IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: 2012 / 4886

FINDING INTO DEATH WITH INQUEST

Form 37 Rule 60(1)
*Section 67 of the **Coroners Act 2008***

Inquest into the Death of: SARAH LOUISE CAFFERKEY

Delivered On:	25 May 2016
Delivered At:	Coroners Court of Victoria 65 Kavanagh Street, Southbank
Hearing Dates:	8, 9, 10 September and 12 & 13 October 2015
Findings of:	JUDGE IAN L GRAY
Representation:	MS F. McLEOD SC with MS A. BRENNAN, MS P. HARRIS and MR D. NGUYEN appeared on behalf of the family. DR I. FRECKELTON QC with MR L. BROWN appeared on behalf of the Victorian Government Solicitor
Police Coronial Support Unit	Leading Senior Constable King Taylor

I, JUDGE IAN L GRAY, having investigated the death of SARAH LOUISE CAFFERKEY

AND having held an inquest in relation to this death on 8, 9, 10 September, and 12 & 13 October 2015

at the Coroners Court, Melbourne

find that the identity of the deceased was SARAH LOUISE CAFFERKEY

born on 20 June 1990

and the death occurred on 10 November 2012

at Unit 6/1A Simpson Street, Bacchus Marsh

from:

1 (a) MULTIPLE STAB INJURIES

in the following circumstances:

BACKGROUND

1. Sarah Louise Cafferkey was born on 20 June 1990 and was the only child of Adrian Cafferkey and Noelle Dickson. She grew up in the close-knit rural community of Bacchus Marsh among loving family and friends.
2. Mr Cafferkey and Ms Dickson met in the early 1980s, purchased a house in Bacchus Marsh and were married a few years later. When Sarah was nine months old, the family moved to Queensland for Mr Cafferkey's work commitments. After approximately two years, Mr Cafferkey and Ms Dickson separated amicably. Ms Dickson and Sarah moved back to Bacchus Marsh.
3. Ms Dickson would accompany Sarah to Queensland in her early years to visit her father and Mr Cafferkey would also travel to Melbourne to see Sarah. When she was around five or six Sarah would travel to Queensland as an unaccompanied minor a couple of times a year, to visit with her father, but as she got older she did this less and less as she didn't want to leave her friends from school.
4. Sarah completed her primary school education at Coimadi Primary School in Bacchus Marsh. She commenced secondary school at Bacchus Marsh Grammar and stayed until the completion of Year 10. She then completed Year 11 at Bacchus Marsh College.
5. Sarah suffered asthma from a young age, however this was not diagnosed until she was about 15 years old. Constant asthma attacks, some which resulted in hospitalisation, caused her to miss a lot of school especially in Years 10 and 11. Sarah attempted to complete Year 12 by home schooling as her asthma was making it difficult to attend school. Sarah had expressed a desire to work within the justice system.

6. Around the age of 15 – 16, Sarah started consuming alcohol. It was not condoned or allowed at home, however she would obtain alcohol from associates. Also around this time, Sarah started using illicit drugs including marijuana, GHB and ecstasy. Sarah was being counselled in relation to her asthma and as such counselling extended to cover her drug use.

7. In September 2011, Sarah started a relationship with Mr Christopher Stewart. The relationship was intermittent and the couple would have various disagreements that would cause them to break up and then get back together again. The relationship eventually ended in late October 2012.

8. Sarah attempted to quit her drug habit and, in August 2012, entered a detox facility in Bacchus Marsh. She completed a one week detox program and at the end expressed a desire to change her life.

9. About one month after attending the detox program, Sarah informed her mother that she was using illicit drugs again. Sarah wanted to get back on the road to recovery and improve her herself and was booked to re-enter the detox facility on 13 November 2012.

10. Sarah most recently worked at a hotel in Melton as a bar and gaming attendant. On Thursday 8 November 2012, Sarah met with her employer at the hotel and was informed that they would discontinue her employment for the time being, as she was becoming unreliable. Sarah was informed that she would be welcome back to work after she got her life together.

11. In September 2012, Sarah met Steven James Hunter through a network of friends. Sarah would visit Hunter at his house at Unit 6, 1A Simpson Street, Bacchus Marsh and they would frequent other places together, including another property Hunter resided at with an associate, 90 Fongeo Drive, Point Cook. They were known to use illicit drugs and consume alcohol together.

EVENTS LEADING UP TO THE DEATH.

12. In sentencing remarks, Justice Bell stated:

> *"You (Mr Hunter) met Sarah through a network of friends. She accepted you as you were. She knew you had a criminal background and had been in gaol but did not hold it against you. Your friendship centred on 'partying' that is, taking drugs with each other and friends...*
>
> *It appears that you had a genuine affection for Sarah and I do not think she would have been your friend if she did not want to be. Being aged 47 years, you were much older than her and saw yourself as a 'father figure'. You were not in a sexual relationship with her.*
>
> *On Wednesday 7 November 2012, Sarah and a female friend spent the night at your premises in Bacchus Marsh, consuming ice and GHB. You and Sarah communicated by i-messages during the afternoon and evening of Thursday 8 November 2012, during Friday 9 November 2012 and during Saturday 10 November 2012. On the afternoon of that Saturday, Sarah*

joined you at your premises at Bacchus Marsh where you both drank alcohol (some of which she brought) and smoked ice."[1]

13. After consuming a quantity of alcohol and drugs, an argument occurred between Sarah and Hunter. Hunter assaulted Sarah with a weapon that was present in the house and stabbed her, causing fatal injuries.

CIRCUMSTANCES FOLLOWING THE DEATH.

14. Following the fatal assault on Sarah, Hunter contacted a number of associates via text messages and phone calls.

15. At approximately 7.00pm on 10 November 2012, Hunter called [redacted] asking him to bring spare keys to his house as he had locked himself out. When [redacted] arrived, Hunter was at the letter box at the front of the block of units. As [redacted] handed the keys over, Hunter stated "*I don't know what I've done*".[2] [redacted] believed that Hunter was referring to a falling out that they had and after telling Hunter he wanted nothing to do with him, [redacted] left the area.

16. Later in the evening, Hunter left the Bacchus Marsh area and drove to Tarneit where a number of associates were present, leaving Sarah's body in the kitchen of the unit in Bacchus Marsh.

17. Investigators believe that Hunter sent i-messages to the mobile phone belonging to Sarah at 10.07am, 12.27pm and 1.36pm on 11 November 2012 in order to avoid suspicion with regard to her disappearance.

18. On 12 November 2012, Ms Dickson became concerned about Sarah's whereabouts as she has not seen or heard from Sarah since the evening of 8 November 2012. She contacted one of Sarah's friend, Ms Alexandra Evans, at lunch time. Ms Evans advised Ms Dickson that she had not seen Sarah since the evening of 9 November 2012.

19. In the afternoon, Ms Evans exchanged a number of text messages with Hunter, asking whether he knew where Sarah was. Hunter advised Ms Evans via text that he had not seen Sarah for two days and that he had tried ringing her.

20. During that day, Hunter returned to the unit in Bacchus Marsh and removed Sarah's body from the kitchen. He wrapped her body in a bag and placed her in the boot of his vehicle and left.

21. At approximately 7.00pm, Hunter went to the home of a friend and told them that he had a body (a young woman) in the car; that he was house sitting, had a party and things had gone wrong. He said a friend had killed the woman and he had to get rid of her.

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[1] Sentencing remarks of Justice Bell

[2] Statement of [redacted]. Publication of this individual's identity was suppressed by order dated 10 September 2015.

22. Hunter asked if he could bury the body at the friend's family property in the country. The friend refused to help Hunter and encouraged him to leave the area. They both drove to the city, where they bought food. Hunter stated that he needed to do something quick as the body was beginning to smell. Hunter asked the friend to direct him to the nearest Bunnings Store and then asked if he could borrow a boat to dispose of the body.

23. Hunter purchased a 20 litre container of hydrochloric acid, three bags of rapid set concrete, one bag of lime and one roll of black plastic. After returning to their cars, the friend refused to assist Hunter and both parties then left the area.

24. In the evening of 12 November 2012, Ms Dickson contacted Bacchus Marsh police station and made a formal report that her daughter was missing. Bacchus Marsh police sent an SMS to Hunter later that evening, asking him to contact them urgently regarding missing person Sarah Cafferkey.

25. During the morning of 13 November 2012, Hunter arrived at 90 Fongeo Drive, Point Cook, and reversed the vehicle up the driveway and removed Sarah's body from the boot. In the garage of the premises, he placed Sarah's body in a green wheelie bin with a blue lid, emptied the bags of rapid set concrete into the bin and mixed a quantity of water in to set the concrete.

26. A police officer from Bacchus Marsh police station spoke to Hunter by telephone later that evening. Hunter advised the police officer that he had been with Sarah at his Bacchus Marsh premises in the afternoon but he had left there at about 5.00pm, leaving Sarah with his keys, and when he did return to the premises two days later, Sarah was not there. He advised that he was currently living at the premises in Point Cook.

27. Telecommunications records indicate that, following this conversation with police, Hunter made no further outgoing calls or sent any SMS text messages from his mobile phone. Investigators believe that he ceased all use of his mobile phone to avoid electronic surveillance and to avoid apprehension in relation to the crime.

28. At approximately 12.00am on 14 November 2012, an external search of the Bacchus Marsh premises was conducted by local police but it revealed nothing out of the ordinary.

29. At about 8.30am, Hunter returned to the Bacchus Marsh premises, removed Sarah's silver Holden Astra from the garage and drove it to Maribyrnong, where he left it in Owen Street.

30. Later that same morning, police from the Bacchus Marsh police station conducted an internal search of the unit in Bacchus Marsh and that too revealed nothing out of the ordinary.

31. On 16 November 2012, police seized Sarah's silver Astra in Maribyrnong where it had been observed the previous day. Police also seized Hunter's car from where it had previously broken down on the Western Highway in Melton.

32. On the evening of 17 November 2012, investigators from the Homicide Squad attended at the Bacchus Marsh premises with a search warrant. A forensic examination revealed that a serious assault had occurred there.

33. At the same time, investigators from the Homicide Squad also attended the Point Cook premises with a search warrant. Whilst in close proximity to the house, investigators could smell a persistent odour of decay. Investigators formed the opinion that the smell was emanating from a green wheelie bin inside the garage. They also found bloodstains on the floor and on a step ladder next to the bin, empty bags of rapid set concrete and a container of acid.

34. On 18 November 2012, the green wheelie bin was removed from the garage at Point Cook and taken to the Victorian Institute of Forensic Medicine (VIFM). A CT scan of the wheelie bin revealed the body of an adult in the bottom part of the bin. The bin was found to contain a quantity of solid set concrete and a body was found to be surrounded by hard concrete and soft lime. The body was removed for further examination.

35. On Tuesday 20 November 2012, Hunter was arrested and charged with the murder of Sarah Cafferkey.

POST MORTEM EXAMINATION

36. On 18 November 2012, Dr Michael Burke, forensic pathologist at the Victorian Institute of Forensic Medicine, conducted a post mortem examination on Sarah's body.

37. The post mortem examination identified multiple stab injuries involving the aorta, left carotid artery, lungs, liver and a combination of sharp and blunt force injury to the calvarium.

38. Dr Burke commented that:

> *"The degree of force, required to cause the sharp and blunt force injury through the skull vault, would be described as severe to extreme.*
> *The post mortem examination showed injuries to the upper limbs which could be described as "defensive" in nature."*[3]

39. Sarah was formally identified by dental records.

40. Toxicological examination showed the presence of alcohol, amphetamines, diazepam, desmethylvenlafaxine, doxylamine, ibuprofen and cannabis.

THE PURPOSE OF A CORONIAL INVESTIGATION

41. The Coroners Court of Victoria is an inquisitorial jurisdiction[4]. The purpose of a coronial investigation is to independently investigate a reportable death[5] to ascertain, if possible, the identity of the deceased person, the cause of death and the circumstances in which death

[3] Medical Examiners Report, Dr Michael Burke, dated 22 January 2013.
[4] Section 89(4) *Coroners Act 2009*
[5] Apart from a jurisdictional nexus with the State of Victoria, the definition of a reportable death in section 4 includes deaths that appear to have been unexpected, unnatural or violent

occurred.[6] The cause of death refers to the medical cause of death, incorporating where possible the mode or mechanism of death. For coronial purposes, the circumstances in which death occurred refers to the context or background and surrounding circumstances to the death, but is confined to those circumstances sufficiently proximate and causally relevant to the death and not merely all circumstances which might form part of a narrative culminating in death.[7]

42. The broader purpose of coronial investigations is to contribute to the reduction of the number of preventable deaths through the investigation findings and the making of recommendations by coroners, generally referred to as the 'prevention' role. Coroners are also empowered to report to the Attorney-General on a death; to comment on any matter connected with the death they have investigated, including matters of public health or safety and the administration of justice; and to make recommendations to any Minister or public statutory authority on any matter connected with the death, including public health or safety or the administration of justice.[8] These are effectively the vehicles by which the prevention role may be advanced.[9]

43. It is not the coroner's role to determine criminal or civil liability arising from the death under investigation, or to determine disciplinary matters.

SCOPE OF INQUEST

44. In a ruling dated 11 May 2015, I determined that the scope of the inquest would be as follows:-

- The terms and conditions of Hunter's release on parole.
- Any risk assessment prepared and relied upon as part of the decision making process to release him on parole.
- The assessments of Hunter as to his suitability for parole prior to his release.
- The monitoring of Hunter while he was on parole.
- Deficiencies (if any) in the Corrections Victoria and Victoria Police systems of monitoring and supervising of Hunter, including the sharing of information and intelligence on him and his activities.
- The details of the requirements for 'assessment and treatment' as a condition of his parole, including:

[6] Section 67(1) of the Act

[7] *Harmsworth v The State Coroner* [1989] VR 989; *Clancy v West* (Unreported 17/08/1994, Supreme Court of Victoria, Harper J.)

[8] See sections 72(1), 67(3) and 72(2) of the Act regarding reports, comments and recommendations respectively.

[9] See also sections 73(1) and 72{5) of the Act which requires publication of coronial findings, comments and recommendations and responses respectively; section 72(3) and (4) which oblige the recipient of a coronial recommendation to respond within three months, specifying a statement of action which has or will be taken in relation to the recommendation

i. Details as to when, where and by whom the 'assessment' was made and the outcome of that assessment;

ii. Details of any 'treatment' provided to Hunter as a fulfilment of that condition; and

iii. Details of any reports on the outcomes of the 'assessment and treatment' provided.

- Details of any breaches of parole by Hunter.
- Reports to the Adult Parole Board (APB) by Hunter's parole officers.
- The transitioning of Hunter from parole to non-parole.
- The implementation of the recommendations of the *Ogloff* and *Callinan* reviews of the Victorian Adult Parole System.
- The response by Victoria Police to the reforms to the parole system as recommended in the Ogloff and Callinan reports.
- The outcomes of the criminal investigation into the disposal of Sarah's body.

TIMELINE – HUNTER'S PAROLE

45. 25 February 1988 - Hunter was sentenced to sixteen years imprisonment with a non-parole period of thirteen years on the charge of murdering Ms Jacqueline Matthews on 9 April 1986. His earliest eligible parole date was 9 December 2000. The sentence expiry was 9 December 2003.

9 December 2000 – Hunter released on parole.

13 March 2002 – Parole cancelled by the APB as a result of a negative drug test, failure to attend the APB interviews and alleged offences on 30 September 2001 involving intentionally causing injury and unlawful assault.

22 May 2002 – A warrant was issued by the APB. Hunter was returned to custody owing two years, eleven months and twenty five days on the murder sentence.

19 June 2002 – Hunter convicted of recklessly causing injury and sentenced to one month, suspended for twelve months.

3 July 2002 – The APB decision to release Hunter on parole on 8 July 2002 with the same core conditions and same three special conditions as his earlier parole. No risk assessment was available to the APB when it made this decision.[10] The parole end date was to be 19 May 2005.

[10] Statement by Mr Stuart Ward, para 107

17 December 2003 – The APB noted that Hunter had been charged with kidnapping, intentionally and recklessly causing injury and stalking between the 10 and 19 March 2002.

13 September 2004 – the APB noted that Hunter had failed to appear at court on those charges and failed to attend supervision appointments.

22 September 2004 – Hunter's parole was cancelled and a warrant issued.

14 October 2004 – Hunter returned to custody, owing two years, ten months and eleven days on the murder sentence.

27 April 2005 – Hunter was found guilty of theft, kidnapping, intentionally causing injury and trafficking a drug of dependence. He was sentenced in the County Court to six years and six months with a non-parole period of four years and six months. This was varied on appeal, on 2 August 2006, to six years with a non-parole period of four years.

9 February 2007 – The APB required Hunter to be assessed for the Violence Intervention Program (VIP).

3 June 2009 – The APB noted a Victorian Violence Treatment Program Tier 2b Specialist Assessment Outcome Advice. Hunter was not recommended for participation in the moderate intensity violence intervention program. His score on the Violence Risk Scale (VRS) was considered to fall into the "low risk" category of committing further violent offences.

6 May 2010 – APB decision to release Hunter on parole on 30 April 2011 (parole would expire on 30 October 2012). The APB had available to it a one-page summary, records from the PIMS database covering a list of tests between 14 October 2004 and 23 April 2010 showing 22 tests (drug tests) with all tests being negative, and 'Incidents for a Prisoner' from 14 October 2004 to 23 April 2010 showing six records of such incidents. A progress report was not available to the APB, but a subsequent progress report was received (31 May 2010). Parole was set for 30 April 2011.

23 June 2010 – APB considered the "Subsequent Progress Report dated 31 May 2010."[11] That report confirmed that Hunter had completed the Cognitive Skills program and one-on-one counselling, as well as a forty-hour drug and alcohol program, and "*had been assessed as unsuitable for the Violence Intervention Program*".

25 February 2011 – Victoria Intervention Screening Assessment Tool (VISAT) assessment of Hunter. The summary of that assessment described his "*general risk of offending as moderate*".

[11] Statement of Mr Stuart Ward, para 136

14 March 2011 – Assessment for drug and alcohol abuse and treatment needs by the Community Offenders Advice and Treatment Service (COATS). Hunter was not recommended for participation in counselling, or other treatment.

30 April 2011 – Hunter released on parole – standard conditions of parole were applied. Parole was set to conclude on 30 October 2012.

June 2011 – Ms Jenny Johnstone becomes Hunters Leading Community Corrections Officer (LCCO)

16 June 2011 – Hunter's case manager referred him for assessment by the OBP. He was not assessed by OBP until 7 October 2011, when he was identified as a suitable candidate for the "Maintaining Change Program" scheduled to commence on 8 November 2011.

10 January 2012 – Hunter's first attendance at the Maintaining Change Program (group program); there were two further attendances.

7 February 2012 – Hunter commenced individual treatment with an OBP clinician (attended 10 of 17 sessions).

1 May 2012 – Report on the non-completion of the Maintaining Change Program.

30 October 2012 – Hunter's parole ended.

21 August 2013 – Hunter was sentenced to life imprisonment with no parole for the murder of Sarah Cafferkey on 10 November 2012.

ADULT PAROLE BOARD CONSIDERATION OF HUNTER

46. Hunter was interviewed by the APB, either in person or by video link, on the following dates:

6-7 May 2010

4 May 2011

3 August 2011

9 November 2011

16 May 2012.

47. After his release, the APB reviewed Hunter's parole and considered his case (normally by accepting and noting a report by his case manager) on the following dates:

4 May 2011

1 June 2011

8 June 2011

3 August 2011

9 November 2011

16 May 2012

8 June 2012

22 June 2012

17 August 2012.

These are the dates of which there are file records.

THE PAROLE DECISION MAKING PROCESS

48. In his statement,[12] Deputy Commissioner for Operations at Corrections Victoria (CV), Mr Roderick John Wise, set out the assessment process before release on parole. Community Corrections Service (CCS) staff members were required to complete a "parole assessment report" comprising the results of a VISAT, a Tier 1 Report and Parole Assessment Summary. It was the APB's expectation that CCS staff would inform them of the prisoner's suitability for release into the community and the offence-related and offence-specific needs to be addressed on parole. CCS members were also required to prepare a Parole Plan for each prisoner in anticipation of parole.

49. Hunter's Tier 1 Report[13] and VISAT report[14] were tendered at the inquest.

50. The Tier 1 Report set out a brief history of the prisoner. The first such report was dated 20 October 2004 and, at that point in time, Hunter was serving his fifth period of imprisonment.

51. A new Tier 1 Report was generated in conjunction with the VISAT report, prior to the APB decision in 2011.[15] Mr Wise pointed out that a Tier 1 Report "*was automatically generated when a long VISAT was completed.*"[16] The Tier 1 Report was designed to assist case managers to develop a case plan by providing an analysis and summary of the VISAT assessment. It was to identify relevant offence-specific and offence-related needs, make recommendations for programs and identify an offender's readiness to engage in such programs.

