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

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

Matter No 2009/00063315

9 September 2010

CORAM: GD WOODS DCJ

In The Matter Of R v HUGH EDWARD MURRAY

Judgment As To Fitness To Be Tried

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

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

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

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

Relevance of Delay To The Charges

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

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

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

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

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

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

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

This is the issue which confronts the court here.

Unfitness Not A Means To Avoid The Law

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

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

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

Conduct of the Inquiry

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

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

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

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

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

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

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

The Evidence

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

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

Non-medical evidence was given by:

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

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

Medical Conditions Affecting the Accused

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

Active Medical History

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

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

Inactive Medical History

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

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

The "Presser Tests"

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

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

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

The Central Conflict

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

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

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

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

A. That is correct.

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

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

...

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

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

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

...

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

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

Dr Roberts was shown other medical reports:

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

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

...

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

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

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

A. Exactly.

...

[p. 16] Q. Compromised cognitive function?

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

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

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

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

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

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

Professor Greenberg, by contrast, took the opposing view:

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

A. Yes.

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

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

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

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

...

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

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

...

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

A. Yes.

...

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

A. Yes.

...

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

A. Yes.

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

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

When cross-examined, Professor Greenberg said:

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

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

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

Some Agreement of the Cardiologists

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

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

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

Dr Kennedy continued:

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

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

Q. Polysystem being?

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

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

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

...

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

A. Outliers?

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

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

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

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

On cross-examination Dr Kennedy was asked:

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

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

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

> [p.136] Q. Yes; now, would you agree with Professor Kiat's description of a moderately weakened cardiac function and dilated heart?
>
> A. Yes. That's a rather non technical way of expressing it.
>
> ...
>
> [p.136-137] Q. So he's got half a heart, half normal, according to
>
> A. His ventricular function is down and he has severely impaired left ventricular function at rest.
>
> Q. And he has a 30 per cent ejection fraction which you've put as very low?
>
> A. At rest he has a low ejection fraction, yes.
>
> Q. Therefore does that mean he's at risk of sudden death?
>
> A. There is a relationship between patients who have had myocardia and sudden death, yes.
>
> Q. There is a strong relationship between impaired left ventricular function and sudden cardiac death?
>
> Q. And he's breathless on minimum exertion?
>
> A. Yeah.
>
> Q. He's in that bottom rung, I think it's in here, NYHA class 3 at best, you see that on page 2?
>
> A. It's on page 1.
>
> Q. Yes, okay, so, do those two components together mean anything?
>
> A. Yes, it means he has very severe cardiac failure.
>
> Q. And his prognosis, then, could be unpredictable?
>
> A. I'm not sure what you mean by unpredictable.
>
> Q. He's a candidate for sudden death?
>
> A. Yes.

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

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

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

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

A. If he was required to maximally concentrate on proceedings

Q. Yes?

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

Q. Yes?

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

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

A. Yes.

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

A. I think so.

Q. Yes?

A. Yes.

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

A. Yes.

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

A. Yes.

...

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

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

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

...

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

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

HIS HONOUR

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

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

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

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

...

[p. 143] These come as anecdotes.

...

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

A. Yes.

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

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

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

...

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

...

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

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

Q. Yes?

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

Professor Kiat further said:

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

...

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

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

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

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

Professor Kiat continued:

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

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

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

Q. So the figure would be much higher?

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

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

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

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

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

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

Q. Without some significant risk?

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

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

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

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

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

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

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

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

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

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

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

As to the various medications he said:

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

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

Professor Kiat was cross-examined:

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

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

...

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

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

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

A. Correct.

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

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

...

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

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

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

Evidence of Dr Neilssen

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

Dr Neilssen diagnosed early dementia, a progressive condition.

In his report and in evidence in chief he said:

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

A. Yes.

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

A. Yes.

Q. Given his multi system deficits.

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

Q. By the various

A. Complainants, yes.

...

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

A. Yes.

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

A. Yes.

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

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

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

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

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

...

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

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

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

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

A. Yes.

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

A. Well, that might assist, yes.

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

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

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

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

...

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

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

As to his possibly giving evidence:

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

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

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

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

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

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

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

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

A. Yes.

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

A. Yes.

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

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

Likely Length of Trial

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

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

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

Conclusions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- the capacity to follow the course of the proceedings;

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

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

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

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

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

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

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

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

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

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

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

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

The accused is unfit to be tried on this indictment.

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

....
G Findlay
Associate.