ORDER PROHIBITING PUBLICATION OF NAMES, ADDRESSES, OCCUPATIONS OR IDENTIFYING PARTICULARS OF CONNECTED PERSONS PURSUANT TO S 202 CRIMINAL PROCEDURE ACT 2011. SEE http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360349.html

ORDER PROHIBITING PUBLICATION OF NAME, ADDRESS, OCCUPATION OR IDENTIFYING PARTICULARS OF DEFENDANT PURSUANT TO S 200 CRIMINAL PROCEDURE ACT 2011. SEE http://www.legislation.govt.nz/act/public/2011/0081/latest/DLM3360346.html

IN THE HIGH COURT OF NEW ZEALAND
AUCKLAND REGISTRY

I TE KŌTI MATUA O AOTEAROA
TĀMAKI MAKAURAU ROHE

CRI-2018-092-7843
[2020] NZHC 1490

THE QUEEN

v

MT

Hearing:	6 May 2020 (Further submissions filed: 22 May 2020 and 25 May 2020)
Counsel:	N E Walker and J C Toebes for Crown M N Pecotic and D S Niven for Defendant
Judgment:	30 June 2020

JUDGMENT OF BREWER J

This judgment was delivered by me on 30 June 2020 at 11:00 am

Registrar/Deputy Registrar

Solicitors/Counsel:
Kayes Fletcher Walker (Manukau) for Crown
Maria Pecotic (Auckland) for Defendant

Introduction

[1] MT was charged with kidnapping and murder. She was scheduled to stand trial with two co-defendants from 2 September 2019. In a decision delivered on 26 August 2019, Downs J held that although MT was mentally impaired she was fit to stand trial.[1] MT appealed the finding that she was fit to stand trial, arguing that Downs J had failed to adequately consider the implications of her foetal alcohol spectrum disorder (FASD) on her fitness to stand trial. On 3 September 2019, the Court of Appeal allowed the appeal and quashed Downs J's finding.[2]

[2] The trial of MT's two co-defendants proceeded. At different points they pleaded guilty to the charge of kidnapping. The jury found both of them guilty on the charge of murder. They have been sentenced.[3]

[3] This judgment determines what should now become of MT.

Background

[4] MT was found unfit to stand trial before the trial itself had commenced. The next step is prescribed by s 10 of the Criminal Procedure (Mentally Impaired Persons) Act 2003 (CPMIP):

> **10 Inquiry before trial into defendant's involvement in the offence**
>
> (1) This section applies if, before trial, the defendant is found unfit to stand trial.
>
> (2) The court must decide whether the court is satisfied, on the balance of probabilities, that the evidence against the defendant is sufficient to establish that the defendant caused the act or omission that forms the basis of the offence with which the defendant is charged.
>
> (3) For the purposes of subsection (2), the court may consider—
>
> (a) any formal statements that have been filed under section 85 of the Criminal Procedure Act 2011:

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1 *R v M* [2019] NZHC 2104.
2 *M (CA424/2019) v R* [2019] NZCA 410. Reasons were released in a separate judgment dated 17 September 2019.
3 *R v Winter & Te Amo* [2020] NZHC 1115.

> (b) any oral evidence that has been taken in accordance with an order made under section 92 of the Criminal Procedure Act 2011:
>
> (c) any other evidence that is submitted by the prosecutor or defendant.

[5] The purpose of the s 10 test is to avoid the possibility that MT is subjected to detention or similar measures when she has not, in fact, committed the offence.[4] In making my determination, I do not need to be satisfied that MT caused the acts which form the basis of the charged offences beyond reasonable doubt – the normal criminal standard. Instead, I need to be satisfied of MT's liability on the facts "on the balance of probabilities".

[6] There has been some debate over how the requirement for causation should be interpreted. The position appears to be that "criminal culpability or justification are immaterial to the assessment under s 10", and the central issue is whether the Court can be satisfied that the defendant was physically responsible for the alleged offence.[5] It is distinct from a finding on 'guilt', per se. That is the question I will address, having regard to the evidence that was put before me.

[7] The second step, if the inquiry under s 10 establishes that the defendant caused the act or omission that forms the basis of the offence with which the defendant is charged, is for the Court to decide the level of care they require as set out in ss 24 and 25 of the CPMIP.

[8] A hearing to determine these matters was scheduled for 4 December 2019. However, only the s 10 decision was made because Ms Pecotic, counsel for MT, applied for, and was granted, an adjournment of the decision-making on the second step.

[9] I decided that the s 10 test was met. In my Minute of 4 December 2019 I said:

> [3] In [MT's] case I heard the evidence in the trial which described her part in the offending. Counsel are agreed, and the Crown submits, that this is

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4 *R v Te Moni* [2009] NZCA 560 at [68].

5 *R v Tongia* [2019] NZHC 3278 at [18]; *R v Te Moni* [2009] NZCA 560 at [81]; *R v RTPH* [2014] NZHC 1423 at [5]-[7].

> evidence I am entitled to take into account in deciding this inquiry. I agree. I also consider I am entitled and should have regard to the various statements [MT] gave to the police.
>
> [4] Ms Pecotic for [MT] accepts that given the low standard of proof, there is no possibility of [MT] being found not to have caused the act that forms the basis of the offences with which she is charged. In my view that is ineluctable.
>
> [5] It follows I find that I am satisfied on the balance of probabilities that the evidence against [MT] is sufficient to establish that she caused the act that formed the basis of the offences of kidnapping and murder. I record that finding. I will give my reasons in more detail later.

[10] The hearing on the second step eventually took place on 6 May 2020.

Section 10 threshold – reasons

[11] I will set out the factual narrative of the incident in which MT participated. These facts form the basis for my conclusion that she caused the acts that constituted the offences of kidnapping and murder. Insofar as her co-defendants are concerned, for the purposes of sentencing, I was satisfied of these facts beyond reasonable doubt. I cannot apply the same standard to MT's position because she did not stand trial and was not given an opportunity to cross-examine the Crown's witnesses or give evidence on her own behalf. However, having regard to the evidence I heard, various formal statements to which I have been referred, and to MT's statements to the police, the threshold of "balance of probabilities" is well and truly crossed.

Factual narrative

[12] The victim, Ms Pairama, was a vulnerable 17-year-old. She had learning difficulties and often acted like a 10-12 year old rather than someone in her late teens. She had personal problems and spent time sleeping rough on the streets of Auckland city.

[13] At some point on the evening of 6 July 2018, Ms Pairama encountered MT, then aged 16 years and 11 months, and MT's sister, RT, then aged 14 years. Also encountered on that evening, and coalescing with the others as a group, were Ms Winter, then aged 27 years, and Mr Te Amo, then aged 24 years.

[14] MT was keeping company that evening with Mr Te Amo. She later described him as her boyfriend. It seems there was a connection between MT and Ms Pairama from school. Neither Ms Winter nor Mr Te Amo had ever met Ms Pairama before.

[15] Eventually, the group of five ended up at an abandoned property at Buckland Road, Mangere. MT got there first with Ms Winter and Mr Te Amo. RT and Ms Pairama arrived 20-30 minutes after they did. By the time RT and Ms Pairama arrived at the abandoned property, MT, Ms Winter and Mr Te Amo had decided to do harm to Ms Pairama.

[16] I am not sure why MT, Ms Winter and Mr Te Amo decided to harm Ms Pairama. I am satisfied part of the decision came from some grievance that MT had around rumours circulating about her which she attributed to Ms Pairama. There were suggestions in the evidence that an ex-boyfriend might have been involved. MT reacts aggressively when she thinks people "are talking shit" behind her back. I also infer that Ms Winter's presence made things worse. Ms Winter, biologically a man although identifying as female, was a dramatic character from a difficult background who found the situation exciting. I am satisfied Ms Winter was the dominant character in what came next but that MT was fully supportive.

[17] Almost as soon as the group of five was at the Buckland Road address the violence against Ms Pairama began. Ms Winter attacked Ms Pairama, pulling her to the floor by her hair, punching her face and kicking her in the stomach. MT also assaulted Ms Pairama while she was on the ground. Ms Pairama was crying and asking for help.

[18] At that stage, quite by chance, police officers came to the door of the property looking for someone. Ms Pairama went to the door and Ms Winter went with her. MT also went to the door. The police noticed Ms Pairama's distressed condition but Ms Pairama assured them there was nothing wrong. Ms Winter joined in the assurances, as did MT. The police went away. The violence against Ms Pairama resumed.

[19] Ms Pairama was made to strip naked and to sit on a chair. MT and Ms Winter used tape to bind Ms Pairama to the chair. Mr Te Amo helped.

[20] After that, Ms Pairama was degraded, tortured and beaten further. MT and Ms Winter cut and shaved Ms Pairama's hair. MT fashioned a makeshift blowtorch using an aerosol can and a lighter. MT used it on Ms Pairama's genital area and on her breasts. Ms Pairama screamed. RT said that there was one blast of fire directed at each region for a short time. The pathologist found charred pubic hair but no burns to the genitals and no burns to the chest area.

[21] Ms Winter poured milk powder over Ms Pairama's head. MT poured bleach over Ms Pairama's head. RT said she heard Ms Pairama cry out and complain about her eyes.

[22] Mr Te Amo took his turn at beating Ms Pairama. Ms Winter beat Ms Pairama for a second time.

[23] It was around this time the group realised that if Ms Pairama were released, she would likely go to the police. The group held a meeting and MT, Ms Winter and Mr Te Amo decided that Ms Pairama had to die. Ms Winter told Ms Pairama that she could choose whether to die by hanging or by being stabbed. Ms Winter and Mr Te Amo went to see if they could find a shovel with which to bury Ms Pairama. On their return, Ms Pairama chose to be hanged.

[24] MT, Ms Winter and Mr Te Amo worked out how the hanging would take place. A wooden bar was found in a wardrobe and it was worked out that it could be placed across the top of a manhole in the ceiling. A rope could be fashioned from torn sheets which could also be used to make a noose. Mr Te Amo fashioned the noose and the rope was tied to the wooden bar.

[25] Once the preparations had been made, including positioning a chair beneath the manhole, Ms Pairama was brought in. Her hands were still tied but her feet had been freed. She was still naked. Ms Pairama was made to stand on the chair and the noose was fixed around her head. The chair was then removed. The noose was too

loose and Ms Pairama fell to the ground. The noose was adjusted and Ms Pairama was again made to stand on the chair. The noose was again put around her neck and the chair removed. This time it worked. MT, Ms Winter and Mr Te Amo stood and watched Ms Pairama die.

[26] Once she was dead, Ms Pairama was cut down by Mr Te Amo. MT, Ms Winter and Mr Te Amo agreed on how to dispose of her body. Ms Pairama was wrapped in sheets and plastic rubbish bags and stuffed in a drum which was at the back of the house.

[27] A plan to set fire to the house to conceal evidence was forestalled by neighbours who noted the group's presence and called out. The group left the house.

[28] There is no evidence that MT displayed any remorse at the time for what had been done. In fact, later that night MT and Ms Winter took a young person back to the address to show her where they had disposed of Ms Pairama's body. MT handled the body to enable the young person to get a better view of it.

[29] In addition to the evidence I heard at the trial, other evidential material to which I have had regard in establishing this narrative is:

New Zealand Police transcript form electronically recorded interview of [AH] dated 10 July 2018

[30] On 10 July 2018 the young person who MT and Ms Winter took back to the Buckland Road address to show where they had put Ms Pairama's body gave an interview to the police. I refer to her as AH. AH told the police that MT was the first one to tell her that she had murdered someone and when AH did not believe her MT took her to the house and showed her where the body was. AH said that MT opened the material in which the body was wrapped "a little bit"; "she tried to put the body up but she couldn't. She said it was heavy so she lifted the sheet up and showed me and only saw the back, a little bit of the skin, just the back and yeah, she put it back down and then we went, that's when we catched the train, walked to the um street, train station."

[31] AH also told police:

AH My friend said that she shaved her head off, oh not her head, her hair, shaved her hair off and burnt her stomach and her private parts and yeah.

NT Okay.

AH She said she was gonna bury her but when the neighbours saw her, the neighbour told them to F off from the abandoned house but the lady didn't know um they were carrying a body cos the lady didn't see them properly.

[32] Later in the interview are the following passages:

AH She that um it was, she said that she regretted it but then um but that girl had um, that girl deserved it at the same time cos she said that the girl that hanged um she said the girl hanged herself but they did damage to her but she the girl hanged herself. Um she said that the girl um um went and grabbed some Black Powers to go bash her and yeah [MT] said that she deserved it but she regretted (*inaudible*) cos that was her best friend.

NT That was who's best friend?

AH [MT's] best friend.

NT So she told you best friend?

AH She she like, she didn't really kill her. She she said that she burnt her body, her stomach, um her, she just burn her body when she was still alive and then the boy came. She said the boy took her, the girl in the room and the boy gave her a hiding and um [MT], [Ms Winter] and [RT] said um they could hear her bones cracking, like breaking and they went in the room to stop him from hitting her and um they said she had a um broken rib, a fat arm and a broken jaw and that um when the cops came, she covered for them. She didn't tell, she didn't nark on them or anything, she covered for them.

…

NT So you said [MT] said she burnt her stomach?

AH Yeah.

NT Did she explain how she did that?

AH With a lighter and a spray.

…

NT And did she say anything when she showed you?

AH She just said :There cuz, that's the body". She said that um she was like, she was tryna like pull her out, pull out of the basket but she said um "I can't pull her out" so um I just said "I wouldn't wanna look at the full body".

