Michael Diamond
MB ChB, FRANZCP

ASSOCIATED CONSULTANTS

MICHAEL DIAMOND MB ChB, FRANZCP
PAUL FRIEND FRANZCP
ELIZABETH O'BRIEN MB BS, DPM, FRANZCP
JULIAN SHORT MB BS, FRANZCP
PETER ANDERSON BA, MB BS (Hons), FRANZCP
RALF ILCHEF MB BS, FRANZCP
ANTHONY SAMS BMed, FRANZCP, FAChAM
MURRAY WRIGHT MB.BS, FRANZCP
JENNY JORDAN MB, MICGP, FRANZCP
PETER YOUNG MB BS, FRANZCP
MELISSA BARRETT MB BS, FRANZCP
AMANDA BRAY MB BS, FRANZCP
HELEN PROSKURIN BA, MB BS, FRANZCP
MARY-ANNE FRIEND MB BS (Hons 1), FRANZCP

1 BERRY ROAD
ST LEONARDS NSW 2065
AUSTRALIA
Telephone: (02) 9906 2333
Facsimile: (02) 9438 5497

CONFIDENTIAL
ML

16 April 2019

Your reference: SG:89829

Mr Stuart Gray
Partner
Cardillo Gray Partners
PO Box 409
NEWCASTLE NSW 2300

Dear Mr Gray

Re: Kathleen Megan Folbigg Date of Birth: 14 June 1967

Thank you for your referral correspondence of 25 March 2019. I am aware that you act on behalf of Ms Folbigg in relation to the Inquiry into her convictions. I examined your client on two occasions, namely 25 and 27 March 2019.

MY EXPERTISE

I am a registered medical practitioner in Australia and am a Specialist Psychiatrist and Fellow of the Royal Australian & New Zealand College of Psychiatrists. I practise clinically. I treat patients with a wide variety of psychiatric disorders. I have post Specialist training in psychodynamic psychotherapy that is particularly germane to the assessment of human behaviour motivations, understanding and interpretation of personality features and the understanding of individual motivation, gratification and internal psychological processes that may influence overt behaviour.

I am an experienced forensic and medicolegal psychiatrist. My experience extends to the provision of assistance to investigators of serious crime. On occasions this

involves the assessment of crime scene material, offenders who may be of interest in serious crimes including murder, kidnappings, extortion and sexual crimes. I am experienced in providing psychiatric and psychological profiles of individuals who are involved in dangerous conduct.

I have provided human behaviour analysis and expertise in the Coroner's Court on many occasions. This experience is particularly relevant in that on those occasions one is seldom afforded an opportunity to examine the individual involved and has to form a view based almost entirely on documents and visual and auditory recordings.

I am familiar with the Code of Conduct for Expert Witnesses. This report is prepared in accordance with the Code. I agree to abide by the Code. I attach a copy of my curriculum vitae.

DOCUMENTATION

In addition to your Letter of Instruction of 25 March 2019, I was provided with a large bundle of documents comprising the following:

1. "Other Documents Index" (4 pages).
2. "Other Documents Material" (1324 pages) comprising the following documents:
   2.1-Statements of Kathleen Folbigg (x 2), undated.
   2.2-Crown Chronology of Deaths / ALTE.
   2.3-Psychological report of Rozalinda Garbutt dated 4/2/00.
   2.4-Letter from ODPP to Dr Yvonne Skinner re seeking opinion and enclosing briefing material dated 6/12/02.
   2.5-Medical report by Dr Yvonne Skinner dated 22/1/03.
   2.6-Letter from Legal Aid to ODPP re Statistical Expert Material dated 26/3/03.
   2.7-Report of Dr Bruce Westmore dated 16/6/03.
   2.8-Report of Dr Michael Giuffrida dated 27/8/03.
   2.9-Dr Bruce Westmore Examination in Chief pages 6-25 and Cross Examination pages 25-30 and Re-examination pages 30-32 dated 29 August 2003.
   2.10-Documents (10- 58) of various dates comprising handwritten letters, diary entries and other personal communications of Kathleen Folbigg from various dates from February 1989 until July 1999.
3. Kathleen Folbigg's Diaries dated 4 June 1996, 6 June 1997, transcribed.
[redacted]
5. Kathleen Folbigg DHS – Individual prescribing history dated from 01/01/1991 to 13/11/2018 inclusive.
6. Affidavit of Megan Donegan dated 18 February 2019.
7. Affidavit of Colin Donegan dated 11 March 2019.
8. Affidavit of Karren Hall dated 28 February 2019.
9. Bundle of Scientific Literature.
10. Documents relating to a number of people who witnessed Kathleen Folbigg after the deaths of her children:
    10.1-Melissa Anne Smith – neighbour.
    10.2-Carol Ann Newitt – sister of Craig Folbigg.
    10.2-Jan Bull – gym instructor.
    10.3-Debbie Goodchild – friend of Kathleen Folbigg from the gym.