52. In Mr Wise's statement, he referred to the VISAT as the "*universal screening tool used to assess prisoners' general risk of offending*". He noted that the screening tool had indicated that Hunter had a "low" risk of general reoffending. He noted, however, that the Community Corrections (CC) overrode this rating and recorded Hunter's risk as "moderate" because of Hunter's "*extensive prison history and a number of dynamic risk factors that were identified.*"[17] Mr Wise pointed out that the CC override ensured that Hunter remained eligible for a number of treatment programs once he was paroled, including the Cognitive Skills Program and Maintaining Change Program.

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[12] Exhibit 1
[13] Exhibit 5
[14] Exhibit RW1
[15] Inquest brief, p 2392
[16] Exhibit 1, p 2
[17] Statement of Mr Roderick Wise, 20 August 2015, para 11

53. The Tier 1 Report deals with the history of the offence for which the prisoner is currently serving a sentence, general criminal history, previous program involvement, drug program involvement, education and employment, family and other relationships, physical and mental impairments (if any), attitudes and beliefs, offence-specific and offence-related risks and needs and readiness to engage in programs. It makes recommendations for programs and services for the particular prisoner. It concludes with a "summary of assessment". The Tier 1 Report dated 23 February 2011 gave a "*general risk of re-offending as low*". As noted above, that risk was overridden. Recommendations were made under the heading "Prioritised Needs" in respect of violent offending and drug treatment.

54. Under the heading 'Readiness to Engage in Programs' in the comments section, the Tier 1 Report states:

"It is understood Hunter has been granted parole with his release date being 30th April 2011. However it is considered, due to his past criminal history and compliance history, he will require very close monitoring and significant supports if he is to remain offence free."[18]

55. In the module dealing with violence, it was noted that "*this person has not previously participated in a treatment program for violent behaviour*". It was then noted that:

"Mr Hunter has an extensive history/convictions for violent offences. These were outlined in Module 1. He has been imprisoned on two occasions for violent offences including Murder in 1988 and his current offences. His prison file indicates he has been assessed for Violence Intervention Program, however had been found unsuitable."[19]

56. Under the 'Offence-specific and offence-related risks and needs' module, it is stated:-

"Mr Hunter is currently assessed as being low risk of offending, however this risk has been overridden to moderate given that he has an extensive history of violent offending, demonstrating extreme violent behaviour. He showed an insight into his violent behaviour in the way he sadistically tied up the victim in the second offence, assaulted, terrorised and traumatised him. The victim impact statement indicates the victim was humiliated, lost self-esteem and confidence and moved interstate out of fear. However his prison file indicates he had been assessed for Violence Intervention Program, however has been found unsuitable."[20]

57. The document titled 'Victorian Violence Treatment Program Tier 2b Specialist Outcome and Advice' (the Tier 2b Report) was tendered.[21] The Tier 2b Report is headed "Confidential" and is undated but no point was taken about its use in evidence. The Tier 2b Report was authored by David Curnow and was written as part of the overall parole assessment process.

58. The Tier 2b Report is a summary of a clinical assessment conducted by CCS Clinical Service Unit. The Tier 2b Report contains a summary of the risk assessment and, in that context, refers

[18] Inquest brief, p 2408
[19] Inquest brief p 2396
[20] Inquest brief, p 2406
[21] Exhibit 11, Victorian Violence Treatment Program, Tier 2b,

to the Violence Risk Scale (VRS), an actuarial instrument measuring both static (historical) and dynamic (changeable) risk factors that "underpin violent offending". It states that "*the VRS is designed to estimate the probability of violent recidivism amongst adult offenders*. It set out part of the summary under the heading "Risk Assessment":-

"*...Mr Hunter's scores on this instrument were considered to fall into the Low risk category of committing further violent offences. This is consistent with the author's opinion based on review of the available depositional and file information and his responses in the clinical interview. The reader should note that the VRS score is a probability estimate only, based on the presence of various risk factors for violence identified in the research literature. The VRS score does not provide a definitive prediction of future behaviour.*"[22]

59. Hunter was not recommended for participation in the "Moderate Intensity Violence Intervention Program". The author (Senior Clinician, David Curnow) noted:

"*As the assessor, I was surprised Mr Hunter's score was not higher given his long prison history, however, it was precisely his long time incarcerated that reduced his score as he had not got a particularly lengthy criminal history. As it was, Mr Hunter's score was very close to the cut-off required for the VIP and it was the fact that his most recent prison incidents were not found proven after an investigation that lead to them to being scored on the VRS, which reduced his score. Within the interview, Mr Hunter noted that he had made significant improvements in his attitude and demeanour as he had aged, and that his major concern was an effective pre-release strategy around work and accommodation. He notes that he was released with the wrong attitude last time, and requires significant support in the community so he does not return to his former approach to managing his life. Mr Hunter recognised that his lengthy incarceration history has meant that he has had been exposed to a long history of violence when he was younger, and acknowledged that upon entering prison he was raped by two other prisoners. He states that during his prison term for murder he virtually grew up in prison, and had taken on many of the attitudes towards officers and jail politics which he knows he needs to reconsider.*

He has completed a wide variety of different programs on violence including Alternatives to Violence, Violence – A way of life and various Anger management programs. On this basis, Mr Hunter is recommended to complete the Cognitive skills program to manage his poor decision making and his strong need to control his life."[23]

60. The evidence is that Hunter's participation in a Cognitive Skills Program was considered to be the better response to the violence issues, apparently more appropriate that the Violence Intervention Program.

61. Under 'Case Management Recommendations', the Tier 2b Report said: "*Mr Hunter requires major support from case managers to avoid him re-networking with former associates which can lead to violence*". The Tier 2b Report then set out a number of "*Case Management Strategies*" and contained a dissemination protocol at the end of it. In that context, it noted

[22] Exhibit 11, Victorian Violence Treatment Program, Tier 2b, p 2
[23] Exhibit 11, Victorian Violence Treatment Program, Tier 2b, p 3

that a copy of the Tier 2b Report "*must be placed on the prisoner's/offender IMP file and a separate copy on the clinical services red file*". It then states:

"*2. The assessing clinician should provide a referral outcome summary to case managers following a Tier 2a assessment and within this summary clinicians should offer to provide verbal feedback to the case manager should they require elaboration on the content of the referral outcome summary (e.g. rationale for treatment recommendations and how case management recommendations can be implemented). Clinicians should also refer case managers to the Tier 2b report for further information.*

3. The assessing clinician is to provide a brief clinical file note on the clinical Services red file documenting a hypothesis of the prisoners/offenders functionality of violence. This will serve to provide a starting point for treating clinician's treatment hypotheses (in combination with hypothesised treatment target areas noted in the body of the outcome report) – see proforma titled "Tier 2b supplementary clinical file note" for an example.

4. For prisoners/offenders who commence a program – and where the assessing clinician and the treating clinicians differ – the assessing clinician must provide a verbal briefing to the treating clinicians regarding overall clinical impressions, hypothesised functionality of violence and any other clinically relevant information."[24]

62. Under the heading 'Offence related treatment needs', the Tier 2b Report set out the details of the murder of Jacqueline Matthews, for which Hunter was sentenced in 1988. The summary states that:

"*He and his girlfriend were in his care together, with her asking him to stay with her while he wanted to go and get the keys to lock up. He became very angry at her insistence that he stay and he struck her, at which point he claims that she took out a knife and attacked him. While he states that he finds it difficult to remember, it is clear that she was stabbed. Mr Hunter then moved the body to the boot, and returned to the shopping centre asking another employee to help him dispose of the body, which he and this individual did.*"[25]

The murder of Sarah bore similar characteristics to that of Jacqueline Matthews.

RISK ASSESSMENT – VICTORIAN INTERVENTION SCREENING ASSESSMENT TOOL (VISAT)

63. The Victorian Intervention Screening Assessment Tool (VISAT) was the subject of intensive focus in this case. Mr Wise gave evidence of the use of the VISAT and of reforms which have led to the adoption of a different risk assessment tool. The VISAT, however, applied to the pre-release assessment of Hunter for the purposes of his parole in 2011.

64. The structure of the VISAT report mirrors that of the Tier 1 and Tier 2b Reports. The VISAT assessment was undertaken on 25 February 2011. A series of modules set out information under the headings of 'current offence details', 'juvenile, adult and interstate criminal history', 'other legal issues', 'extended violent offending', 'acute risk factors for violent offending', 'scoring of violent offending', 'use of drugs' and scoring in relation to that, 'use of alcohol'

[24] Exhibit 11, Victorian Violence Treatment Program, Tier 2b, p 5
[25] Exhibit 11, Victorian Violence Treatment Program, Tier 2b, p 3

and scoring in relation to that, 'accommodation in the community', 'social and other supports', 'basic skills and education level', 'level of support from family and friends', 'intellectual disability', 'mental health', 'acquired brain injury' and the like, 'physical capacity and impairments' (if any) and 'attitudes and beliefs'. It is a comprehensive coverage of the issues. In the summary of the assessment, the general risk of re-offending was stated to be "low", however had been overridden and was raised to "moderate". This meant that, for the purposes of the VISAT tool, Hunter's risk assessment category was moderate. Reflecting the Tier 2b assessment, his score on module 2 (Violent offending) was 7 out of 10.

65. It was noted in the VISAT assessment that Hunter had an extensive history of convictions for violent offences. It was noted that a score of more than 1 in respect of violent offending required a referral to the Violence Intervention Program.

66. The case note states that, "*Hunter has been assessed for the Violence Intervention Program (VIP), however has been found unsuitable*". As surprising as it seems that Hunter was found unsuitable for the Violence Intervention Program, I have noted earlier that it appears that an alternative program was considered to be more appropriate.[26]

67. The case notes state, "*it is considered appropriate Hunter undertake a drug and alcohol treatment focusing on harm minimisation, education and relapse prevention upon release*"[27]. This reflected a total score of 5 under the heading of 'Scoring of drug treatment need'.

68. As to specific and offence-related risks (module 11), the VISAT report notes Hunter's release date as 30 April 2011 and states, "*however, it is considered due to his past criminal history and compliance history, he will require very close monitoring and significant supports if he is to remain free.*"[28]

69. This sentence appears to sound a clear note of reservation and caution in the mind of the author.

70. When asked whether an offender's criminal history is relevant to risk assessments, Mr Wise said that it is not relevant 'as far as the tools are concerned'. He stated that the tools take into account the number of terms of imprisonment, but do not account for nature or gravity of each offence leading to imprisonment, whether it be murder or shoplifting. Mr Wise confirmed that VISAT has been criticised and determined inadequate on the basis it does not take these factors into account and that is, *"one of the reasons we moved away from VISAT"*[29], but that

[26] See paragraph 60 of these findings
[27] VISAT assessment, February 2011
[28] VISAT assessment, February 2011
[29] Inquest transcript p 28

its predictive capacity *"was not that different"* to other tools.[30] He confirmed that the VISAT is not used by Corrections Victoria today.[31]

71. In relation to scoring for violent offending (module 2), the VISAT report picks up the same language as the Tier 2b assessment, noting that Hunter had been imprisoned on two occasions for violent offences, including murder in 1988. It again noted that his prison file indicated that he had been assessed for the VIP, however had been found unsuitable. In addition, module 2 sets out historical matters. As to the question, "*How many times have you been found guilty of a violent offence?*" the answer was 10. As far as previous program involvement was concerned, the question "*Have you ever taken part in a treatment program for violent behaviour?*" was answered "No".[32]

72. The Parole Assessment Summary (PAS) was dated 21 February 2011. The author of the PAS was Mr Alan Davidson, (a leading Community Corrections Officer - LCCO) of the Shepparton office of Community Correctional Services. The PAS referred to Hunter's parole history, the fact that he had been subject to two periods of parole (2000 – 2003 and 2002 – 2005), with both having been cancelled by the APB for non-compliance and further offending. It noted that Hunter's "*current sentence includes time owed to the APB from his previous parole*" – (that refers to time still owed for unexpired parole on Ms Matthews' 1988 murder).

73. The PAS summarises the kidnapping and drug trafficking offences. The PAS then deals with mental health; there were said to be no current concerns in respect of mental health. In relation to drugs and alcohol, it noted that Hunter, "*was in possession, using and trafficking amphetamines prior to his arrest*".

74. In relation to programs undertaken, it noted:

> "*Mr Hunter has completed Forty-Hour Drug And Alcohol Program at Lodden in 2006, with no further drug and alcohol issues identified. He is to complete General Harm Reduction and Exit Prep prior to being released. Mr Hunter has been assessed for Violence Intervention Program, however has been found unsuitable. He has completed Cognitive Skills at Loddon Prison in 2006.*"[33]

75. The PAS noted that there was no confirmed accommodation, however arrangements to source accommodation had been made with the Link Out Program. It further noted Hunter had no confirmed employment upon release.

76. The CCS recommendation was that "*the offender be released on parole?*" The only special condition recommended was 'Assessment and Treatment'. In addition, it was recommended

[30] Inquest transcript p 28
[31] Inquest transcript p 30
[32] Inquest brief, p 2654
[33] Inquest brief, p 2386

that, given his unknown accommodation situation, a parole plan should be prepared closer to his release date, to allow for finalisation of reporting locations.

77. On 10 March 2011, Hunter was assessed for drug and alcohol abuse and treatment needs by COATS.[34] COATS did not recommend that Hunter be required to participate in counselling, consultancy or continuing care, on the basis of his presenting information and the fact that he scored a zero rating on the "*psycheck*[35] screening tool"[36].

78. A Parole Plan was also prepared. This is a short document, dated 12 April 2011. Again the author was Mr Alan Davidson. The Parole Plan is consistent with the Parole Assessment Report. The Parole Plan relates to accommodation, employment and the special condition that Hunter undergo assessment and treatment for alcohol or drug addiction or submit to medical, psychological or psychiatric assessment or treatment as directed. It nominated the supervising CCS location as Melton and contained a brief recommendation referring to the current assessment of Hunter as a "moderate" risk of re-offending. The same note of caution was sounded,

> "*It is understood Hunter has been granted parole with his release date being 30 April 2011, however it is considered due to his past criminal and compliance history he will require very close monitoring and significant supports if he is to remain offence free.*"[37]

HUNTER'S PAROLE CONDITIONS

79. On 6 May 2010, the APB had decided to release Hunter on parole on 30 April 2011. Hunter was to be released on parole and subject to the supervision of Corrections Victoria until expiration of his parole on 30 October 2012. He was in fact released on parole on 30 April 2011. The evidence was that it was routine for the APB to set parole terms and conditions a year out from the actual release date, to allow for the development and formulation of appropriate programs, including the Parole Plan. (See also paragraph 90).

80. Hunter's parole consisted of three months of intensive parole at the outset (30 April 2011 – 29 July 2011). Intensive parole required twice-weekly reporting to his parole officer/case manager.

81. The conditions of Hunter's parole order included the following:

- "*That he undergo assessment & treatment for alcohol or drug addiction or submit to medical, psychological or psychiatric assessment & treatment as directed by the Centre Manager.*
- *That he have no contact whatsoever either directly or indirectly with the victim or any member of the victim's family.*

[34] Community Offenders Advice and Treatment Service
[35] The Psycheck tool is an instrument detecting common mental health conditions mainly substance use.
[36] Exhibit 1, para 12
[37] Inquest brief, p 2271

- *That he reside at 2/218 George St, Fitzroy until otherwise determined by the APB. The address was varied on 8 June 2011 to 6/1A Simpson Street Bacchus Marsh.*
- *That he report before the APB for interview as and when directed by the APB.*
- *That he be assessed by COATS and participate in programs as directed by the Community Corrections Officer (CCO) in consultation with COATS.*
- *That he be assessed by Offending Behaviour Programs (OBP) and, if found suitable, participate in recommended OBP interventions as directed by his CCO.*
- *That he attend the Community Forensic Mental Health Service (CFMHS) for assessment, as required, and undergo such treatment as directed by the Director, Victorian Institute of Forensic Mental Health or his nominee."*[38] [39]

82. The condition that Hunter be assessed by Offending Behaviour Programs (OBP) and, if found suitable, participate in recommended OBP interventions, was an important factor. It became a key issue in the case. Hunter's participation in, and the reports arising from, the relevant OBP programs give rise to a number of comments that I make later in these findings.

83. In relation to the APB's parole decision, the Family submission states:

"The Adult Parole Board set conditions for Hunter's parole that were not onerous and, in fact, were standard for many parolees. Despite having a significantly violent past; having committed an extensive list of prior drug offences; having a history of lying to parole officers and a wilful disregard for previous parole conditions; Hunter's parole supervision was, in effect, minimal. Hunter did not have onerous conditions placed on his parole, such as attending drug and alcohol counselling. He was not subject of more stringent supervision, rather the supervision of him amounted to a requirement to reside at a particular address; to attend work or education/training within the first three months; to report, at ever decreasing intervals to his caseworker; and to attend counselling. The counselling condition first required group counselling, but was then changed to a one-on-one counselling with an OBP clinician when Hunter's poor engagement with group counselling meant he could no longer engage with that program. Hunter was not required to attend at violence management programs, even though he had not undergone such programs in his most recent stint in prison."[40]

84. In my opinion, this is a fair critique.

85. The evidence given by Mr Wise and his parole officer/case manager Ms Johnstone was that, from the Correctional point of view, Hunter's parole conditions were reasonable and appropriate. They were, in essence, standard conditions.

86. Although Hunter had conditions in relation to undertaking therapy from the beginning of his parole period, it was not until he had already been out on parole for some eight months (of an eighteen month parole period) that he attended his first therapy session. From 30 April 2011

[38] Statement of Mr Roderick John Wise, 20 August 2015, paragraph 13

[39] By letter dated 18 May 2011 Forensicare notified Mr Volkan Cichan that, as a consequence of the condition of his parole order requiring assessment for mental health services and noting Mr Cichan's description of Hunter's current mental state as 'very good', Hunter had been assessed at an intake meeting and it had been decided not to offer him an appointment at this time as "he has adequate services". The letter also notes that "Mr Hunter had no known mental health diagnosis."

[40] Submissions on behalf of the Cafferkey Family, para. 12

(when he was released on parole) until 10 January 2012, Hunter did not engage in any form of therapy, or any other type of program. It was said this kind of lag in program provision happens because a certain program might not be available when a parolee is first released and they then have to wait until the program becomes available. On this point, I note the Family's submission, "*This lag is not ideal in any circumstances, but is particularly problematic when the parolee's other conditions are standard and non-onerous.*"[41] I agree.

87. Both Mr Wise and Mr Stuart Ward gave evidence about the materials available to the APB when it made the parole decision. Mr Ward is the Chief Administrative Officer and Secretary of the APB. Mr Wise stated that the Board has a range of officers who research offenders' files thoroughly and bring the salient points to the APB members' attention. A meeting coordinator gets the files together and ensures the APB members have the materials required to make the decision. Mr Wise conceded that, other than assuming someone had read and summarised the critical parts, there was no specific additional mechanism to ensure the APB knew about all the reports (specifically in reference to reports about Hunter's previous breaches of parole).

88. When asked whether the APB would have considered reports dating from 2003 as relevant to current parole consideration, Mr Wise stated that they would, but it would not necessarily be a 'critical consideration' seven years on, because the APB would also consider contemporary information regarding matters around the offender's current management and response to treatment. This is obviously reasonable.

89. In addition, in relation to long term prisoners, it was not uncommon for the APB to visit the offender in prison and have discussions regarding their pending release. Mr Wise was unsure whether the APB met with Hunter in prison. He stated that no additional risk assessment was done before the APB's May 2010 decision to release Hunter on parole in April 2011, because he was in a minimum security facility and was 'well behaved'.[42] The APB considered that Hunter's custodial management had been successful. The Risk Assessment report came later (25 February 2011). I make the comment here that it appears illogical for an updated risk assessment to follow, not precede, a decision to grant parole.

90. When asked why the APB made a decision in 2010 to release Hunter on parole in 2011, Mr Wise's evidence was that by giving a parole date 12 months in advance, work can be done on transitional activities; for example agencies can be engaged to find stable accommodation and offenders are able to take leave days where they can speak to prospective employers in order that they can go straight into employment on release. Mr Wise expressed the view that it is

[41] Submissions on behalf of the Cafferkey Family, para. 14
[42] Inquest transcript p 38

more responsible to allow transitional work to be done at the earlier point, than to deny parole and allow offenders to be released straight into community unsupervised and without transitional support.

91. Mr Wise further said that the offender's support needs on release must be addressed in the final 12 months of a custodial sentence, so that work can be done to improve their chances of successfully transitioning. I infer from this statement that Mr Wise means that 'successful transition' means a corresponding reduction in the risk of re-offending.