NT Yeah.

AH And then she, she just left it and then she lifted the sheet up and then showed me. I was gonna spew yeah. I just went straight away down the driveway.

NT And where were [Ms Winter] and [RT] at that time?

AH Down the driveway waiting for us.

NT Okay. So you mentioned about hanging?

AH Yeah.

NT So explain.

AH She said that um [MT] said that um when they were beating and stuff in the house and burning her, um while you're burning her, I remember she said that um they asked her if she wanted um um cos the girl that died, she said she wanted to hang herself so they, they just let her and um but [MT] wanted to stop her from hanging herself but then she, she said that she thought about what she did to them like when they talk about (*inaudible*) and stuff that's why um [MT] said that she deserved to die and um yeah that's when that girl hanged herself and [MT] said when, when she finished hanging herself, they cut the rope and wrapped the body around the, um around the sheet and then pulled her, pulled her like were holding her, taking her outside and threw her in the basket and put the thing bag, the rubbish bags in front of her.

Notes taken at Auckland Central Police Station on 8 July 2018 by Senior Constable Mortimer who was speaking to MT

[33] The notes record MT saying:

- Has been friends with her for about 9 years
- [Ms Pairama] has said that she wants to commit suicide
- [Ms Pairama] has had some family problems
- On Saturday the 7th of July she was with [Ms Pairama] at [Buckland Road]
- Also present were [RT] and [Ms Winter]
- [Ms Pairama] said she was going to kill herself

- Took her clothes off
- Had already tied a sheet into a noose
- Tied the sheet to something metal
- Hooked the metal item into an opening into the ceiling
- Stood on a chair
- Pushed the chair away and hung herself
- Others told her not to do it
- Stayed in the house for two hours after the suicide
- Cut the sheet and took [Ms Pairama] down
- Wrapped her in sheets
- Carried her to a drum lying in the back of the property
- Put her in the drum
- [Buckland Road address]
- No one lives at the address
- They go there to chill out
- Went there yesterday
- [Ms Pairama] was at the rear of the house
- Called out to [Ms Pairama] to ask what she's doing
- She went to where [Ms Pairama] was in the house
- [Ms Pairama] was tying a knot in the sheet
- She asked what she was doing
- [Ms Pairama] said she was going to kill herself
- The suicide took place in the hallway of the house
- Afterwards she moved the chair into another room
- She carried [Ms Pairama] on her own to the drum

[34] I pause to note that MT omits entirely that Mr Te Amo (who she later described as her boyfriend) was there.

Formal statement taken from MT by Detective Constable Wylde on 9 July 2018

[35] The following are excerpts from the formal statement:

> 26. [Buckland Road] is an empty house we all go to to hang out. I knew about [Buckland Road] being an empty house cause I used to live next door … It was my idea to go there.
>
> 27. I think it has about 6 bedrooms. The house has a wooden yellow outside and is only one level.
>
> 28. This was our first time hanging there. It was only [Ms Winter], [Ms Pairama], my sister [RT], and I.
>
> 29. I don't know what the time was when we got there. We climbed into the house through the toilet window which was open.
>
> 30. Once we got inside we went into the living room area and sat around talking, listening to music, and having a smoke.
>
> 31. We were doing this for a while and that's when [Ms Pairama] said that her family had abused her and she wanted to go kill herself. She was pissed off and said her Nana had given her a hiding.
>
> 32. She had a lump on her upper left arm and was complaining that she had broken ribs too. She was crying but saying she was angry as.
>
> 33. That's when [Ms Pairama] went into the back room.
>
> 34. I didn't follow her straight away but went to check up on her maybe like 2 minutes later.
>
> 35. When I walked in I saw her tying a knot in a sheet. The sheet had different colours on it.
>
> 36. She was tying the knot around a metal pole. I asked 'hey sis what are you doing' she said 'I'm doing this for myself' I said 'why would you want to kill yourself?' she showed me the lump on her arm and said 'I've had enough'.
>
> 37. [Ms Pairama] then told me it was her Dad's birthday on Friday just been. She said she wanted to be with him.
>
> 38. The pole she was tying the sheet to was about 1 metre long.
>
> 39. She stood on a chair and put the pole into this hole in the ceiling that you can lift up and go into. That ceiling access is in the hallway in front of the first room.
>
> 40. [Ms Pairama] walked into the front bedroom and started taking her clothes off. She left them there along with her cell phone.
>
> 41. She wrapped another sheet around herself to conceal her body.

42. [Ms Pairama] went back to the hallway where the sheet was hanging and she stood on the chair.

43. She told me that she loved me and thanked me for being there for her and being a good friend. She thanked me for being by her side the whole way.

44. That's when [Ms Winter] walked into the hallway and told [Ms Pairama] to kill herself. I think she said 'go kill yourself bitch, you don't deserve to live'.

45. I told [Ms Winter] to 'shut the fuck up' and she just walked away to the sitting room.

46. [Ms Pairama] didn't say anything to [Ms Winter] when she made that comment to her.

47. I told her to not do it but she said to not look and that I didn't have to look.

48. I started to cry and walked into the second room where I looked out the window. I didn't think she was going to do it.

49. Not long after I heard the chair fall down.

50. I don't know how much time passed, but I walked back to the living room where the others were and that's when I passed [Ms Pairama] hanging from the ceiling.

51. When I passed her she was struggling. I think she couldn't breathe. She was grabbing at the sheet around her neck and it looked like she was trying to take it off but she couldn't.

52. I didn't help her cause it was scary. I didn't want to touch her. It was freaky seeing her hanging from the ceiling like that.

53. I went into the living room and say to [Ms Winter] 'G, she actually hung herself'. [Ms Winter] walked into the hallway and started crying too.

54. [Ms Winter] hugged me and started crying. She said sorry to me. I said 'what for we haven't done anything' she said 'sorry for your loss'.

55. I grabbed a pair of scissors from the kitchen bench and went to where [Ms Pairama] was.

56. I lifted [Ms Pairama's] body up with my left arm around her waist, while I cut the sheet with my right hand.

57. I managed to lower her down without her falling. Once she was down I wrapped her in a yellow sheet that was on the ground. [Ms Winter] helped wrap her up but not much cause she walked back into the living room scared.

Formal statement taken from Tehiwa Marsters by Detective Gong on 10 July 2018

[36] Ms Marsters is an adult known to MT and RT. The following are excerpts from her formal statement:

> They rocked up to my place this morning around 8.30am. I remember looking at the clock at this time. They were knocking on the ranch slider. I opened up for them and they came in.
>
> Andrew was also home at the time. He was asleep in the lounge.
>
> [MT] asked me "did you hear about what happened to [Ms Pairama]?" I said, "Nah". She told me that [Ms Pairama] passed away. [MT] said it was a girl called [Ms Winter] who killed her and that [RT] gave [Ms Winter] a hiding. [MT] said "[Ms Pairama] died and it serves her right". I don't know what she meant by that.
>
> I asked how [Ms Pairama] died and they said they don't know. That was it I didn't ask anymore. I don't know of the [Ms Winter] they were talking about.

Formal statement by Detective Constable Mapp dated 23 July 2018 in which the Detective Constable describes speaking to MT

[37] The following are excerpts from the formal statement:

> [MT] was asking me about [Ms Winter] and where she was.
>
> [MT] told me that she had lied in her statement given a few days earlier because she was scared.
>
> [MT] told me that [Ms Winter] had given [Ms Pairama] a hiding and told her to kill herself and that [Ms Winter] had been the instigator for setting up [Ms Pairama] to hang.
>
> [MT] told me that it was only herself, her sister [RT], [Ms Pairama] and [Ms Winter] at the house that day.
>
> She mentioned that Police had come to the door at some point during the day and spoken to them and that [Ms Pairama] had covered for [Ms Winter] for some reason.
>
> [MT] told me that [Ms Winter] had made [Ms Pairama] undress and that she had given [Ms Pairama] a sheet to cover herself.
>
> [MT] told me that she tried to stop [Ms Winter] from doing what she did but that [Ms Winter] overpowered her and her sister.
>
> [MT] told me that after the body was hidden she was threatened by [Ms Winter] to lie to the Police otherwise she would be killed.
>
> [MT] finally told me that she was not too worried herself about these threats but was worried about her younger sister hence why she lied to the Police.

> This information was provided in general discussion that I had with [MT] and I did not probe into asking detailed questions because I knew that she would need a support person present if she was to give a formal statement.
>
> I had a general discussion with her about what she had been doing the past few days and where they had been staying.
>
> She told me that her and her sister had been sleeping rough and that they had been using methamphetamine and sniffing glue as recently as the day before.
>
> …
>
> At 3:23pm I began the DNA processes with [MT]. I started with the intention to charge sample. I read [MT] the advice on the POL811 form. I used language that was straightforward and that I knew she would understand. I read the entirety of this form and answered any questions [MT] had as I went through it with her.
>
> By 3:55pm this sample had been obtained by way of buccal swab. I ensured that all relevant paperwork was filled in.
>
> I then moved on to requesting [MT] provide a suspect sample. I made it clear to [MT] that this was optional and explained the difference between this sample and the one I had just taken. Detective Sergeant GOLLAN advised [MT] that her lawyer's advice was that she does not provide a sample by consent.
>
> At 4:05pm [MT] refused to provide a sample by consent. I recorded this decision on the relevant paperwork.

Formal statement taken from Tui Taotua by Detective Constable Gardiner on 31 July 2018

[38] Ms Taotua was a residential youth support worker at an Oranga Tamariki facility where MT and RT were placed temporarily. Over the course of two weeks MT had conversations with Ms Taotua in English and Samoan. Some of the things Ms Taotua recalls MT saying are:

- She was with [RT], [Ms Winter], [Ms Pairama] and "another person". She didn't tell me who this was yet.
- They were chilling out in all the 6 rooms of the house when she heard screaming.
- Went into a room and saw [Ms Winter] questioning [Ms Pairama] and beating her up.
- [Ms Winter] asked [Ms Pairama] about Black Power that was going to rape her or something.
- [Ms Winter] told her to join in on beating [Ms Pairama] up.

- She started beating [Ms Pairama] up too but didn't know why and didn't really want to. Did it because [Ms Winter] told her to.
- She did say that [Ms Pairama] was talking a lot of BS about her though.
- [Ms Winter] kicked [Ms Pairama] heaps to her side and stomach.
- Ms Winter started cutting [Ms Pairama's] hair off.
- They went and tried to burn the hair in the kitchen sink but had to put it out in case the house set on fire.
- [Ms Winter] started pouring liquids on [Ms Pairama].
- Described as gas and washing liquid.
- [Ms Winter] lit [Ms Pairama's] chest with fire.
- She told [Ms Winter] to stop.
- She grabbed something to put fire on [Ms Pairama] out.
- Before the burning, [Ms Winter] told her to finish cutting [Ms Pairama's] hair.
- Before they cut her hair there was a knock at the door.
- [Ms Pairama] told them all to hide. [Ms Pairama] answered the door. Police asked her if she was ok. [Ms Pairama] told Police she had lost someone and that's why she was upset.
- Also before the cutting of [Ms Pairama's] hair [Ms Winter] made [Ms Pairama] get naked and stripped her clothes off.
- She told [Ms Winter] that was enough and she didn't think it would get that far.
- [Ms Winter] kept telling her what to do and she didn't want to.
- [Ms Winter] dragged [Ms Pairama] to another part of the house. She thought it was over.
- Heard screaming again so went back in and saw [Ms Winter] had pulled [Ms Pairama] off a chair onto the floor.
- [Ms Winter] told [Ms Pairama] she had two choices on how she could die. One was hanging and second was stabbing.
- [Ms Winter] told [RT] to go away to another part of house.
- [Ms Pairama] said that she wanted to be hung and that she wanted to die.

- [Ms Pairama] told [Ms Winter] to hurry up and do it.
- She felt bad for [Ms Pairama].
- [Ms Winter] had something up in the ceiling and [Ms Winter] had hooked something on it and that was how [Ms Pairama] was hung.
- [Ms Winter] was tying [Ms Pairama] up after she was stripped and after the Police came.
- [Ms Pairama] was tied up when she was hung.
- She saw [Ms Pairama] struggling when she was hanging and her legs were trying to get the chair that was underneath her.
- [Ms Winter] kicked away the chair that [Ms Pairama] was struggling to get with her legs.
- She wanted to help [Ms Pairama], but [Ms Winter] was there.
- After [Ms Pairama] was struggling she got her down.
- She was holding her 'best friend' in her arms as she was dying.
- [Ms Winter] had told [RT] to go away because she "was too young".
- She covered [Ms Pairama] with something after she got her down.
- [RT] then came back with that other person.
- She was crying and holding her friend who was dying.
- [RT] tried to fight [Ms Winter] when she realised what happened.
- Other person was called [Mr Te Amo].
- [Mr Te Amo] was with [RT] saying how wrong it was.
- [Mr Te Amo] had nothing to do with it.
- [Mr Te Amo] had been with her and [RT] all night (the night before).
- [Ms Winter] told them to rid of the body because [Ms Winter] didn't want to touch a dead body.
- She wrapped [Ms Pairama] up and put her in a bin near the house.

Formal statement taken from Mona Monazahian by Detective Worth on 31 July 2018

[39] Ms Monazahian was a youth worker at a facility that gave temporary accommodation to MT. Ms Monazahian in her statement sets out discussions she had with MT:

[MT] started telling me what had happened. I wasn't asking her any questions at all as I was a bit shocked myself.