10.4-Judith Patterson – friend of Kathleen Folbigg from the gym.
11. Extracts of evidence from the trial from the following people:
    11.1-David Hopkins – Ambulance Officer.
    11.2-Deborah McDermid – Ambulance Officer.
    11.3-Stephen Saunders – Police Officer.
    11.4-Brian Wadsworth – Ambulance Officer.
    11.5-Kathleen Coyle – Ambulance Officer.
12. Clinical File of Singleton Heights Medical Practice.
13. Justice Health Medical Records.

You provided the documentation relevant to the Expert Witness Code of Conduct. I am familiar with the Code of Conduct for Expert Witnesses. This report is prepared in accordance with the Code. I agree to abide by the Code. I attach a copy of my curriculum vitae.

INTRODUCTORY COMMENTS REGARDING THE SCOPE OF THIS REPORT IN KEEPING WITH THE REFERRAL CORRESPONDENCE

The scope of this report is limited to those issues raised in your referral correspondence. Whilst this is an unusual assessment insofar as it deals with an individual convicted on 21 May 2003 of the following offences:

1. Manslaughter of Caleb Folbigg on 20 February 1989;
2. Maliciously inflicting grievous bodily harm upon Patrick Folbigg on 18 October 1990, with intent to do grievous bodily harm;
3. The murder of Patrick Folbigg on 13 February 1991;
4. The murder of Sarah Folbigg on 30 August 1993; and
5. The murder of Laura Folbigg on 1 March 1999;

these convictions are in the process of being assessed at the Inquiry pursuant to Section 77(1)(a) of the Crimes (Appeal and Review) Act 2001.

I understand that it is not my role to form a view, one way or the other, as to the guilt of Ms Folbigg.

My assessment and expert opinion is limited to the psychiatric condition and psychological vulnerabilities of Ms Folbigg generally. I have assessed her, as far as is possible, to form a view of her psychiatric state over the years and in particular, pertaining to her functioning in relation to the offences.

In this assessment I am reliant on whatever information can be obtained about the early life experiences and those circumstances that play a part in the developmental history of Ms Folbigg. As will be apparent, Ms Folbigg has no detailed direct knowledge of her early life experiences. The material in this regard is obtained from the files of the Department of Community Services (DOCS) that were reviewed in detail by psychiatrists who saw Ms Folbigg at the time of her trial in 2003 (Drs Westmore and Skinner). The DOCS material was intensively examined and commented upon by Dr Giuffrida who provided an extensive report after the convictions but before Ms Folbigg was sentenced.

The opportunity to carry out a psychiatric assessment of Ms Folbigg on the occasions I was able to see her was limited by the time available and could not include detailed discussion or evaluation of the material contained within her writings and diaries.

I am of course aware that this material has been commented upon by others in great detail and played an important part in the trial leading to her conviction. The evaluation of diary material and the writings of Ms Folbigg is addressed later in this report insofar as understanding her long term psychiatric condition and the psychological features associated with it. The contextualisation of this material is an important part of assessment as is discussed later in this report.

For the rest, my assessment of Ms Folbigg was carried out as a traditional forensic psychiatric assessment eliciting information about psychosocial and developmental history, relevant family history, identification of special issues that may have influenced personality development and assessment of family history of psychiatric conditions, previous psychiatric illnesses and excluding a history of substance use. The assessment included a detailed interview of the relevant history as far as was possible to elicit and a careful evaluation of mental state.

With regard to assessment of psychiatric features that may be associated with the offences, these are assessed in the course of the forensic psychiatric examination.

In the course of the examination when it became apparent that there was good evidence to suspect the effects of early childhood trauma and abuse were relevant considerations, this was explored in greater detail in the course of this assessment.

The current mental state examination that includes observations of Ms Folbigg at present and in particular her responses to the evocative material that was addressed during the assessment, were carefully observed and are described in this report.

PSYCHIATRIC ASSESSMENT

Introduction

Kathleen Megan Folbigg was assessed at Silverwater Women's Correctional Centre initially on 25 March 2019 at an interview of about an hour and a quarter. The interview was continued on 27 March 2019 for a further four hours.