92. Mr Ward said, consistently with Mr Wise's evidence, that the APB had a practice of setting a release date in advance, to enable planning, and to review that date based on material received in the intervening period. On 20 April 2011, the APB reviewed and confirmed Hunter's release and set conditions for his release. Mr Ward confirmed that the conditions formulated on 6 May 2010 were not 'set in concrete', and were not final, until 20 April 2011.

93. Mr Wise said that the APB can revoke an early parole decision if it was not satisfied that the offender had achieved the desired progress. Theoretically, the APB was able to revoke its May 2010 decision to grant Hunter parole in April 2011, if it had not been satisfied of his progress over the period May 2010-April 2011 period, and in fact up until 30 October 2012.

94. However the evidence suggests that once the date was set, there was an expectation on the part of the prisoner that it would be honoured, and more importantly, a presumption on the part of the case managers that it would remain the release date. It appears to me that this, lead to an accommodation of lapses by the prisoner in his performance and attitude. The culture appears to have been to prioritise, over all else, the achievement of parole release on the pre-ordained date. This has now been completely altered, with the requirement that the prisoner must make an application for parole, and effectively justify its granting.

THE MANAGEMENT OF HUNTER'S PAROLE AND HIS PERFORMANCE ON PAROLE

95. In his statement, Mr Wise summarised the supervision arrangements for Hunter after his release on parole. As a serious violent offender (SVO), he was allocated a Leading Community Corrections Officer (LCCO) as his case manager. He stated that this was the practice at the time, i.e. higher risk and more complex offenders were allocated to LCCOs for supervision. Hunter's LCCO was Ms Johnstone. She was based at the Melton Community Correctional Services office. Ms Johnstone took over responsibility for Hunter's management in June 2011. There was an initial three-month intensive period, requiring Hunter to report twice weekly. That period concluded on 31 July 2011. Hunter was then reporting weekly, from August 2011 until the end of September 2011, then fortnightly, then three-weekly. Hunter's last attendance for supervision was on 30 October 2012.

96. Mr Wise gave evidence that Hunter was, broadly speaking, compliant with his parole conditions and that his overall performance on parole was acceptable. Ms Johnstone said the same. Based on the reports of his LCCO, Hunter was not presenting to parole appointments as drug effected, was employed and had stable accommodation. For Ms Johnstone, these factors tended to corroborate his assertion that he was not using drugs. However, Hunter did disclose to Ms Johnstone further offences including speeding and assault.

97. In the context of Hunter having disclosed offending while on parole to Ms Johnstone, Mr Wise was questioned on the sorts of behaviour considered 'sufficiently serious' to trigger the revocation of parole. He stated that the Board's, *"first concern is around community safety"* and noted that certain behaviours in one offender may give rise to serious concerns (as it is linked to their offending) but may not trigger concerns in respect of another offender.[43]

98. Mr Wise gave drug use as an example of a 'sufficiently serious' behaviour likely to raise concerns about offender's capacity to remain in the community in a law-abiding manner.[44] Another behaviour which the Board might consider 'sufficiently serious' is consistent, "*low-level breaches of the Criminal Code*". Mr Wise explained that, although it may not seriously endanger the community, such offending is concerning as an indication of a "*disregard for the normal rules of the community*".

99. Other concerning behaviours identified by Mr Wise, which "*might give rise to major concerns ... sufficient to warrant their return to custody*", include associating with other offenders.[45] He stated that for Serious Violent Offenders and Sex Offenders (SVOSOs) who reoffend by way of violent or sexual offence, there is now a presumption that the Board will cancel their parole. This was not the case in 2011.

100. Mr Wise's evidence was that Hunter performed the early, intensive parole period as required and, generally speaking, responded well to parole. In his view, Hunter had given the APB no reason to believe that he was a serious risk to the community. He said in evidence that he did not have any concerns about the quality of Hunter's management while on parole, stating that he considered the staff "*did a good job*". Mr Wise explained that a parolee's supervision reduces over the parole period, but if the parolee gives the CCO a reason to consider that their risk of harm or re-offending is escalating, more frequent attendance and 'different structures' can be imposed on the parolee and, where necessary, parole conditions can be formally altered.[46]

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[43] Inquest transcript p 82
[44] Inquest transcript p 82
[45] Inquest transcript p 83
[46] Inquest transcript p 17

101. When Ms Johnstone was assigned to his case, Hunter had been on parole for approximately two months. Ms Johnstone gave a short account of her employment experience, stating that she became a CCO in 2008, a LCCO in 2009 and had been an assessment officer. Ms Johnstone had been a LCCO for two years when she was assigned Hunter. She had a caseload which included 12 SVOs while she was working at Melton; her overall caseload was over 30 parolees, consisting of primarily SVOs, intellectually disabled offenders and SOs. She stated that the majority of her clients were "high need" (in terms of management). Ms Johnstone reported having undertaken SVO training as part of her LCCO further training. Additional training on SVOs was in-house and she recalled it being a one or two-day course. Ms Johnstone could not recall any specific training on the attitudes of offenders or on manipulative prisoners or parolees but reported that she was aware that offenders can manipulative. She stated that, on a case by case basis, "*you can't always have the training you're required to deal with a particular offender*".

102. When asked about adequacy of training, Ms Johnstone said that she considers LCCOs receive adequate training for dealing with SVOs but "*every offender is different ... there's only ... so much training you can do*". Ms Johnstone did concede that she could have received more training on *"meaningfully identifying risky attitudes on the part of those who are SVOs, attitudes which indicate that they should raise a red flag"*. In this context, I note the submission made by the family on the matter of training:

> "*...While Ms Johnstone was the most experienced case manager at the Melton office at the relevant time, the internal management review of Hunter's parole found that there was a possibility that Hunter was experienced enough in the parole system to know how best to represent himself and his life to the case manager, thereby managing the impression held of him by the case manager."*[47]

103. I make the comment here that both Ms Johnstone and Mr Wise conceded that Hunter was capable of playing the system. Although apparently compliant, there was, as Mr Wise conceded, "*probably an element him putting up a façade.*"[48] There can be little doubt that is exactly what happened. The evidence supports the proposition that Hunter was able to convey the impression he wished and that what he said would be accepted.

104. In terms of support and guidance for managing her clients and determining case management strategies, Ms Johnstone stated that the Officer in Charge was available when she needed to discuss files, dynamic risks and management plans. Ms Johnstone stated that she would write to the APB if an issue arose which she considered needed attention. She gave examples – a parolee committing offences or a parolee presenting as drug affected, as reasons she would

[47] Submissions on behalf of the Cafferkey Family, para 22, 23, 24
[48] Inquest transcript p 89

write reports to the APB. In Hunter's case, from her point of view, there was no need to do so.

PROGRESS REPORTS

105. Progress reports were written to the APB on the following dates: 18 May 2011, 2 June 2011, 22 July 2011, 20 October 2011, 30 April 2012, 21 May 2012 and 7 August 2012. Two reports requested changes to parole conditions – one to accommodate a change of address and one to provide for individual counselling with the OBP.

106. The CCS reports were tendered. Ms Johnstone was the author of the parole progress reports, with two exceptions – the special report dated 2 June 2011 and the progress report dated 18 May 2011, which were both authored by Volkan Cihan.

107. The progress reports to the APB were broadly favourable and none raised significant concerns for the APB's attention. It is clear that the APB was receiving nothing to suggest that any change of course was necessary, that there was any elevation of the perceived or assessed risk. The thrust of the information being provided to the APB was that Hunter's parole was progressing generally well and in accordance with expectations.

108. The first CCS report to the APB was dated 18 May 2011 and the last was dated 7 August 2012.

109. The report of 18 May 2011, authored by Volkan Cihan, noted in its conclusion that:

"*Hunter is a moderate risk offender with a criminal history which details drug, driving, theft and serious violent related matters. He has been progressing well since his release from custody and appears to be motivated to live a legitimate lifestyle by obtaining employment and securing stable accommodation*".[49]

110. A special report dated 2 June 2011 sought the APB's approval for a change of address for Hunter's accommodation. In that report under the heading 'Responses to the Order', it stated that, since the report of 18 May 2011, Hunter had "*attended all appointments as directed (with one exception relating to community work).*" It also noted, "*advice from Forensicare on 23 May 2011 that they had decided not to offer him an appointment for assessment at that time as he had adequate services.*"[50] A condition of Hunter's parole was that he attend the Community Forensic Mental Health Service (CFMHS) as directed by the Director of the Victorian Institute of Forensic Mental Health. The Forensicare report advised that he would not be offered an appointment because he had adequate services.

111. The progress report dated 22 July 2011 noted in its conclusion that, "*Hunter has been progressing in a positive manner on his order and will complete his intensive period on*

[49] Inquest brief, p 2252
[50] Inquest brief, p 2263

29 July 2011". It further noted, "*Hunter presents motivated to change and reduce his rate of recidivism while becoming a productive member of society*". It referred to his accommodation and employment at the time.

112. In the progress report dated 20 October 2011, there was an update provided to the APB. In the conclusion it was stated that "*Hunter is participating in his parole requirements to a satisfactory level*". The report was positive. It noted that Hunter had been found suitable for the Maintaining Change Program to begin in November that year. I note here that this meant that he would not begin participation in a substantive program directed at behaviour and attitude change until approximately seven months after his release on parole. This was a long delay, and a system weakness.

113. In the progress report of 30 April 2012, under the heading 'Response to Order', it was stated that Hunter was "*currently attending three-weekly appointments due to satisfactory compliance and positive engagement during supervision.*" It also noted that Hunter appeared to be "*placing himself in some high risk situations concerning negative peer associations.*" It stated that he had disclosed no illicit drug use and minimal alcohol consumption and noted that he had been found unsuitable for further drug and alcohol treatment by COATS.

114. The conclusion of the report stated that:

> "*Hunter is currently attending three-weekly appointments for supervision and engaging well*" and "*Hunter continues to remain positive in his personal direction at the completion of his parole and is taking steps to ensure that once his parole is completed he can travel interstate for employment within the mines.*"[51]

115. The special report of 22 May 2012, noted the special condition of Hunter's parole, that "*he be assessed for and participate as directed in OBPs maintaining change program*". The report advised the APB that the OBP was not continuing that program for Hunter, rather proposing one-on-one sessions to "*specifically targets his risks and needs*". A variation of the parole was sought, so that it would read "*that you be assessed by OBP programs and, if found suitable, participate in recommended OBP intervention as directed.*" The APB made this change.[52]

116. In the conclusion of that report, it was noted that "*since the last report Hunter had continued to comply with his parole order and there have been no changes to his circumstances.*"

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[51] Inquest brief, p 2220

[52] I note the email from Matea Doroc to Jenni Johnstone of 30 April 2012 stating "The program was actually cancelled due to insufficient numbers to continue. However, Steven was removed from the group by facilitators due to concerns about his suitability for a group based intervention. As such we recommended that he engage in individual intervention instead of commencing a new Maintaining change group."

117. Ms Johnstone's final report (dated 7 August 2012) was accompanied by a 'Breach/further offence report'.[53] This related to a speeding offence. In her report of the same date, Ms Johnstone stated "*Mr Hunter continues to present motivated to complete his parole with no further incidents*" and "*Mr Hunter is currently engaged with Offender Behaviours Programs and attends one-on-one sessions fortnightly*" and "*reports advise that Mr Hunter will complete a further five appointments prior to his parole expiration.*" It was recommended that the APB note the report and stated that the author would advise the APB if any further incidents occurred while Hunter was on parole.

118. Ms Johnstone's evidence was that, apart from the progress reports referred to above, there were no other reports to the APB. Mr Wise stated that any risk assessment, after the VISAT assessment undertaken on 25 February 2011, would not routinely go to the APB. He made the point that it was all "always open" to a LCCO (Ms Johnstone) to submit a report to the APB or to raise concerns with their managers. He also indicated that the LCCO would be obliged to inform the APB where there was "an unacceptable" risk to the community and he/she considered that parole should be breached. I make the comment that I consider that the APB should have been, and I understand it now is, routinely provided with a copy of any reports on updated risk assessments conducted throughout the parole period.

119. As to performance and compliance when an offender is on parole, Mr Wise said he would expect that Case Management Review Meetings (CMRMs) would pick up any concerns[54]. He stated that if the Community Corrections Officer (CCO) saw a parolee's risk escalating and considered that they could put the community at risk, they could put in a special report to the APB at any time.

120. Ms Johnstone gave detailed evidence in relation to Hunter's performance/compliance on parole. She regarded Hunter's parole conditions as fairly standard. She gave evidence at length about the discussions she had with Hunter in case management meetings.

121. Ms Johnstone stated that they often discussed Hunter's "negative peer associations", but she never considered breaching him on this basis. She was aware that Hunter had previously been imprisoned for murder and that his current offence was a breach of parole related to kidnapping involving assault, theft and trafficking amphetamines. Surprisingly, she was not aware that the Chair of the APB had, in 2000, asked for Hunter to be supervised by a senior, male CCO. Ms Johnstone could not identify why this direction would have been made, as

[53] Inquest brief, p 2196

[54] There were CMRMs applicable to Hunter on 10 June 2011, 27 July 2011, 23 September 2011, 5 March 2012, 19 September 2012 – Reviews of Hunter's parole at Case Management Review meetings (CMRM). These were required because of Hunter's classification as a serious violent offender (SVO). The focus was on his progress with OBP treatment

"plenty of offenders have offended against women and still had female case managers".[55] To put this into perspective, her evidence was that she did not feel threatened by Hunter.

122. In her evidence, Ms Johnstone repeatedly stated that, in her view as his CCS officer, Hunter performed satisfactorily on parole. At no point did she consider that there were concerns justifying any special report to the APB (apart from the report relating to a speeding offence), or justifying any breach action.

123. Mr Wise also stated that from a CCS perspective, Hunter was, broadly speaking, compliant with his parole conditions and that his overall performance on parole was acceptable.

RISK ASSESSMENT DURING PAROLE

124. As noted (at paragraph 64), the VISAT rated Hunter at a 'low' risk of re-offending, based on static factors. Taking into account "dynamic factors", Hunter was re-assessed as 'medium or moderate' risk. During parole, Hunter's assessed risk remained as "moderate risk".[56]

125. When asked whether Hunter would have been more accurately assessed as 'high' risk, Mr Wise stated that even if assessed as 'high' risk, there is a further distinction then between 'high' and 'unacceptable' risk of reoffending.[57]

126. Mr Wise stated that if an offender is rated a high risk, then Corrections Victoria insists the offender receives treatment before release into community.[58] Mr Wise stated that high risk offenders are still granted parole, but that they are not 'untreated high risk', rather Corrections Victoria ensures that they receive *"appropriate treatment and appropriate supervision in the community"*.[59] When recalled to give evidence, on 12 October 2015, Mr Wise told the Court that the assessment as 'low', 'moderate' or 'high' risk does not impact on an offender's release on parole. Its chief purpose is to determine access to programs and the level of case management and requisite level of experience of case managers to be assigned to the parolee.[60]

127. Ms Johnstone did not believe that Hunter was a risk to the community. She said she was reassured by Hunter's stable accommodation, which she said was a significant protective factor against increased risk of further offending. In her own words, Hunter "*was working and trying to better himself*" by attending school. Hunter had bought a dog, a factor she considered was a big responsibility and "*indication that ... he wanted to remain in the community*".[61] Ms Johnstone considered these aspects of stability and planning to be

[55] Inquest transcript p 162
[56] Inquest transcript p 22
[57] Inquest transcript p 22
[58] Inquest transcript p 24
[59] Inquest transcript p 25
[60] Inquest transcript p 506
[61] Inquest transcript p 145

protective factors. She considered the moderate risk assessment to be appropriate. In her view, Hunter's risks, including negative peer associations and associations with other offenders and drug users, were similar to other offenders. I accept that these were, and are, common risks for parolees generally.

128. Ms Johnstone was asked whether, in her view and in light of Hunter's history of drug use and trafficking, there should there have been a drug testing condition. She said, "*I probably would have put a testing condition on there. When they're on intensive parole (if testing is condition of parole) offender is required to go to testing once a week for the first three months of their parole. After that, it's as directed when presenting drug affected.*"[62] But this was not a condition of Hunter's parole. Ms Johnstone could have asked the APB for that condition if she felt the need, but stated that she "*probably didn't look at the VISAT to that extent*", and considered that the assessing officer is "*generally is accurate in the conditions that they put on a parole order*". Remarkably, Ms Johnstone conceded she did not always look at the parole conditions and consider their appropriateness in context of individual offender, and that she did not do so for Hunter. In addition, based on Hunter's presentations from session to session, she did not believe it necessary to write APB requesting a drug condition.

129. I make the comment here that, in my opinion, her approach was lacking in rigor. She did not display a conscientious application to the task in respect of this issue. I infer that this approach flowed, at least in part from cultural factors, and from a heavy caseload. In any event, the lack of rigor reflected in this approach is, in my view, unacceptable. It is difficult to see how it could ever be acceptable for a parole officer to be unaware of, and not made him or herself entirely familiar with, the parole conditions of a parolee being case managed by that officer.

DRUG USE BY HUNTER

130. Hunter was using the drug "ice" when he killed Sarah Cafferkey.

131. Hunter's VISAT recording of his drug use history showed that previously when on parole he used two different types of drugs, several times a day. Ms Johnstone agreed that this showed a "*possible*" propensity for Hunter to use drugs on parole, but she did not agree that it put him at "*grave risk of re-offending in terms of his drug use*".[63] Ms Johnstone stated that Hunter was not presenting as though he was using drugs and there was no indication that he was actually doing so. When questioned on the issue, Ms Johnstone stated that if she had suspected he was using drugs, she "*probably (would have) given him a lawful direction to go for a drug test ...*

[62] Inquest transcript p 201
[63] Inquest transcript p 180

or (written) to the Parole Board".[64] Ms Johnstone agreed that she was surprised that Hunter had not been taken into the ACSO COATS program (in light of his prior offending), stating that "*he probably could have maybe done a couple of sessions*".[65] However, she noted that Hunter's drug and alcohol programs undertaken while in custody may have influenced the COATS decision. I accept that this may well have been the case.

132. Ms Johnstone accepted, on questioning by Ms McLeod, that there was a "*likelihood*" that Hunter would recommence using drugs on his release from prison. She stated that she would "*like to hope that ... some of those programs do work*".[66] s Johnstone accepted, on further questioning, that it was not just a "*likelihood*" but "*a high likelihood*" that Hunter would resume drug use. She stated that, if the offender was not substance affected at the time they presented to a parole meeting, she would not be able to tell if they were using drugs or not and would rely on self-reporting. In my view, Ms Johnstone's evidence on this point revealed an over reliance on self-reporting.

133. It was not Ms Johnstone's responsibility as Hunter's LCCO/parole officer to do the assessment reports or the pre-parole planning. It was, however, her obligation to report serious concerns to the APB. As she repeated during her evidence, Ms Johnstone never had concerns which, in her view, justified a report to the APB; she never had concerns which led her to believe that Hunter was likely to be a risk if released in the community, either specifically to a specific person or, more generally, to members of the community.

134. Ms Johnstone stated that her progress reports to the APB included references to photographs of Hunter in his home with other ex-prisoners and having seen a letter to a prisoner on the bench his home, but that her report was quite positive regarding Hunter having obtained employment. For her, the positives outweighed the negatives.

135. I asked Ms Johnstone the question, "*So many of them raise what might be called red flags that you tend not to distinguish between them?*" She responded, "*Well, red flags to you and I, but in an offender's community it's – if they're associating with other offenders, it's not always going to be a red flag.*"[67] I accept the point she makes about parolees and their post-release associates. It is understandable that these associations are common for offenders and, in and of themselves, do not necessarily 'raise a red flag' for CCOs/parole officers.

136. In summary, Ms Johnstone's evidence was that her overall impression of Hunter's lifestyle on parole was that he was "*trying to do the right thing ... his intention was to complete parole*

[64] Inquest transcript p 181
[65] Inquest transcript p 183
[66] Inquest transcript p 185
[67] Inquest transcript p 260

and he had that plan to move forward ... (it) was all a positive move to ... release himself from the justice system";[68] and there was never a "red flag" in her mind about him.

137. In relation to his behaviour programs, Ms Johnstone's evidence was that at the time she took over management of Hunter's parole, he had been out for two months and was not undertaking any therapeutic treatment programs. Ms Johnstone stated that she took steps to get him into 'Maintaining Change'. I consider that this was a positive and appropriate action on her part. Ms Johnstone conceded that it was "not desirable" that Hunter did not enter directly into a program on his release, but stated that programs are not always available when a prisoner is released and they must wait until something is available. This is consistent with Mr Wise's evidence, as discussed above. Clearly from a system point of view, such time lags are a problem. At the very least they can reduce the available time and scope for effective behaviour change and similar interventions.

