Till thought confabulation would be very difficult to feign – t 1-25.
[16] p 14 of his report, 18 August 2015.
[17] t 1-15, l 32; t 1-17, l 5 and t 1-23, l 17.

measures of effort and standard cut-off scores for effort measures applied [to] dementia sufferers likely result in misclassifying of impairment as low effort."[18] As discussed above, while this may be true as a general proposition, it is not helpful in a case where the issue is whether or not the subject of testing is feigning or exaggerating dementia. Dr Till discusses the same difficulties which I have canvassed above at pages 8 and 9 of this report. It is clear from this discussion that Dr Till accepted the defendant's presentation as genuine and accepted what the defendant's wife told him as true, and interpreted the test scores with that assumption in mind. This was confirmed in his oral evidence, see above.

[25] Some of the test results were outstandingly poor, for instance, tests of intellectual processing speed put the defendant below the first percentile of the population – see paragraph 7.5.2 of Dr Till's report. Further, other tasks put him in the second percentile of the population for attention/concentration and working memory – see paragraph 7.5.4 of Dr Till's report.

[26] Overall, Dr Till thought that the defendant had performed worse on testing on the second occasion than he had on the first occasion of testing. Dr Till thought that the defendant's presentation was consistent with "advancing dysfunction in Alzheimer's dementia".[19] He thought that the degree of impairment on testing was consistent with the degree of functional impairment in the activities of daily life described by the defendant's wife – paragraph 8.2 of the report. As to the effort issue he said:

> "I concluded from my examination of his effort that [HYX's] performance could not be conclusively declared sub-optimal due to inherent difficulties in the measures applied to assess his effort. That is, due to their reliance on memory effort measures are inherently confounded in individuals with an identified dementia condition. That confound raised the risk of misclassifying [HYX] as lacking effort when he more likely had an neurodegenerative disorder.
>
> *Extend effort assessment*
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> In the current assessment, [HYX] performed within normal limits on subtle indicators of effort that are considered much less susceptible to the impact of dysfunctional memory. When considered in the context of consistent performance across time on other performance validity indicators, worse presentation at interview, decline in daily functioning reported by his wife, and subtle memory performance consistent with that observed in Alzheimer's disease clinical groups; [HYX's] performance on the new effort indicators supports the conclusion that his deficits are real and do not represent sub-optimal effort tin order to avoid consequence." [20]

[27] Dr Till's opinion that the defendant was unfit for trial remained unchanged.

Dr van de Hoef

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[18] p 8 of his report, 10 January 2018.
[19] See paragraphs 7.4.6 and 7.4.7 of his report.
[20] Paragraphs 8.7 and 8.8 of his report, 10 January 2018.

[28] Dr van de Hoef saw the defendant in the company of his wife on 25 November 2015. Dr van de Hoef notes that the defendant was arrested on the charges which are before the Court on 22 December 2012. Dr van de Hoef deals with the nature of the charges at pp 2-5 of her report and notes that, "The very detailed descriptions of the alleged offences repeatedly indicate the use of force … on his part, as well as threats to keep the alleged events quiet, which in my opinion indicates an intimidatory, even sadistic, element to the allegations." She notes that two of the complainants describe other forms of threats made to them. [Redacted]. Two of the complainants were of the view that the defendant was drunk at the time of the offending. The defendant's daughter described him as someone who committed violence when drunk on a regular basis.

[29] At pages 8 and 9 of her report, Dr van de Hoef summarises evidence from witnesses other than the complainants, some of whom supported the complainant's evidence, but others of whom did not.

[30] To Dr van de Hoef the defendant disputed the facts in relation to "each and every charge". He cited a number of reasons why some of the charges could not have been true, having regard to a car he owned at the time of one allegation, and having regard to where he lived or worked in relation to other charges said to have taken place in a particular country town. He made detailed refutations of some of the corroborative evidence.

[31] The defendant and his wife described years of symptoms of PTSD and depression, which Dr van de Hoef details at p 11 of her report.[21]

[32] So far as the charges were concerned, the defendant was able to give the history that it all started as a civil suit in which the complainants asked for money, [redacted]. He attributed motive to the complainants – wanting money, and gave instances of his daughters in particular requesting money from him at other times during their lives. Dr van de Hoef comments that the explanation of the complainants being motivated by money made no sense to her as it was apparent to her that the defendant and his wife were "fairly impecunious" – p 13 of her report.

[33] [The defendant's wife] said that she noticed that her husband was forgetting things [redacted] in 2012. She also thought that he was depressed and anxious. He took an overdose in 2013.

[34] The defendant's wife told Dr van de Hoef that she could not leave her husband alone because he was a suicide risk and that he would mix his tablets up or leave the stove on. She said that he was able to shower, shave, dress and toilet himself and to eat unaided. She said her husband repeated himself a great deal and was unable to remember instructions she gave him. She put clothes out for him to dress in. He no longer remembered how to rig up the caravan and had lost interest in [redacted] (previous hobbies). He had stopped attending to handyman tasks at home. He rarely went out.

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[21] See tt 1-47-48. Dr van de Hoef did not receive enough information to allow her to independently verify the diagnosis of PTSD.

[35] The defendant told Dr van de Hoef that "it's just all gone". He said he loved reading because it takes everything out of his head and that he watched a fair bit of TV. He said he could use the remote control, but rarely used the phone or the computer since 2012. He said he mowed the lawn. He did not use their banking key-card any more. He did not use public transport.

[36] Dr van de Hoef detailed a past psychiatric history being treated by a Gold Coast psychiatrist from about 1997 for PTSD and depression. She noted an admission for the first time at the Currumbin Clinic in November 2013, after having taken an overdose of prescription medications [redacted]. She notes that it was the Currumbin Clinic who referred the defendant, first to the memory clinic at that hospital, and then to Dr Penny King (who has treated the defendant ever since). She noted that to Dr King in 2013 it was reported that the defendant had a history of decline since 2011 in "memory (of dates and times), and procedural tasks".[22] She notes another admission at that clinic for 22 days from 20 January 2014, where the diagnoses on discharge were PTSD, depression, (early) dementia (about which he was "upset") and alcohol abuse.

[37] The defendant was able to give Dr van de Hoef a history of alcohol abuse and smoking throughout his life in some detail, including the ages at which his consumption changed, and what alcohol he drank at different times. He could give a history of his childhood, his schooling, his early work years, his first marriage and the children he had with his first wife. He could give a history as to the ending of that marriage and the commencement of a relationship with his second wife. He could give a history of their relationship through the 1990s and his work roles through the 1990s. Notwithstanding all of that, Dr van de Hoef records, "The striking feature of the interview was how many times [HYX] said 'I can't remember' or 'if only I could remember' and deferred to his wife to fill in details."[23]

[38] As to that latter observation Dr van de Hoef said:

> "I don't have any recollection of [HYX] being uncooperative, but I noted that in my report because I thought it was unusual. When I've interviewed people with dementia – and I've interviewed many – not as many as Professor Byrne, but many – they sometimes comment on the fact they can't remember, but – but I thought this was also an unusual or an exaggerated – maybe not exaggerated, but a very – very striking feature of that interview. When I went back to test further his understanding of the charges and to assess him for fitness for trial then, it was clear that he didn't have the extent of memory lapse for the period involved that might have been reflected in most of the interview. And I did that deliberately because I believe that one of the arms for assessing fitness for trial is whether a person can participate in their trial and mount a defence. And so the – the questions that I asked that have been alluded to earlier in this hearing and the answers he gave about the – how the charges had to be impossible or untrue came from his memory, not hers. And I thought that that was interesting for two reasons clinically. Firstly, it informed my assessment for

[22] p 14 of Dr van de Hoef's report.
[23] p 17 of Dr van de Hoef's report.