Ms Folbigg was born on 14 June 1967. She will turn fifty two this year. She has served sixteen years of incarceration after being sentenced in April 2003.

Ms Folbigg understood that I was seeing her at the request of her solicitors in relation to the current Inquiry. She understood that the assessment was in the context of providing a report to her solicitor. She gave her consent to be assessed and for me to provide the report.

Early Developmental and Family History

Ms Folbigg explained that she had no childhood memories before she was fostered on a long term basis by the Marlborough foster parents from the age of about three years. She referred to this couple throughout the assessment as her parents. Her knowledge of her early life is compiled from information provided by others.

There is considerable detail about her family of origin, her catastrophic early life experiences and disruption of attachments within a violent and abusive family of origin that includes the murder of her mother by her biological father.

This material is described later in the report derived from the information primarily from the Department of Community Services (DOCS) files and reiterated in various reports that I have reviewed.

Ms Folbigg's earliest recollections include being within the household of the Marlborough family where there were pets including dogs and cats. She remembers having her own bedroom and she remembers having toys. She said in that environment she felt safer but could not compare that with any previous memories. She said the feeling was that she was safer when she reached that family and it was more settling for her.

There were two older children, a foster brother, Russell who died recently from cancer at the age of about sixty nine or seventy and a foster sister, Lea who is now aged sixty seven. She referred to both as her brother and sister throughout the assessment. Ms Folbigg said she lost contact with her brother in her thirties before she was charged with any criminal offences. Recently she had re-established contact with him before he died.

Over the years she said she was extremely close to her older sister until her sister turned on her during the trial and gave damning evidence against her. She said her sister said that she was rough with her youngest daughter Laura when Laura was uncooperative. Her sister also gave evidence that Ms Folbigg was capable of looking someone in the eye and lying outright to them. She appreciated the extent this had of damaging her credibility.

In an attempt to test whether Ms Folbigg had any additional memory of her early life, I put to her some of the material that I was aware of from the DOCS file. She said she had no memory of early life experiences including problematic sexualised behaviours as a very young child or of having difficulty regarding her intellectual functioning. She did recall that she was domineering towards the other children who were introduced into the foster family household at the Marlboroughs from time to time. She would be difficult when they were around.

She said her foster brother and sister left the family home when she was young and she was essentially raised as an only child. They were much older than her, eighteen and sixteen years respectively. She said that when they visited, she was doted upon and was regarded as special. She was told that she had been "chosen". She said that she believed that she was formally adopted by the Marlboroughs but later found out that this was not the case.

In later years she became aware that she was fostered by relatives of her deceased mother and at some stage had spent time with one of those families. There were name changes over the years until she became Kathleen Marlborough and later when she married, and became Kathleen Folbigg. As far as she could remember, however, she was always known as Kathleen Marlborough in her early life.

She grew up in the family home in Kotara at Newcastle. She described the home as secure and familiar. In the suburb she had little do with children her age. The local neighbours seemed to be an older group of people. There was one girl who lived next door who was aged about ten that she recalls. The Marlborough family were not particularly religious. Her foster mother's mother was a Jehovah's Witness who lived with the family when she was older. Ms Folbigg has no recall of going to preschool.

Her recall is of a small primary school at Kotara. She remembers her first experience of being with a larger group of children. She remembers that she stuck to herself and was a loner. She was more comfortable being active and running around with the boys at the school rather than playing with dolls with the peer group of girls. She does not recall being invited to birthday parties. She was not allowed to sleep over at friends' houses.

She described her mother as controlling to an excessive degree. She was intent on teaching her domestic chores and having her perform these in the household. She said her mother was someone who wanted her to be seen so that she could be shown off as someone who had been well raised by her foster mother. The description subjectively of her childhood, was one of isolation, few friends and restricted social activities outside of the family.

She learnt to read competently and could easily get lost in a detached fantasy way by reading books. She said this made her mother happy because she was quiet. For her it allowed her to remain isolated and engaged in the content of the books. She read age-appropriate books as a child including The Golden Book series, Enid Blyton books and other children's literature.

Her mother allowed her to walk the dog in a park across the road. The park had a hidden area with a drain and a creek. Although her mother didn't like her to go there, she liked to be in that environment to experience the nature and wildlife in the creek. I specifically asked her whether there were any acts of cruelty towards any animals. She said this was not the case.