138. Ms Johnstone conceded that, after his release, she had the ability to recommend to the APB that Hunter participate in a violent behaviour program, but did not do so because he was intended for participation in the Maintaining Change Program. I note that no specific violent behaviour-related program was offered to Hunter while on parole and comment that I consider this was, in the context of Hunter's criminal offending history, a missed opportunity.

139. Ms Johnstone gave evidence that she was not 'overly' worried by reports of Hunter's cognitive distortions, pro-violence attitudes and passive aggressive communication style, in the context of the people she dealt with. She stated that, "*the majority of them were high risk or ... intellectually disabled offenders (who) didn't have any empathy at all for their offences or their victims*".[69] Hunter was not unlike other prisoners and did not 'trigger alarm bells' for her.

140. On this point the family made the following submission:

> "*...It is this supervision that the Adult Parole Board relies on in deciding whether a parolee should remain on parole.*
> *...the evidence shows that caseworkers and clinicians want the parolees to succeed at parole, and focus on this outcome, rather than the safety of the community. This can lead to minimisation of problematic parolee behaviour by caseworkers and clinicians. In the case of Hunter, he appears to have been accommodated in many ways for his own convenience by his parole workers, for example by allowing him to change his parole special conditions to allow him to exit group therapy, which he did not want to attend, and instead partake in one-on-one counselling; by allowing him dictate appointment times with his workers; and by allowing him to bring his dog to meetings. This likely allowed him to create a power imbalance with is workers which endangered the rehabilitative possibilities of parole.* I agree.
> *...The focus was firmly on his successful completion of parole, rather than on community safety.* I agree.

[68] Inquest transcript p 278
[69] Inquest transcript p 142

...As noted, the Adult Parole Board relies heavily on the discretion of caseworkers and clinicians to bring to their attention matters which might indicate heightened risk, such as non-completion of programs or other potential breaches. Reliance on self-reporting where parolees know how to game the system may mean important information does not reach the Parole Board. I agree.

...In the context of the supervision of parolees like Hunter, the level of attention able to be given to parolees in these circumstances is problematic. This is particularly true in light of the evidence that risky behaviour engaged in by parolees, like Hunter, was assessed by reference to other offenders, not by reference to the community as a whole. Otherwise obviously risky behaviours appeared normal in reference to that cohort of people."[70] I agree.

141. In my opinion Ms Johnstone was over confident in her opinion that Hunter did not pose a risk on release in to the community. It appears that her view was heavily coloured by the fact that, with respect to his attitudes, Hunter did not stand out in a cohort of other violent offenders. On the whole of the evidence, it is difficult to resist the conclusion that CCOs tended to "normalise" offender attitudes which are in their view normal within the prisoner cohort but from a community point of view would be likely to be considered unacceptably risky. There is a gulf between what is "normal" in the Corrections' view of the world and what is "normal" to the broader community. I accept that the correctional environment gives a different frame of reference when comparing prisoner to prisoner, as distinct from comparing the prisoners to ordinary and normally law abiding citizens. But the evidence suggests strongly that there was a tendency to over accommodate certain attitudes (including attitudes in respect of violence); attitudes which are, completely unacceptable in the ordinary outside world.

142. I note the Government submission in the follow terms:

"Ms Johnstone and Dr Doroc should not be criticised for seeking to help Hunter succeed with his parole. It would be strange if it were otherwise. One key purpose of parole is to give offenders a graduated step back into the community. It is to be expected that an offender will need assistance and guidance to develop the necessary community supports to remain offence-free at the end of their sentence...Ms Johnstone and Dr Doroc were flexible in their approach to ensure that he could maintain education and employment opportunities – both of which were protective factors in the scheme of Hunter's parole, and in the risk posed by Hunter to the community...In this case, the flexible approach did not indicate any escalation of risk and, if anything, involved his supervisor and clinician consolidating the protective factors that Hunter had developed."[71]

143. I accept the general validity of these points. However, I conclude on the whole of the evidence that there was a tendency to accept, and to discount, attitudes (for example 'pro violence attitudes') amongst prisoners, which would not be considered acceptable in the broader community. This tendency led to an underestimation of risk. It is one thing to accept that the attitudes in question are common within the prisoner/offender cohort; it is another thing

[70] Submissions on behalf of the Cafferkey Family, para 16-20

[71] Submission on behalf of Corrections Victoria, The Adult Parole Board and Victoria Police, para 49

altogether to conclude that they do not indicate a level of ongoing risk, perhaps a 'high' or even 'unacceptable' level of risk, on release in to the community.

THE OFFENDING BEHAVIOUR PROGRAMS AND INFORMATION SHARING

144. Hunter was required to participate in an Offending Behaviour Program as a condition of his parole. He was assessed for the Maintaining Change Program on 7 October 2011 and was identified as suitable for the program scheduled to commence on 8 November 2011. Hunter's first attendance was on 10 January 2012 and there were two further attendances. On 7 February 2012, he was moved to the individual OBP program and attended 10 of 17 sessions.

145. Dr Doroc was the psychologist responsible for Hunter in that program. Dr Doroc is a clinical psychologist and Senior Clinical Programs Officer with Offending Behaviour Programs, within the then Department of Justice (now the Department of Justice and Regulation, **DOJR**). At the time she was dealing with Hunter, Dr Doroc was provisionally registered as a psychologist. Her focus is on serious violent offenders and brings an "*understanding of violence and working with violence*".[72] Dr Doroc was the most experienced person in the team, other than the senior clinician, which is why they assigned Hunter (as a SVO) to her.

146. The Maintaining Change Program was 10-13 sessions, and is designed to assist with reintegration in to the community. There were seven topics relating to re-offending behaviour, including attitudes, peers, family relationships and thinking styles. Offenders could refuse to undertake programs in prison, but that would have repercussions for the timing of their release and potentially for parole. As I understand it, (as a result of reforms) the position now is that if someone does not do the programs they are unlikely to be released on parole.

147. The group program was cancelled due to insufficient numbers and Hunter was then transferred to a one-on-one "Maintaining Change" program. Dr Doroc stated that it was "*obvious that (Hunter still had) a treatment need ... to (be) addressed*".[73] When questioned on Hunter's attitude, in relation to the decision to move him to one-on-one counselling, Dr Doroc stated that they were "*the level of norm within which we work*",[74] but the decision to transfer him to one-on-one counselling was based on his identified needs and was not "*something we do lightly or isn't something we ... offer to everybody*".[75] The plan was to continue individual intervention until Hunter completed his parole.

[72] Inquest transcript, p 300
[73] Inquest transcript, p 299
[74] Inquest transcript, p 298
[75] Inquest transcript, p 298

148. Dr Doroc stated that her main aim in individual therapeutic sessions with Hunter was to address his "*cognitive distortions, lack of empathy, pro-violence attitudes and passive aggressive behaviours*".[76]

THE PARTICIPANT NON-COMPLETION REPORT

149. There was a 'Participant Non-Completion Report' on Hunter's involvement with the (group) Maintaining Change Program. The report was signed on 20 April 2012 by Provisional Psychologist, Kathy Karefilakis and co-signed on 1 May 2012 by Senior Psychologist, Rebecca Warburton.

150. The Participant Non-Completion Report was not provided to Ms Johnstone or to the APB. I will say more about this later in these findings.

151. I set out extracts from the Participant Non-Completion Report:

> *"The Maintaining Change Program assists offenders to develop awareness of various issues that support their offending behaviour, monitor their individual risk factors and reinforce strategies to reduce their risk of re-offending, engage in a supportive environment to discuss issues related to their risk of re-offending, rehearse and practice of strategies to manage high risk situations, and develop strategies to enhance their ability to reintegrate back into the community.*
> *At the commencement of the program, Mr Hunter advised the facilitators and the group members that he did not want to attend the program as he had completed numerous programs during custody and had maintained positive behavioural change, such as avoiding associations with previous peers. Mr Hunter was familiar with a couple of the group members from time spent in custody thus appeared to become comfortable with the group members and the group process fairly quickly.*
> *During the first session, Mr Hunter participated well during the discussions and activities. Mr Hunter demonstrated an ability to lead several group discussions. Mr Hunter failed to attend the second session. Mr Hunter attended the third session and contributed well to other participant's discussion about their transitional issues. However, Mr Hunter presented with a high level of resistance and refused to participate in the group activities and discussion relevant to the session topic. When the writer attempted to support Mr Hunter in completing the activities, he maintained his resistance and passive aggressive behaviour. This was evidenced by Mr Hunter walking away as the writer spoke to him, turning his chair away from the writer and not participating in the group activities. Mr Hunter also demonstrated current antisocial thinking styles. This was evidenced by Mr Hunter reporting that he had quit his employment and threatened his employer as he believed that his employer was talking negatively about him. He demonstrated cognitive distortions and lack of empathy towards the woman murdered by his friend. Mr Hunter justified the murder as the female was a "whore" and smiled during the disclosure.*
> *Mr Hunter demonstrated some insight into his risk factors to re-offending and has reportedly made some positive behavioural changes (e.g. he had fulltime employment and had ceased contact with negative peers).* ***Mr Hunter still presents with a number of risk factors, such as cognitive distortions, lack of empathy, pro-violence attitudes and passive aggressive communication style. Mr Hunter presented with limited insight to current challenges and low motivation to seek assistance.*** (My emphasis).

[76] Inquest transcript, p 336

Overall, Mr Hunter did not complete the Maintaining Change Program as the program had been cancelled due to insufficient numbers. Mr Hunter was not placed on a waitlist for the next Maintaining Change Program as the program does not appear to meet Mr Hunter's treatment needs. ***Mr Hunter's anti-social thoughts and resistance during the program suggest that he is not at a maintenance stage of change. As such, it appears that Mr Hunter requires further intervention to address his anti-social beliefs and behaviours that he continues to exhibit.***"[77] (My emphasis).

152. Hunter's "overall performance" in the program was rated as "adequate", but the following comments were made about him:[78]

- It was recommended that he "engage in individual intervention to address his risk of re-offending; and
- That his case manager, (Ms Johnstone) refer him to CMRM as required in accordance to the management of parolees who have committed specific serious violence offences.

153. I emphasise here that the Participant Non-Completion Report stated that Hunter still had a number of risk factors, in particular "*pro-violence attitudes*" with "*limited insight to current challenges*" and "*low motivation to seek assistance.*" These assessments of Hunter were not communicated to the APB.

154. It is difficult to accept that the APB, considering the case of a man with Hunter's background, in particular with a prior conviction for murder, would not wish to know, indeed insist on being made aware of, the assessment contained in that report. But the report appears to have had no influence on any decision making relating to Hunter's parole.

155. The Participant Non-Completion Report was signed off on 1 May 2012. The APB considered Hunter's case on 16 May 2012, 8 June 2012, 22 June 2012, and 17 August 2012. There were, therefore, four routine opportunities for the APB to be notified of, and respond to, the concerns raised in that report or (if confidentiality reasons dictated it) to be advised of a summary of those concerns and their import. However, this did not happen.

156. The comments in the Participant Non-Completion Report become all the more graphic when seen in the context of the 'Individual Intervention Completion Report' (the Completion Report) written by Dr Doroc after Hunter was arrested and charged with Sarah's murder.

157. The Completion Report was dated 23 November 2012 – 19 December 2012.

158. Dr Doroc gave evidence about the purpose of the Completion Report and contextualised the writing of it – it was written after Hunter's arrest for the murder of Sarah. She said that, but

[77] Maintaining Change Program – Participant Non-Completion Report – 20 April 2012
[78] Maintaining Change Program – Participant Non-Completion Report – 20 April 2012

for the murder of Sarah, "*it may have been written in a more positive way in terms of making some gains*".[79]

159. The following passages appear in the Completion Report:

"From the outset, Mr Hunter did not acknowledge any treatment goals and reported that he was not particularly interested in engaging in treatment, but was only doing so due to parole requirements. However, with ongoing discussions, Mr Hunter developed two goals...
Throughout treatment themes of power, control and domination emerged, which were related more strongly to certain masks. Mr Hunter's risk of violence would escalate when he sought to gain power, control and domination, as he would utilise aggression and violence as tools to achieve such feelings. Towards the end of treatment, Mr Hunter was able to acknowledge that he was at greater risk of offending when operating in certain masks; however, there was no indication of any motivation to address this...
It appears as though his thinking style supported the use of violence as a means of protecting the people he cares for, gaining excitement, and establishing or maintaining power and his reputation. Despite Mr Hunter's ability to acknowledge these anti-social thinking patterns, ***he was not motivated to address or change them.*** My emphasis.
Criminal thinking patterns and distortions
Mr Hunter displayed a number of antisocial thinking patterns and beliefs that support violence, which did not alter throughout his treatment. As such, criminal thinking patterns and cognitive distortions remain a risk factor for Mr Hunter.
Personality factors
As noted earlier, Mr Hunter appeared to be quite sensitive to others judging or criticising him, particularly if he felt that it was a judgement on his identity, beliefs and values. When he experiences perceived or actual judgement/criticism he can fell vulnerable and weak, which are feelings he struggles to manage. Mr Hunter is likely to engage in aggressive and violent behaviour in order to regain as sense of power and control if experiencing such feelings...
Furthermore, within treatment, Mr Hunter noted that he experiences a sense of excitement from the use of aggression. It appears that Mr Hunter seeks out feelings of empowerment and control, which he has typically done with the use of violent and/or aggressive behaviours. There was insufficient time within treatment to address this and develop alternative strategies for gaining control and power. As such, this remains a risk factor for Mr Hunter.
Emotion regulation
...Although Mr Hunter was able to identify his emotional state, he appears to have difficulty managing his emotions; particularly those emotions that make him feel vulnerable. This would often result in Mr Hunter shifting into one of the masks that assisted him to cope with such feelings, which often lead to an increased risk of aggression and violence.
Attitude towards women
Throughout his treatment episode, Mr Hunter displayed attitudes towards women that were hostile and demeaning. He often appeared to place women in one of two categories resembling the Madonna versus whore theme. Mr Hunter also demonstrated no empathy towards women who experienced victimisation if he viewed them within the 'whore' category. Although these attitudes were challenged as they arose, treatment did not specifically address them and as such, this remains a risk for Mr Hunter.
Lack of remorse and empathy
Mr Hunter displayed no remorse or empathy when discussing his use of aggression and violence or his history of offending behaviour. The current treatment episode did not specifically address these factors; as such, they remain a risk for Mr Hunter.[80]

[79] Inquest transcript p 304
[80] Individual Intervention Completion Report, 23/11/2012 – 19/12/2012

160. The conclusion I draw from these matters is that Dr Doroc did not believe that Hunter was prepared or motivated to address significant issues in his attitudes and behaviour. She confirmed this in her evidence. On a plain reading of the Completion Report Hunter's attitudes were seemingly entirely unchanged at this point; this suggested that Hunter's attitudes posed a risk on his release from parole.

161. In giving evidence about the Completion Report, Dr Doroc said, in relation to his "*very poor attitude toward women*",[81] that Hunter categorised women into a '*Madonna versus whore*'[82] role and justified certain behaviours toward women that he considered fell into the '*whore*' category.[83] Hunter's attitude toward women was not the focus of the sessions, but it came up from time to time. The main focus of the intervention was addressing Hunter's antisocial thinking styles and trying to assist him to gain an understanding of himself and his key values, in order to achieve a more 'pro-social' attitude. For example, Hunter's key values included his '*being there for his friends*' or '*being a loyal friend*'[84] and Dr Doroc assisted him to try to "*build up his skills to do that in a pro-social way*"[85], i.e. by not resorting to violence when he felt his friends were being threatened.

162. Dr Doroc stated that she was not alarmed at hearing Hunter 'would kill to protect his friends', as it is "*a pretty common attitude amongst offending populations that we work in ... a con code ... they are very loyal and protective of their friends*".[86] Dr Doroc considered Hunter's views in that respect as not a threat to society but "*a risk ... that can be managed*". She had not seen a reason to breach him, but she could have reported to the APB if she did. Dr Doroc stated that there "*wasn't any sign ... no behaviour change or anything that indicated that his risk was increasing*".[87]

163. Dr Doroc acknowledged that Hunter had disclosed to her that he had assaulted another person, and that a friend had stored illegal items at his house. Hunter did not give Dr Doroc specifics of these matters as, Dr Doroc stated, unless she had "*specific information about who, what, when, where, we can't report it*"[88]. However, she stated that Hunter "*was actually starting to realise that his desire to lead a pro-social life was not compatible with maintaining friendships with people that were still engaging in illegal behaviour...and was starting to think and put things in place to change that*".[89] Dr Doroc stated that she was concerned about

[81] Completion report.
[82] Inquest transcript, p 305
[83] Inquest transcript, p 306
[84] Inquest transcript p 306, 307
[85] Inquest transcript p 306
[86] Inquest transcript p 307
[87] Inquest transcript p 312
[88] Inquest transcript p 396
[89] Inquest transcript p 396

his reported antisocial and even violent behaviour, but that "*that's why we spent a lot of time exploring those high risk situations*".[90] She considered his response to being assaulted, (Hunter reportedly "*only punched the alleged attacker once*"), was an "*improvement, in terms of in his history it could have been a lot worse and he was able to think about the consequences and not take it further*".[91]

164. Dr Doroc did not make any reports to the APB or contribute material to Ms Johnstone's reports to the APB and was never invited to speak to the APB about Hunter.

165. Mr Wise was also questioned about the Maintaining Change Participant Non-Completion Report, in particular the passage:

> *"Mr Hunter still presents with a number of risk factors, such as cognitive distortions, lack of empathy, pro-violence attitudes and passive aggressive communication style. Mr Hunter presented with limited insight to current challenges and low motivation to seek assistance...Mr Hunter's anti-social thoughts and resistance during the program suggest that he is not at the maintenance state of change...appears that Mr Hunter requires further intervention to address his anti-social belief and behaviours that he continues to exhibit."*

166. Mr Wise was asked, noting that the parolee is about to be released with no supervision at that time, what they can do to make sure the offender does not re-offend (violently). Mr Wise stated that giving the offender *"strategies to control his behaviour, that's the best you can do and hope that compliance with parole conditions continues (post-parole)"*[92].

167. Mr Wise said that if the CCO formed the view two weeks prior to the end of parole that unconditional release is a significant threat to community, they can arrange treatment and make sure appropriate referrals to community agencies are put in place, but they have no capacity to mandate the offender's attendance. He said, "*(w)e have no jurisdiction once he's a free person*".[93]

168. Mr Wise stated that all of the people Dr Doroc sees have got unmet treatment needs and there are *"things that are of concern"*[94]. He stated that, unless they are *"out of the ordinary"*[95], it would not be expected to be reflected in a report or CMRM. It is difficult to accept that this was a sound practice, however, I accept that, as Mr Wise told me, the reports in question (some written with the benefit of hindsight, post Sarah's murder) did not emphasise the "*protective factors*"[96] which may in fact balance out certain elements that pointed to risk.

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[90] Inquest transcript p 396
[91] Inquest transcript p 463
[92] Inquest transcript p 98
[93] Inquest transcript p 108
[94] Inquest transcript p 492
[95] Inquest transcript p 492
[96] Inquest transcript p 482

169. Mr Wise was questioned on the matters that might alert the CCO to concerns about the offender's behaviour. He replied that such concerns are weighed against the positive things an offender is doing and a judgment is made that the offender poses a significant and unacceptable risk to the community. If so, the CCO would write to the APB to recommend that they cancel parole. Mr Wise stated that Hunter was complying, but he accepted that there was probably an element of façade. Hunter was not presenting at appointments as drug affected, he was still working and had stable accommodation. These factors were said to support the assessment that he was not using drugs.

170. The following propositions were put to Mr Wise for his comment:

a. That Hunter acknowledged that he had maintained antisocial peer associations and had no intention of ceasing them, as peers were "like family";

b. That Hunter reported several incidents of being placed in "high-risk" situations, which could have led to criminal charges if they had been reported; and

c. That Hunter acknowledged he'd be willing to offend, even kill, in order to protect a friend.

171. Mr Wise accepted that *"is hard to disagree with"*[97] the suggestion that these should raise an *"enormous red flag"*[98], particularly given Hunter's previous murder conviction. He agreed with the proposition put by Ms McLeod, that CCOs assess parolees by reference to and in comparison with the offender population with whom they are familiar, rather than by reference to any general community standard. This is a key point in this case. As the submission by the Family put it, "*Hunter was assessed by reference to other offenders, not be reference to the community as a whole. Otherwise, obviously risky behaviours appeared normal in reference to that cohort of people*".[99]

172. Mr Wise was asked if the Participant Non-Completion Report had gone to Ms Johnstone and the APB, was it likely that Hunter's parole would have been revoked. He replied that the Participant Non-Completion Report would not have gone to the APB, because it was not designed for that purpose. The APB would only be alerted to those matters if the clinician and/or CCO considered it an imminent risk to the safety of another person. This was a narrow criterion. It required a level of precision that appears to be somewhat artificial. It did not allow for a more generalised risk to be drawn to the APB's attention.