> fitness for trial. Secondly, it sort of put the lie to his general presentation that he would rely on his wife for many, many gaps in his knowledge."[24]

[39] Of Dr Till's effort testing Dr van de Hoef said:

> "Dr Till found [HYX] unfit for trial based on deficits in his intellectual speed processing (borderline range on testing), and opined such unfitness would be permanent in nature. Several tests to detect 'suboptimal effort' and malingering were administered; the results to me seem inconclusive to me i.e. there is some doubt."[25]

[40] One of the tests which Dr Till had administered was the ACE-R. Dr van de Hoef administered this test and she said this about the results:

> "This reporter (November 2015) also administered the ACE-R; [HYX] scored 54 (a very large decline in his scores in 2 years); moreover, it did not, in my view match his functioning at home over the same time period. In other words, it was a catastrophic drop in test scores, whilst his functioning, though impaired, had not declined similarly."

[41] Dr van de Hoef spoke about this topic in her oral evidence. She said:

> "… [HYX's] history of performance on that test, I found to be very hard to explain on the basis of a dementing illness alone unconfounded by any other factors because when Dr King performed the test in November 2013 he scored 83 out of 100. Now, depending on which paper you read, the cut-off score to diagnose a dementia is anything between about 82 and 88. I go with 88. So, at worst, that score in late 2013 would have been a mild or perhaps even very mild dementia or an indication of that. Dr Till first examined [HYX] about four months before I did, and I thought his test results – very comprehensive testing. I don't have any issue with that, but I thought the scores actually were in keeping with what Dr King had found, you know, 18 months, 20 months earlier. I performed the ACE-R again in November 2015, four months after he saw Dr Till, and [HYX] scored 54. That is a catastrophic drop, and it did not seem to me to match up either with his and his wife's description of his functioning at home. It did not match up with previous testing, and I guess more importantly, it doesn't even match up with testing in my view that's happened since, because he's had the ACE-R performed again in June this year and scored 58, higher score than when I did it three years ago. So if the hypothesis is that he had a mild dementia in late 2013 and late 2015 when I saw him and it's progressed, and that's why I assume we've been all looking at scans and other things, then why did he score higher in June this year than he did three years ago, very nearly? It doesn't make sense to me. I think there have to be other confounding variables, other factors. Now, Professor Byrne's alluded to some, or some possibles. In my report, I also made the point that this man has been previously diagnosed with depressive illness and post-traumatic stress disorder, and I thought the diagnostic dilemma in 2015 was

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[24] t 1-46.
[25] p 19 of Dr van de Hoef's report.

> not did he or didn't he suffer from any of these, but the emphasis that I would've given to contributions from each of those disorders would've been vastly different from those given by Dr King or Dr Till subsequently. And that flows on to fitness. So I diagnosed him with mild dementia in late 2015. I thought he was fit for trial. Before then, Dr King had said his dementia was worse than that and that he was unfit, really unfit very early. That's a bit [big] difference of opinion."[26]

[42] Dr van de Hoef was taken back to this inconsistency in examination by counsel for the defendant. She was asked whether other factors such as depression might have accounted for the score of 54. She said:

> "Yes, it could've affected it. But that's a drop of almost 30 points.
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> Yes?--- And that's very hard for me to lay at the feet of, say, the – what I thought was his more severe disorder when I saw him. That's the depression. In other words, I thought the major depressive disorder with which he'd been diagnosed was more significant than the PTSD. Honestly, if he were really functioning at that level largely because of depression, he should've been hospitalised on the spot, and I probably would've made moves to do that.
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> And that test in and of itself, you indicate that was one that had a catastrophic drop. The other testing that you administered to him on that day didn't necessarily have a correlating drop or difference that caused concern?--- Well, no. That was – that was – I focused on the ACE-R, but in – but the clinical impression and the history of his functioning at home I thought also did not marry up at all well with such a low score on the ACE-R."[27]

[43] Dr van de Hoef thought there were inconsistencies between what the defendant and his wife reported his disabilities to be, and his results on testing:

> "There is – there are inconsistencies, in my view, between what both [HYX and his wife] say he does, and the level of support he has apparently required since the time of diagnosis by Dr King in late 2013. I mean, I agree with Professor Byrne. By the time someone's got a mini-mental state score – and that's one of the simplest tests that's been administered to this man – of 15 out of 30, I don't understand why he hasn't got maximal supports in the community, or rather in a nursing home now, or at least for the last year or two. That to me is a bit [big] inconsistency."[28]

[44] I thought Dr van de Hoef's analysis of the conflicts in the evidence before me was useful. She said:

> "I accept Dr Till's expertise. I do. I do. It's our interpretation of why his performance was so low and so variable that differs, I think. It seems to me that I differ with Dr King in that when you match our opinions, it would

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[26] tt 1-46-47.
[27] t 1-50.
[28] t 1-48.

> seem my opinion would be that perhaps the diagnosis was applied too early and the severity overstated, for various reasons. But all the clinicians who've seen this man have seen him for different purposes, and I believe [HYX] would be aware of that. Dr King is his treating doctor and therefore must and does and should advocate for him and try and make him as well as she possibly can. I have no doubt she has done all of that. Dr Till's main purpose was to perform extremely comprehensive, careful and – cognitive testing over time, and he has done that, but he has said that he did not really address the 38 charges over 35 years to any great extent.
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> Yes?--- That task fell, as I see it, to Professor Byrne and me. So we had different focuses coming into this, and it's quite possible that [HYX] has responded differently to all of us simply because of that, too."[29]

[45] I also thought Dr van de Hoef's opinion about the defendant's preservation of memory was very interesting. The charges are dated and span a period of 50 years. Her first observation about that was that people suffering from dementia tend to forget more recent things first, rather than older memories – t 1-51. Her second observation was that the events alleged against the defendant were very significant, so they would not "be easy to forget for an ordinary individual" – t 1-51. She then dealt, I thought very sensibly, with the idea that if the allegations are false, the defendant could not possibly remember them – t 1-51. So far as that latter proposition was concerned, Dr van de Hoef had already given this evidence to the Prosecutor:

> "In terms of the importance so far as assessments of fitness for trial in relation to trying to ascertain whether the accused is able to give an account of the alleged events, are you able to assist us in terms of the significance of that matter to a question of fitness? I note you spent some time trying to ascertain information from him?--- Well, I did. But there's a problem, because [HYX] has consistently, over a long period of time now – because let's not forget, before this became a criminal matter and a Mental Health Court matter, as I understand it, it had reared its head as a potential civil case, and he was aware of the allegations for months, as I understand it, before he was charged. He's always denied them. He's consistently said they never happened, it's a pack of lies, and so to ask him to recall events he said never occurred is a bit of a problem. So that's another reason why I asked him to think of anything he could around many of the material times that could disprove it.
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> Yes?--- And that's when he came up with that list of, I thought, quite impressive potential issues for mounting a defence."[30]

[46] Dr van de Hoef concluded that it was likely the defendant had cognitive deficits caused by a dementing illness which deficits were across a number of cognitive domains. She doubted that the illness began as early as his wife described, given the history that in 2012 [redacted]. If there was a dementing process then, Dr van de Hoef comments that it must have been "very early and mild".[31] Dr van de Hoef thought that the defendant's

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[29] tt 1-50-51.
[30] t 1-48.
[31] p 19 of Dr van de Hoef's report.

functioning had declined since then, and especially since 2013, having regard to his declining test scores and his psychosocial functioning. In that context she mentions the number of psychiatric admissions he had commencing in 2013. She also mentions that, "the timing of this worsened mental state and functional decline coincides with the large number of serious criminal charges laid against him, and the fact that [redacted] the ignominy, fear, and disgrace attached to those charges and their potential consequences [redacted] would be greater than for the average person."[32]

[47] Dr van de Hoef thought that the dementia which the defendant suffered from was mild.[33] She thought that the dementia probably had multi-factorial causation, including cerebrovascular disease, long-term alcohol abuse and chronic untreated sleep apnoea.[34] Dr van de Hoef did not think that the defendant's decline in functioning and symptoms were all clearly attributable to a dementia. She thought his chronic PTSD and his significant depressive illness were contributors to the clinical picture painted by him and his wife. She comments that the latter two conditions were theoretically reversible or amenable to treatment, although she conceded that the stress of Court proceedings might render recovery less likely. Dr van de Hoef concludes:

> "In my view, the issue of 'suboptimal performance'/ malingering/ exaggerating deficits to obtain poor test results remains a live one, i.e. is not fully clarified. I simply think it cannot be ruled out, especially given the very poor performance on the test with me, 4 months after Dr Till's assessments. I also think it is possible [HYX] [redacted] might know dementia could help avoid conviction and jail."[35]

[48] As to fitness for trial, Dr van de Hoef said in her report:

> "[HYX] said he knew he had 'more than 12' charges (of which he could name indecent dealing), and that the complainants were his 2 daughters [and his nieces]. He said he knew these were serious matters, and that he could go to jail if convicted. He was aware of the allegations now being a criminal matter, and that a custodial sentence could be imposed if he were convicted. He said he hoped he 'could remember enough to defend (him) self.' He knew the difference between guilty and not guilty, and intended to plead not guilty (to all charges). He understood the functions of the agents of the court. He could, in my view, withstand the rigours of a trial without detriment to his mental health.
>
> I have considered whether his dementia, depressive illness or PTSD impacted any of these abilities sufficiently to render him unfit; I am sure they would be affected by all 3 conditions (probably via impaired concentration and attention, and perhaps by reduced processing speed) but not so much as to render him incapable of understanding proceedings and participating in them (especially given [redacted] and his long term memory seems relatively well preserved.) If his depression were to resolve, I think his abilities might actually improve.

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32 p 19 of Dr van de Hoef's report.
33 In coming to that conclusion, she disregarded the catastrophic ACE-R score of 54 mentioned above.
34 p 20 of Dr van de Hoef's report.
35 p 20 of Dr van de Hoef's report.

> In my opinion, therefore, notwithstanding his dementia and depression, [HYX] is currently fit for trial."[36]

Professor Byrne

[49] Professor Byrne specialises in geriatric psychiatry, and for 25 years has run the Alzheimer's Disease Research Clinic at the Royal Brisbane and Women's Hospital. He said that he had seen "hundreds and hundreds of patients each year where the question of Alzheimer's disease arises, and where detailed assessments are done, psychometric assessments, clinical assessments, neuroimaging assessments."[37]

Non-co-operation

[50] Professor Byrne saw the defendant for two "long interviews", one on 11 May 2017 and one on 15 June 2017. He had short interviews with the defendant's wife on those dates. He wrote a report dated 19 September 2017.

[51] Professor Byrne's view was that the defendant did not co-operate with the examination except to a "quite limited" extent. That was the reason for his asking for two extended examinations – p 9 of Professor's Byrne's report.

[52] As to his conclusion that the defendant was unco-operative in his interview with him, Professor Byrne said the following:

> "… So it was unchanging. So one often might start an awkward interview, you know, with a little bit of harrying and then once things get going, you know, repartee develops and guards are dropped and, you know, accurate testing can be performed. And at the end, the person who's being assessed feels a bit better about it even though they may be in difficult circumstances. So that wasn't the case. So in this circumstance, what happened on each of the occasions was that [HYX] was uncooperative the whole time.
>
> Yes?--- There was no mellowing. There was no – my attempts to engage in sort of fairly inconsequential, normal conversation in order to break the ice – unsuccessful.
>
> Yes?--- So that struck me as very unusual."[38]

[53] As to Professor Byrne's assessment that the defendant was not co-operating with his testing, Dr Till thought that might be accounted for by dementia or perhaps the defendant's emotional state or a lack of willingness to be assessed.[39] Professor Byrne did not agree that the defendant's presentation on interview with him could be accounted for by anything other than an unwillingness to co-operate.[40] In this regard see the extract from his evidence at [56] below.

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[36] p 21 of Dr van de Hoef's report.
[37] t 1-30.
[38] t 1-37.
[39] p 7 of Dr Till's report, 22 October 2017.
[40] See the extract from Professor Byrne's evidence at [52] above.