Her recall of primary schooling was that she "skirted through primary school". I asked her what this meant. She said she was a disengaged, disconnected child in the primary school environment. Sometimes she was reprimanded for not paying attention. She said she recalls she was not good at maths. She described herself as a distracted, disengaged, disconnected girl. She has some recall of one of the teachers taking her aside and trying to engage her in a one to one fashion. She said she recalled that she enjoyed that but it was not sustained.

As far as group activities at primary school were concerned, she said she joined in at sports carnivals but she was not particularly engaged. She was not involved in team

sports. She played tennis at high school. Her mother wanted her to do classical ballet but she was not drawn to that, but she did enjoy jazz ballet later on. Generally, she avoided attracting attention. Her academic results were average.

Attendance at Kotara Public Primary School in a coeducational environment was dealt with in the manner described above. She preferred being around the boys and viewed them simply as kids to run around with. There was nothing sexualised. There was no overt abuse or bullying.

She was physically punished by her mother and was hit with objects such as a feather duster handle, a wooden spoon and a belt. Her mother's physical punishment could result from any perceived misbehaviour. She said her mother was unpredictable and moody. Her mother was the major caregiver and homemaker and dominated the household.

In contrast she described her foster father as "a shadow in the background". He worked in a wholesale food business in an accounting and bookkeeping role. He was a good provider for the family. She said she remembered him as "a very closed book … he didn't give a lot away."

Ms Folbigg continued to describe her memories of her earlier life within a foster family as a young girl growing up in an isolated and detached state. She said she looked forward to growing up in terms of physical maturation. She was however not prepared for menarche. She received no education from her mother and she was shocked when she first menstruated. She said she thought she was dying. Her mother left it to her older sister to deal with educating her. She had no peer group or school friends that she could talk to in this regard. She described herself as "a lone wolf" person and someone who was not engaged with other people.

With regard to her psychosexual development she said she accepted the changes to her body and felt that she was growing up physically to match how she had developed intellectually. Subjectively she never thought that she was attractive or pretty but she was told by others that she was. Overall she said she was accepting and happy with herself as she developed.

Her relationship with her father during the years of puberty remained disengaged. She had little to do with him. He was the ultimate disciplinarian and she was somewhat intimidated by that. Her mother left it to her father to deal with what was considered to be the more serious misdemeanours in the household. She reiterated that her mother controlled everything. Her mother controlled the finances and apportioned resources to address what she perceived as the needs of others in the family.

She grew up to view males as being the providers and as the last resort of responsibility and resource for the family group when there was a need. She described her brother as a steady rock who was present if she needed him, but she was not close to him on a day to day basis.

Overall Ms Folbigg said that she took it upon herself to be self-sufficient. As she grew up, she did not respond to her mother's attempts to include her in her mother's

activities. She rejected her mother's attempts to show her things and preferred to explore things independently from a precocious age.

Ms Folbigg then volunteered that she had "a bad trust issue … had it all my life".

Continuing psychosocial and psychosexual development

Apart from her relationship with her father and brother, she then discussed the various males in her life as she grew up.

She had a two year relationship with her first boyfriend from the age of fifteen until seventeen when they were both at school. She described him as a non-demanding boy who was essentially a "science nerd". He didn't intrude into her life or try to control her. He had a good sense of humour and could make her laugh. The relationship progressed. They would sit together at lunch and recess.

With him she was able to join a peer group for the first time. It was a major developmental step for her to feel that she was within a group of people where she could experience some acceptance and some degree of trust. It was a revelation to her to feel accepted in a group. She felt pleased to fit in with a group of peers who were regarded as "the highly educated group". She said she felt something of "a ring-in", but she did feel that she was accepted. She felt more relaxed in that environment and retained three or four friendships with girls that have persisted from school.

The relationship with her boyfriend became intimate. She said she took control of it after he showed some interest. She took the initiative, attended the Family Planning Clinic for contraception advice and engaged in an intimate relationship successfully and naturally. Overall she said the experience was positive.

She had no other relationships but had some encounters with boys until she met Craig Folbigg whom she later married.

Ms Folbigg spoke about the context of the development of her relationship with Craig. She met him while her previous boyfriend was overseas visiting relatives. She was affected by his departure overseas because she was not told about it and felt abandoned and betrayed. She felt it justified her decision to end that relationship and to become involved with Craig.

When she met Craig, she was about eighteen years old. Family life had deteriorated. She was in conflict with her mother who was trying to control her social activities. Her peer group was going out on weekends. Her mother forbade this. She responded by rebelling and ended up living with a friend and her friend's single mother. She became defiant and rebellious. Her mother resented her independence. It was a conflicted time for her involving subjective feelings of rejection and insecurity.