[MT] told me she had beaten 'her'. She told me she, her sister, [Ms Winter] and her cousin had taken 'her' over to the Mangere house. She told me [Ms Winter] was a 28 year old transgender. She told me 'she' had been talking smack about [MT] behind her back to the other boys and [MT] was really mad at 'her' for that.

I didn't know the name of the person [MT] was referring to at this stage as who was being beaten – she just kept referring to this person as 'she' or 'her' or 'my best friend', but it was obvious she was talking about the person who had died.

I said to [MT], "Are you sure she did it?" - referring to the talking smack.

[MT] said, "Yeah, 'she' admitted it, but I was too angry, so I kept beating her."

[MT] told me she and [Ms Winter] had been beating this person – as she was talking, her body language involved her gesticulating kicking at the floor and punching.

[MT] told me the person who was being beaten was crying and asking her and [Ms Winter] to stop.

[MT] told me that while she and [Ms Winter] were beating this person, her cousin had come in and wanted them to stop the beating. [Ms Winter] didn't want to stop, and [MT] told me the cousin fought with [Ms Winter], but that [Ms Winter] is a trainer and fit, so the cousin couldn't fight [Ms Winter].

[MT] told me [Ms Winter] had told 'her' to take 'her' clothes off; and that 'she' was really sore and couldn't really stand but the clothes came off and 'she' was naked.

[MT] told me they then tied 'her' to a chair and gave me the impression she had been involved in the tying to the chair.

[MT] told me [Ms Winter] started burning 'her' pubic hair and stomach; and that 'she' was crying at this time and was really out of it in so much pain.

[MT] told me she looked at 'her' hands and saw they were really purple. She said to me, "We tied her hands too tight", which confirmed to me [MT] had been involved in the tying.

[MT] told me she said to [Ms Winter], "That's enough torturing; we should stop this."

I said to [MT], "Why didn't you stop it?"

[MT] told me [Ms Winter] said to her, "We're not going to stop now".

[MT] told me [Ms Winter] then said to her that if [MT] stopped, [Ms Winter] would hurt her family. She said that she was really scared of [Ms Winter] and that's why she couldn't stop.

> [MT] then told me they untied 'her' and that 'she' had a huge lump on her arm from where [Ms Winter] had beaten her – [MT] indicated to her left upper arm when she said this. She said to me, "It was huge".
>
> [MT] told me 'she' couldn't get up on her own, so [MT] helped 'her' up out of the chair.
>
> [MT] told me her cousin then walked in again and was screaming at her and [Ms Winter], "You guys are being stupid! Put some clothes on the poor girl!"
>
> [MT] told me she then grabbed a blanket and wrapped it around 'her' as 'she' was shaking; and that they put 'her' on the floor.
>
> [MT] told me [Ms Winter] then poured petrol, car oil and a cleaning product with a duck on it over the person on the floor, all over her body, her face, her hair, the blanket.
>
> [MT] said that 'she' was really scared; and [Ms Winter] was scaring 'her' and making it sound like she was going to burn 'her'.
>
> I said, "Did you guys?" – referring to the burning.
>
> [MT] said, "No, we didn't".
>
> [MT] told me [Ms Winter] made a noose and put it up.
>
> [MT] told me 'she' had always been saying 'she' wanted to commit suicide.
>
> [MT] told me [Ms Winter] asked 'her', "Are you going to kill yourself, or do you want me to do it for you?"
>
> [MT] said that 'she' was really scared about what [Ms Winter] was saying, didn't want to do it, and that [MT] said to 'her', "You don't have to do it. You don't have to do it if you don't want to."
>
> [MT] said that 'she' then turned to [MT] and whispered to her, "It's okay sis. I do want to do this now. I want to be with my dad anyhow."
>
> [MT] said something about 'her' father passing away some time earlier and that his birthday had been the day before this all happened.
>
> [MT] then told me, "[Ms Winter] pulled the chair out".
>
> [MT] hadn't mentioned how 'she' had gotten from being wrapped in the blanket on the floor to being on a chair with a noose around 'her' neck.
>
> [MT] said to me, "We put her down on the floor and went our separate ways."

[40] Overall, the formal statements show that MT was distancing herself from what happened, particularly when talking to the police. She placed the blame on Ms Winter and tried to characterise the murder as a suicide. She kept Mr Te Amo out of it. The evidence of MT's sister, RT, showed the true extent of MT's involvement.

Options for care

[41] In this case there are really only two options for how MT should be cared for by the State as a result of the finding I have made under s 10. The first option is that I order MT to be detained in a secure facility as a special care recipient under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR).[6] I can only do that if I am satisfied that the making of the order is necessary in the interests of the public.[7] The second option is to order that MT be cared for as a care recipient under the IDCCR. I can only do that if I am not satisfied that detention as a special care recipient is necessary.

[42] I have the benefit of extensive reports from Ms McFadden, a consultant clinical psychologist. Ms McFadden's recommendation is that MT be detained in a secure facility as a special care recipient.

[43] I also have the benefit of reports from Dr McGinn, a clinical neuropsychologist with a particular expertise in FASD engaged on behalf of MT. Dr McGinn's recommendation is that MT be cared for as a care recipient.

[44] I will, before considering the views of Ms McFadden and Dr McGinn, outline the differences between detention in a secure facility as a special care recipient and being cared for as a care recipient. In doing so, I draw extensively on the decision of the Court of Appeal in *H (CA841/2012) v R*.[8]

[45] The Court of Appeal describes the Court's task as follows:

> [10] In determining whether to make either a special care or a care order, the Court is undertaking a balancing exercise which involves the need to protect the public from persons who may reoffend while subject to an incapacity (on the one hand) and the desirability of rehabilitating the defendant (on the other). The Court must consider relevant aspects of the public interest, the purposes for which the disposition order is being made, and the consequences (to both the public and the defendant) of making either a special care or a care order.
>
> [11] In the context of a special care order, this is achieved by requiring the court to be satisfied that it is "necessary" to make such an order. Even if it

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6 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 24(2)(b).
7 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 24(1)(c).
8 *H (CA841/2012) v R* [2013] NZCA 628. I will not footnote all the material I reference.

> were "unnecessary" to make a special care order, the court must still balance those competing considerations in determining whether a care recipient should be detained in a secure facility. The term "secure facility" is defined by s 9(2) of the [IDCCR]:
>
> > **9 Meaning of facility and secure facility**
> >
> > …
> >
> > (2) A secure facility is a facility that—
> >
> > (a) has particular features that are designed to prevent persons required to stay in the facility from leaving the facility without authority; and
> >
> > (b) is operated in accordance with systems that are designed to achieve that purpose.
> >
> > (Footnotes omitted)

[46] The Court referred to an earlier decision of the Court of Appeal, *M (CA819/11) v R*,[9] on what is meant by the concept of "necessity". In that case the Court of Appeal held that the "standard of necessity obviously sets a high threshold", putting it somewhere on the spectrum "between expedient or desirable on the one hand and essential on the other".[10]

[47] The maximum period for which MT can be detained under a special care order is 10 years from the date of the making of the order because she is charged with an offence (murder) which carries a maximum penalty of life imprisonment.[11]

[48] A special care order for MT will continue in force for the whole of the 10 year period unless an earlier decision is made for MT to be brought before the Court,[12] or until a direction is made under s 31 of the CPMIP that MT be held as a patient or as a care recipient.[13] If the charges against MT are subsequently withdrawn or dismissed, a special care order would be treated as cancelled.[14]

[49] If, before or on the expiry of the 10 years period for which detention would be ordered, a certificate is given under the IDCCR to the effect that MT is no longer unfit

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9 *M (CA819/11) v R* [2012] NZCA 142, (2012) 28 FRNZ 773.
10 At [17].
11 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 30(1)(a).
12 Section 30(3)(a).
13 Section 30(3)(b).
14 Section 30(5).

to stand trial, the Attorney-General must either direct that MT be brought before the appropriate Court, or that she be held as a care recipient.[15] If a certificate were given under the IDCCR to the effect that, although MT is still unfit to stand trial, her continued detention is no longer necessary, the Minister of Health, with the concurrence of the Attorney-General, must determine whether detention should continue.[16] If the Minister forms the opinion that detention is no longer necessary, he or she must direct that MT be held as a care recipient.[17] Were such a direction to be given, MT would be treated as if she were subject to a compulsory care order, under the IDCCR, and the provisions of that statute would apply accordingly.

[50] A special care recipient must remain in a secure facility and may not leave the facility without authority given under the IDCCR.[18] Nevertheless, the Director-General of Health may authorise leave from the secure facility for a period of not more than seven days on such conditions as he or she specifies.[19] Leave for any longer term must be obtained from the Minister of Health.[20]

[51] If a direction were given under s 31 of the CPMIP that MT be held as a care recipient, instead of a special care recipient, her charges of kidnapping and murder would be stayed and MT could not be charged again with those offences.[21] This is because once classified as a "care recipient" MT would fall under the definition of "care recipient no longer subject to the criminal justice system" in s 6(3) of the IDCCR.

[52] If MT were ordered to be a care recipient, that is to be regarded as a compulsory care order for the purposes of the IDCCR.[22]

[53] If MT were ordered to be a care recipient, then the Court is required to direct whether MT is to be detained in a secure facility and to specify the term of the order.[23]

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15 Section 31(2).
16 Section 31(3)(a).
17 Section 31(3)(b).
18 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 63.
19 Section 67(1), subject to the qualifications set out in s 67(2) and (3).
20 Section 66, subject to the qualifications set out in s 66(3) and (4).
21 Criminal Procedure (Mentally Impaired Persons) Act 2003, s 32.
22 Section 26(2).
23 Section 26(2).

The term may not be longer than three years.[24] However, any term specified, even if it is the maximum of three years, can be extended by the Family Court on the application of the co-ordinator having responsibility for MT's case.[25]

[54] On an application to extend, the Family Court would have to decide whether MT should receive supervised or secure care, taking into account the danger supervised care might pose to MT's health and safety or the health and safety of others in the community. Also, the Family Court must make its own (contemporary) assessment of whether supervised or secure care is required.[26] In other words, the Family Court would focus on the balance to be struck between the legitimate interest of the community in protecting the health and safety of MT and others against MT's interest in being at liberty.[27] It is possible for more than one extension application to be made. The Family Court could order that MT continue to receive secure care "if it considers that supervised care would pose a serious danger to the health or safety of the care recipient or of others".[28]

The experts' reports

[55] There are four expert reports. Two are from Ms McFadden and two from Dr McGinn. The difficulty is that the experts differ. In many respects, they entirely contradict each other. Before outlining the parties' submissions and how I reconcile the reports, I will outline the central findings of each report.

Ms McFadden's reports

[56] Ms McFadden's first report is dated 26 November 2019 and the second is dated 10 March 2020.

[57] For the first report, Ms McFadden interviewed MT on 11, 21 and 25 October 2019. MT declined to see Ms McFadden on 8 November 2019 as previously scheduled but relented and there was a further interview on 15 November 2019.

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24 Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003, s 46(2).
25 Section 85.
26 Sections 85(2) and (3).
27 *RIDCA Central (Regional Intellectual Disability Care Agency) v VM* [2011] NZCA 659, [2012] 1 NZLR 641 at [36].
28 Intellectual Disability Act, s 85(3).

Ms McFadden also interviewed members of MT's family as well as other health professionals caring for MT at the Totara Unit of the Mason Clinic.

[58] For her second report, Ms McFadden interviewed MT on 18 February 2020 for one-and-a-half hours, consulted other health professionals caring for MT and reviewed clinical notes recorded by Mason Clinic staff for the period 3 December 2019 to 19 February 2020. The clinical notes included file notes and psychiatric reviews.

[59] I had the benefit of Ms McFadden's oral evidence given at the hearing on 6 May 2020.

[60] Ms McFadden's overall opinion given in the first report is as follows:

> 167. The objective of this assessment was to provide the court with the information necessary to complete inquiries under S23 CPMIPA and to determine the most suitable method of dealing with [MT] under S24 or S25 CPMIPA.
>
> 168. Dealing first with a disposition pursuant to S 24.
>
> 169. [MT] is an 18-year-old Samoan female who was found unfit to stand trial for charges of murder and kidnapping. [MT] was co-charged with two offenders. The co-offenders were found guilty following a defended hearing. The involvement process for [MT] is yet to be completed.
>
> 170. [MT] was determined to have met eligibility criteria for a diagnosis of intellectual disability as laid out in S7 IDCCR Act 2007 with the S38 process. She is also diagnosed with foetal alcohol spectrum disorder as set out in the Revised Canadian Guidelines.
>
> 171. [MT] recently turned 18 years old. In my opinion she may still have to capacity in increase her level of cognitive and adaptive functioning. This has happened with other adolescents who have entered the IDCCRA framework, from a background of early life adversity and severe psychosocial difficulties. Factors that could contribute to a shift are the positive effects of care and rehabilitation and issues such as increased maturity, effort, motivation and exposure to a developmentally facilitating environment. Data gathered within the current assessment indicated that issues of effort and motivation remain areas of concern, for those observing [MT's] behaviour longitudinally across a range of contexts and interactions. I respectfully recommend that the court consider the potential for changes in functioning within the disposition process.
>
> 172. There is no current evidence that [MT] is mentally disordered, therefore an order under 24(2)(a) is not indicated at this time.

173. The facts in this case describe offending of the most serious nature, that included the perpetration of torture and severe violence over a prolonged period time towards a vulnerable victim.