[54] Professor Byrne thought that the defendant was unwilling to discuss the offences with him. The defendant referred to his poor memory in refusing to discuss the offences. However, Professor Byrne says, "In this regard, it is worth noting that the offences were alleged to have been committed over a period of 24 years and that the first of the alleged offences may have been committed about 50 years ago. However, HYX was able to speak about his experiences [redacted], which occurred around the same time as the alleged offences."[41]

[55] Professor Byrne expanded on this in his oral evidence:

> "Well, I always endeavour to address the charges with the accused to assess their understanding of it. [HYX] said he could not recall these, and then – then I read them out to him seriatim, and he still couldn't recall them. He – I read out who the named individuals were who were making the claims. He said no, they were different people, and anyway, it was all a lie, and it was all to collect money from him. So he had an alternative theory, but he was unwilling to engage on the specifics of the individual charges.
>
> … So when he reviewed [refused] to be engaged on that after, you know, multiple attempts to do so, I proceeded to other matters.
>
> Yes. And you make the point in your first report that he did have apparent reasonable recall of his life [redacted] around that same period?--- Well, that's right. I mean, he was able to refer to a whole range of [redacted]. So he was able to provide a reasonable amount of detail of that, and more importantly, he was able to tell me about his grandson, [redacted]. He was able to tell me those details. That's not something from the distant past. That was a contemporaneous fact.
>
> Yes?--- And very few people I've spoken to would be able to say [redacted]. I mean, it's a fairly sort of specific fact which suggests that he was able to generate new memories, at least on things that were important to him."[42]

[56] Professor Byrne's conclusions were:

> "I still felt the presentation by [HYX] was exaggerated, and that he had excessive slowness which couldn't really be explained properly by any depression, post-traumatic stress disorder, history of alcohol abuse, or mild cognitive impairment, or perhaps very early dementia. I thought it was all too much. I've probably conducted between eight and 10,000 interviews of people with dementia or where the question of do they have dementia has arisen, mostly not in forensic settings, but sometimes in civil forensic and sometimes in criminal forensic settings, and I've never encountered someone who presented in this way, in such an exaggerated fashion and such an uncooperative fashion for testing. The fact that I formed the view that [HYX] was not being cooperative and was exhibiting low or poor effort doesn't mean that there may not have been some mild cognitive impairment. It simply means that the presentation is a sham - - -

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41 p 3 of Professor Byrne's report.
42 tt 1-34-35.

> Yes?--- - - - and undermined the value of the evidence that I might have otherwise been able to assign some value to, so – so that was my problem, that I left thinking, well, I can't be sure of any aspect of his evidence because of the way he performed when I assessed him, which was quite unlike any of the other thousands of people I've assessed under similar and different circumstances."[43] (my underlining).

[57] I will record that Professor Byrne was very definite in his views. He was not dogmatic, indeed under cross-examination he certainly made concessions, but I was left with the impression that there was no doubt about these matters in his mind.

Testing

[58] Professor Byrne administered a test for memory malingering to the defendant. In his report he said this about it:

> "Valid cognitive testing is reliant upon an appropriate degree of effort being exerted by the testee. Effort was assessed on Trial 1 of the Test for Memory Malingering (TOMM). [HYX] was shown 50 line drawings of common objects and asked to remember these. He was then shown drawings of pairs of objects, where one of the objects had been shown before. He was asked to point to the object that had been shown before. He was not required to name the objects. Although this task appears difficult to the testee, it is actually very easy, even for people with mild to moderate dementia. [HYX] obtained a score of 26, indicating grossly reduced effort. Grossly reduced effort is likely to invalidate the findings from other cognitive tests that require the testee's cooperation."[44]

[59] Further, Professor Byrne administered the mini mental state examination and said:

> "On the Mini Mental State Examination (MMSE), a screening test for cognitive impairment in older people, [HYX] scored 15/30. Scores of 18/30 and below are usually found in people with at least moderate dementia, many of whom are residing in residential aged care facilities and many of whom require assistance with basic activities of daily living, such as washing, dressing, feeding and toileting."[45]

[60] Professor Byrne administered other tests and considered that the defendant's performance was "grossly impaired" to the point that the scores he produced were "generally found in people with at least moderate dementia".[46]

[61] Professor Byrne had the defendant complete two trail-making tests. In the first he had to join 25 numbered circles, i.e., 1-2-3 … and so on, as quickly and accurately as possible. He took five minutes and 30 seconds to complete the task, whereas a normal person in his age range would complete it in 37 seconds if their IQ was at the 50th

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43 t 1-30, ll 3-20.
44 p 11 of Professor Byrne's report.
45 p 12 of Professor Byrne's report.
46 p 13 of Professor Byrne's report.

percentile, or 53 seconds if it were at the 10th percentile. The second trail-making test had to be discontinued after four minutes and 20 seconds because the defendant behaved as though he could not continue. At that point he had joined only three of the points. That second test is slightly more difficult. A normal person of the defendant's age at the 50th percentile of intelligence, would complete it in 86 seconds, and at the 10th percentile of intelligence, would complete it in 137 seconds.[47] There were other similarly poor results on other tests.[48] Professor Byrne concluded as follows:

> "[HYX] had a predicted premorbid IQ in the normal range. He exhibited grossly reduced effort on the Test of Memory Malingering (TOMM), thus calling into question the validity of subsequent cognitive testing. If the findings from extended clinical cognitive testing were to be taken at face value, they would be indicative of moderate to severe dementia. However, the reduced effort he exhibited on the TOMM, the generally uncooperative nature of his performance at interview, the inconsistencies in his memory performance, and the collateral history obtained from his wife about his current everyday function at home all suggested to me that his actual level of cognitive function is likely to be considerably better than that seen on formal testing.
>
> It is possible that [HYX's] posttraumatic stress disorder, depression, and history of excessive alcohol intake have combined to produce mild cognitive impairment. However, his current level of markedly reduced effort suggests to me that he is exaggerating any genuine cognitive impairment in the hope of being found unfit for trial."[49]

[62] Further Professor Byrne said:

> "In my opinion, the degree of apparent cognitive impairment exhibited at interview is not consistent with [HYX's] reported level of function, nor with his ability to recall recent and remote matters of interest to him. His clinical presentation appears to me to be a poor facsimile of dementia and seems likely to be due to markedly reduced effort or to deliberate exaggeration of deficits.
>
> While it is difficult to exclude the presence of mild cognitive impairment (mild neurocognitive disorder), which might be related to current depression or post-traumatic stress disorder, or possibly to untreated sleep apnoea or past excessive alcohol intake, the extent of exaggerated cognitive impairment appears to be considerable.
>
> …
>
> I should point out that the prior probability of [HYX] have dementia with an onset at the age of 60 years is low, even if his mother had dementia in her 80s.
>
> Although a diagnosis of dementia was made by [HYX's] treating psychiatrist shortly after the current charges were laid, I do not think there is

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47 p 14 of Professor Byrne's report.
48 See p 14 of Professor Byrne's report.
49 p 15 of Professor Byrne's report.

> sufficient evidence to confidently conclude that [HYX] is suffering from dementia."[50]

[63] I turn to the analysis made by Dr Till of Professor Byrne's cognitive testing. The difficulty so well described by Dr Harden at [16] above re-emerges. Dr Till acknowledges that the defendant's performance could be categorised as reflective of sub-optimal effort on Professor Byrne's TOMM test but qualifies this by saying, "However, [HYX] has a diagnosis of Dementia from two practitioners. … When [HYX's] various scores are compared to the clinical dementia sample in the test manual, his performance is within the range that could be expected for the condition."[51] Dr Till refers to some literature which discusses the difficulties in using this test to differentiate sub-optimal effort from dementia.[52]

[64] Dr Till said he was not aware of any literature specifically supporting Professor Byrne's opinion that a score of 18/30 on a mini mental state examination was consistent with moderate dementia such that someone scoring at that level would be in residential aged care facility, requiring assistance with basic activities of daily living.[53] He further comments that mini mental state examination scores are not, in his opinion, a particularly robust estimate of functional ability or the need for support.