173. He was also asked if, on the basis of the Participant Non-Completion Report, plus information about balancing factors to give the whole picture, the APB would be likely to draw the

[97] Inquest transcript p 101
[98] Inquest transcript p 101
[99] Submissions on behalf of the Cafferkey Family

conclusion that Hunter should not be released on parole or that he should be brought back in during his parole period. Mr Wise's evidence was that *"if that report were ... made available to the...Board, and that were routine, then it would have been written very differently"*[100]. Mr Wise considered that the practitioners would use different terminology and provide some more balanced advice, stating that *"it would be a very different report"*[101]. Mr Wise stated that if Dr Doroc's concerns were "*appropriately explained and counterbalanced and put into context*"[102], it would be "*helpful*"[103] for them to have been before the APB. "Helpful" is in my view an understatement.

174. I accept Mr Wise's evidence on this, consistent with that of Dr Doroc, however the question has to be asked whether the 'counter balancing and contextualising' would ultimately be an exercise in underplaying and understating risk. If that was the effect, it would not assist the APB.

175. Mr Wise reiterated that Dr Doroc believed that Hunter was managing his risks and attitudes, that his behaviour was appropriate and that he represented a low level risk to the community, despite the underlying attitudes that did concern her. This does appear to be a correct representation of her evidence. Overall, it is clear that Dr Doroc did consider Hunter to be a relatively low, manageable risk due to the balancing protective factors that were present – accommodation, employment and some social supports. However, that assessment was, in my view, starkly at odds with the tenor and the terms of the Participant Non-Completion Report.

INFORMATION SHARING

176. Dr Doroc and Ms Johnstone gave evidence that they discussed Hunter's appointment arrangements with each other but not the content of the sessions conducted by Dr Doroc.

177. Towards the end of the inquest, Mr Wise was recalled to clarify aspects of information sharing spoken about by Ms Johnstone and Dr Doroc in their evidence. Ms Johnstone's evidence on the matter was that, in May 2012, Dr Doroc wrote to her and indicated that OBP would no longer be providing case managers with notes of treatment session, only attendance confirmations. From then, as she understood it, progress updates were subject to clinical confidentiality.

178. Ms Johnstone was unaware of what prompted the change, but she believed that from then on Dr Doroc would still be able to communicate concerns at the 'debriefing' after the supervision and the OBP appointment. These 'debriefs' occurred sporadically or occasionally, after

[100] Inquest transcript p 511
[101] Inquest transcript p 512
[102] Inquest transcript p 512
[103] Inquest transcript p 512

Hunter's appointments with Dr Doroc. Ms Johnstone could not recall the content of these conversations but stated that they may have been around his presentation, "*if he was presenting abrupt*" or if he was "*open in communications that particular day ... if it was a productive session*" and that they shared "*some information*" "*on occasions*" to "*keep each other in the loop as much as we could*" on "*information that was allowed to be disclosed*".[104]

179. Mr Wise gave evidence on report-sharing policies. In relation to the changes to information-sharing between CCO and clinicians, his evidence was that it was brought about to ensure CCOs understood clinical meanings and did not interpret clinical terminology incorrectly. The evidence was that the change took effect in May 2012. Mr Wise clarified that there was however an "*absolute*"[105] expectation that clinicians would continue to talk to case workers and provide summaries of critical parts of treatment. He also confirmed that clinician and CCO were each expected to report to the APB if they held any serious concerns relating to elevation of risk of re-offending.

180. Ethical obligations and confidentiality rules applied. As a result, clinicians could not disclose everything that was discussed in a session. As Dr Doroc said, without confidentiality, their clients would never talk to them about risky thoughts and situations, which "*is the whole purpose of therapy*"[106]. I accept that is an appropriate policy and practice in respect of confidentiality. However, it leaves open the question of what was to be done, and what information shared and passed on to the APB, when a red flag was raised. Dr Doroc stated that she would report any concerns she held about an offender's risk level to the CCO. As she said, she was never sufficiently concerned to do so.

181. As to the situation now (post reform), Mr Wise told the Court that the APB now has automatic access to clinicians' reports (progress and completion reports), but made the point that the APB cannot access "*file notes and other things that are confidential between the prisoner on parole and the clinician*".[107] The progress and completion reports are contained on the database relating to programs. Mr Wise gave evidence that he understood that, other than confidential clinical materials, the APB was otherwise not limited in what information it could access regarding parolees' treatment.

182. Dr Doroc stated that she would update Ms Johnstone on Hunter's presentation, the overall theme of their discussions and any matters she felt needed following up, but not specific details.

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[104] Inquest transcript p 286
[105] Inquest transcript p 475
[106] Inquest transcript p 314
[107] Inquest transcript p 476

183. At that time, the APB did not receive clinicians' case notes. The evidence was that the APB and CCOs are now (post the reforms) notified at the start of treatment, they receive a mid-treatment review and then the Completion Report. They now have a new intervention management system that the APB, CCOs and clinicians have access to. Everything that they do is uploaded onto the system so the APB can access it at any time. But, in this case, the way the system worked at the time meant that the APB could not have known Dr Doroc had noted Hunter had a 'very poor' attitude toward women, unless that was directly reported to it.

184. Mr Ward gave evidence[108] that the APB could only rely on information provided to it. He stated that there was no record of the Maintaining Change program Participant Non-Completion Report ever having gone to the APB. He stated that if the APB had been aware of that report having been prepared, it could have obtained it but was dependant on being told of its existence. He noted that the APB was aware of Hunter being transferred to a one-on-one Maintaining Change program.

185. However, Mr Ward's evidence was "*(t)here was nothing in that which would have excited the Board's interest...(based on) the way it was presented*".[109] I have difficulty accepting that. In my view, it would be likely that certain comments in the report would have "excited" the APB's interest. Indeed, as I see it, it is a reasonable expectation that the APB would have taken a strong interest in the Participant Non-Completion Report, particularly the comments in the report I have emphasised. I presume the APB would do so in reviewing Hunter's progress, in order to determine whether the parole ought to be maintained, changed or cancelled.

186. Dr Doroc confirmed that certain attitudes and risk factors did not change throughout Hunter's treatment and remained risk factors for him at the completion of his parole, but that the APB could not have known this because it did not receive the Participant Non-Completion Report. Dr Doroc expanded on that to say that she had never been in a situation where a particular parolee's risks had "*completely been addressed or changed ... the presence of that risk factor is usually always there. It's a matter of how it's being managed*".[110] I accept that, but in this case the APB was not put in a position to review the risk factors in question.

187. Dr Doroc went onto say:

> "*I don't think I saw 'no improvement' ... there were sessions that went really well and ... there were sessions where he didn't want to be there and it was difficult ... which is what you expect within treatment. We talk about really difficult things, we push buttons to make them*

[108] See paragraph 206 and following
[109] Inquest transcript p 612
[110] Inquest transcript p 317

think, so there's times when they don't want to be there and there's times where they do, and its fruitful discussions".[111]

188. On questioning, Dr Doroc agreed that the long term goals of the program could not have been realised because Hunter's parole came to an end. This goes to a real issue arising from the case – *Should the fact of the expiration of parole, in and of itself, remove society's obligation to continue to maintain prisoners on programs and within structures designed, to over time, to reduce the risk to the community on their ultimate and complete release?* I will return to this question later in these findings.

189. On the evidence, the APB did **not** know what risks Hunter posed when they dealt with him for the last time. Dr Doroc agreed that she considered the APB would have been interested in whether Hunter was still presenting with risk factors after his release on parole. She repeated the point that risk factors were not unusual among offenders and that whether a clinician made a report depended on "*whether the risk is imminent, whether we know that they're about to do something to someone*".[112] On the evidence, there had to be an imminent threat to a specific person before a report was made to the APB. Dr Doroc considered that Hunter's comments, attitudes and disposition never crystallised into a specific threat of that nature. She reported never reaching that conclusion about him.

190. Dr Doroc agreed that, without Ms Johnstone having access to case notes, she (Dr Doroc) was the only person who could have informed the APB of her ongoing concerns.

191. Significantly, Dr Doroc's evidence was that she had never seen a protocol or guideline dealing with the issue of what level of risk ought to be reported to the APB. The evidence is that, in fact, there was none. She said that her training meant that, as a psychologist, she would "*only report things if there's an imminent risk to self or somebody else*".[113] I make the comment here that that appears to be a very narrow criterion and not one consistent with promoting the safety of the general community.

192. When asked whether she considered that she had achieved any long-standing success in their program, Dr Doroc stated that there was not time to measure that, but she "*believed that there were things in place where he was managing his risks and he had some good skills to manage (his behaviours)*" and to "*meet (his identified) values in a pro-social way*".[114] Dr Doroc conceded that this was in the context of "*improvement in one presentation and then he'd fall back on the next*".[115] On later questioning, Dr Doroc conceded that '*whatever insight he was*

[111] Inquest transcript p 319
[112] Inquest transcript p 338
[113] Inquest transcript p 338
[114] Inquest transcript p 458
[115] Inquest transcript p 422

gaining (into his risk of offending when operating in certain masks) was not coupled by any motivation to change his behaviour.'[116]

193. Dr Doroc conceded that, in relation to Hunter's failure to disclose to her his drug use, threats of violence against other people and illegal actions, she could only respond to his self-reporting and information from external sources (such as his CCO). Importantly, Dr Doroc also conceded that Hunter may have lied when he told her that he was acting in self-defence in relation to an assault prior to his 15 October 2012 session with her (his last session before completing parole).[117] Dr Doroc confirmed that, ideally, she would have had many more sessions to the address Hunter's issues. Dr Doroc stated further that Hunter "*(had) been displaying these sorts of attitudes for years. He's someone that could use years of intensive psychological therapy, not just in a forensic context but in a clinical one*"[118], but that most offenders they work with would benefit from such treatment so Hunter was not considered unusual. Dr Doroc stated that she did not report her belief that Hunter would benefit from ongoing therapy to the APB, and that it was normal not to do so. This is a major system flaw. In my view, the APB should have insisted, as a matter of internal procedure, that it be made aware of a perceived and assessed need for parolees (eg Hunter) to be subject to further intervention/therapy (for the balance of their parole period).

194. Although unable (for confidentiality reasons) to disclose to the APB the specifics of matters discussed in the therapeutic sessions, Dr Doroc did state that she could have reported that he "*has cognitive distortions around violence or ... he still has ... violent attitudes*".[119] However, she did not do so.

195. Dr Doroc reiterated that Hunter's disclosures about his actions and thought processes which demonstrated his ongoing "*cognitive distortions*"[120] about violence were insufficient to trigger reports to the APB because they were not specific enough and didn't disclose imminent threats of harm to specific individuals. However, she accepted that she could have reported them if she had thought it appropriate and necessary.

196. Whatever interpretation I place upon her evidence, the fact is Hunter was a SVO whose attitudes towards violence had not changed. That is the evidence. In my opinion, it is reasonable to believe that the APB would have wanted to know about this position. Then, as now, community safety was a critical factor for the APB – although it was not expressly

[116] Inquest transcript p 449
[117] Inquest transcript p 441
[118] Inquest transcript p 444
[119] Inquest transcript p 443
[120] Inquest transcript p 443

paramount at that time. I cannot speculate about what the APB may have done, if made aware of Dr Doroc's clinical opinion regarding Hunter's attitudes towards violence.

197. When asked whether she saw a purpose in raising Hunter's recent acts of violence with the APB two weeks before the end of his parole, Dr Doroc conceded that "*there could be a purpose*"[121], but that she did not do that. Under questioning by Dr Freckelton, Dr Doroc accepted that she could have reported her concerns to the APB by writing a report that explained generally her concerns. Dr Doroc stated that she did not do this because she did not feel that Hunter was at an increased risk of violence and she considered he had "*learnt strategies to manage himself*".[122] She considered Hunter's "*range of protective factors ... were kind of mitigating what risk factors he did have*"[123] and she did not "*have a feeling that he was going to do something like this*".[124] I note what Dr Doroc says about this but her evidence is inconsistent with the tenor and terms of both the Participant Non-Completion Report and the later Completion report.

198. My assessment of Ms Johnstone and Dr Doroc is that each tended to minimise the unacceptable behaviours and attitudes of parolees, who they treated effectively as their clients. They appeared to be overly focused on ensuring that parole was successful and lacked what I would consider to be an appropriate level of scepticism about the answers given to their questions by Hunter. They were naïve in their acceptance of what he told them. This was particularly evident in relation to his self-reporting of personal associations and his drug use. I believe the reason for this attitude and acceptance was the culture within which they worked and the systemic approach to parole – that is, to ensure to the maximum extent possible that each parolee "*successfully complete*"[125] their parole, even in the face of concerns about risk. In their evidence, they were somewhat defensive of their actions and, from time-to-time, surprisingly unable or unwilling to accept that the approach taken by them (as part of the broader institutional/systemic approach) had the flaws that were pointed out during the inquest.

199. Ms Johnstone said that she did not believe that any of the matters in the Participant Non-Completion Report were reported to her prior to completion of his parole, indeed the first day of inquest was the first time she'd heard about it. This was a disturbing revelation – reflecting a poor internal system and a lack of information sharing.

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[121] Inquest transcript p 447
[122] Inquest transcript p 463
[123] Inquest transcript p 463
[124] Inquest transcript p 464
[125] Inquest transcript p 264

200. It needs to be said, and said emphatically, that no one is to blame for Sarah's death except Hunter. Any critical comment I make about the work of the officers involved with him in no sense carries the implication that they made a contribution to Sarah's death. I note that, in any event, his parole had expired by the time he killed Sarah.

APB MEETINGS WITH HUNTER

201. In paragraph 46, I set out the dates the APB interviewed Hunter. Aside from those meetings, the APB relied entirely on Ms Johnstone's reports regarding Hunter's compliance and any concerns regarding his behaviour post-release. Ms Johnstone stated that the meetings were "*quite positive meetings ... about going forward.*"[126] She did not recall any discussions about violence, risk or risk assessment. Ms Johnstone was the only Corrections employee attending these meetings. Dr Doroc did not attend these meetings. In relation to her information provision to the APB, Ms Johnstone considered that she was giving them information that enabled them to follow up whatever they thought they needed to follow up (according to her standard practice and consistent with directions from her employer), if they wanted to.

202. According to the APB meeting reports,[127] they interviewed Hunter on the following occasions after the commencement of his parole on 30 April 2011:-

4 May 2011

3 August 2011

9 November 2011

16 May 2012.[128]

203. At the meeting on 9 November 2011, there was brief reference to the Maintaining Change program. Ms Johnstone advised the APB that the program had been deferred until "the next one". Asked whether it was because of a "willingness to get involved" she said that Hunter was "partially going to it because obliged to do it". When Hunter appeared before the APB on that occasion, he was told that the APB still wanted him to complete the program. He was asked "*how are you going?*", to which he responded, "*alright*".

204. At the meeting on 16 May 2012, a member said to Hunter, "*you have been out for just over a year with just over 5 months to go. You are doing well. Working with OBP?*" He answered simply, "*yes*". The same member said, "*we would just like you to continue working with OP=BP – don't associate with any unsavoury people.*" Again, Hunter answered simply, "*yes*". There was then very brief further conversation and the same APB member, "*I don't think we*

[126] Inquest transcript p 269
[127] Exhibit 3
[128] See paragraph 46

will need to see you again" and "*your CCO will keep us informed of any issues. Otherwise keep doing what you are doing and good luck*".

205. These conversations reveal a brevity and superficiality in the interaction between the APB and Hunter. However I note the evidence that at the time, the APB was dealing with a very heavy caseload at each meeting, and a paper based system of file documentation within an overloaded and inefficient set of administrative arrangements. Critically it was entirely dependent on issues being drawn to its attention by case officers and others.

THE EVIDENCE OF STUART WARD

206. Stuart Ward is the Chief Administrative Officer and Secretary of the Board. He was not in that position at the time of the Hunter parole decision-making process. He made a lengthy statement and gave helpful and detailed evidence about the APB practices and procedures both at the time of Hunter's parole and after the reforms.

207. Mr Ward set out the conditions and obligations of Hunter's parole and the APB's interactions with Hunter during the parole period. Specifically, the APB required Hunter to have an interview with the APB after his release (on 4 May 2011) and another after a progress report (to be provided by 25 May 2011).[129] The APB interviewed Hunter on 4 May 2011 and set dates for a further interview date and further progress report. The APB received a progress report, dated 18 May 2011, noting that Hunter had been progressing well on parole and was motivated to "*live a legitimate lifestyle*".[130] It noted further that, on 8 June 2011, it received a 'special report' requesting a variation of residence condition.

208. The APB interviewed Hunter on 3 August 2011 and had available to it a progress report dated 22 July 2011. That report advised that Hunter had been "*progressing in a positive manner and would complete his intensive period on 29 July 2011.*"[131]

209. The APB interviewed Hunter again on 9 November 2011 with the benefit of a progress report dated 20 October 2011. It noted that Hunter had "*been found suitable for a 12-week Maintaining Change Program commencing in November 2011.*"[132] At the interview on 9 November 2011, the APB told Hunter that it wanted him to complete the Maintaining Change Program despite his work commitments and determined to see him on 16 May 2012 with another progress report to be received prior.

210. On 16 May 2012, the APB noted a progress report dated 30 April 2012 and interviewed Hunter. The report described Hunter as "*engaging well at supervision appointments every*

[129] Statement of Stuart Ward, para. 143
[130] Statement of Stuart Ward, para. 146
[131] Statement of Stuart Ward, para. 149
[132] Statement of Stuart Ward, para. 151

three weeks."[133] The APB was informed that "*Hunter continued to remain positive in his personal direction following the completion of his parole*".[134] The progress report advised the APB of Hunter's move from the group sessions to the one-on-one sessions with an OBP clinician.

211. Mr Ward's statement set out the background to the sentencing process under Victorian law and made the point that "*almost all prisoners must be freed unconditionally into the community at the end of their sentence (exceptions being those serving a life sentence or serious sexual offenders who are placed on a detention order).*"[135] He set out the statutory functions and composition of the APB and the method by which parole is granted and/or cancelled.

212. He makes the point that the legislation (the *Corrections Act 1986*) "*does not specify the circumstances in which the Board may cancel parole, but leaves the power open–ended.*"[136]

213. In his statement, Mr Ward said, "*...even if no condition has been breached, the Board may cancel parole if it considers the risk posed to the community by the offender remaining on parole has become unacceptable.*"[137]

214. Mr Ward set out the basis on which the APB makes decisions and the sources of information available to it when it does. He also set out the role of the meeting coordinator, whose responsibilities include ensuring that the APB's file was up-to-date and in proper order and that all required reports had been received and were on the file for the APB's consideration. I have set out earlier the detailed evidence about Hunter's parole, as given by Mr Wise.

215. In his statement, Mr Ward outlined the powers of APB's decision-making about Hunter, from 1988. He noted that on 18 April 1997, the APB had received a psychiatric report which stated, amongst other things, in relation to Hunter's murder of Jacqueline Mathews on 9 April 1986, "*The crime remains something of an enigma. Hopefully, the main elements in this tragedy were an overexcited sleep deprived young man struggling to cope with roles and responsibilities way beyond his years or capacities who responded with dreadful violence to a momentary frustration. f this is indeed the explanation, it need not be seen as having any continuing implications for his future behaviour.*"[138] The tragic irony here is that it appears, from the known facts of the murder of Sarah, as reflected in the sentencing remarks of Justice

[133] Statement of Stuart Ward, para. 153
[134] Statement of Stuart Ward, para. 153
[135] Statement of Stuart Ward, para. 9
[136] Statement of Stuart Ward, para. 23
[137] Statement of Stuart Ward, para. 24
[138] Statement of Stuart Ward, para.47(b)

Bell, that again Hunter may well have responded with a "*dreadful violence*" to what may have been a "*momentary frustration*".[139] History appears to have repeated itself.

216. Mr Ward set out a summary record of Hunter's completion of programs relating to violence and drugs in prison. He completed eight courses between November 1996 and August 1997.[140] I note that these pre-date (by over a decade) the decision not to require him to undertake violence-specific courses prior to his April 2011 release on parole.