174. The risk of future violent reoffending is currently estimated to fall in the high range over the next 12-month period. This risk is underpinned by multiple psychosocial factors that will require careful monitoring in order to better understand her risk profile. The indicators of low empathy and her deriving gratification from causing pain to others, are particular areas for concern.

175. Further, it is my view that the risk of reoffence needs to be conservatively assessed and managed at this time. This is because of the nature of the alleged offending, the large number of criminogenic needs found upon assessment, and the limited number of internal and motivational protective factors identified at present. The current risk assessment has demonstrated that compulsion is required and necessary in this case to ensure that [MT] engages in care and rehabilitation that is aimed at reducing the risk of reoffence.

176. Considering all of the clinical and risk data described above, the very serious nature of the alleged offending and the current evaluation of risk, it is my carefully considered opinion that it is necessary in the interests of the public or any class of person who might be affected, for the court to make [MT] a special care recipient order pursuant to S 24(2)(b).

177. Should the court decide not to make [MT] a special care recipient pursuant to s24(2)(b) then disposition under s25(1)(b) would also be appropriate. Some benefits can be identified by disposition under S 25(1)(b). For example, this represents the least restrictive option, it could support a higher level of community integration, and there may be more opportunities for FASD specific interventions to be delivered. However, in my opinion, these advantages need to be carefully balanced against the increased risk of absconding, the risk of violent reoffence, the severity of the index offending, and the interests of the public and any person or class affected by the court's decision. The possibility of changes cognitive functioning is an additional issue for consideration. If this option were chosen, placement in a secure facility for the maximum term of three years would be indicated.

[61] I found a number of passages in the report particularly relevant in assessing Ms McFadden's recommendations. The first were Ms McFadden's comments about MT's lifestyle leading up to the offending:

17. [MT] provided a detailed account of her transient lifestyle prior to the alleged offending, and of the alleged offending. She appeared to idealise periods of homelessness and her association with other substance users, drug dealers and gang members. Her account of her family history and familial relationships was comparatively sparse. When questioned about these issues, or provided with information contained in other reports she became irritable, and defensive.

…

42. In 2018, Oranga Tamariki became involved due to a further report of concern regarding physical abuse of [MT] by her mother. There were additional concerns that [MT] was engaging in risk taking behaviour including prostitution, substance abuse, running away from home and living on the streets. In May 2018 [MT's mother] informed Oranga Tamariki that [MT] had absconded more than 20 times, and said that she no longer wished to contact the police anymore because it had become a regular behaviour.

[62] The following passages consider her intellect and mental capabilities:

12. [MT] understood that the assessment was not a confidential process. She knew that I would prepare a report that would be read by the Judge and other people including lawyers, the police and people involved in her care. She demonstrated her ability to understand the limits to confidentiality by stating who she did and did not agree for me to consult with. She asked why I needed to talk with collateral informants and the type of information I was seeking. On several occasions [MT] asked why I was asking specific questions (e.g., about her family history) and requested an explanation of their relevance. She challenged various aspects of the previous health assessors' reports (e.g., information that was recorded about care and protection issues, her mother's use of alcohol in pregnancy, and the way her behaviour was described). She was able to say when she was fatigued and either needed a break or was ready to finish and interview.

…

59. Assessments completed at [school] over the course of 2018 and 2019 indicated that [MT] enjoys reading and writing, but not maths. Her reading age when last measured was between 11.5-12 years and her spelling age of 12 years. [The teacher] reported that [MT] loved to read young adult fiction and could accurately recount the contents of novels she was reading.

60. Dr McGinn assessed [MT's] academic ability using the Wide Range Achievement Test Third Edition. She reported that spelling was an area of strength for [MT] (age equivalence 15-year-old). Her reading comprehension measured at the 8.5-year age equivalence, her reading at the 10-year-old age equivalence.

61. There appears to be some disparity between the data gathered by [the school], observations made by OT staff of her functional reading abilities (level of reading observed and comprehension) and the results obtained by Dr McGinn.

…

77. Overall, [MT] has settled well into the ward environment. [MT] has been observed to have a bubbly, pleasant and sociable nature. She was described by those supporting her as wanting to please others, and adept at moulding herself to whatever social situation she finds herself

in. She was initially placed on 2:1 staffing but this was quickly reduced to 1:1 support. There have been no concerns about her ability to understand the expectations or the ward or manage her interactions with other patients. There have been nil concerns documented about her ability to comprehend information or communicate with others. Her short-term recall of routines can be inconsistent, but her long-term memory was described as intact. She reads the newspaper regularly, and often comments or reacts to what she reads. She is one of the few patients on the unit who read the newspaper. She keeps a journal, and enjoys reading song lyrics. She has not presented as impulsive, dysregulated or disorganised in her behaviour. Staff on the unit observed that [MT's] level of functioning is higher than anticipated given her diagnosis of intellectual disability.

78. [MT] has demonstrated a good capacity to read social cues, and to understand the various dynamics occurring on the unit. Staff have observed to [MT] to have a capacity for humour. She can joke and be witty. At times she has teased others on the unit, and has been responsive to feedback from staff when she has crossed the line between humour and being hurtful. [MT] has stated that she prefers the company of older people. She has conversed fluently in Samoan and English on the unit, forming friendships with other patients of Samoan descent. Staff have observed [MT's] behaviour to be congruent with her age. There have been no clear reports of childish or regressed behaviour, although some staff have noticed that [MT] may sometimes present as more closed or passive within meetings with professionals who are visitors to the unit. She is assertive within her communications and interactions with nursing staff on the unit.

[63] Ms McFadden commented a number of times on MT's changeable mood and nature:

16. When seen individually, approximately 45 minutes later, [MT] was relaxed and bubbly in her mood. She made good eye contact. Her demeanour was somewhat child-like. Her nurse subsequently reported, that this was different from the way [MT] typically presents on the ward, where she tends to fit in and engage a level which is comparable to her adult peers. [MT's] speech and demeanour was more age-congruent at all subsequent meetings. Although the quality of her engagement was observed to be dependent on her mood. The rapport established in the first session became fragile in subsequent sessions whenever [MT's] responses were probed, or an alternative perspective was presented.

…

69. There were few concerns about [MT's] interactions with peers. [The teacher] reported, "she had good presence of mind, was a good leader to others and stayed out of fights and gossip". [MT] enjoyed reading the bible and was observed to be rigid about her beliefs. She showed low tolerance for others expressing a different point of view. [MT] was observed to be assertive on the unit, and able to articulate and maintain her point of view. [The teacher] recalled that from the outset

> of the admission [MT] was clear, "nobody makes me do what I don't want to do". [MT] also expressed this to me within the current assessment.
>
> …
>
> 71. Staff at the residence observed [MT's] behaviour and presentation to change dependent on who she was engaging with. [The teacher] stated that this was apparent within the S38 assessment process, where there were significant differences in the way she presented to each assessor. The residential staff formed the impression that [MT] could present herself as less able to some people. [The teacher] said that this behaviour was incongruent with the level of understanding and comprehension [MT] demonstrated at other's times (e.g., in her reading and discussion of young adult fiction, her engagement with teachers, her ability to converse fluently in English and Samoan, her ability to reason issues through, her understanding of social dynamics). [The teacher] noted that at times [MT] described symptoms of psychosis (e.g., seeing people) during meetings, and that her reports had a disingenuous quality.
>
> …
>
> 81. [MT] is more oriented to peers and states, and has consistently stated that she would seek out the support of peers over staff members. On occasions [MT] has presented as vigilant towards and mistrustful of staff. Following an incident where she shut herself in her room and posted a sign tell staff members to leave her alone (in expletives), [MT] stated that she felt staff were talking/laughing about her behind her back. Periods of irritability, frustration and moodiness have been observed, which can trigger withdrawal and low-level pushing boundaries, for example refusing to engage with coaching, refusing to come out of her room, refusal to engage with meals or take medications. On several occasions she has verbalised a desire to "play up". On occasion, [MT] has expressed her irritability or frustration by swearing at staff, slamming doors, pushing furniture and shutting herself in her room. Once [MT] forged her key workers signature on an incentive form, and on two occasions she has stood by the door of the unit, and behaved in manner that led staff to caution her about efforts to leave the unit. There have been isolated instances of [MT] making sexualised comments to other patients.

[64] Ms McFadden also noted that MT had a tendency to idealise violence, and could be violent herself:

> 83. On several occasions [MT] has initiated discussions about gang related issues with other patients. Notes indicate that [MT] was animated within these discussions and appeared to idealise women in gangs and the use of violence as part of initiation ceremonies. [MT] has told patients and staff that she was looked after and cared for by gang members. She has been observed to be attuned to others on the unit making gang related gestures/signs. She is also attuned to references to substance use. Her communications regarding substance

use, have oriented around how to access, prepare and use substances. She has been observed to associate drug use with a more desirable body image. She has told staff that if she was not in the unit she would likely be hanging out with peers and using substances.

…

99. At this point in the interview [MT] disclosed feeling recently upset with the nursing staff and wanting to "smash them" because she thought they were "talking shit about me". She added, "I hate people talking about me. It is so obvious".

100. [MT] confirmed that she had "been around" gangs, commenting that most of her contact had been with Black Power members, who were mostly, "really cool, kind and caring". She said that some were "mongrels". [MT] was supportive of women being in gangs, and had considered joining a gang herself. When asked what the consequences of impacts of being a gang member or affiliate could be, she responded:

> It is dangerous sometimes. For example, if you quit, they might kill you or go after your family. I wouldn't want to put my family in danger.

[65] Ms McFadden concluded that there was a high risk that MT would be violent in the future:

144. The risk of potential violence, and the risk of violence that causes serious harm is currently considered to fall within the high range.

145. In respect of future scenarios for violence recidivism, [MT] is vulnerable to engaging in further violent offending, with antisocial co-offenders. She is likely to be vulnerable to influence of older more able peers, but data indicates that that sophisticated younger peers could also be sought out and relied upon as role models. If others are modelling the use of violence as desirable or necessary to inclusion of the group or social status, this may be highly motivating to her.

146. It is also possible that [MT] may lack the capacity to inhibit violent behaviour in a scenario where she is under the influence or substances, is emotionally dysregulated, feels undermined or belittled or is unable to accurately assess/perceive the risk of harm to others. [MT] may justify the use of violence as a means of dealing with stressors within her intimate partner relationships, or in related non-intimate domestic settings.

147. A further scenario for violence is one where [MT] is destabilised by internal psychological states. [MT] is highly reliant on avoidance and suppression of negative emotion, to manage stressors or increased psychological/environmental demands. If these mechanisms fail, she may seek to use violence (threatened or actual) to problem-solve or exert control over the environment.

148. Finally, there is emerging data to support that [MT] may derive pleasure from inflicting pain on others. This is a hypothesis that warrants very careful exploration and monitoring in order to determine its validity.

[66] Ms McFadden considered that MT did not show a willingness to change:

109. Efforts to explore psychosocial issues, as they related to her involvement with, and attitude to the alleged offending were unsuccessful. [MT] became visibly tense, stating:

> Talking to you about this is not going to help me go home. I might not be going home. If I do this report how will it help me in court? You are just going to put me in a home with sick people. I just want to go home I don't want to stay here any longer…I am not going to reoffend. I told you it was unexpected.

[67] The following passages relate to Ms McFadden's risk assessment:

125. In this case establishing [MT's] risk of reoffence is a key concern of those faced with making decisions about disposition. In addition, information about risk, need and responsivity factors also informs decision making about rehabilitation needs. As part of this assessment I utilised a multimethod approach. Each of the risk measures identified static and dynamic risk factors and protective factors that are known to be associated with recidivism. All have been found to have predictive value and accuracy with female offenders.

126. [MT's] account of the alleged offending was explored as part of the process of determining risk and appropriate disposition options. [MT's] description of the alleged offending was relatively consistent with the summary of facts. She provided additional information about her contacts with the police officers, who visited the home prior to the victim's death; and the events that led to her arrest. Her demeanour during these sections of the assessment was animated. She expressed regret for some of her choices (e.g., asking her sister to accompany her into town, suggesting the group go to the abandoned house) and regarding the death of the victim. However, her communications on the whole, conveyed an externalisation of responsibility to the co-offenders (e.g., acting into response to directives, feeling fearful of the consequences of not complying). [MT] consistently recounted the events and the death of the victim in a matter of fact way.

[68] The first instrument used by Ms McFadden to assess risk is called Level of Service/Case Management Inventory:

127. This instrument is a risk/need assessment tool that is designed specifically to determine the level of risk that an offender presents to the community across a 12-month period and the characteristics of the offender that contribute to such risk (commonly called criminogenic needs), some of which may be addressed through various kinds of active intervention and treatment. The LS/CMI also considers the

approaches to supervision and the treatment that are likely to be most successful in supporting the offender through a rehabilitation process. The LS/CMI is comprised of eight primary risk domains. The results are described below.

[69] Some of MT's scores are:

131. [MT] scored in the very high range for companions. There is compelling data to support her association with antisocial companions. There was evidence of her quickly forming associations with antisocial peers who were previously unknown, as evidenced by her description of not knowing Ms Winter until immediately prior to the alleged offending, and collateral data which described her quickly entering into friendships or relationships with people she had just met.

132. [MT] scored in the medium range for alcohol/drug problems. She identified herself as being previously addicted to alcohol and substances (methamphetamine, synthetic cannabis, marijuana). [MT] remain positive about substance use, and can identify few negative consequences. She has provided contradictory information about her desire to remain substance free. She is currently substance free because of her placement in secure environment. There have been no substance related difficulties for over 12 months, because of her placement. The risk of relapse to substance use should [MT] return to the community is estimated to be high.