[65] Professor Byrne gave evidence after hearing Dr Till expand on his views in oral evidence and said:

> "I mean, I listened carefully to what Dr Till said, and I agree with his – the technical argument that he made, but he was scoring – [HYX] was scoring at chance levels.
>
> Yes?--- I've administered this test for a number of people with dementia and none of them have scored at chance levels.
>
> Do you accept that this could be problematic for people with dementia?--- I – I accept that if you have moderate or severe dementia, almost all psychometric tests start to deteriorate in their reliability and validity, and you have – you have floor effects where you can't get below the certain score and – and you start to wonder whether the person has the basic brain functions necessary to even understand what's being asked of them, so certainly that will affect anything, including the Test of Memory Malingering.
>
> Yes?--- But the overall circumstances of [HYX's] presentation and what his wife said to me really didn't accord with moderate or severe dementia.
>
> At that time?—At that time. That's right.
>
> Just if you could bear with me, Professor Byrne. And on page 12 of your initial report, you refer to the Mini Mental State Examination. You note he

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50 p 18 of Professor Byrne's report.
51 p 4 of Dr Till's report, 22 October 2017.
52 p 4 of Dr Till's report, 22 October 2017.
53 And yet the defendant does not require this level of care – a point made by Dr van de Hoef, see [41] and [42] above, and Professor Byrne, see [65] below.

> scored 15 out of 30 and scores of 18 out of 30 and below are found in people with at least moderate dementia?--- Commonly. Yes.
>
> And many whom are in residential aged care facilities and need assistance. Given the reporting from [the defendant' wife] at the time, was the level of assistance he was being provided at that time not in the area of what one would get in terms of assistance in respect of activities of daily living if he had been in residential care?--- I don't think so, because she was providing a low level of assistance with complex instrumental activities of daily living but not with basic activities of daily living, which you would normally expect someone to require in order to go to a nursing home. So I thought there was a mismatch there."[54]

[66] As to the defendant's abnormal slowness in completing the trail-making tests, Dr Till says that the most that can be concluded is that the defendant was abnormally slow compared to equivalent peers. He thought that while behavioural features in his completion of this measure might suggest insufficient effort, he thought it more likely having regard to all the assessments which had been done that the behavioural features would likely represent deficient ability.[55] His oral evidence was that the defendant's performance on Professor Byrne's testing was "relatively consistent with mine".[56] Further, Dr Till did not think that failure to complete the second trail-making test was unusual. He says that there is a high rate of failure to complete this test amongst people with dementia.[57]

The Defendant's Behaviour at Hearing

[67] While Professor Byrne gave the evidence I quote at [52] above, the defendant reacted as described:

> "HER HONOUR: And I'll just – I'll just interpose. That – as you were saying that, [HYX] rolled his eyes to the ceiling, shook his head and shrugged his shoulders in a contemptuous manner, which indicates to me – and I would like your opinion on it – that he well understood what you just were saying at a rapid rate of speech to Ms Loode. Are you able to draw any - - -? ---Well, thank you, your Honour. I – I wasn't watching the screen.
>
> I know you can't – I know you can't see it?--- But I'll take you at your word that that's what happened, and I think it's very telling.
>
> Yes. It does to – I – I would interpret that as meaning that he could understand the import of what you were saying, and you were using relatively complicated language and you're speaking relatively quickly?--- I agree with that, and I think it goes to fitness, as well, because it goes to ---
>
> I will ask Dr van de Hoef about it, too, because she saw it and you didn't. But---? --- All right.

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54 t 1-39.
55 p 6 of Dr Till's report, 22 October 2017.
56 t 1-28, l 37.
57 p 6 of Dr Till's report, 22 October 2017.

> But I do – I am forming views as I watch him, and that's – it's – it's important, I think, that I record them and to get expert opinion on them."[58]

[68] I would comment that Professor Byrne gave evidence in an intellectually energetic way. He was very engaged in the process. Ms Loode was at the end of the Bar-table closest to the witness box and at the time of the evidence just recorded, Professor Byrne was very engaged with her and speaking rapidly. The video monitor on which the defendant appeared was behind Professor Byrne so he could not see the defendant as he spoke. Dr van de Hoef was sitting in the jury box facing a larger-than-life-size projection of the defendant's head and shoulders at the time. She said this:

> "My understanding of your opinion is, in fact, that you feel that [HYX] is in a position where he would be able to understand proceedings and participate in them. You would've just seen the interaction around [HYX's] response to some of Professor Byrne's evidence. Was that something you witnessed yourself? Were you looking at the screen?--- Yes, I was.
>
> Are you able to give the court your impressions of that, and perhaps whether you clinically – think it's clinically significant?--- Well, her Honour's commented on it, and you're asking me to comment on it too. In some ways it's a little unfair, that question, because [HYX's] attending this hearing on a screen.
>
> Yes?--- Unfortunately for him, there's a room full of psychiatrists and anybody sitting over there will have been watching him. There seemed to me – to me to have been a number of occasions during this morning's hearing where [HYX] has clearly and rapidly understood what was being said. What her Honour referred to was a striking example of that, but there were other examples too, including reference to his past alcohol abuse, which he actually told me about himself in our interview, and he looked surprised, instantly, the moment that was raised. So I think in terms of what we've heard about his slow processing and ability to retain information and – and understand it – comprehension – which goes to the heart of fitness for trial, too – one of the many things, there has been evidence this morning that he has understood at least some of the very relevant things that have been raised in this morning's hearing and understood them quickly.
>
> Thank you, Doctor. Now ---
>
> HER HONOUR: Just before you leave that, can you say anything further about even when he's not expressing through his body language, I suppose, and his facial expressions and so forth an understanding of what's going on, can you say anything about his general demeanour as we've sat here now for two and a-half hours?--- I think if it's accepted or proposed that [HYX] has a moderate to severe level of dementia, I am amazed that his apparent attention and concentration and alertness and engagement, it would seem, with the hearing has been as good as it appears to be. To me, that's another inconsistency. So I don't accept – not just because of that but for multiple reasons, I don't accept that he, at least when I saw him, suffered from a moderate to severe degree of dementia.

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[58] tt 1-37-38.

> MS ROBB: And despite not having seen him for some time now, what you see today is, in fact, consistent with your initial impressions?--- Well, yes, it's pretty weak evidence overall, but, yes, it's not consistent, I think, with moderate to severe level of dementia today."[59]

[69] My observations of the defendant throughout the hearing were that he remained focussed in a very direct way, staring at the screen of the video proceedings at his end. The focus of the picture in the Court was very much on him. It could be seen that there was a gentleman sitting to his right, but that gentleman was not often within camera shot. There may have been other people in the room with the defendant. He did occasionally appear to speak to the gentleman on his right. He sometimes engaged in activities such as pouring himself a glass of water and drinking it. However, he remained intensely focussed on the screen display of what was happening in the courtroom. There was never an indication that he lost concentration; looked around the room he was in; asked for assistance in remembering where he was or what he was doing, or reacted to goings-on in that room, real or imaginary.