217. In dealing with the 6 May 2010 decision to set a date for release on parole, Mr Ward detailed all of the information available to the APB when that decision was made. His evidence was consistent with that of Mr Wise. He noted that the APB considered Hunter's case on several occasions between that date and the release date of 30 April 2011. He noted that, on 23 June 2010, the APB considered the Subsequent Progress Report dated 31 May 2010. That report confirmed that Hunter had completed the Cognitive Skills Program and one-on-one counselling, as well as a 40-day Drug and Alcohol program and that he had been assessed as unsuitable for the Violence Intervention Program. As I have earlier observed, there is no cogent explanation as to why he was considered unsuitable for the Violence Intervention Program. However, I infer that this assessment was consistent with the assessment outcome and advice considered by the APB on 3 June 2009, when Hunter was not recommended for participation in the Moderate Intensity Violence Intervention Program as a consequence of his VRS score falling into the "*low risk category of committing further violence offences.*"[141]

218. In relation to the Maintaining Change Program Participation Non-Completion Report, Mr Ward notes "*this document is **not** on the Board's files and there is **no record** of the Board which establishes that it was given to the Board, save for the information contained in the Progress Report dated 30 April 2012 referred to above* (My emphasis)".[142] He confirmed in his oral evidence that the Maintaining Change Program Participation Non-Completion Report was not provided to the APB.

219. It is clear that the APB never saw that report and was never given an opportunity to consider the risks which it highlighted. This was a significant system flaw. The report or, if confidentiality required it, a summary of its key findings should have been available to the APB and drawn to its attention.

220. On 8 June 2012, the APB noted a Special Report dated 21 May 2012. That report requested a change the condition relating to one-on-one treatment sessions. It advised the APB that the Maintaining Change Program group sessions were not being continued and also that one-on-

[139] Sentencing remarks of Justice J Bell
[140] Statement of Stuart Ward, para. 55
[141] Statement of Stuart Ward, para. 129
[142] Statement of Stuart Ward, para. 155

one sessions were being undertaken "*to address his risks and needs specifically.*"[143] The APB then received a follow-up request by email dated 19 June 2012, "*that OBP was no longer willing to engage with Hunter under the wording of his current condition as it did not reflect their involvement correctly.*"[144] In response to this, the APB varied his parole conditions to allow for Hunter to be provided with individual treatment sessions by the OBP.

221. In the final part of the statement, Mr Ward set out in detail a summary of the reforms which have significantly changed the APB's practice over the past three years. He referred to the detailing of practice changes in the 2014/2015 Annual Report of the APB.[145]

222. Mr Ward's oral evidence was consistent with his statement. He confirmed that the APB can be informed of a parolee's escalation of risk through the Corrections Officer or clinician. Mr Ward stated that the APB is able to access certain information relating to parolees and prisoners through the Prisoner Information Management System (PIMS), which is a system within prisons that records information about prisoners, including incidents. E-Justice is database that records CV and CCS information such as APB decisions. He stated that the level of information being provided to the APB in written material has improved.

223. Mr Ward's evidence was consistent with Mr Wise's in that the CCO can report to the APB at any time if they consider that there is an issue that the APB should be made aware of. As he put it, a clinician would be in regular communication with a CCO and the CCO would be reporting outcomes of participation programs through their reports to the APB. Indeed, that is what occurred in Hunter's case. Mr Ward's evidence was consistent with that of Mr Wise, Dr Doroc and Ms Johnstone's, in that if the clinician believed certain things needed to be raised with the APB, they could have communicated that to the CCO. Mr Ward said, "*(i)f there was some urgency about it, I think the clinician could raise the matter directly in a report to the Board.*"

224. Mr Ward also said that, generally, the conduct of treatments and assessments would be relayed to the APB through the CCO's reports, but that there was nothing stopping a clinician from reporting directly to the APB.[146]

225. In relation to clinicians' ethical considerations, Mr Ward commented that the APB can only rely on information provided to it. He said that he would hope sufficient information is provided to enable the APB to understand the risks or escalation of risks. Noting again that there is no record of the Maintaining Change program Participant Non-Completion Report having gone to the APB, Mr Ward was unaware of any requirement that it should have. He

[143] Statement of Stuart Ward, para. 158
[144] Statement of Stuart Ward, para. 159
[145] Annual Report of the Adult Parole Board of Victoria 2014-15, p 19-23
[146] Inquest transcript p 588

put the general proposition to the Court that, *"the more information ... available to the Board, the better it is ... positioned to make decisions."*[147] There can be no doubt about that.

226. Mr Ward acknowledged that there was no indication that the document had ever even been on the file;[148] it would appear that the APB was not aware of its existence[149], but that it was *"not necessarily"*[150] the type of document that would have been routinely available to the APB.[151] He said, however, if the APB was aware of a Participant Non-Completion Report having been prepared, the APB could have obtained it. However, for the APB to obtain such a report, it depended on being advised its existence. He also said, *"There was nothing in that which would have excited the Board's interest ... (based on) the way it was presented."*[152] (see my earlier comments about this at paragraph 172). However, Mr Ward agreed that it was open to the APB to ask questions about the decision to undertake one-on-one sessions targeting Hunter's particular risks and needs and *"it could have done that if it chose to do so"*.[153] If that was to occur, the normal practice was for clinician's reports/assessments/concerns to be incorporated with in the CCO's report to the APB.

227. Mr Ward was not able to tell me if there is any material regarding the APB's expectations about notifications or information they require from CCOs or of any recent training for CCOs on the issue of expectations about disclosure of information to the APB. I would be surprised if such guidance has still has not been provided to CCOs. It would appear to be potentially very helpful to them and, indirectly, the consequences of this information could potentially benefit the community.

228. I note the following submissions made on behalf of the Family:-

"The internal management review of Hunter's parole highlighted failings in communication between Hunter's caseworker and clinician, particularly the sharing of relevant information...
...This left Ms Johnstone relying on ad hoc verbal updates on Hunter from Dr Doroc, which Dr Doroc said would have involved details of how Hunter presented, what overall themes were discussed during therapy and if there was anything Dr Doroc needed Ms Johnstone to follow up with Hunter, however the verbal reports did not contain specific details of things discussed as Dr Doroc felt that would be a breach of her confidentiality requirements. These reports were not provided to the Adult Parole Board, except through the caseworker.
Two weeks before Hunter ended his parole period he engaged in violence, which he reported to Dr Doroc. This was not reported to the Adult Parole Board...This raises serious concerns that information directly relevant to the Parole Board's oversight of parolees is not being provided to them because of beliefs about what information can and cannot be shared.

[147] Inquest transcript p 593
[148] Inquest transcript p 611
[149] Inquest transcript p 622
[150] Inquest transcript p 611
[151] Inquest transcript p 611
[152] Inquest transcript p 612
[153] Inquest transcript p 619

...It cannot know what it does not know. The Board is a decision-making body and does not have an investigative or case management responsibility for capacity. It relies completely on the information provided to it by the relevant Corrections workers that report to it. Those workers in turn fetter themselves in the information they provide to the Board, by reason of confidentiality concerns, and because their conflicting roles of both supervising parolees but also assisting the parolees to complete their parole period results in the normalising of behaviours that in other contexts might be of greater concern.[154]
Given that it is the caseworker who reports to the Adult Parole Board, and given the Board's heavy reliance on those reports, this is concerning. Notes from the Board meeting with Hunter indicate minimal probing beyond the information provided by the caseworker. The concern is that the Board's oversight once a person had been released on parole is minimal.
Also concerning...lack of protocols and guidelines surrounding what must be reported...Dr Doroc...showed a lack of clear understanding of what information was and should have been conveyed to Adult Parole Board, by whom and when. Her evidence suggests that her belief was that their clinical duties and ethical responsibilities prevented her from reporting anything less than an imminent risk posed by a parolee to an identified target to either police or the Adult Parole Board...
In addition, Dr Doroc's belief that she could not use her clinical judgement to comment to the Adult Parole Board on a change in dynamic risk factors and/or the potential consequences of that change suggests that either the VISAT should have been redone systematically or that OBP clinicians cannot be expected to provide any useful guidance to the Adult Parole Board about changing risk levels while an offender is on parole."[155]

This is a fair critique. I agree, that Dr Doroc showed a lack of understanding of what information should have been conveyed to the APB. This is not entirely surprising given the absence of clear directions as to what the APB expected/required.

INTERNAL MANAGEMENT REVIEW REPORT

229. After Hunter's arrest for the murder of Sarah on 10 November 2012, CCS conducted an internal review. A report was produced, dated 9 January 2013 (the Internal Review Report). The review was conducted by Ms Maria Groh and Ms Jan Noblett. Its Terms of Reference included, "*How effectively Mr Hunter was managed by the Case Manager and the Region, in relation to his Serious Violent Offender (SVO) status.*" The review was essentially a file review and took into account a review of the VISAT, parole reports and other documentation. It also took into account information provided by the OBP and involved an interview with OBP staff. It noted that the parole in question (30 April 2011 – 30 December 2012) was Hunter's third parole.

230. The Internal Review Report noted the reference to Forensicare as a condition of the parole order. It states "*The case was considered by the Forensicare Intake Panel and on 18/5/11. A report was received from Forensicare confirming that they would not provide treatment as Mr Hunter had no known mental health diagnosis and had adequate services already in place*

[154] Submissions on behalf of the Family, para 27-30
[155] Submissions on behalf of the Family, para 24-26

in the community."[156] I note that this is consistent with other evidence relating to Hunter's mental health. There is no evidence to suggest that Hunter had a mental health disorder or illness.

231. The Internal Review Report notes the referral to the OBP. It notes the commencement and deferral of the Maintaining Change Program (group) and Hunter's then commencing on the individual program. This passage in the Internal Review Report makes no mention of Hunter's attitude towards participation in the group program. Other documents do make reference to it. I infer from all of the evidence on the point that both the cancellation of the program and Hunter's attitude were factors in his move to the individual treatment program. In any event, he did participate in the individual treatment program and attended ten sessions in total.

232. The Internal Review Report noted that Hunter was managed by the same CCO (Ms Johnstone) from July 2011 to the expiry of the parole order. It noted evidence of regular liaison between the case manager and the OBP clinician in relation to Hunter's progress in treatment and "*the initial file notes from the treatment sessions were provided to the case manager and are placed on file. As the OBP process for providing these changed in May 2012, no subsequent file notes were provided.*"[157] I infer here that although the change took place in May 2012, it is clear that the Participant Non-Completion Report dated 20 April 2012 was not provided to Ms Johnstone, nor were the key comments of the author made known to her.

233. The Internal Review Report sets out program attendance by Hunter between May 2011 and end of October 2012. It comments on various absences from required attendances. On that issue, it makes the comment that "*A more formal liaison/consultation process between the case manager and OBP may have identified some concerns in relation to Mr Hunter perhaps avoiding the OBP sessions, and this is identified as a recommendation/improvement in the latter part of this report...*"[158]

234. The Internal Review Report then goes on to deal with a Qualitative Case Management Assessment. In dealing with his "treatment" it noted:

    a. That the Maintaining Change Program in January 2012 was "*unfortunately cancelled due to low participant numbers.*"[159] (I have already noted that there appears to also have been an attitude factor in this decision).

[156] Community Correctional Services Internal Management Review Report 9 January 2013, p 5
[157] Community Correctional Services Internal Management Review Report 9 January 2013, p 7
[158] Community Correctional Services Internal Management Review Report 9 January 2013, p 9
[159] Community Correctional Services Internal Management Review Report 9 January 2013, p 10

b. The referral to the individual program, but that there was a lapse of seven months before Hunter actually commenced treatment with the OBP and that "*this is considered to lengthy for SVO's.*"[160]

c. That there had been an improvement in that system and that there were prioritising and fast tracking arrangements to deal with this.

235. The Internal Review Report noted the Tier 2B outcome summary, identifying ongoing risks for Hunter including:

- Antisocial peer associations;
- Criminal thinking patterns and distortions;
- Personality factors;
- Emotion regulation;
- Attitude towards women;
- Lack of remorse and empathy;
- Substance use/trafficking; and
- Reintegration needs.[161]

236. The Internal Review Report went on to note that "*while there appears to have been regular contact between the case manager and OBP clinician, the depth of collaboration around the treatment goals or challenging Mr Hunter's thinking and attitudes could have been stronger.*"[162] It gave the most "*concrete example*" as relating to Hunter's "*antisocial peer associations*".[163]

237. There is a comment in the Internal Review Report to this effect, "*It is the view of the reviewers that there was insufficient evidence of a uniform approach by the case manager and clinician. Both have approached the issue separately.*"[164] (This is the antisocial peer associations). I make the point again that in my opinion the extent of collaboration between clinician and CCO should have extended to the clinician informing the CCO of the salient matters contained in the Participant Non-Completion Report, even though Dr Doroc was not the author of that report.

238. The Internal Review Report goes on to note as 'Challenges' that, "*Experienced and long term offenders can be extremely skilful and their compliance can hide resistance to more intensive interventions.*"[165] There appears little doubt that Hunter was in that category.

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[160] Community Correctional Services Internal Management Review Report 9 January 2013, p 10
[161] Community Correctional Services Internal Management Review Report 9 January 2013, p 11
[162] Community Correctional Services Internal Management Review Report 9 January 2013, p 11
[163] Community Correctional Services Internal Management Review Report 9 January 2013, p 11
[164] Community Correctional Services Internal Management Review Report 9 January 2013, p 11
[165] Community Correctional Services Internal Management Review Report 9 January 2013, p 12.

239. In its concluding commentary, under the heading 'How effectively Mr Hunter was managed by the Case Manager and the Region, in relation to his Serious Violent Offender status', the following paragraph appears:

"While all efforts were appropriately made (in compliance with procedures) to address Mr Hunter's risk factors, attitude, thinking, compliance and associations, it appears that closer and more structured working arrangements between the OBP clinician and the case manager to plan joint interventions may have yielded a greater capacity to challenge Mr Hunter. Given his experience in the correctional system, it is possible that his ability to manage his presentation maintained a superficiality in these interactions."[166]

240. It is clear on the whole of the evidence in this case that a "*more structured working arrangement*" between the OBP clinician and the CCO may have yielded a number of benefits, including the benefit of planning joint interventions. But to do so meaningfully and effectively would have required information sharing. The CCO was not privy to the information coming out of the OBP sessions. Allowing for the necessary confidentially considerations, the essence of Hunter's continued negative attitudes towards women and positive attitudes towards violence should have been revealed to her. There was a failure to share that vital information. This was a significant flaw in the process.

241. In my opinion, the assessment in the Internal Review Report fails to get to the heart of the issue. This was a case where all involved with Hunter (including the APB) should have been made aware of the ongoing and extremely serious concerns expressed in the Participant Non-Completion Report and their implications for risk on his release into the community.

242. The Internal Review Report itself notes:

"It is noted in the report from OBP that Mr Hunter was resistant during the 2 out of 3 sessions he attended for the Maintaining Change Program, and in one session refused to participate in the group activities. The report identifies that "Mr Hunter still presents with a number or risk factors, such as cognitive distortions, lack of empathy, pro-violence attitudes and passive aggressive communication style." As he progressed in individual treatment, he did engage appropriately, however, there was still some resistance to treatment and he needed probing to illicit information, admitting that he was attending the appointments as it was a condition of parole."[167]

243. The Internal Review Report goes on to describe the 'Level of intervention' provided to Hunter during the most recent period of parole as "*adequate*". At the same time it noted the Completion Report and quoted from that report:

"from the commencement of treatment, Mr Hunter would make comments that demonstrated pro criminal beliefs, particularly about violence" and "he was able to acknowledge that the beliefs he had about violence would be considered cognitive distortions and therefore risk

[166] Community Correctional Services Internal Management Review Report 9 January 2013, p 14.
[167] Community Correctional Services Internal Management Review Report 9 January 2013, p 15

factors for further offending behaviour." He expressed that these would be difficult to change and did not appear willing to change."[168]

244. In relation to violence programs, the Internal Review Report noted that Hunter "*did not complete the Violence Intervention Program (VIP) while in prison.*"[169] It noted that "*At the time of the assessment in 2008, Mr Hunter was found unsuitable for the VIP as his score on the Violence Risk Scale was below the cut off for referral to the program.*"[170] It goes on, "*While he would have benefitted from the opportunity to undertake the VIP while in prison, the assessment that he was unsuitable was based on the criteria in place at the time, and alternate options for intervention were provided to Mr Hunter...*" It refers to the cognitive Skills Program and his completion of it.

245. Finally, in relation to recommendations, the Internal Review Report refers to the VISAT review and recommended "*...that the VISAT review consider the development of a more detailed and sensitive risk assessment module for SVOs given the serious nature of their violent offending. Under the current VISAT risk assessment, most SVOs are likely to rate as low risk which requires decisions to override the assessment to better reflect the seriousness of their offending.*"[171] As noted previously, the evidence is that VISAT has been replaced by a new and more sensitive risk assessment tool.

REFORMS

246. Both Mr Wise and Mr Ward outlined recent reforms to the legislation and to the Adult Parole System in detail.

247. Mr Wise gave evidence of the changes implemented in April 2015, in respect of Serious Violent Offenders and Sexual Offenders (SVOSOs), and noted that they are now managed by senior parole officers. He gave evidence that this approach "*appears to be working*"[172] but confirmed that there is, as yet, no empirical data to support that belief. He advised that CV is conducting an evaluation of parole system, including these matter and he "*would expect for it to have reduced recidivism*".[173]

248. Mr Wise gave detailed evidence in respect of risk assessment tools. At the time the APB decided to release Hunter on parole, CV was using the VISAT. In 2011, following a spate of murders committed by parolees in Victoria in the period July 2008 – November 2010, the Office of Correctional Services Review (OCSR) undertook a number of reviews into the

[168] Community Correctional Services Internal Management Review Report 9 January 2013, p 15
[169] Community Correctional Services Internal Management Review Report 9 January 2013, p 15
[170] Community Correctional Services Internal Management Review Report 9 January 2013, p 15
[171] Community Correctional Services Internal Management Review Report 9 January 2013, p 16
[172] Inquest transcript p 18
[173] Inquest transcript p 19

management of parolees and other offenders, including a *'Review of parolee reoffending by way of murder'* by the OCSR and Professor James Ogloff (Professor Ogloff's Report). My finding into the death of Margaret Burton,[174] dated 2 October 2014, considers these reviews and the issues of parolee management, pre-parole assessment of prisoners and supervision of parolees.

249. Corrections Victoria incorporated the outcomes and findings of these reviews, including Professor Ogloff's Report findings, and produced them in a report entitled *'Consolidated Responses to Reviews of Offenders Charged with Murder'* (the Consolidated Response Report). In 2013, CV published a redacted copy of the Consolidated Response Report and Professor Ogloff's Report on their website.

250. In May 2013, former High Court Judge Ian Callinan was engaged to conduct a review of the effectiveness of the APB. The *'Review of the Parole System in Victoria'* (the Callinan Review) was released in July 2013 and covered the APB's operations, including construct and membership, the legislative framework and options for increased transparency in the APB's decision making. The Callinan Review recommended 23 measures, to improve the APB's operations.

251. I note that the APB, in conjunction with CV as of 30 June 2015, had implemented 22 of the 23 recommended measures from the Callinan Review.

252. In line with the Callinan Review recommendations and advice received regarding the tool's appropriateness, CV has now replaced the VISAT with the 'Level of Service – Risk, Needs and Responsivity' (LS/RNR) tool for assessing offenders' general risk of re-offending. The LS/RNR was implemented in early 2015, with associated IT changes and CV staff training. In the period prior to the LS/RNR's introduction, CV refined the VISAT's use and operation, to ensure that all SVOSOs were also assessed by the Violence Risk Scale to determine their risk of re-offending

253. As to the predictability of re-offending, Mr Wise compared the Level of Service (LS) tools with the VISAT. He stated that VISAT had a *"fairly good"* predictive capacity but that Professor James Ogloff had raised concerns with VISAT's predictability accuracy.[175] Mr Wise stated that the LS is rated *"slightly higher"*[176] for some groups of offenders and has a better reputation worldwide as a risk assessment tool with a greater predictive validity over a wider range of people. The LS tools better identify those offenders at a higher end of risk of re-offending and, importantly, those whose offending might cause the greatest harm.

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[174] COR 2009 3158
[175] Inquest transcript p 19
[176] Inquest transcript p 19

254. Mr Ward referred to the critical change in 2013 – an amendment creating s.73A of the *Corrections Act 1986*, providing that the "*paramount consideration of the Board when making parole decisions is the safety and protection of the community.*"

255. He then set out the new system of the APB dealing with parole applications and reports, noting the eligible prisoners are now required to apply for parole. He notes that the APB is "*provided with all information that is pertinent to its decision-making.*"[177] These reports include the Parole Suitability Assessment (PSA).[178] Mr Ward went on to set out details of the sitting arrangements of the APB.