133. [MT] scored in the very high range for pro-criminal attitude and orientation. Prior to her arrest [MT] was immersed in an unconventional lifestyle with high levels of exposure to antisocial behaviour. Although [MT] has articulated a desire for a fresh start, her communications with the assessment and to peers, and nursing staff indicate an idealisation of antisocial lifestyle (gang affiliation, use of initiation ceremonies). [MT] conveyed a street wise attitude, and a capacity to survive on the streets. She understood that violence can lead to harm. Her capacity to assess that certain actions could be harmful or fatal to others, was better developed than her ability to assess the risk of harm/exploitation to self. Although she expressed some regret about the alleged offending, there was evidence of minimisation of her behaviour, and cognitive avoidance. For example, [MT] consistently communicated that the alleged offending was "unexpected". She was assessed to have an external locus of control and responded defensively to efforts that were aimed at assessing her ability to see things from another perspective. [MT] consistently indicated that she views herself as a victim of circumstance. She remains unrealistically hopeful that she will be allowed to go home at the conclusion of the court process, and her focus on this as possibility is likely a psychological defense mechanism. Her attitude to treatment is currently negative, her attitude to supervision can vary, dependent on the demands being placed upon her by nursing and clinical staff.

134. [MT] scored in the medium range for antisocial pattern. There was data to support severe problems of maladjustment in childhood. I note that she absconded from two care and protection placements following her arrest but prior to being formally charged. She presented

with an attitude that was supportive of criminal behaviour, and had a pattern of generalised trouble.

135. An area of strength for [MT] was the absence of a criminal history. She does not have a previous history of youth justice involvement.

…

138. As a result of this analysis, [MT] was scored in in the high risk/need category on the LS/CMI.

[70] The second instrument used was the Historical Clinical Risk Management-20, Version 3. Ms McFadden describes this instrument:

139. The HCR-20V3 is comprised of historical, clinical and risk management factors. These factors are used to guide the collection and interpretation of information, in order to understand a person's potential to engage in future violence; and to determine what can be done to prevent them from doing so.

[71] Ms McFadden also used an assessment guideline called SAPROF which was developed to complement the assessment of the risk of future violent behaviour in offenders and forensic psychiatric patients. It identifies factors that might compensate for identified risk factors. The presence or absence of protective factors can provide a more complete view of the individual. Ms McFadden said:

150. The key protective factors identified for [MT] were her current placement in secure environment where she has access to professional care and there are clear external controls. Her history of positive secure attachment with her maternal grandmother was a further protective factor. However, this is moderated by the attachment issues present in her relationship with her mother, and grandmother being located overseas.

151. Areas where protective factors are present to some extent included: empathy (can be caring to others, may subvert her own needs for those she cares about), self-control (although suppression and avoidance areas of concern), capacity to engage in leisure activities (sports, pottery, reading, music, cultural), engagement with chores/incentives in residential/hospital setting, use of medication as prescribed, and the presence of prosocial support in extended family (great aunt).

152. Key treatment goals were: building motivation for treatment, development of adaptive coping mechanisms, development of realistic and feasible life goals, and increasing self-control skills within less structured and controlled environments.

[72] Ms McFadden's clinical summary includes:

156. In the months leading up the alleged offending, [MT] appears to have been entrenched in a transient lifestyle, which involved frequent and severe substance abuse, prostitution and association with other vulnerable and antisocial youth. There is reliable data to suggest that [MT] was also associating with older people, who were exploiting her, although her insight to this is poor. The data gathered from [MT] and collateral sources indicated that while vulnerable she also demonstrated the capacity to be streetwise and to meet her needs (hustling, prostitution). She continues to idealise an unconventional and criminal lifestyle. She has low insight to the negative impacts of her substance dependency. [MT's] communications on this issue indicated that she is highly vulnerable to relapse in the future, should she have an opportunity to access substances. Of note [MT] did not come to the attention of authorities for offending, although she has provided a clear history of association with others who were engaged in rule breaking and criminal activities.

…

158. In this case it was difficult to establish a clear history of prior violence. [MT] was not previously charged with violent offending. Her self-reports and clinical data indicated isolated issues with [MT] getting into fights with others, or using aggression in response to feeling aggrieved, threatened or to defend self or others. There is compelling data to support that [MT] has been exposed to chronic violence perpetrated by women towards each other within the home environment. Her exposure to intimate partner violence of this nature, has likely desensitised her to the use of violence, both between and by women; legitimising this as a valid or justifiable way of dealing with interpersonal issues, or exerting control.

…

160. A multimethod approach to risk assessment was used. I have considered [MT's] past and present functioning. In my opinion [MT] has a large number of the risk factors known to be predictive of general and violent reoffending. While she does not have a history of prior violence offending, at present she has a large number of the risk factors known to predict likely future interpersonal violence. Of particular concern is the presence of attitudes supportive of violence, [MT's] significant history of exposure to violence, modelling of violence as a solution to problems, her poor insight to the impacts of violence for self and other, and her history of victimisation and childhood adversity.

161. Additional risk factors of relevance included her antisocial (or dysocial) lifestyle in the months preceding the alleged offending; her disengagement from social, recreational and educational activities normative to her developmental stage; her association with vulnerable and antisocial peers, of varied age; her heavy use of substances; the absence of effective prosocial supports; her resistance to interventions aimed at addressing care and protection needs (lack of engagement, absconding from care and protection facilities); and her current lack of motivation to engage in therapy that addresses the risk of future violence or other reoffending.

162. The neurodevelopmental consequences of [MT's] fetal alcohol spectrum disorder are also likely to contribute to her risk of violence reoffending. Prevalence data has consistently shown persons' with FASD caused, and/or otherwise caused neurodevelopmental difficulties, are overrepresented in correctional settings. Involvement in the criminal justice system has increasingly emerged as a negative outcome for some individuals with FASD. Research indicates that the courts' management of offenders who have FASD is also varied, dependent on the stage at which the disorder is flagged, and/or the expertise and understanding of the legal and clinical professional involved with individual cases. Within the literature reviewed, it is evident that FASD can be viewed as a mitigating and aggravating factor. How it will be viewed in this case, in respect of disposition considerations, is a matter for the court.

163. Although [MT] has impairments typically associated with FASD (social vulnerability/naivety, poor awareness of risk, poor insight, executive functioning deficits), some aspects of her presentation suggest she retains some surprisingly adaptive skills. Within the hospital environment she has demonstrated a greater ability to read and navigate social dynamics than is seen as being typical. In this controlled environment at least, she has not presented as being clearly impulsive, disinhibited, suggestible or intrusive. When information is well known to her, she can clearly assert and maintain her point of view. When overwhelmed she tends to withdraw (physically or mentally). [MT] has shown a propensity to push boundaries in ways that are covert (forging signature, refusing supports, standing by exit door, pulling hair while plaiting, using a ball to intimidate), and do not generate a high-level response. Nonetheless, overtime these behaviours could significantly undermine the building of effective therapeutic rapport and impact management decisions. They may also well be appropriately seen as offence paralleling behaviour and if so, are a risk factor for future violent offending.

164. The subtle shifts in presentation observed over course of early November may be reflective of increased stress, a greater sense of familiarity or ease in the unit, and/or her growing awareness of the seriousness of her situation. There are indicators she may have a currently somewhat masked \capacity to react to interpersonal stress with anger and threatened aggression, and reactivity to perceived slights. [MT's] reluctance to shared internal experience with staff, limits their ability to check and moderate her interpretation of triggering events. To date she has exerted considerable control over her emotions and behaviour, even though others on the unit regularly model dysregulated behaviour.

165. It is not unusual for persons with FASD to function more adaptively within highly structured and predictable settings, but to still remain vulnerable to more able/sophisticated peers within forensic /correctional settings. The data to hand, indicated that [MT] successfully navigated the youth residential setting, being described as someone who could show leadership and avoid the many of the social issues affecting her female peers. She has adapted better than anticipated a hospital secure adult forensic environment, showing few clear indicators to date, of marked social or emotional vulnerability.

> 166. Although, [MT] is currently resistant to therapeutic intervention there is a shared view that she has the capability to benefit from psychotherapy and from other forms of rehabilitation (educational or vocational training, cultural interventions etc). Interventions that addresses the risk of violence reoffending, trauma exposure, substance related issues, emotional regulation and coping skills are all indicated. As is the development of a rehabilitation programme that provides opportunities for physical activity, cultural activities and mentoring and education.

[73] Ms McFadden's report of 10 March 2020 took into account MT's behaviour before, during and after the disposition hearing scheduled for 4 December 2019 which was adjourned at the beginning of the hearing on the application of MT's counsel, Ms Pecotic.

[74] Ms McFadden's report begins by providing details on how MT understands the progress of the proceedings, and on what she feels about it:

> 18. [MT] expressed feelings of anger and frustration about the adjournment. She referred briefly to a series of incidents that had occurred at the High Court and then upon her return to the Mason Clinic. [MT] was reluctant to be drawn on specifics of her behaviour, but acknowledged that she had hurt herself, and was very angry. [MT] said that she was now in control of her behaviour. She gave a recent example:
>
> > The other day I got pissed off with another patient. I was going to smash her. Instead I told staff. It is hard to make the right decision but I don't want to stay here any longer, I have Court next month. I am working really hard to stay in control. I am trying my hardest to stay out of trouble.
>
> 19. When asked how she might feel if the outcome of Court is not what she hopes, [MT] stated:
>
> > If I felt like it didn't matter. I'd be more inclined to go for it.
>
> 20. [MT] initially stated that reason for adjournment was to allow the Judge more time to decide. She then said she was not listening in Court, and had been heavily medicated because she was feeling nervous about the outcome.
>
> 21. [MT] has since tried to get in touch with her lawyer on several occasions, although said this had not been successful. She said that no one had gone over the reports with her. She is aware that the court had been given differing recommendations by the assessors. When asked about her preference [MT] stated:
>
> > I prefer nothing I just want to go home. If I can't go home, I want to get my own home.

22. [MT] is feeling nervous about the next hearing. She does not enjoy sitting in the dock, feels shy, and "hates" people looking at her. [MT] then asked me, "Do you get nervous when you have to go on that stage (witness box) and talk? Without waiting for a response, she described her experience of watching Dr McGinn, Dr Duggal and Dr Billing, give evidence and be cross-examined in previous hearings. She offered an opinion about who had appeared more confident, and who had appeared stressed and nervous. [MT] described the observations she had made of these professionals' body language, facial expressions and physiological state (flushing, voice quality) and how she interpreted this. [MT] stated that she enjoys observing others and trying to "work out" what is going on in social situations.

23. [MT] maintained that she does not want to engage in therapy. She said that it is not hard to talk about her feelings, rather:

> I just don't want to. I will talk when I want to… I will do my time and get out.

[75] Ms McFadden describes MT's behaviour around the time of the hearing on 4 December 2019:

28. [MT] engaged in some self-harm (cutting) in the lead up to the hearing and reported increased anxiety. The night before the hearing she was given a low dose of lorazepam to reduce her anxiety. Nursing staff reported that this had little noticeable effect. A further dose was given in the morning before the hearing. A decision was made by clinical staff to administer a second dose.

29. In the cell prior to going into the court room [MT] could be seen doing push-ups and tricep dips. She was observed pulling the finger at the camera in the corner of the cell. She appeared activated and alert. No signs of fatigue or sedation were apparent.

30. When making her way to and from the courtroom [MT] appeared sedated, was bumping into walls and verbalising she felt drugged up.

31. When [MT] was returned to her cell, she resumed pulling the finger, began punching and scratching at the walls, threw water at the wall. When engaged in conversation by nursing staff [MT] said she was fine. No slurring of words, or poor balance was observed.

32. Upon being transferred into the vehicle to be returned to Mason Clinic [MT] presented as unsteady on her feet, and appeared to be veering towards doorways. She would not communicate with staff. On route in the van she managed to slip her cuffs.

33. On return to Totara Unit [MT] was hostile and aggressive. She again appeared to veer towards doorways. She cycled through periods of being mute, swearing at staff and punching walls. She was placed in high care. Her engagement with staff was poor. She wrote "F*** you bitches" on a door with lipstick. She verbalised a desire to die, and made several suicidal gestures (wrapping sheets around her neck, superficial scratches to her arms). She reported hallucinations of an

elderly lady in her room, who she said was making derogatory comments. She was managed between high care and her room.

34. When seen the next day by Dr Duff, [MT] laid in the doorway to high care forcing people to step over her to enter the room. She was angry and oppositional to efforts from staff to communicate and settle her mood. [MT] made several requests for lorazepam. Clinical staff became concerned that she was drug seeking, and did not feel the medication was having a positive effect. The oral prescription was withdrawn. Over the course of 36 hours, it was observed that [MT's] behaviour was variable, dependent on who was present.

35. On 6th December 2019, [MT] continued to present as volatile and changeable in mood. She met with a cultural worker and denied there had been issues with aggression. She continued to intermittently hit and punch out at walls. It was suspected that her hand was fractured. When informed that she would be treated in the Totara Unit, [MT] expressed that she had wanted to go to hospital. Clinical staff considered [MT] to be at high risk of absconding.

36. Over the course of 7 and 8 December 2019, [MT's] behaviour settled. When efforts were made to discuss her behaviour [MT] responded, "That was not me, I am not like that".