[70] My assisting psychiatrists were cautious in the use that could be made of the defendant's appearance during the hearing. Dr Harden said:

> "I mean, although I too saw his reaction, the issue of – and his reaction is not in keeping with that of someone who's disconnected from the hearing. Right. His reaction was to something that we all saw in the hearing that was happening and that he seemed to react. I mean, but one has to be very careful not to over egg that one observation."[60]

Wider Examination by Professor Byrne

[71] It is clear that Professor Byrne's opinions were based not just on the results of testing but on his assessment of the defendant at the two interviews he conducted, in the context of all the information about the offending. Dr Till's examination and opinions were, to the contrary, almost entirely limited to the administration of testing. As noted above, he assumed that the defendant had dementia. He did not press him in relation to any of the charges with which he was faced.[61] He did not try to discern whether or not the defendant could remember any of the offending, or his life at the time, and in the places, where the offending was alleged to have taken place.[62] Dr Till did not have any explanation for how it was that the defendant could provide details to Dr van de Hoef and Professor Byrne, which he did not provide to Dr Till.[63] To be fair to Dr Till, his role was primarily to administer testing. It was more the province of a psychiatrist to conduct a full interview and examination as to fitness for trial. This different approach to assessing the defendant as to his fitness for trial is very important to my decision to prefer the evidence of Professor Byrne and Dr van de Hoef. Professor Byrne addressed the matters this way:

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[59] tt 1-43-44.
[60] t 1-80, ll 32-36.
[61] t 1-6, l 30 and t 1-10, l 24.
[62] t 1-9, ll 25-47.
[63] t 1-8, ll 20-45.

"His [Dr Till's] results are similar to my results, actually. It's the interpretation of the results which is at stake. I don't have any problem with the tests he's administered or the numbers that he's got or his interpretation of those numbers. It's the question of, in the clinical context and for the court in terms of fitness for trial, do those results mean that the findings are valid and reliable and do they then mean that [HYX] is not fit for trial. Now, [HYX] is an unusual person because he [redacted] understands the nature of the court process. He understands – well, one would imagine he would understand the defences that have been employed previously, and so he – he's not just a man in the street. And then, secondly, he's a youngish man in dementia terms. He's not someone in his mid-80s, and this court has seen people in their mid-80s where – where the question of dementia has been asked. The prior probability of dementia in someone in their 60s is much, much lower. It' quite low. So the vast majority of people walking around in the streets of Queensland who are in their 60s do not have dementia. So – so there has to be something to convince me that he's not in that ordinary category; he's in the other category of a very small group of people who do have dementia. The nature of the offences raised concerns in my mind [redacted] that there may be a greater than normal sort of attempt to muddy the waters and – shall we say. So I had sort of concerns before I'd even seen him that there could be issues at stake here, and when I saw him I was expecting a normal, somewhat reticent but – but generally reasonably cooperative person who would answer questions in good faith, possibly would be avoidant about answering questions about the alleged offences because of embarrassment and shame and the nature of the offences. Sure. I could understand that. But I couldn't really see what the argument was for exaggerating disability if the disability was really there, anyway. It just didn't make sense to me. And then it wasn't just the performance on the cognitive testing or the TOMM, the measure of effort. It was his whole presentation over – over more than – or at least three hours of interviews conducted on two occasions that – that just didn't gel with me and didn't fit any pattern that I'm familiar with from interviewing large numbers of people with – with dementia. So I immediately thought this is an exaggerated presentation. It wasn't simply the numbers. The numbers, if they're taken at face value, do indicate, as Dr Till has said, that [HYX] probably has moderate dementia.

And so just to pick up on what you've said then. So your clinical assessment, then, is informed by the results of those tests, which, taken on face value, as you say, may indicate a particular thing, his life experiences but perhaps of particular importance, I think, you've distinguished between non-forensic dementia patients and forensic dementia patients. That the fact – that, in fact, he is facing the charges may, in fact, be of material weight?--- Yeah. The demand characteristics of the interview are entirely different - - -

I see?--- - - - for the person being interviewed.

So is it fair to say, then – or, Professor Byrne, I will ask it as a question. Your fundamental opinion, then, about fitness for trial and this man's current status quo would be - - - ? --- Well, my opinion back then, 15

> months ago, was that he was exaggerating his deficits and therefore I couldn't rely on anything he told me.
>
> Yes?--- So I – I took the default position that he was likely to remain fit for trial."[64]

Insight

[72] Professor Byrne gave evidence that 80 per cent of people who have dementia, especially the Alzheimer's type, have no insight into that fact. As a consequence, "They don't tell you there's anything wrong with them at all". In this sense, the defendant was therefore unusual in explaining to all the doctors who assessed him that he was suffering from cognitive problems, which he specified, see eg., [10] and [35] above.

Dr King

[73] Dr King specialises in geriatric psychiatry [redacted]. Dr King has been the defendant's treating doctor since November 2013 – t 1-54. It seems to be the case that the defendant attends at that hospital for one or two days respite per week.[65] As well he consults with Dr King every six weeks. The defendant has had numerous admissions [redacted] as an inpatient over the years under Dr King's care which are summarised in her report.

[74] Dr King gave the opinion at paragraph [3] above in 2014. Her report of 30 July 2018 is longer. By that stage she had both Professor Byrne's report and Dr van de Hoef's report which indicated clearly that two independent psychiatrists, both very experienced in forensic work and, in the case of Professor Byrne, an authority on Alzheimer's disease, had given opinions to the effect that the defendant was feigning or exaggerating cognitive impairment.

[75] In answer to a question from my assisting psychiatrist Dr Harden, Dr King said that she was "coming from a role of advocating and – and treating [HYX]" – t 1-66. She had never provided an assessment of fitness for trial before – t 1-68.

[76] I am surprised that a treating doctor would give a report to the Court in such circumstances.[66] Were the treating doctor to come to the conclusion before or during the evidence at hearing that their patient was exaggerating or feigning, the doctor would be obliged to say so in giving evidence on oath. To do so might well destroy the relationship between patient and doctor and might have considerable adverse consequences for the patient. This is, I would have thought, particularly acute in the case of a psychiatrist. It may have other consequences for a doctor who has [treated] a patient very intensively on a wrong basis. In this case, Dr King was not persuaded by the independent reports, or listening to the evidence of Professor Byrne and Dr van de Hoef.[67] So the problems just discussed did not arise. However, it must be recognised that there will be factors, conscious and unconscious, which would make it difficult for

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[64] tt 1-31-32.
[65] t 1-64, ll 25-33.
[66] See my comments in the Court of Appeal decision of *Berg v DPP* [2012] QCA 91.
[67] See Dr Harden's questioning between t 1-68, l 42 and t 1-69, l 15.

a treating doctor to objectively assess opinions such as those given as to feigning and exaggerating in the current case.