256. In relation to SVOSO Division of the APB, Mr Ward's statement contains the following:

> "*All decision about whether to release a Serious Violent Offender or Sex Offender on parole are now made by the Serious Violent Offender or Sexual Offender (SVOSO) Division of the Board (which must include the Chairperson of the Board) after another panel of the Board recommends that parole is granted. In essence, this creates a two-tiered decision-making process for offenders that fall within this category.*"[179]

257. Finally, under the heading 'Effect of reforms', Mr Ward's statement says:

> "*The reforms to the Board's practice that I have summarised above mean that the Board is now armed with more and better information about the offenders for which it is making parole-making decisions. Further, the increase in the number of members of the Board, the use of electronic files, the rationalisation of the Board's sittings and interviews with prisoners, and the increased resourcing of the Board's Secretariat mean that the Board is able to consider more effectively all of the information that is before it so that decision-making is enhanced with the outcome that the risk to the community from parolees is reduced.*"[180]

These are clearly positive developments.

OTHER SYSTEM IMPROVEMENTS

258. It is clear that the changes implemented as a consequence of the Ogloff and Callinan Reviews and legislative reform, have emphatically placed community safety ahead of the interests of the parolee. It is also recognised that the community has a strong investment in effective programs to promote successful completion of parole and reduction of the risks of re-offending by parolees.

259. I note the evidence of Mr Wise that the CMRMs have been "*significantly strengthened*"[181] since Hunter was released on parole and that Corrections Victoria is moving to ensure that all SVOSOs have a CMRM, which is chaired by a principal practitioner and, where possible, a General Manager or Operations Manager or Officer in Charge are also expected to attend. As Hunter falls into the SVOSO category, under the new system he would require regular

[177] Statement of Stuart Ward, p 32
[178] Statement of Stuart Ward, p 32
[179] Statement of Stuart Ward, p 33
[180] Statement of Stuart Ward, para. 165
[181] Inquest transcript p 478

CMRMs. Mr Wise stated that he considers there are now "*adequate safeguards*"[182] in the process now, with supervision by senior CCO, CMRM, oversight by senior staff and input from the clinician. I accept that as a reasonable assessment at this early stage of the new system.

260. In relation to the APB process, Mr Wise's evidence was that the APB remains largely dependent on the CCOs and clinicians' reports but can be informed from a range of other sources. In Mr Wise's assessment, approximately the same amount of information goes from clinicians reports now as it did in 2012. He emphasised, however, the reduced CCO caseload and the employment of more experienced staff. Today, on the evidence, Hunter would be supervised/case managed by a senior parole officers, of higher rank than Ms Johnstone.

261. He also described what he referred to as "*new inputs into the parole process*"[183], both from the intelligence holdings of Victoria Police and those of Corrections Victoria.

262. Finally on this topic, Mr Wise referred to the employment of larger numbers of senior personnel than was the case in 2012 and of additional training. He understood the specialised training course to be four weeks long, before commencement of taking on clients, and that there was emphasis in the course to changes in the parole system including the "*paramountcy*"[184] of community safety.

ADULT PAROLE BOARDS ANNUAL REPORTS

263. The APB's Annual Report for 2014/15[185] sets out details of the operations of the APB since the implementation of reforms flowing from changes to the *Corrections Act 1986* (by way of the *Corrections Amendment Act 2013*) and the *Justice Legislation Amendment (Cancellation of Parole and other matters) Act 2013*. These are changes are also referred to in the evidence given by Assistant Commissioner Fontana.

264. The APB's Annual Report highlights the creation of the SVOSO division. This "Second Tier" Division was commenced on 1 July 2014. Were it in existence at the time, the two-tiered approach would have applied to the consideration of Hunter's parole. It is clearly a positive development. I note that in the year 2014/15, the SVOSO division considered 750 matters. The two-tiered system assures that there will be "*an extra layer*" of consideration in respect of all SVOSO decisions.

265. The APB's Annual Report provides a summary of highlights. One of the features of the modernisation of the APB has been full digitisation of its files, completed late in 2014. I note

[182] Inquest transcript p 489
[183] Inquest transcript p 515
[184] Inquest transcript p 516
[185] Exhibit SW1

that all APB hearings are now conducted electronically. I note the reference to improvements to roster arrangements leading to a reduced caseload at meetings. This clearly enables the APB members to give greater and more detailed consideration to cases, many of which are complex.

266. The APB's Annual Report contains an outline of the legislative framework within which parole is considered and granted, including a statement of the purpose and principles underlying parole. I note that:

"*The purpose of parole is to provide a structured, supervised and supported transition back into the community for offenders who have served the non-parole period of their sentence and are approaching the end of their prison sentence, under conditions that are designed to minimise their risk of reoffending. Parole cannot completely eliminate the risk of reoffending.*"[186]

267. I accept the importance of each of these propositions. Coupled with them is the emphasis on community safety under the amended legislation – community safety is the paramount consideration applicable when parole is being considered and granted. I note also that from a historical point of view, as far back as 1957 when legislation was introduced to create the parole system in Victoria, community protection was a key consideration. It has now been elevated to a position of absolute paramountcy. The message could not be more emphatic.

268. In relation to SVOs (Hunter was a SVO), I note that according to the Annual Report, 38.8% of parole orders granted in 2014/15 (a total of 520) related to serious violent or sexual offenders. Clearly, the creation of the two-tiered approach to be applied to these offenders is a mechanism to strengthen community protection by the imposition of a second level of consideration of each of these applications for parole.

269. It is early days in the implementation of the reforms referred to, but they certainly constitute significant and positive changes from a risk assessment and management point of view. It would not be appropriate for me to comment further on the matter and time will tell whether these measures have had the desired effect. However, I should note in this context an unintended consequence of one of the changes – the requirement that a prisoner make his or her application for parole before they will be considered for parole. An investigation by the Victorian Ombudsman, Deborah Glass in 2015 found, according to the report "*a growing number of prisoners choosing not to apply for parole upon eligibility in favour of completing their maximum sentence and leave on straight release without the watchful eye of authorities.*" In her report released in September, Ms Glass said "*This is also not consistent with the intent of any parole system and means that many prisoners are simply being warehoused, leaving*

[186] Adult Parole Board of Victoria Annual Report 2014-15, p17

prison without the reasons behind their offending and risk of re-offending being addressed."[187]

270. The submission on behalf of the CV, APB and VicPol stated:

> *"The assessment and management of parolees is a very difficult issue of public policy. There is a clear public benefit in a parole regime to ensure, as best as can be, that prisoners are motivated to reform whilst in prison, and then have an opportunity to be re-integrated into the community with support and supervision before they are released from their sentence without restriction. Such a program cannot come at the cost of community safety and, accordingly, over the last few years significant steps have been made to address perceived deficiencies in the parole system identified in a variety of inquiries. These steps have included mandating that prisoners apply for parole; better communication of information between CCS and the APB; a CCS parole stream that means SVOSOs are case managed by experienced practitioners with a reduced work load; and an approach to parolee management that has changed from a focus on compliance with parole conditions to risk identification and management."*[188]

271. I commend the commitment to "better communication of information between CCS and the APB". This is clearly another positive development.

THE VICTORIAN AUDITOR GENERAL'S REPORT

272. In February 2016, the Victorian Auditor-General reported on the 'Administration of Parole' (Auditor-General's Report). In the opening comments, the Auditor-General referred to the Callinan Review and the finding including that the "*APB required reform, that there was insufficient information sharing between agencies and that the case loads of Community Corrections Officers were too high.*" This case has borne out each of those propositions very strongly. In its summary the Auditor-General's report contains the following relevant findings and recommendations:

> *"DJR now has a requirement that all serious violent or sexual offenders are screened and undertake programs in prison, when required. However, it does not monitor how many serious violent offenders have not completed the required offending behaviour programs OBP by their earliest eligibility date for parole. The APB is unlikely to grant a prisoner parole unless they have completed all required OBPs. DJR has targets for the provision of OBPs, however, it is achieving these less than half the time....*
> *Information sharing between agencies has improved and there are now clear protocols for communication around breaches of parole. However, information sharing between DJR and community-based service providers and clinicians could be improved. Service providers and clinicians do not always have access to information such as detailed assessments and clinical information collected in prison, which inhibits their ability to support parolees. Parole officers also do not always receive appropriate information form service providers and clinicians, which hinders their ability to properly supervise parolees and inform the APB.*

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[187] Victorian Ombudsman Report – Investigation into the rehabilitation and reintegration of prisoners in Victoria, September 2015

[188] Submission on behalf of Corrections Victoria, The Adult Parole Board and Victoria Police, para 57

DJR now provides OBPs to parolees in the community as well as in prison. However, there is no evidence that DJR monitors wait times for OBPs in the community or that risk or therapeutic timing are considered when prioritising access to programs for parolees in the community."[189]

I refer to my earlier comments about the delay in Hunter's OBP commencement in this case.

273. Under the heading 'Adult Parole Board Operations', the Auditor-General's Report contains the following:-

"The Parole System Reform Program (PSRP) has improved the operations of the APB. Both the reviews of the parole system by the Sentencing Advisory Council (SAC) and former High Court Justice Ian Callinan, found that the case load of the APB was very high, with little time to consider individual cases. There are now more board members, and each board member considers fewer cases on average per sitting day. As of 31 December 2015, there are 39 members of the board, including four full-time members and a full-time chairperson. This is a large increased from 2011-12 when there were 24 members, only one of whom worked full-time. Case loads have subsequently dropped from an average of 55 matters considered per meeting day in 2011-12 to 33 in 2014-15. APB members reported significant improvements in the time they have available to consider each case."[190]

This is a very positive outcome of the reform. I have referred earlier to the apparent brevity of the APB's meetings with Hunter.

274. Other relevant comments made in the Auditor-General's Report were as follows:-

"In the day-to-day operation of the APB, the parole suitability assessment PSA) is the most important document. It is the primary source of information APB members use to determine suitability for parole. It is therefore critical that parole officers – who are responsible for completing PSAs – are able to access comprehensive information themselves, have clear guidance on how to correctly complete PSAs and fill them out in line with this guidance and on time...
Current PSAs are a significant improvement on the previous system used to inform th APB about prisoners. Information was often outdated and not always available when needed, and files were held in hard copy rather than electronically. However, some issues remain – in compiling PSAs, parole officers have to consult at least six different databases to gather information. This is inefficient and onerous and increases the risk of missing information."[191]

275. In a concluding remark the Auditor-General's Report states:-

"It is too early to determine whether the Parole System Reform Program (PSRP) has improved community safety outcomes overall. However, there are now fewer parolees convicted of committing serious violent or sexual offences."[192]

276. Under the heading 'In-prison programs', it was noted:-

"The objective of all in-prison programs is to reduce reoffending by helping offenders to deal with the issues that led to their offending. According to the APB's Parole Manual, if prisoners are unable to complete necessary programs in prison for any reason, the APB

[189] Victorian Auditor-General's Report – Administration of Parole, February 2016, p x-xi
[190] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 8
[191] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 10-11
[192] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 16

would only consider granting parole if the risk to the community was mitigated. In practice, this means that prisoners – particularly serious violent or sexual offenders – who have not completed required programs are unlikely to receive parole. DJR therefore need to ensure prisoners are able to complete these programs before their earliest eligibility date (EED) for parole so that program completion is not a barrier to them receiving parole.

There are two main categories of prison programs:

- *Offending behaviour programs (OBP) provided by DJR*
- *Alcohol and other drug (AOD) programs provided by a private contractor."*[193]

277. Under the heading 'Information Sharing', Auditor-General's Report states:-

"Given that DJR, the APB and Victoria Police all play a part in the parole system, information sharing between the three agencies is vital to ensure that issues with the system as a whole are identified and addressed. For the management of parolees, relevant information is exchanged by the three agencies as well as relevant service providers. Parole officers are required to monitor the behaviour and activities of a parolee and inform the APB of any issues. This means that police members and service providers must, in turn, keep parole officers informed when they come into contact with parolees."[194]

278. Finally, recommendation 3 states:

"That the Department of Justice and Regulation:
Assesses and addresses barriers to the consistent provision of comprehensive information sharing to community-based service providers including:

- *Appropriate clinical and medical information*
- *Results of in-prison assessments*
- *Detailed program participation information."*[195]

279. Under the heading 'Outstanding recommendations from earlier reviews' the Auditor-General's Report states:-

"The secondary objective of the PSRP was to respond to any outstanding recommendations from the 2011 Ogloff and OCSR review and the 2012 SAC review. While DJR implemented the majority of these, there are several outstanding recommendations that are still relevant to the department.

Of the 10 recommendations in the Ogloff and OCSR review, there were recommendations that DJR:

- *Implement a single prisoner information file within the prison and community corrections system*
- *Allocate parolees to available offending reduction services based on offender risk and need.*

The lack of an integrated offender information system remains an ongoing concern for DJR. In addition, we did not find evidence that parolee access to offending behaviour programs is based on their risk or need.

From the recommendations in the SAC review, our analysis found five outstanding recommendations and two that were only partly completed. The majority of these relate to minor issues, aside from:

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[193] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 11
[194] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 21
[195] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 27

- *Providing factual reports prepared for the APB to prisoners and parolees*
- *Implementing an annual audit of the APB's processes.*

DJR began work to respond to these during the PSRP, however, these responses are not yet complete. It is important that DJR completes them along with the remaining PSRP work."[196]

280. I note all of the above without further comment.

RESPONSE BY VICTORIA POLICE TO THE REFORMS TO THE PAROLE SYSTEM AS RECOMMENDED IN THE OGLOFF AND CALLINAN REPORTS

281. The evidence was contained in a statement made by Assistant Commissioner of Victoria Police, Stephen Fontana.[197]

282. In his statement, AC Fontana outlined Victoria Police's response to the legislative and policy reforms of the parole system undertaken since Sarah's death in November 2012, in particular in relation to the sharing of information about offenders' release on a parole order between Victoria Police, the APB, and Corrections Victoria. AC Fontana summarised the history of the reforms and the police response to them.

283. Attached to his statement were relevant parts of the Victoria Police Manual setting out procedures and guideline. In addition, there were two Memoranda of Understanding – one with the APB and one with Corrections Victoria. There was also a Commissioners Instruction (CCI 06/14) updating police with a summary of the reforms flowing from amendments to the *Corrections Act 1986*. I note that the introduction to CCI 06/14 states *"Parole is to be viewed as a privilege and not a right, and the safety and protection of the community is paramount."* This is consistent with the theme of all of the reforms.

284. AC Fontana's statement provided a summary of both the "First wave" and the "Second wave" of legislative reforms. As a result of reforms, there is a clear commitment to the exchange of all relevant information, as early as possible, for the purposes of compiling intelligence assessments on SVOSOs.

285. AC Fontana summarised the LEAP parole flag project (enabling sharing of parole status from the DJR with Victoria Police), the reforms brought about by the *Corrections Amendment Act 2013* establishing a statutory information sharing regime, allowing the APB, Corrections Victoria and Victoria Police to exchange information about prisoners and parolees for the purposes of managing the parole regime, and the *Justice Legislative Amendment (Cancellation of Parole and other matters) Act 2013*, which provided for the cancellation of parole in circumstances where a prisoner was charged with or convicted/found guilty of certain offences while on parole. The reforms provided specifically for automatic cancellation

[196] Victorian Auditor-General's Report – Administration of Parole, February 2016, p 33
[197] Exhibit 10

of parole in cases where a prisoner released on parole for a sexual offence or serious violent offence was convicted while on parole of a sexual offence or violent offence during the parole period. The Victoria Police Manual (referred to earlier) was amended accordingly.

286. AC Fontana's statement then dealt with the Callinan Review and summarised its effect. As a consequence of the Callinan Review, on 28 April 2014, Victoria Police analysts commenced working at the Victoria Police Prisons Intelligence Unit to manage parole information and intelligence. The statement sets out the composition of the Victoria Police Parole Intelligence Team (VPPIT) and its work.

287. AC Fontana's statement summarised the effect of additional powers given to Victoria Police under the reforms. His statement then dealt with generally the offence of breach of parole and police powers to detain after the arrest of a parolee pursuant to the *Crimes Act 1958* or any other statutory power. If police become aware that a parolee is in breach of a prescribed term or condition of parole, the arresting member must now make an assessment as to whether the parolee is required to be detained in custody in accordance with the *Corrections Act 1986* (section 78B). If so, the arresting member must cause the APB to be notified of the detention as soon as possible and at least within 12 hours of the arrest. The parolee cannot then be released from custody until the APB provides further instruction.

288. AC Fontana noted that, for the purposes of implementation of the legislation and policy reforms, Victoria Police is "*developing and implementing information sharing enhancements to its information technology systems.*"[198] He set out the details of those developments.

289. Finally, AC Fontana set out the particulars of police involvement with Hunter during 2011/2012 (the parole period). In summary, this involved Hunter being issued with traffic infringements on 30 April 2012, 27 May 2012, 2 June 2012 and 28 July 2012. He made the point that none of the traffic infringement notices issued to Hunter related to offences for which imprisonment was a possible penalty and that "*therefore, under the current legislation, police would not be required to arrest him pursuant to section 78B(1) of the Corrections Act.*"[199]

290. I note each of the matters referred to by AC Fontana and accept his evidence. Clearly, Victoria Police undertook significant reform activity as a response to the legislative reforms. These responses appear to have been swift and comprehensive. There was no criticism at the inquest of the adequacy of the reform response by Victoria Police.

OUTCOME OF CRIMINAL INVESTIGATION INTO THE DISPOSAL OF SARAH'S BODY.

291. This was an extremely important issue for the family.

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[198] Statement of Assistant Commissioner Stephen Fontana, 28 August 2015
[199] Statement of Assistant Commissioner Stephen Fontana, 28 August 2015

292. The evidence on this issue was given by Detective Senior Sergeant Stephen McIntyre, the Coroner's Investigator for the purposes of the coronial investigation and inquest. He played a particularly helpful role in assisting me with the matter.

293. He gave evidence by way of two statements[200] and was cross-examined at the inquest.

294. DSS McIntyre gave a summary of events after Sarah was notified as a missing person (by her mother). He summarised information he received in relation to a burnt out silver Astra found at the intersection of Mount Cotterell Road and Boundary Road, Melton, the locating of Ms Sarah's vehicle at 22 Owen Street, Maribyrnong, information received via Crime Stoppers about the movements of Hunter, the seizing of Sarah's silver Astra, the attendance at 1 Examiner Court, Maribyrnong, and a search of that property, the attendance at 6/1A Simpson Street, Bacchus Marsh, for the purposes of searching the premises there, receiving information in relation to a wheelie bin found in the garage at 90 Fongeo Drive, Point Cook, and later information that the wheelie bin was filled with semi-set concrete and the presumption at that point that the body of Sarah was inside that wheelie bin. He then referred to the transfer of the wheelie bin to the Victorian Institute of Forensic Medicine, the identification of the remains in the wheelie bin as those of Sarah and Hunter's arrest on 20 November 2012. He referred to the interview with Hunter, which included a confession to having killed Sarah.

295. In his second statement, DSS McIntyre outlined investigative work done in respect of persons who, it was considered at the time, may have assisted Hunter after the murder. The investigation of these parties took place partly as a result of the statements made by Hunter in his police interview regarding what he had done and who had assisted him. In addition, Hunter had nominated persons who he had told that he was "in trouble", but did not indicate to them what he had done.

296. DSS McIntyre spelled out the details of the "*secondary parties*" and the investigation of their role (if any) in the matter. Those investigated were:

a. [redacted]
b. [redacted]
c. [redacted]
d. [redacted]
e. [redacted]
f. [redacted][201]

[200] Exhibits 13 and 14. This statement (Exhibit 14) is the subject of a Suppression Order dated 4 September 2015 prohibiting its publication or broadcast.

[201] Publications of the names, dates of birth and addresses of these individuals was suppressed by Order dated 10 September 2015.

297. DSS McIntyre gave evidence of the investigation of each, including searches conducted at various properties and the results. The evidence included the results of telephone record searches and interviews with some of the named individuals.

298. Finally, there was evidence given of forensic analysis of items seized at relevant properties.

299. In the conclusion of his second statement, DSS McIntyre said that the available evidence was not capable of excluding Hunter's claim that he acted alone in killing Sarah Cafferkey and transferring her body to 90 Fongeo Drive, Point Cook. H stated that he believed that further investigation on the issue could not be justified at that point in time, based in particular on the fact that the offence of Misprision of a Felony no longer exists within Victorian law.

300. In evidence at the inquest, DSS McIntyre confirmed that he was concerned from the outset as to whether any of the named individuals should be charged in respect of the murder. The family was particularly interested in whether any had been, or would be, charged in respect of the movement or disposal of Sarah's body. Ultimately, DSS McIntyre was not able to satisfy himself that any of the individuals should be charged with any offences. He confirmed that at the time of the inquest there were "*no ongoing investigations in respect of the individuals named*".[202] I note that, at the very conclusion of the inquest, I pointed out to the family that if new evidence was to be forthcoming in the future relating to Sarah's murder and the disposal of her body, the coronial investigation could be re-opened and the matter taken further.