37. On 10 December 2019, a collection of newspaper articles from recent cases depicting the murders of young women were found in [MT's] room. She told staff she was reading them. When the appropriateness of this was discussed with her [MT] appeared confused. Following a conversation with her care manager the next day the articles were removed.

[76] Ms McFadden then discusses MT's behaviour at this time with Dr Duff, the consultant psychiatrist who had the lead care role for MT:

41. Dr Duff described [MT's] presentation in the 36-48-hour period following her last court appearance as distinct and unusual, when compared to a population of inpatients with mental health and disability related needs. She observed that although [MT] was in a rage, she exhibited an ability to exert control, "choosing not to unleash the full extent of her rage". Dr Duff identified that within the ward setting the use of lorazepam appeared to have a paradoxical effect, in the sense that it did not provide sedation, rather it appeared to slightly reduce her capacity to control the rage state. This observation in combination with indicators that [MT] may have been drug seeking underpinned the decision to remove the medication as an 'as required medication'. Dr Duff also referred to one instance where [MT] mistakenly perceived that she had been given lorazepam (it was her normal morning medications) and then began to complain that she felt wobbly on her feet.

42. Dr Duff described [MT's] engagement with staff members (clinical and supportive) as superficial. She has observed that [MT] continues to present in differing ways to certain people. These "set"

presentations show stability over time. Apart from the period following the last hearing, has [MT] consistently presented as cheerful to Dr Duff and Ms Nu'u. However, her presentations to staff within the Totara Unit are more variable.

43. Dr Duff reported that much of the information gleaned about [MT's] interest in substance abuse, violence and a gang related lifestyle, have come from other patients who have expressed concerns to nursing staff.

…

46. Dr Duff noted that [MT's] comments to peers on the unit, indicate that her previous lifestyle of living on the streets continues to hold appeal. Her actions in the period following the last court hearing, were assessed as being indicative of a heightened risk of absconding.

…

48. Dr Duff stated that there was shared sense amongst the clinical team that they are yet to see the "real [MT]", with her comments and behaviour clearly signalling that she is "holding it together for court". The clinical team have noticed that violence generates interest and excitement in [MT] (e.g., idealisation of gang lifestyle and associated violence, causing pain while braiding, collecting articles about recent murders); and there is a continued lack of clarity about the presence of sadistic thought patterns/interest.

[77] Ms McFadden, having reviewed Dr McGinn's supplementary report, states:

54. I maintain my assessment of [MT] exhibiting a street wise attitude and a capacity to survive and meet her primary needs on the streets. I note that this view is shared by other clinical staff, who have now observed [MT's] behaviour over an extended period of time. Her behaviours and peer interactions on the unit have consistently demonstrated that she has a capacity to observe and effectively read others' behaviours and intentions. File notes, staff reports indicate that [MT] is able to avoid situations of potential risk on the unit. She has also expressed frustration when she perceives more vulnerable female peers are at risk. It would appear that substance abuse, and the nature of her peer associations and competing needs (access to drugs, food, shelter, social acceptance), in combination with the neurodevelopmental consequences of foetal alcohol spectrum disorder, were factors which contributed to her previous patterns of behaviour.

…

57. I maintain the view that [MT] may have the capacity to increase her level of cognitive and adaptive functioning. In my experience young people can manifest changes in their performance on measures of cognitive ability over time.

58. This opinion is based on:

58.1. Longitudinal observation by the multidisciplinary team within Totara Unit, and forensic intellectual disability specialists about the atypical nature of [MT's] presentation within the unit.

58.2 [MT] is a young person who has experienced significant instability and deprivation across her lifespan, which included long periods where she did not engage in formal education.

58.3 Data which indicates that [MT] is able to understand and retain information, and then generalise to this to other social interactions. This is not consistent with someone who is simply mimicking others.

58.4 [MT] is yet to reach developmental maturity.

58.5 [MT] will have access to a range of interventions which are anticipated to improve her functional academic, social and communication skills.

58.6 The data gathered within this updated assessment has further illustrated the impact that [MT's] detrimental life experiences (attachment disruptions, complex trauma exposure) likely have on her current level of functioning. The marked variability in [MT's] presentation, is in my professional opinion, indicative of a poorly developed and unstable sense of self. During the period surrounding the last hearing [MT] presentation appeared to cycle through differing self-states, and the risk of harm to self and others was clearly elevated. There are indicators of significant personality disturbances. In addition, there are indicators of dissociative states at times of heightened stress. These are factors that cannot be neatly or comprehensively accounted for by the diagnosis of FASD. These are also factors that could impact upon her performance on cognitive tests.

[78] In her summary, Ms McFadden concludes the following:

62. Bar the period surrounding the previous hearing, [MT's] behaviour has been reasonably settled and contained within Totara Unit. By her own account she is managing/suppressing her emotions and behaviour in the hope that this will lead to a more favourable outcome. There was a marked change in her behaviour on the day of the previous hearing and in the 36-48 hours that followed. There is a view that [MT] exhibited the capacity to exert self-control, even when in a rage state. There is data to support that some of her actions may have been goal directed, and variable dependent on who was present; and there was a lack of congruence between periods when she appeared sedated and then highly activated in mood and behaviour.

63. [MT] demonstrates a significant capacity for suppression of her emotions and behaviours. She is largely mistrustful of professional support, preferring to confide in peers. The data gathered within the

> current assessment also points to the importance of considering dissociative states, as part of the clinical formulation.
>
> …
>
> 65. It remains my opinion [MT] has a complex and multifaceted presentation. I am of the view that the diagnosis of foetal alcohol spectrum disorder does not wholly account for the complexity of [MT's] presentation, her involvement in the offending, or the dynamics of the offending behaviour. [MT] will require careful and intensive monitoring in order to better understand her risk/need profile and her responsivity to intervention.
>
> 66. It is important that those tasked with the formulation and delivery of the care and rehabilitation plan are able to work with models of complex trauma and personality development; alongside the foetal alcohol spectrum informed models identified by Dr McGinn. [MT] will need therapies that target her emotional regulation and the emerging personality issues, in addition to interventions that target the risk of future violence. [MT's] therapeutic needs in these domains will likely be long term.
>
> 67. Considering all of the new data to hand, there is no change in my opinion on disposition.

Dr McGinn's reports

[79] Dr McGinn first assessed MT on the instructions of MT's counsel for the purpose of providing an opinion on whether MT was fit to stand trial. Dr McGinn gave evidence to the Court of Appeal on this issue. Subsequently, MT's counsel instructed Dr McGinn to prepare a disposition report on MT's behalf. The report is dated 27 November 2019.

[80] Dr McGinn visited MT on 25 October 2019. She also interviewed the staff member involved in MT's day-to-day care at the Mason Clinic. Dr McGinn held a family meeting at MT's mother's home on 24 October 2019 and met further with a family member on 23 October 2019.

[81] Dr McGinn commences her analysis by giving the following opinion:

> In my opinion [MT] was involved in this tragedy due to a lack of suitable disability care and this is still required. She was a 16-year-old disabled girl developmentally at 8 to 9 years of age, without adequate care and entirely vulnerable in the community. Until 2015, [MT] was raised in a closely protected traditional Samoan extended family with Christian beliefs. It was only on moving to her mother's home in Auckland that she began running away and mixing with homeless, transient and antisocial adults. She was

> overly trusting due to her disability, calling and treating everyone as her mother, sister or cousin without being able to recognise the inherent dangers in indiscriminately trusting everyone. In my opinion, it would not be safe for [MT] to be living outside of supported disability services due to her vulnerability. She is very impressionable and copies others so she needs to be kept away from antisocial influences.
>
> [MT] has a family who love and care about her, including her Aunt [L] who would be in a position to offer her care in the future with the disability supports that she is entitled to, provided. Her mother, according to Aunt [L] has recently re-established contact with the family, has stopped drinking and has visited [MT]. [RT] has now been placed back in her mother's care by Oranga Tamariki. However, I would not consider it an option yet for [MT] to be living with her mother. It will take some time to re-establish contact and for her mother to show that she can maintain a substance free home and lifestyle before [MT] could be placed with her. In my opinion, [MT] should be cared for within disability residential care services and be gradually and safely transitioned back to the community. I respectfully advise against option three, immediate release.
>
> As I see it, the issue is the degree of containment required to meet [MT's] needs and whether she should receive care and rehabilitation in a secure or community-based setting. This determination is a matter for the Court to decide taking into account her circumstances and the level of risk. The spirit of the IDCCR Act is that the care and protection provided should be the least restrictive necessary to keep [MT] and the community safe.

[82] Dr McGinn explains:

> FASD is a lifelong severe and pervasive form of brain damage and in [MT's] case has resulted in an intellectual disability as well as a dysexecutive syndrome. Some parts of the brain may be spared and others damaged depending on the extent and pattern of drinking. [MT] obtained deficits in the 8 brain domains of cognition (IQ 64, 1st percentile, with 50th being average), adaptive function, academic achievement, language, motor function, attention, memory and executive dysfunction. She does not show known abnormalities in the brain structure or emotion regulation domains. [MT] does not show the extreme emotional dysregulation that some individuals with FASD suffer and she has no prior history of aggression or violence. With repetition [MT] can learn and retain a limited amount of information.

[83] Dr McGinn has assessed MT as being markedly suggestible on the Gudjonsson Suggestibility Scales. Dr McGinn concludes that MT is easily influenced and there will remain a risk that she will do things on the instruction of others without being able to think through to the consequences. She comments:

> [MT] excels in domestic chores and she is a helpful and friendly young person who respects authority and is well versed in her culture. However, it is her poor reasoning and low level of comprehension that is most severely impaired, significantly limiting her decision-making capacity. In my opinion, she will lack the capacity to make her own lifestyle and health decisions and manage

> her own financial affairs as an adult. She will require a Welfare Guardian appointed once she is living back in the community.

[84] Dr McGinn's discussion with a staff member at the Mason Clinic presents a picture of MT consistent with the opinions summarised above.

[85] Dr McGinn expands on her view of MT's personality:

> [MT] appeared settled and she told me that she was enjoying being able to draw and have books and pens in her room at Totara. These were not allowed at YJ residences because others would use them to tag. [MT] has never shown such antisocial interests. She has also enjoyed watching TV and playing games. [MT] was happy to be able to keep her shoes and clothes in her room. She added that 'everyone here is nice' adding that at Korowai Manaaki if you left anything in your room someone would steal it. I had noticed [MT] to adopt a mildly antisocial façade after moving from Te Au Rere to Korowai Manaaki. She had even sworn at the assessing Psychiatrist which I did not think was in her nature. At Totara I noticed her to be back to her usual self and the antisocial edge was totally gone. [MT] is very impressionable and she mimics what she sees around her so I was glad to see her away from antisocial youth and in a more prosocial setting. [MT] has also been able to attend some Church Services which are held at Mason Clinic. At te Au Rere the staff would have liked to take her to Church but due to the high-profile nature of her case they could not take her off site. They did not consider her a risk to be taken into the community at all.
>
> It is known that the prognosis for those with FASD and low IQ is better than those with high IQ. They generally have less resources to get themselves into trouble and are more accepting of help. They are however, more vulnerable to victimisation and highly reliant on others to keep them in a safe environment. This is critical in the teenage years when they are developmentally like young children in teenage bodies. This is all true for [MT]. She is immature, gullible, may act on impulse without realising consequences, lacks abstract reasoning and takes thing said to her literally. These factors need to be taken into account in her care with expectations being set at best at a 10-year-old level. However, she does not have the. history of offending, dishonesty, defiance, school exclusion, ease to anger or criminal thinking that would indicate that she is a risk to others.

[86] Dr McGinn administered the Youth Level of Service/Case Management Inventory 2.0 with an adult relative of MT. Dr McGinn also made an estimate with the relative's help "about how [MT] may have scored on this measure in the time leading up to the murder when she was not being well looked after". Dr McGinn said:

> Considering her personality and behavioural traits, [MT] has a low rather than inflated self-esteem and she has many times expressed regret at being involved in the death of [Ms Pairama]. Her insight is limited by her brain damage but she certainly does not minimise the seriousness of what happened. [MT] does not have tantrums nor is she physically or verbally aggressive. She does have

a short attention span and low frustration tolerance when compared with others of her same age, which are symptoms of her FASD. In discussions with [adult relative of MT] and staff [MT] does not have antisocial or pro-criminal attitudes nor does she defy authority. She likes to help others and has been doing so at Mason Clinic. She is completely accepting of any help or assistance offered to her. Overall, currently there are no indications that [MT] warrants or requires a custodial level of care and she was also rated as low risk for a community placement.

Evaluating [MT's] future risk by how she functions in a safe and structured custodial environment may not be entirely valid when considering how well she may function without this. I therefore also considered retrospectively the YLS/CMI 2.0 ratings that may have been applied at that time of the murder. Her result of 11 placed her in the low risk/need for a custodial sentence but moderate risk for a community placement. The differences were that in the care of her mother, she was receiving inadequate supervision, inappropriate discipline and inconsistent parenting. She was also truanting from school and had met delinquent peers and acquaintances on the streets. As a result, she was being given drugs and was being sexually exploited. At that time, these factors all raised her level of risk as would be expected if a disabled girl was in the community without adequate care and supervision. Other results remained the same and [MT] had not been aggressive, violent or involved in any law breaking until the day of the murder as far as is known.

[87] Dr McGinn opines:

Her FASD and ID are lifelong conditions that cannot be rectified but they can be well managed using FASD-informed care so that [MT] can live a safe and successful life with a circle of disability supports wrapped around her. Tragically, this was lacking when she was in Oranga Tamariki care and the events unfolded that lead (sic) to [Ms Pairama's] death.