[77] Dr King acknowledged that she felt uncomfortable in her role and acknowledged, "I can't take a forensic role, but I can help to clarify his underlying medical problems" – t 1-58. In fact, where the existence and extent of any underlying medical problems were squarely in issue, I do not think that is a sensible distinction for her to make.

[78] The first eight-and-a-half pages of Dr King's report simply summarise her (quite intensive) treatment of the defendant. She then outlines that on 5 June 2018, 19 June 2018 and 17 July 2018 she had specific interviews with the defendant for the purpose of assessing his fitness for trial, and that on 24 July 2018 she had a specific interview with the defendant's wife for the purpose of gaining information for this proceeding. On the first of those three occasions she administered one cognitive testing instrument.

[79] In the information which Dr King summarises as given by the defendant, there is less detail of his childhood, upbringing, and work history than in the independent reports. He gave very sparse details about the proceedings and how he would approach them.[68] Dr King did not ask questions to see if the defendant did in fact have any memory around about the time of the alleged offences – t 1-59. She took his comments – that she would have to ask his wife – at face value – t 1-60. She relied upon the fact that he could tell her nothing about the charges in her assessment that he was not fit for trial – t 1-60. She concluded that his inability to give that information was consistent with his low performance on testing – t 1-62. She did not deal with the circumstance that both Professor Byrne and Dr van de Hoef had extracted information from him about the relevant periods of time – t 1-63.

[80] Under the heading "Consideration of other Professional Reports", Dr King gives a very brief summary of her understanding of the information in other reports to the Court but does not offer any analysis or criticism of any other report.[69]

[81] In her report Dr King says:

> "[HYX] has displayed evidence of significant cognitive decline over the 4.5 years I have known him. He has shown decline in memory, frontal lobe function, verbal fluency, attention, and concentration.
>
> This is supported by serial standardised cognitive screening tools and serial neuroimaging with MRI and SPECT scans.
>
> …
>
> Meeting the criteria for the DSM V conditions for Major Neurocognitive Disorder: he has deficits in more than one domain of cognitive function and he has impairments to his day to day functioning. He is increasingly reliant on his wife and increasingly dependent on hospital staff during admissions.

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[68] p 10 of Dr King's report.
[69] pp 13 and 14 of Dr King's report.

> I would describe his current level of overall cognitive impairment as moderate."[70]

[82] It is clear from her evidence that Dr King interprets this decline as being typical of the progression of Alzheimer's disease – t 1-56.

[83] These conclusions are not entirely convincing when the evidence for them is examined.

[84] Dr King organised magnetic resonance imaging and PET scan testing. In her report she quotes from the radiologist's reports on those scans.[71] The radiologist's report on the MRI report speaks of quite mild progressive atrophy and "slight progression" of white matter changes. This report does not say anything about cognitive functioning and, indeed, does not mention dementia. Dr King quotes directly from the radiologist's reports, but offers no analysis or opinion of her own as to the imaging.

[85] Dr King is seeing the defendant regularly (every six weeks); has had him as an inpatient under her care several times over the past few years, and occasionally observes him briefly in group therapy sessions organised at the hospital. I would have thought she could have given a plethora of convincing examples of his functional disabilities, but she did not. She referred to him forgetting medical appointments.[72] This seems an odd example to give in circumstances where she reports that [the defendant's wife] is acting as full-time carer for the defendant. If this is so, the defendant would not be in charge of making and remembering his own medical appointments in order to demonstrate forgetfulness by missing them.[73]

[86] Dr King gave an example in late 2017 where the defendant misunderstood what another patient was saying. He became agitated – t 1-65. This is one isolated example which maybe Dr King witnessed, but likely someone reported to her.[74] Another individual example was given that the group co-ordinator of the day program had noted that the defendant asked when the group was going to complete a particular project after he had actually completed that project – t 1-71. This information was hearsay, so that its rendition rather lacked force. Further, once again it is a pretty isolated example in a context where Dr King believes this man to have increasingly severe dementia.

[87] Otherwise Dr King gave very general evidence that the defendant was quiet, had at times fallen asleep, and sometimes forgot to come to his appointment with her from his day sessions.[75] He had little spontaneous language and responded monosyllabically to questions rather than answering in sentences. He described a low mood and lacking energy. He reported being worried and feeling confused in a dysphoric way.

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[70] p 15 of Dr King's report.
[71] p 13 of Dr King's report.
[72] See t 1-56, ll 25-45 and t 1-63, ll 32-40.
[73] t 1-64.
[74] cf t 1-70, ll 35-40, where she says that she has only observed his behaviour in his respite group therapy for "brief periods of time".
[75] tt 1-70-71.

[88] The cognitive testing tool ACE 111 which Dr King administered on 5 June 2018 put the defendant at 58 out of 100, where scores of 82 and below are highly indicative of dementia.[76] Dr King notes that the defendant's ACE 111 score and mini mental state score have declined from 83/100 and 24/30 (respectively) in 2013, to 58/100 and 13/30 in 2018 and 2017 (respectively). She says that this is consistent with the pattern of cognitive decline that would be expected with Alzheimer's disease.[77] Dr King accepted that the defendant's testing scores fluctuated from time to time. She explained this by saying that she thought, "There is a fluctuating level to his capacity" – t 1-56 – and that there were times when the defendant had had "a catastrophic level of anxiety, and that has impaired his functioning at that time, cognitive and otherwise" – t 1-56.

[89] Dr King thought that the way the defendant had presented since 2014 was consistent with his having a progressive Alzheimer's disease. She did acknowledge there was a slight mismatch between some of the testing and his day-to-day abilities – t 1-56.

[90] Dr King's view was that the defendant is not fit for trial. She thought his dementia was at "the severe end of moderate level of impairment" – t 1-59.

PET Scanning

[91] After all the reports in this matter had been provided, Dr King organised a PET amyloid scan. The radiologist's report is dated 25 October 2018 and the radiologist concludes that there was "pronounced beta amyloid deposition" in the defendant's brain.

[92] Professor Byrne said that an amyloid PET scan could be positive for 10 or 20 years before the onset of any clinical symptoms – t 1-36. The amount of amyloid material found in the brain is not strongly correlated with the degree of cognitive impairment in any case – t 1-36. Professor Byrne said that having such a scan as the defendant has, "means that you're at higher risk of going on to develop dementia of the Alzheimer's type if you live long enough, but plenty of people with positive amyloid PET scans of their brains don't have any cognitive impairment currently. … they probably have Alzheimer's disease, but they don't have dementia." – t 1-31, l 10. The PET scan did not change Professor Byrne's view – t 1-29, l 45.

[93] Dr King said that the most recent PET amyloid scan "supports that he has a level of Alzheimer's disease that has been a part of his progressive cognitive decline". I accept that the scan is consistent with her diagnosis and opinion, but I do not accept that it provides independent support for his having a dementia. I prefer the more precise evidence given by Professor Byrne on this point.

[94] For all the reasons discussed above, I prefer all the other evidence in the case to that given by Dr King.

Time Since Examination by Professor Byrne and Dr van de Hoef

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[76] p 12 of Dr King's report.
[77] p 15 of Dr King's report.