301. I note the brief submissions on behalf of the family in respect of the role of accessories. I note that the family remain concerned about the police investigation and whether enough was done to thoroughly investigation those who may have assisted with the disposal of Sarah's body. The submissions notes particular "concern" about three of the individuals investigated and makes a comment about another individual.

302. I fully understand the family's concern about this issue. It is entirely reasonable for there to be an ongoing concern about the manner of the disposal of Sarah's body, a profoundly sensitive and difficult issue for the family. However, I accept DSS McIntyre's evidence. There is no basis, on the evidence revealed in this investigation, to criticise either he or other police investigators as to the adequacy of the investigation on this aspect of Sarah's death. If any further evidence comes to light, an application can be made to re-open this aspect of the investigation, pursuant to section 77 of the *Coroners Act 2008*.

SUBMISSIONS

303. I agree with the points made in the following submissions made on behalf of the family:

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[202] Inquest transcript p 369

- *"The risk assessment tools used for assessing Hunter's suitability for parole were deficient.*
- *...Hunter had a history of drug use and drug offences, yet the ACSO COATS assessment concluded that he did not need ongoing treatment in the community, based in part at least on his own self-reporting during the interview process. There is clear evidence to show that Hunter was in fact engaging in drug use while on parole, and it was within the context of this drug use that the murder of Sarah took place.*
- *The VISAT, the violence risk scale and the ACSO COATS assessment had serious limitations as effective tools in determining risk in the case of Hunter, yet each was relied upon heavily in granting parole, setting parole conditions and in providing a source of information and reference for Hunter's caseworker and clinician.*
- *It appears that Hunter's admissions against interest, by self-reporting exposure to drug use through peer associations, was reason to believe he was telling the truth about his abstinence, self-reporting being the only method by which caseworkers and clinicians could assess drug abstinence in the absence of testing...This belies the general problem associated with caseworkers and clinicians relying on self-reporting alone to assess drug abstinence. A testing condition could have been attached to Hunter's parole order, and Hunter's caseworker thought one should have been imposed.*
- *There is an inherent conflict in the roles that caseworkers and clinicians play in managing paroles. On the one hand, caseworkers and clinicians play a supervisory role in assessing the parolee's compliance with their parole conditions. It is this supervision that the Adult Parole Board relies on in deciding whether a parolee should remain on parole.*
- *On the other hand, the evidence shows that caseworkers and clinicians want the parolees to succeed at parole, and focus on this outcome, rather than the safety of the community.*
- *Reliance on self-reporting where parolees know how to game the system may mean important information does not reach the Parole Board.*
- *Two weeks before Hunter ended his parole period he engaged in violence, which he reported to Dr Doroc. This was not report to the Adult Parole Board...This raises serious concerns that information directly relevant to the Parole Board's oversight of parolees is not being provided to them because of beliefs about what information can and cannot be shared. On the evidence, there was a complete lack of clarity about who can be expected to report what, and by what method to the APB, and what confidentiality restraints apply. Clearly guidelines would have assisted on this.*
- *The Board...It cannot know what it does not know. The Board is a decision-making body...It relies completely on the information provided to it by the relevant Corrections workers that report to it. Those workers in turn fetter themselves in the information they provide to the Board, by reason of confidentiality concerns, and because their conflicting roles of both supervising parolees but also assisting the parolees to complete their parole period results in the normalising of behaviours that in other contexts might be of greater concern."*[203]

304. The submission made on behalf of Corrections Victoria, the APB and Victoria Police made the following point:

"Significantly, for the purpose of this inquest, Hunter did not have a condition that required him to submit to drug testing when directed. However, at the time he was released on parole he had not had any positive tests in prison in the period 2004-2010. It follows that there was nothing at that point to indicate that Hunter had, in the reasonably recent past, any particular propensity to use drugs. In any event, as set out above, under DI 7.7 Hunter's CCS parole

[203] Submission on behalf of the Cafferkey Family

supervisor could have directed him to submit to testing if he or she had reason to suspect Hunter was using illicit drugs."[204]

305. I note this, but I agree with the family's submission that, given Hunter's history of drug use and drug offences, the assessment that he did not need ongoing treatment in the community, based at least in part on his own self-reporting, was flawed. I agree with the family's submission that there is "*clear evidence to show that Hunter was in fact engaging in drug use while on parole*". As the submission says, "*it was...within the context of this drug use that the murder of Sarah took place.*"

306. The submission on behalf of Corrections Victoria, the APB and Victoria Police made the following point in relation to the parole conditions fixed by the APB for Hunter:

"*In fulfilling its statutory functions the APB relies on information and advice provided to it by external persons and bodies and, in particular, Corrections Victoria. In this case, there is nothing to suggest that the APB's decision to release Stephen Hunter on parole on 30 April 2011, with the above conditions, was anything other than an appropriate decision on the material that was available to it.*"[205]

307. This submission highlights the very problem I have referred to earlier: the APB had no alternative but to make a decision based on the material available to it; but some critical material was not available to it. The APB was not aware of the Maintaining Change Participant Non-Completion Report. The APB was therefore not aware of the risks associated with Hunter's pro-violence attitudes and the other comments made about his need for further treatment in that report. It was a flawed system that required decision-makers to base decisions of this magnitude on limited material. However, even accepting that there were at least theoretically, confidentiality constraints, the issue did not actually arise because it was never contemplated that the report or its comments or criticisms would be put before the APB in any event. An awareness, and an appreciation, of the importance of the content of that report was the issue. Dr Doroc and Ms Johnstone should, in my opinion, have assessed the Participant Non-Completion Report as important and ensured that it (or a summary or even the gist of it) was brought to the attention of the APB. As noted, the Participant Non-Completion Report revealed Hunter's completely unreformed attitudes towards violence and, in particular, violence towards women.

308. In its submission the APB, Corrections Victoria and Victoria Police crystallised a key point in paragraph 5.4 reflecting the scope of the inquest, the question is "*Was there any information in the possession of Corrections Victoria in the course of its supervision of Hunter that ought to have been passed to the APB?*"

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[204] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police
[205] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police, p 13

309. In my view, the answer to that question is yes.

310. The same submission on this issue states:

> *"The report author noted that Hunter 'still presents with a number of risk factors, such as cognitive distortions, lack of empathy, pro-violence attitudes and passive aggressive communication style'. However, significantly, in the clinical opinion of Dr Doroc and the opinion of Ms Johnstone, none of these comments represented any increase in risk that Hunter presented to the community whilst on parole. They emphasised to the court that many offenders present with similar profiles. The APB was not given the Maintaining Change Program Participant Non-completions Report or informed of its content as neither Dr Doroc nor Ms Johnstone considered it necessary to give the report to the APB, as it was not remarkable or demonstrative of any change in Hunter's level of risk to the community."*[206]

311. In my opinion, Hunter's criminal history, including the 1988 murder and Sarah's murder – both displaying remarkably similar characteristics – represent the complete answer to the proposition put forward in this submission. Dr Doroc and Ms Johnstone should have considered it necessary to give the Participant Non-Completion Report to the APB or ensure that the APB was aware of its existence. Whether there was any "change" in Hunter's level of risk to the community is not the point. The fact is, the terms of that report made it clear, or should have made it clear, that when it was written and when he was released, Hunter represented a risk to the community which was unmitigated through treatment.

312. The submission on behalf of the APB, Corrections Victoria and Victoria Police goes onto state, *"There was nothing in Hunter's presentation that indicated, or should have indicated, that Hunter's risk to the community was escalating. It follows that there was nothing that Ms Johnstone could have reported to the APB or which could properly have been used by the APB to cancel Hunter's parole."*[207] I disagree with this proposition. The Participant Non-Completion Report conveyed elements of Hunter's presentation implying risk to the community. Whether the risk was stable or was escalating, it was, on a plain reading of the language in the report, a real and continuing risk.

313. I agree with the submission that, *"the assessment and management of parolees is a very difficult of public policy."*[208] I agree, too, that there is, *"a clear public benefit in a parole regime to ensure, as best as can be, that prisoners are motivated to reform whilst in prison, and then have an opportunity to be re-integrated into the community with support and supervision before they are released from their sentence without restriction."*[209]

314. I note the reform steps that have been taken. In the words of the submission, these have meant *"an approach to parolee management that has changed from a focus on compliance with*

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[206] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police, p 15
[207] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police, p 18
[208] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police, p 19
[209] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police, p 19

parole conditions to risk identification and management." This is a paradigm shift – one that is likely be to promote and better serve the safety of the community.

315. I also note this submission by the same parties:

> "*At the end of his parole period, Hunter undoubtedly had a range of behavioural issues that had not substantially ameliorated over his time on parole and he would have benefitted from further therapeutic intervention in the nature of that provided by Dr Doroc. Equally, the evidence was clear that Dr Doroc was a capable and committed clinician who was astute to Hunter's particular treatment needs and did her best to assist in a transformation that would reduce the risk to the community of violence from Hunter. Ultimately, as is common in the cohort of clients of which Hunter was a member, Hunter was a challenging treatment subject and further therapeutic intervention was required.*"[210]

316. The last sentence in this submission highlights the very point I have emphasised. On the evidence, further intervention *was* required. It was required because it was necessary to reduce Hunter's risk of re-offending in a violent way. He was unreformed. The risks arising from his attitudes and beliefs had not been mitigated. In the interests of community safety, this fact should have been drawn to the attention of the APB. Without speculating as to how the APB would have responded, the fact is that there was very little time left within which more work could have been done on Hunter as his parole was due to expire - on 30 October 2012. After that, he was entitled to be released unconditionally into the community. However, no attempt was made to intervene between 1 May 2012, the date of the Participant Non-Completion Report, and 30 October 2012, the date of Hunter's discharge from parole. This was a limited, but missed, opportunity.

A RECOMMENDATION FOR FURTHER REFORM

317. Section 72(2) of the *Coroners Act 2008* provides:

> (2) A coroner may make recommendations to any Minister, public statutory authority or entity on any matter connected with a death or fire which the coroner has investigated, including recommendations relating to public health and safety or the administration of justice.

318. The following discussion is directed at the matter of "*public health and safety.*"

319. The case raises the question of whether it is appropriate to recommend a consideration of legislative reform designed to reduce the risk to public safety by Serious Violent Offenders (SVOs) who may continue to pose a risk on their release, by providing that, like Serious Sex Offenders (SSOs), SVOs become eligible for a form of post sentence supervision.

320. Late in the inquest, I asked Mr Wise:

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[210] Submission on behalf of Corrections Victoria, Adult Parole Board and Victoria Police

"Have you got a view as to whether the system ought to change in this way, namely that there could be provision given to SVOs, similar to the provision given and the particular arrangements able to be made in respect of sex offenders by way of supervision order? Do you believe that SVO with significant unresolved issues which indicate potential violence or lack of resolution of attitudes posing significant risk, would be appropriate to have a statutory mechanism similar to SOs by way of supervision orders?"

He responded, *"It's a policy that has been contemplated for some time and it's got some merits. But it would be a very difficult scheme to administer, depending on the expectations of that post-sentence supervision. It has been under active consideration previously and no doubt will be in the future. There are some people who are advocating for such a scheme. It is in the process of being reviewed (within Government) and they are exploring that as an option."*[211]

321. Hunter was a SVO. On a fair reading of the evidence he appeared to pose a risk to society on his release. Programs and interventions in prison and during parole had not mitigated that risk in respect of his attitude towards violence. As the submission quoted above (paragraph 312) accepted, *"he remained a challenging treatment subject and further therapeutic intervention was required."* Despite that he had to be released into the community unconditionally at the end of his parole (30 October 2012). He killed Sarah Cafferkey 10 days later.

322. From a risk perspective, SVOs appear to be in an analogous category of prisoner/parolee to those targeted by the *Serious Sex Offenders (Detention and Supervision) Act 2009.*

323. On the basis of the evidence in this case there is good reason to consider systemic reform that would promote public safety by way of a similar legislative framework. I intend to recommend accordingly.

324. The *Serious Sex Offenders (Detention and Supervision) Act 2009* created a system enabling detention and supervision of certain offenders after they had completed their sentence, if they continue to pose an unacceptable level of risk of further offending. Section 1 of that Act provides *"the main purpose of this Act is to enhance the protection of the community by requiring offenders who have served custodial sentences for certain sexual offences and who represent an unacceptable risk of harm to the community to be subject to ongoing detention or supervision."*

325. The legislation is unambiguously directed at protecting the community. It enacts a scheme that defines "eligible offenders" who can be placed under an order, persons who may make applications for such orders, courts which may make the orders, the terms of orders, the conditions of orders, applications for review of orders and stipulates that a court making the

[211] Inquest transcript p 521-522

order may impose a condition authorising the APB to give direction to an offender in relation to the operation of any conditions.[212]

326. Section 9 provides:

> **9 When may a court make a supervision order?**
> (1) The court may make a supervision order in respect of an eligible offender only if the court is satisfied that the offender poses an unacceptable risk of committing a relevant offence if a supervision order is not made and the offender is in the community.
> (2) On hearing the application, the court may decide that it is satisfied as required by subsection (1) only if it is satisfied—
> (a) by acceptable, cogent evidence; and
> (b) to a high degree of probability—
> that the evidence is of sufficient weight to justify the decision.
> (4) In determining whether or not the offender poses an unacceptable risk as set out in subsection (1), the court must not consider the means of managing the risk or the likely impact of a supervision order on the offender.
> (5) For the avoidance of doubt the court may determine under subsection (1) that an offender poses an unacceptable risk of committing a relevant offence even if the likelihood that the offender will commit a relevant offence is less than a likelihood of more likely than not.

327. I have expressed my view as to the risk Hunter posed, at least appeared to pose, on his discharge from parole. It is obviously not appropriate to speculate as to, (a) whether Hunter would have been made the subject of an application for a form of supervision order applicable to SVOs; and (b) the outcome of any such application. However I note that if such provisions had applied to SVOs at the relevant time, it would only have been necessary to satisfy a court that Hunter was likely to commit a relevant offence. It would not have been necessary to satisfy a court that it was *more likely than not* that he would do so.

328. Since completing a final draft of these findings, I have been made aware of the Report of the Complex Adult Victim Sex Offender Management Review Panel. The Report is dated November 2015 and was released by the Department of Justice and Regulation on 24 April 2016. It has direct relevance to this case.

329. I note the following passage in the Executive Summary:

> *"The SSODSA, as its purposes show, was never designed to provide for protection from other than those who have served custodial sentences for the sexual offences to which the Act applies. No Victorian legislation has as its purpose the enhancement of post-sentence protection from offenders who have committed offences of non-sexual interpersonal violence...there is, rightly concern about the present legislative provisions for the protection of the community generally from offenders who, having served a custodial sentence, present an unacceptable risk of committing offences causing serious interpersonal harm, whether that harm is sexual or not."*[213]

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[212] *Serious Sex Offenders (Detention and Supervision) Act 2009*, s 20.
[213] Report of the Complex Adult Victim Sex Offender Management Review Panel, vii

330. I also note the following passage set out under the heading "The Panel's view: targeting eligibility to the risk of serious interpersonal harm:

"The Panel considers that the post-sentence supervision and detention scheme in Victoria should operate to reduce the number of victims of the most serious interpersonal harm caused by acts of violence, whether sexual or not. In the Panel's view, this is best achieved by directing the greatest resources and expertise towards those offenders who present the greatest likelihood of committing an offence involving serious interpersonal harm and it should be irrelevant to categorise offences according to whether they involve sex, or violence, or both. The existing post-sentence supervision and detention scheme should therefore be reformed to the extent required to achieve these ends."[214]

331. The proposal put forward by the Panel would create a system under which those deemed to constitute an unacceptable risk at the conclusion of their sentence could be made subject to an order which would ensure a seamless transition to continued treatment and management. The Report proposes a new "Public Protection Authority"[215] for that purpose.

332. Finally I note the first recommendation of the Panel as follows:

"Eligibility for the post-sentence supervision and detention scheme should be broadened to include serious violent offenders, in addition to sex offenders."[216]

333. In my opinion, this case lends strong support to that recommendation.

SUMMARY OF FINDINGS

334. I find that Sarah Louise Cafferkey, born 20 June 1990, died on 10 November 2012 at 6/1A Simpson Street, Bacchus Marsh, Victoria and that her death was caused by Steven James Hunter.

335. I find that Hunter alone was responsible for Sarah Cafferkey's death and that no other individual contributed to the death.

SUMMARY OF KEY CONCLUSIONS AND COMMENTS

336. The risk assessment tools used in assessing Hunter's suitability for parole were deficient (I note the evidence that the VISAT has been replaced).

337. Hunter was assessed on both the VISAT, and the Violence Risk Scale as "low risk". Each assessment had to be corrected/overridden by Corrections staff. The tools used failed to make an accurate assessment.

338. Hunter had a long history of drug use and drug offences, however the ASCO COATS assessment concluded that he did not need further intervention in the community. Yet Hunter

[214] Report of the Complex Adult Victim Sex Offender Management Review Panel, p 61
[215] Report of the Complex Adult Victim Sex Offender Management Review Panel, p xiv
[216] Report of the Complex Adult Victim Sex Offender Management Review Panel, p xxi

admitted to exposure to drug use and killed Sarah Cafferkey in the context of using the drug "ice".

339. Hunter's case workers were overly prepared to accept his self-assessment of his progress on parole. They did not bring sufficient rigor or scepticism to the task. Hunter was able to play the system.

340. The Participant Non-Completion Report made it clear that Hunter needed substantial further intervention and that he was unreformed in relation to his attitude towards violence, including violence towards women.

341. Dr Doroc should have drawn the Participant Non-Completion Report relating to the group OBP to Ms Johnstone's attention, or at least a summary of its salient points.

342. Because of his unchanged attitude towards violence, in particular violence against women, Hunter posed a real risk to the community, both when he commenced his parole and at the end of his parole period.

343. Dr Doroc and Ms Johnstone, or both, should have ensured that the Participant Non-completion Report was drawn to the attention of the APB.

344. There were failures of information sharing within the system as highlighted by the Correctional Review Report.

345. Despite these matters, both Dr Doroc and Ms Johnstone were clearly hardworking officers under heavy caseload pressure, and both were obviously personally affected by Sarah Cafferkey's death.

346. There should have been clear guidelines applicable to Ms Johnstone and to Dr Doroc as to the circumstances in which they were expected to bring information to the attention of the APB.

347. The APB interactions with Hunter were brief and superficial. The members of the APB were however not placed in a position where they could take up the issues expressed in the OBP Participant Non-Completion Report. The structure and system of the APB should have ensured that they were.

348. There was an opportunity to intervene with Hunter before his parole finished. It was only a brief window of opportunity but should have been taken. The evidence suggests however that it would have taken longer, probably far longer, than the time available within the parole period, to bring about genuine and lasting changes. The end of the parole period brings an end to the opportunity for further work to be done with persons such as Hunter to bring about behavioural and attitudinal change. This does not serve the interest of public health and safety.

349. The proposals put forward in the Report of the Complex Adult Victim Sex Offender Management Review Panel provide a potential solution to this problem.

350. There have been major, far reaching reforms to the parole system since Sarah Cafferkey's death. They have entrenched the paramountcy of community safety. The reforms are to be commended.

RECOMMENDATION

Pursuant to section 72(2) of the **Coroners Act 2008**, I make the following recommendation connected with the death:

1. Noting the Report of the Complex Adult Victim Sex Offender Management Review Panel, I recommend that that the Victorian Government consider the establishment of a statutory scheme applicable to serious violent offenders (SVOs) analogous to the scheme that applies to serious sexual offenders (SSOs) under the Serious Sex Offenders (Detention and Supervision) Act 2009.

Pursuant to section 73(1) of the **Coroners Act 2008**, I order that the following not be published on the internet:

- The name set out in paragraph 15 in this finding.
- The names set out in paragraph 296 in this finding.

I convey my sincere condolences to the family and friends of Sarah Cafferkey

I direct that a copy of this finding be provided to the following:

Noelle Dickson, Senior next of kin

Coroner's Investigators – Snr Sgt Steve McIntyre, Sgt Damien O'Mahoney, Victoria Police

Premier of Victoria

Victorian Attorney General

Victorian Government Solicitors Office on behalf of:

- Corrections Victoria
- Victorian Adult Parole Board
- Chief Commissioner of Police

Paula Shelton, Shine Lawyers

Menzies Arva Lawyers, on behalf of [redacted]

Signature:

JUDGE IAN L GRAY

Date: 25/5/16

Coroners Court of Victoria