[88] Dr McGinn's final opinion is:

In my opinion, [MT] does not pose a risk to herself or others that would warrant her being made a special care recipient. She is currently rated as low risk for a community placement, taking into account the results of the actuarial assessment and from the report of a range of family and her current and previous caregivers. There are aspects of her FASD that pose a potential risk to herself due to her vulnerability to exploitation and inability to judge the character of others. She remains entirely trusting and this risk will need to be mitigated by ensuring that she does not come into contact with antisocial influences or predators who could exploit her. She does extremely well in settings that are well structured and supervised with activities that play to her strengths and with compensation for her areas of impairment.

Having discounted the option of [MT] being immediately released, it is my opinion that she should be made a care recipient pursuant to s 25 (1)(b) of the Criminal Procedures (Mentally Impaired Persons Act) 2003. Given that she has already been contained in secure settings for 18 months a period of transition may be required as she leaves Mason Clinic and enters a RIDSAS community facility.

[89] Dr McGinn's second report is dated 18 February 2020. Dr McGinn says she was informed by Ms Pecotic that at the first disposition hearing held on 4 December 2019 MT appeared heavily sedated. Her sedation indicated to Dr McGinn that there may have been a deterioration in MT's mental health since Dr McGinn had last seen her on 25 October 2019. Dr McGinn felt she should provide an updated opinion.

[90] For this purpose Dr McGinn spoke to an aunt of MT by telephone on 17 February 2020 and on the same day met with MT in the Totara Unit at the Mason Clinic. Dr McGinn spoke with Dr Duff by telephone, also on 17 February 2020. Dr McGinn also had reference to an earlier email from Dr Duff sent on 10 December 2019 which Dr McGinn said she found very helpful.

[91] Dr McGinn sets out the description given by Dr Duff of MT's actions around the hearing held on 4 December 2019. It is consistent with the description given by Ms McFadden and I will not repeat it. However, Dr McGinn also says:

> 5. Dr Duff reported that during the course of this anger outburst, [MT] had said "this is the real me" and indicated that she had just been pretending to be nice for the previous three months. Prior to this outburst, Dr Duff reported that staff had seen no anger, swearing or abuse of staff members. There had been occasional noncompliance and a need to remind her not to talk about drugs or other antisocial themes on a couple of occasions but [MT] was able to quickly correct herself. She had once tagged and had put her preferred rap music onto the public system without permission, denying both. The others at Totara are generally much older, so it was obviously her choice of music. If annoyed, she would withdraw to her room and listen to music. She could be intrusive and attention seeking but in general she was not attracted to trouble situations involving other patients. She would normally help out where she could. It took a few days for [MT] to calm down and she then returned to her normal state which Dr Duff described as 'largely sunshine and light'. Once able to talk about it, [MT] said that she was angry because she thought that the 04/12/19 would be the end of her Court and she might be able to go home, or back to Youth Justice. She said that this had not been her 'real me' and that she was now back to her usual self. Dr Duff reported that [MT] said that she would prefer to go to prison or anywhere else rather than remain at Totara.

[92] Dr McGinn, during her interview with MT, was reinforced in her view that MT does not pose a risk so long as she is well supported:

> 13. [MT's] reasons for making a change in her life continued to centre around the effects on herself ('it got me here') rather than making any

> mention of the victim. When I asked about the effects on [Ms Pairama], [MT] reported that she misses her and thinks that she is still alive, sometimes forgetting that she is gone. When asked if she regretted anything, she said "I regret not getting help ... now I would get help ... realise that someone's life's being taken". My impression was still that her understanding of her role in the murder is limited and she sees the tragedy mainly from how it has affected her own life, rather than the· victim and her whanau. This is consistent with her brain damage and a reasoning approach is known to not change these sorts of underlying brain damage limitations. This cannot be viewed as callous or willful (sic) as it is common to most individuals with FASD. I continue to advise that the risks of [MT] behaving dangerously in the future will be best reduced or removed by ensuring she is well supported for her disability. Although she has had a severe emotional outburst on the day of her last Court appearance, I continue to have the opinion that she is not within the group of individuals with FASD who suffer severe emotional dysregulation and aggression. She has no prior history of violence or even of offending with her greatest risk being for being victimised and exploited.
>
> 14. When asked about what she could do in the future to make sure something like this doesn't happen again in the future, [MT's] response was also limited. She insisted that she had 'learned her lesson'. When I asked what that lesson was, she said "not running away or doing drugs or going out ... that's stupid". She was now aware that going home soon was not an option. She said "I want to go home but I need to learn before ready to go home". Her only ideas about staying out of trouble in the future was to 'stay home and never go out'. She said "I will look after my family ... not anymore … I've learned my lesson". When asked what she had learnt, she responded again in an egocentric manner 'not to be locked up'. She did not think she needed any help from others, including professionals to be able to live a more successful life in the future. This corresponds with her reported general reluctance to talk about her feelings to those trying to help her. There will be a limit to [MT's] capacity to engage and make use of reasoning based therapeutic interventions, unless they are very simple and disability based as I believe the upcoming women's group will be.

[93] Dr McGinn commented on Ms McFadden's report dated 26 November 2019. Any negative features of Ms McFadden's report relating to MT's behaviour are explained by Dr McGinn by reference to MT's FASD. Dr McGinn is also influenced by her own discussions with MT:

> 17. Ms McFadden reported that [MT] discussed gang related talk, idolising violence and drug talk during her sessions with her. I have never elicited this from her and neither had Dr Duff. She commented that it may depend on the relationship you have with her. Nevertheless, this antisocial talking has been reported by other patients who were sufficiently concerned to report it to staff. There is no denying that the year or so [MT] spent living away from safe care has had a negative effect on her. Being victimised on the streets and

likely becoming increasingly addicted to drugs might still be 'idolised' by [MT]. She clearly does not realise the intentions of others or the risks of mixing with antisocial men on the streets. Although she has not expressed to me any pro-criminal attitudes, she will be likely to mimic what is going on around her. If others hold these antisocial attitudes, [MT] will be highly at risk of adopting them. Likewise, when with a Church group she will be strongly influenced by these positive attitudes, which she is currently expressing more interest in.

18. [MT] was described by Ms McFadden as 'streetwise' with 'an ability to survive on the streets'. As a disabled girl, it is my opinion that she was only victimised and prostituted by others which I cannot agree is streetwise, surviving or adaptive in any way. [MT] is entirely trusting due to her FASD reasoning impairments. She may talk as if she was a willing participant in the things that happened when she was not being cared for and was living on the streets. However, this can only be perceived as abuse and sexual exploitation of a disabled underage girl, in my opinion. She has executive brain dysfunction so is trusting and has poor capacity to realise the intentions of others. Ms McFadden reported an earlier psychological assessment by Ms Cornelius in July 2018 which recorded her opinion that '[MT] was trying to meet her emotional needs within her intimate relationships with males'. However, this was prior to the FASD and intellectual disability diagnoses when [MT's] inappropriate behaviours were considered deliberate. This has turned out not to be the case.

19. Ms McFadden has provided the opinion that [MT] presents herself differently to different professionals and this is true. If [MT] is talked with kindly and at her developmental level rather than her chronological age then she can manage. This is how I treat her, in an FASD informed way. However, if she is pressured, confused and challenged then she will become stressed, irritable and may respond inappropriately. In this respect, [MT] is exactly like all others with FASD. She has brain damage everyday of her life so her varying moods cannot be seen as willful when a disability-informed paradigm is adopted. Individuals with FASD are manipulative to get their own way and these skills can sometimes be misinterpreted as evidence that they don't really have a disability. However, it is known that individuals with FASD, even with high IQ are severely disabled and cannot make use of their skills to be productive in their everyday lives, unless they are provided with structure and disability support. [MT] is living in an entirely structured environment with a high level of support and she is doing well with this. However, this does not mean that she would do well without this care and she will require Disability Support Services in an ongoing way throughout her life.

[94] Dr McGinn gives an updated risk assessment using the same instrument used previously but taking into account the further period MT has been in custody:

26. Using an actuarial assessment [MT's]?s level of risk has increased since I saw her previously soon after arriving at Mason Clinic. She has become frustrated with the Court process and is now being managed in an adult facility without schooling everyday as was her

> routine at the Youth Justice Residence. Nevertheless, Mason Clinic are providing her with a full range of activities to increase her life skills and once she is able to venture out into the community more will be available to her. I continue to be of the opinion that [MT's] risk can be well managed as a Care Recipient pursuant to s25(1)(b) and Mason Clinic have indicated a willingness to manage this. There is no doubt that they have the requisite skills. Ms McFadden also considered this option viable and noted that it represented the least restrictive option, it could support a higher level of community integration and would provide opportunities for FASD specific interventions to be delivered. Although [MT] has been established as having been involved in a situation of the most serious offending, I doubt that she would have been had she been receiving adequate care and protection suitable to her special needs. The highest priority should be on ensuring that her disability needs are met to keep her and others safe. In my opinion, this would be better achieved with a care recipient status.

[95] Finally, Dr McGinn highlights changes in the Oranga Tamariki Act 1989, which stipulate that the United Nations Conventions of the Rights of the Child and of Persons with Disabilities must be respected and upheld. Dr McGinn went on to advise:

> 27. … Previously decisions of the higher Courts stated that they should be used 'as a guide'. Two recent sentencing decisions of the Youth Court for young people with FASD; *P v KM* (CRI-2018-204-000238 (2019) NZYC 436) and *P v MQ* (CRI-2018-204-000150 (2019) NZYC 456) state that "the wellbeing of a young person must always be a primary consideration and that when it comes to balancing a young person's wellbeing against the need for public safety and sanctions, the scales should tip in favour of wellbeing'. Judge Fitzgerald added that 'young people are to be treated in a manner that takes into account their age and the desirability of promoting their reintegration and assuming a constructive role in society'. In my opinion, what will be best for [MT's] welfare will also be best for society. A cautious, well supported and supervised reintegration to the community will be better in the long term than a prolonged period of containment. Care recipient status will allow Mason Clinic better opportunities to cater to [MT's] disability needs, in my opinion.

Submissions

The Crown

[96] The Crown supports Ms McFadden's opinion that MT should be a special care recipient. It does so because:

> 9.3 First, the offending [MT] was involved in was extremely serious: the unprovoked group kidnapping, torture and murder of a vulnerable 17 year old girl. Ms Pairama was beaten, tied down, stripped, shaved, burned on her genital and breast areas, covered in chemicals and baby

formula, and then hanged. As detailed above in this memorandum, the Crown submits [MT] was an important participant in this offending. The Crown submits it is offending which involves many of the risk factors identified by Ms McFadden.

9.4 Second, there is also substantial evidence that [MT] poses a heightened risk of harm to the community. The evidence of Ms McFadden strongly suggests [MT] poses both an immediate and long term risk to the community which requires detention as a special patient. In particular the Crown notes the following findings of Ms McFadden:

(a) [MT] has a large number of risk factors known to be predictive of general and violent reoffending. These include her antisocial lifestyle in the months preceding the alleged offending; her disengagement from social, recreational and educational activities normative to her developmental stage; her association with vulnerable and antisocial peers; her heavy use of substances; the absence of effective prosocial supports; her resistance to interventions aimed at addressing care and protection needs (lack of engagement, absconding from care and protection facilities); and her current lack of motivation to engage in therapy that addresses the risk of future violence or other reoffending.

(b) The neurodevelopmental consequences of [MT's] FASD are likely to contribute to her risk of violent reoffending.

9.5 Third, the Crown also considers this is a case where the need to comprehensively manage and treat [MT] (a matter in the interests of the public in the immediate term and the long term) supports an order under s 24(2)(b). As Dr McFadden has found:

(a) [MT] is currently resistant to therapeutic intervention, although there is a view she has the capability to benefit from psychotherapy and from other forms of rehabilitation; and

(b) she presents with multiple psychosocial factors which require careful monitoring.

9.6 Fourth, the greater level of oversight provided by detention as a special care recipient is necessary to manage the risk of [MT] absconding and potentially violently reoffending. This risk is such that any change of [MT's] status should require approval of the Minister of Health.

[97] In a supplementary submission dated 19 March 2020, the Crown addressed the subsequent reports by Ms McFadden and Dr McGinn. The submission is that both reports indicate that MT has a heightened risk of harm to the community. Insofar as there are differences between Ms McFadden and Dr McGinn in this regard, the Crown

submits that the reliance by Ms McFadden on observations by clinical staff gives weight to Ms McFadden's opinion.

The Defence

[98] Ms Pecotic for MT supports Dr McGinn's views.

[99] Ms Pecotic emphasises MT's young age and the effect on her of being a special care recipient which might well mean she would be 29 years old at the expiry of a special care order. Ms Pecotic submits this would not be the least restrictive option available.

[100] Ms Pecotic emphasises the flexibility of a care order and stresses that if MT were to present as requiring continued care then the Family Court is empowered to extend the period of any care order.

[101] Ms Pecotic makes the point that no rehabilitative measures have been employed with MT to date. In Ms Pecotic's submission, MT's young age, "her very good prospects of rehabilitation", the monitoring she would receive as a care recipient, the ability to extend the period in which she would be a care recipient, and the oversight by Oranga Tamariki as her guardian until she is 25 years old, justify MT being a care recipient rather than a special care recipient.