[95] Three years had passed between the time when Dr van de Hoef examined the defendant, and this hearing. Fifteen months had elapsed between Professor Byrne's examination of the defendant and the hearing.

[96] Drs Till and King gave more recent reports than Dr van de Hoef and Professor Byrne. Professor Byrne acknowledged that this put him at a disadvantage.[78]

[97] In Professor Byrne's letter of 27 September 2018 he acknowledged that his last examination was undertaken more than 15 months ago and therefore "it is possible that [HYX's] cognitive function has deteriorated since then". However he said of Dr Till's second round of testing, "The validity of these findings, which if taken at face value suggest dementia of at least moderate severity, rely critically on the application of honest and consistent effort by the testee. I do not know whether this was the case."

[98] In this context he noted that both Dr King and Dr Till reported that the defendant had deteriorated over time but he questioned whether the defendant continued to exaggerate his performance.[79] The defendant's performance might be brought about by depression, PTSD, alcohol abuse or "wilful poor performance".[80]

Conclusions

[99] There is no method of scientifically proving whether or not the defendant has dementia, or if he has, whether it is mild or affects him more seriously. As at the date of Professor Byrne's last examination, my view is that the evidence does not show the defendant to have any cognitive impairment sufficient to make him unfit for trial. I come to this conclusion for several reasons.

[100] Firstly, Professor Byrne's very great experience in examining dementia patients. For him to say that the defendant performed unlike any of the thousands of people he has examined – [56] above, has great weight. This is not just to rely on the *ipse dixit* of a learned medical man;[81] Professor Byrne was at pains to explain why he reached the conclusions he did.

[101] Secondly, Professor Byrne's examination, and that of Dr van de Hoef, were of a different type to that of Dr Till. Dr Till did not conduct a medical assessment of the defendant. He did not push him to find out if he could remember the charges or the times when the subject matter of the charges allegedly took place. He saw his role (correctly) largely as administering testing – [71] above. Professor Byrne and Dr van de Hoef took a larger view of things and analysed matters other than the defendant's test scores. I thought Dr van de Hoef explained the difference well at [44] above. Using this approach, both the independent psychiatrists came to the same conclusion: lack of effort.

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[78] t 1-32, l 35 – t 1-33, l 10.
[79] t 1-32.
[80] t 1-33.
[81] cf *Makita (Australia) Pty Ltd v Sprowles* [2001] NSWCA 305, [66].

[102] Thirdly, Dr Till started with the belief that the defendant had moderate to severe dementia. Of course, that is the very question for the Court. It was not really Dr Till's role to come to a conclusion on medical matters. That he did so did not invalidate his testing. But it did mean that his interpretation of the test results was not impartial. When the test results might equally be consistent with lack of effort or dementia, the assumption that in fact the defendant had dementia meant that Dr Till's opinion was a foregone conclusion.

[103] Professor Byrne and Dr Till were in agreement that it would be necessary to have cognitive ability in order to exaggerate disability, or feign poor results, on testing. Professor Byrne said:

> "I would anticipate if he was cognitively deteriorated that the extent of any exaggeration would diminish as he'd lose cognitive control over the exaggeration. In fact, the fact that I thought he was exaggerating made me think he still had quite good cognitive control.
>
> Yes?--- Because it requires some cognitive ability and effort to maintain an exaggeration."[82]

And

> "[HYX's] ability to apply markedly reduced effort to cognitive testing suggests to me that he retains the capacity for tactical thinking and behaviour".[83]

[104] I prefer Professor Byrne's view to Dr Till on this point, because of his great experience, but also because he came at the test results without an assumption that the defendant suffered from dementia. This preference is in accordance with the advice from my assisting psychiatrists.

[105] Fourthly, there are a group of indicators which favour the idea that the defendant was exaggerating or feigning:

(a) The defendant's complaints of memory difficulties (to health professionals) emerged after arrest: [28], [32], [36] and [46] above.

(b) Unusually for someone with dementia the defendant complains of the symptoms of it: [72], [10], [35], [37] and [38] above.

(c) The defendant's performance on testing was remarkably bad; inconsistent, and not consistent with the descriptions of the care he needed: [40], [41], [42], [43], [56], [57], [58] and [61] above.[84]

(d) The defendant claimed on direct questioning by all three independent examiners: Byrne, van de Hoef and Till, that he had no memory of any of the events the subject of the charges: [11], [38], [45] and [32], [30], [54] and [55] above.[85] But

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[82] t 1-33.

[83] Professor Byrne's report, p 20.

[84] This finding involves preferring Dr van de Hoef's evidence to Dr Till's. I do so on the basis of the nature of her examination (discussed above), and also because of Dr Till's assumption that the defendant has dementia.

[85] While, in every case denying the charges, a logical impossibility for someone with no recollection.

to Professor Byrne and Dr van de Hoef the defendant gave accounts which showed he could remember the time of the subject matter of the charges, see the paragraph references already given.

(e) The defendant's behaviour at the hearing was to remain focussed on the screen for about four-and-a-half hours. He did not at any time appear vague, unsure of what was going on, or distracted. His facial expression was intent but neutral for most of the hearing, but he did at times give every appearance of understanding what was being said. It was Professor Byrne's opinion that he did understand at these times – [67] above. Dr van de Hoef thought so too – [68] above. Dr van de Hoef said that the "apparent attention and concentration and alertness and engagement" he showed during the hearing were amazing if it was proposed that he had a moderate to severe level of dementia – [68] above. I fully accept that a finding of fitness cannot be made from these observations. However, they are not consistent with, say, the person Professor Byrne described at [61] above. I use the defendant's behaviour at the hearing as support for the conclusions reached by Professor Byrne and Dr van de Hoef that his presentation at examinations required by this Court was not genuine.

[106] For all the foregoing reasons my conclusions are that, as at the date of the second examination by Professor Byrne, the preponderance of evidence was very clearly that the defendant was fit for trial. There was no reliable evidence that he had anything more than a mild dementia, if any dementia at all. He could remember the times at which the subject matter of the charges were said to have occurred, and he had enough cognitive ability to present falsely to those examining him.

[107] The difficult question is whether the evidence still supports a finding of fitness. Dr Till and Dr King have made more recent examinations of the defendant. However, they have been taken in by his false presentations in the past, and have not forensically questioned whether he has dementia. There is no reason why their most recent examinations should have more weight than their original examinations. Dr Till thought his second round of testing showed deterioration on some tests. On others, the defendant's performance originally was so bad that it could not decline. Dementia progresses over time, so a decline is consistent with this. However, as Professor Byrne said, it is consistent with various other things – [98] above. Furthermore, the defendant's performance on testing has been inconsistent, and inconsistent with his reported functioning all through the proceeding in this Court – see the references at [105(c)] above. The worst score he obtained on the ACE-R, 54, was when he was examined by Dr van de Hoef three years ago.

[108] I am very conscious that no party bears the onus of proof in the Mental Health Court. Looking at all the evidence, I am not persuaded on the balance of probability that the defendant is unfit.