[102] Ms Pecotic filed a further memorandum regarding disposition on 22 May 2020 to address the further reports of Ms McFadden and Dr McGinn and the evidence I heard on 6 May 2020. Ms Pecotic continues to support the views of Dr McGinn.

Disposition

[103] I have set out at such length excerpts from the reports of Ms McFadden and Dr McGinn because they make clear the two sides of the balancing exercise I must undertake. On the one side, MT took an active part in the kidnapping, torturing and hanging of a young woman. She exhibits a number of risk factors which are predictive of general and violent offending. On the other side, MT was 16 years and 11 months old at the time, mildly intellectually impaired and with FASD. The first side raises

real fears for public safety if MT is not kept secure. The second side mandates that the level and period of secure care must not be beyond the least restrictive required in the interests of public safety.

[104] Ms McFadden and Dr McGinn took different approaches to assessing and describing MT. Ms McFadden (I simplify) took a real-life approach, starting with the nature of the offending with which MT was involved. Ms McFadden looked at MT's difficult upbringing, her street-wise later years and carried out formal risk assessments. Ms McFadden was also very interested in how MT presented in the period after her arrest. Ms McFadden had access to the health professionals caring for MT and to their clinical notes. Ms McFadden was particularly concerned by MT's behaviour around the court hearing on 4 December 2019.

[105] Dr McGinn took a therapeutic approach. Her concentration was on MT as a person with FASD. She contends that MT is in need of care and support and will be of little risk to others if she receives it.

[106] As a result of Dr McGinn's considerable focus on MT's FASD, I do not think that Dr McGinn properly considered MT's risk to the public in the light of the offending with which she was involved.

[107] Because MT has FASD she is vulnerable in a number of ways. Both report writers noted that she exhibits social vulnerability, poor awareness of risk, and poor insight, particularly into the impacts of violence both on herself and others. To Dr McGinn, that vulnerability made MT, in a broad sense, a victim in the offending, not an offender. She notes that "[MT] was involved in this tragedy due to a lack of suitable disability care". Dr McGinn diagnoses MT as very suggestible. In turn, that suggestibility means that MT was not in a safe situation on the streets, was easily led and did not make "good" decisions.

[108] I accept Dr McGinn's diagnosis that MT has FASD. Dr McGinn, based on her research and clinical experience, is very understanding of people with FASD. She fully attributes both the risk associated with MT and her behaviour on the night in question to her FASD diagnosis. This, Dr McGinn says, reduces MT's culpability

which, in turn, changes the nature of the care she should receive. As a result, Dr McGinn uncritically accepts MT's descriptions of herself and her motivations and dismisses any concerns reported by Ms McFadden about MT's observed behaviour.

[109] However, Dr McGinn does have the firm view that MT has a life-long need of care and that so long as she is kept away from trouble, she will not re-offend. During the hearing on 6 May 2020, there was the following exchange between us:

> Q. But isn't the problem for me that sometimes one can say – because my assessment is all about what is necessary in the public interest and if we were talking about somebody who had been picked up for shoplifting and you were saying to me, "Well she has no previous record of offending and so long as she is in this environment I don't see her shoplifting again," well that is easy. But we are talking about kidnapping, torture and murder and so – and as I understand your evidence it is so long as she is kept away from bad company she won't kidnap, torture and murder again. So if she falls into that company again what's the risk?
>
> A. Well I think that what's important for the future of her and society is that she gets looked after within disability services to suit her disability needs and that will keep her safe.

[110] I find it telling that Dr McGinn continued to focus on keeping MT safe. Although that is because Dr McGinn contends that the best way to protect society is by giving MT proper care, I consider that this downplays the real nature of the risk MT in fact presents. It is also not necessarily incongruent with mandating that she be a special care recipient.

[111] I find that when I assess the level of care necessary for MT in the public interest, I should concentrate on Ms McFadden's evidence.

[112] I accept Ms McFadden's opinion that MT's case is a complex one. There are discrepancies between her diagnosed limitations and her observed behaviour. I accept that MT is still developing in her maturity and competencies. MT might develop to the point where she no longer meets the criteria necessary for care under the IDCCR. I accept, and it is worrying, that MT might have underlying mental health conditions that have yet to be fully recognised. Together, the evidence suggests that her FASD

diagnosis does not wholly account for this complexity.[29] Addressing that alone will not mitigate the risk that she presents to the community if made a care recipient.

[113] I consider that MT's risk to the public is heightened by her ability to be deceptive. In her interviews with the police she knew the jeopardy she was in. She serially denied involvement, distanced herself from what happened, attributed to Ms Winter the use of the improvised blowtorch, cast Ms Winter as the sole perpetrator of what happened, and never admitted the presence and role of her "boyfriend", Mr Te Amo. She portrayed the hanging as suicide and herself as supportive of Ms Pairama.

[114] I consider MT's behaviour around the court hearing on 4 December 2019 to be particularly troubling from a risk assessment perspective. She broadly understood the nature of the proceedings, and of the conflicting evidence by the two report writers.[30] MT thought the hearing was a disposition hearing (as it would have been if Ms Pecotic had not made an unheralded application for adjournment). MT had asked Ms McFadden whether she got nervous "on that stage".[31] MT gave Ms McFadden a quite insightful critique of the performances of the experts who gave evidence before the Court of Appeal in relation to her fitness to plead. MT was anxious before the hearing and was given medication for the anxiety. However, when it came time for MT to come into Court she affected a drugged demeanour and portrayed herself in Court as so drugged as to be incapable of participating in the hearing. As soon as she left the courtroom she reverted to her actual state. But, having been taken unawares by the adjournment, she was enraged. The description of her behaviour, and what she said, is troubling.[32] It leaves open the real possibility that MT, wanting an outcome that would allow her to seek freedom on the streets, deliberately adopted a mode of behaviour at the Mason Clinic designed to obtain as less restrictive outcome as possible.

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29 Ms McFadden's report, 26 November 2019, at [65].
30 See, for example, Ms McFadden's report, 26 November 2019 at [9].
31 Ms McFadden's report, 10 March 2020 at [22].
32 At [31] – [35].

[115] I find, on the balance of probabilities, that MT engages with the mental health professionals assessing her (including Dr McGinn) in the manner she thinks best suits her interests.

[116] I make it clear that I do not attribute to MT any great sophistication. I accept MT is mildly intellectually impaired and that her FASD reflects brain damage that will not improve. But she is aware of her jeopardy, wants to get back "home" and shapes her behaviour to what she considers her best interests.

[117] Particularly troubling is the risk of MT violently reoffending. In *H v R*, the Court appeared to endorse the view held by Warren Brookbanks that "this differentiation of disposal is not based on any formal evaluation of the seriousness of the offence with which the defendant is charged or the measure of culpability the defendant might attract if tried, but simply on whether he or she meets some undefined standard of dangerousness".[33] However, I consider that the particularly callous and serious nature of MT's offending needs to factor into the assessment of risk. MT's offending was unusually cruel, involving kidnapping, torture and murder. Combined with Ms McFadden's risk assessment, in which she considered MT has a "large number of the risk factors known to be predictive of general and violent reoffending", I am satisfied MT's risk of reoffending is significant.

[118] So, I conclude to this point:

(a) MT actively participated in the kidnapping, torture and murder of Ms Pairama. MT did not participate as the helpless thrall of suggestibility. MT was the only one of the group with a grudge against Ms Pairama (that Ms Pairama had been "talking shit" behind her back). Indeed, with the exception of her sister, RT, MT was the only member of the group who knew Ms Pairama. By the time Ms Pairama reached the Buckland Road address, the decision had been made to harm her.

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[33] *H (CA841/2012) v R* [2013] NZCA 628 at [5], citing Warren Brookbanks *Competencies of Trial: Fitness to Plead in New Zealand* (LexisNexis, Wellington, 2011) at 318.

(b) Although Ms Winter was dominant in the violence that led to Ms Pairama's death, MT did not simply act under her direction. It was, for example, MT who fashioned and used the makeshift blowtorch.

(c) MT displayed no empathy for Ms Pairama and little remorse afterwards. She took a young person to see Ms Pairama's body afterwards.

(d) MT knew she had done wrong. Her explanations to the police establish that. Further, she actively concealed the involvement of her "boyfriend", Mr Te Amo.

(e) MT wants to be free of the restrictions she is under. To that end, it is more likely than not that she has acted at the Mason Clinic in the way she considers is most beneficial to her. Her rage after the 4 December 2019 hearing is telling.

(f) MT might have mental health problems going to a desire to hurt others which are consistent with her offending against Ms Pairama but which are not yet identified.

(g) MT has yet to reach developmental maturity. Acknowledging the limitations of her intellectual disability and FASD, she might come to no longer be subject to the IDCCR.

[119] Bearing all this in mind, I accept Ms McFadden's opinion that MT is at a high risk of reoffending. I agree with Ms McFadden that the best response to MT's needs, and the needs of the public, is for MT to be a special care recipient. In my view, that is necessary in the public interest.

[120] In reaching this view, I have considered how the alternative of MT being a care recipient might address both the public interest and MT's rehabilitative needs. I have read two care and rehabilitation plans from Mr Ram, a compulsory care co-ordinator.

Mr Ram gave evidence before me. I have also had a most helpful joint memorandum dated 25 May 2020 regarding the statutory disposition framework.

[121] I conclude that given MT's level of involvement in the death of Ms Pairama, her deceptive behaviour subsequently, and her evident desire to be free of restrictions, the higher level of secure care is necessary. Further, to monitor, understand and properly address MT's complex presentation and challenges, long-term intensive monitoring and care are required. That goes beyond what can be provided if MT is a care patient. A greater level of oversight and support is needed. Put simply, I find that even with the ability of MT's carers to apply periodically to the Family Court to keep her in secure care, the risk that MT might abscond and not receive the treatment she requires is too high.

[122] There is also the risk that if MT develops to the point she is no longer subject to the IDCCR then she could be back where she was on the night of 6 July 2018 when she encountered Ms Pairama and the others of the group.

[123] I have taken into account that an order that MT be a special care recipient does not mean that MT must spend 10 years at that status or that her life will be unduly constrained. Special care is not a punishment. It is the most secure care option available for a person in MT's position. MT will be cared for, her interests advanced and she will be assessed every six months. If the health professionals form the view that MT should no longer be a special care recipient then they will apply to change her status.

[124] Finally, the Court of Appeal in deciding MT was unfit to stand trial was careful to confine that decision to the trial situation she was facing. This was a situation the Court of Appeal felt was complex. The Court did not rule out MT being fit to stand trial in a less complex situation. For example, the Court contrasts this type of trial with a relatively straightforward trial, involving a single defendant and, possibly, a less serious charge.[34] With the trial of MT's co-offenders concluded, it might be that with further developmental maturity MT will be found fit to stand trial to determine

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[34] *M (CA424/2019) v R* [2019] NZCA 461 at [57].

her actual role in the murder of Ms Pairama. As a special care recipient that possibility remains open. As a care recipient it would not. I think it is in the interests of justice for the option to remain open.

Decision

[125] I order that MT be detained as a special care recipient.

Name suppression

[126] MT applies for permanent name suppression. Ms Pecotic submits that publication would be likely to cause extreme hardship to MT, and lead to the identification of her sister, RT. RT's name has already been suppressed.

[127] The Crown accepts there would be extreme hardship if MT's name were published, and submits that it will abide by the Court's decision on the application.

[128] The relevant subsections of s 200 of the Criminal Procedure Act 2011 state:

> **200 Court may suppress identity of defendant**
>
> (1) A court may make an order forbidding publication of the name, address, or occupation of a person who is charged with, or convicted or acquitted of, an offence.
>
> (2) The court may make an order under subsection (1) only if the court is satisfied that publication would be likely to—
>
> (a) cause extreme hardship to the person charged with, or convicted of, or acquitted of the offence, or any person connected with that person; or
>
> …
>
> (f) lead to the identification of another person whose name is suppressed by order or by law; or

[129] Name suppression involves a two-stage inquiry. First, I must determine whether MT has satisfied any of the grounds in s 200(2). This is a jurisdictional pre-requisite. Next, I am required to consider whether, after weighing competing private and public interests, I am satisfied that MT's name should be suppressed. MT's personal circumstances are relevant to this discretionary assessment. They are to be

balanced against other factors such as the seriousness of the offending, the views of the victims and the public interest in an open and transparent criminal justice process.

[130] "Extreme" hardship requires a very high level of hardship connoting severe suffering or privation.[35] It requires a comparison between the hardship identified by MT and the normal consequences associated with publication.

[131] MT is a young person with psychological conditions and particular vulnerabilities. She is going to be in secure care for some years. I accept that if her name is published her life within secure care will be very difficult because of the notoriety of her case. Her prospects of rehabilitation will be compromised. I accept that this constitutes extreme hardship.

[132] I bear in mind that MT has not been convicted of any offence. She has been involved in offending which has attracted significant news media attention, but her impairment means she has not been found fit to stand trial. This factor reduces the legitimate public interest in knowing her name.

[133] Further, I am satisfied, given the extensive media coverage of the case, that if MT's name is published there is a high risk that her sister's (RT) suppression order would be compromised. There was a lot of reported evidence linking MT and RT as sisters.

[134] I am satisfied that MT's name should be suppressed. With one stipulation, I make an order for permanent name suppression accordingly.

[135] The stipulation is that if MT should subsequently be found fit to stand trial in relation to this case then the suppression order would not apply to such future proceeding.

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Brewer J

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[35] *DP (CA418/2015) v R* [2015] NZCA 467, [2016] 2 NZLR 306 at [6].