At that stage Craig was six years older than her. He worked at BHP locally in what she believed was a clerical role. He was complimentary about her looks. She felt sexually awakened. He was charming and seductive.

The first interview ended at this point.

Continuation of the Assessment on 27 March 2019

Ms Folbigg was interviewed for a period of four hours. She commented that after the first interview she found herself thinking about what she could remember from her early life. She said she remembers always trying to please her foster mother. She feared being criticised or rejected.

Her relationship with her brother Russell was distant. Her relationship with her sister Lea was a closer relationship. She was mothered by her older sister. It was her older sister who taught her things when she was young. Her sister also protected her from her mother's severe attitudes and demands. She said her brother also did this and he would step up in a protective way.

She said her parents were always involved in fostering children. She does not recall having ex-foster children come back to the home.

Experiences as an Adolescent and Young Adult

Ms Folbigg attended Kotara High School, a government coeducational school, from Year 7 until she was six months short of completing her HSC in Year 12. I asked her why she had left school at that time. She said it was in the context of the breakdown of her relationship with her mother. She was rebellious at that stage and had stopped trying to please her mother. She was overtly challenging towards her mother and was determined to be socially active with her group of girlfriends. The conflict became difficult. Simple requests to go to the pictures with her friends resulted in a prolonged interrogation by her mother. Ms Folbigg then said that she was also older than the girls in her peer group. She explained that she had repeated Sixth Class at primary school in order to prepare her to function more competently at high school. It related to her detachment and isolation from other children at primary school. She said repeating the year was helpful. She felt she was better able to connect with others at high school.

By Year 12 she was keen to leave home. She was wise to her mother's outbursts of bad temper. She could see it building up and knew that it would end up with conflict or even a slap in the face. The final point of breakdown of their relationship resulting in her leaving home followed an incident where she stopped her mother's hand from hitting her. She warned her mother never to do that again. She then spoke about physical punishment by her mother. She said her mother always slapped her about the head. Her father would intervene and tell her mother to stop hitting her around the head. She learnt to hide from her mother and to avoid her wrath. Her father would also interrupt the fights in order to interrupt the mother's anger. Sometimes he acted as a moderator but not frequently enough.

She spoke about the development of her relationship with Craig Folbigg. He was five or more years older than her. She was going to discos with her friends. She was not much of a drinker and she stayed away from drugs and cigarette smoking. She found that she could enjoy "getting lost in the music". She enjoyed being anonymous in a crowd and doing what the others were doing. It provided a way for her to express herself more openly rather than feeling inhibited and anxious. She met Craig on the

dance floor. He was a good dancer. She said she went home with him the first night they met and they remained in a close relationship after that. She recalled that he had not long ended a relationship with a woman who was older than him. Apparently she left him for another man.

By this stage Ms Folbigg was living with her girlfriend from school (BJ) and the girl's mother at Cardiff at Newcastle. She had left home before she was eighteen. Her mother intimidated her, saying that she was still a Ward of the State and she was not legally permitted to leave home. Although intimidated, Ms Folbigg stood up to her mother and was able to continue living with her friend and her mother relented. She also spoke of feeling rejected by her boyfriend from school who failed to tell her that he was going overseas. She felt rejected and abandoned.

During the period when she was just eighteen and thereafter until she was nineteen, she explored aspects of independence. She went out a lot and said that she was "a bit out of control … a bit promiscuous but nothing radical." She said this persisted until she met Craig.

Relationship with Craig

Initially her parents, and especially her mother, approved of Craig. Craig was one of eight siblings in a large family. Apparently her mother liked that. Ms Folbigg said she was drawn towards Craig's large family. Craig's mother had died when he was about fifteen. Craig's father had repartnered. Ms Folbigg said that Craig was shattered by that development. She believed that it drove Craig to want her to connect with her mother, Deidre.

Her parents remained supportive of her relationship with Craig and her relationship with her parents did improve until there was a fallout with her parents about the size of the proposed wedding.

Craig was from a large family and it was expected that his family members, including his nieces and nephews, would be part of the wedding celebration. Ms Folbigg's parents opposed this. It was anathema to Craig and his family to exclude family members from the wedding. The conflict escalated to the point where none of Ms Folbigg's family were at the wedding. She resented her mother for ruining what began as an exciting and normal experience of planning a wedding. It reaffirmed the message from her mother that if she did not accept her mother's control, the disapproval would result in rejection. Ms Folbigg said she was deeply hurt. She responded by talking her father out of walking her down the aisle at the wedding. Apparently her mother did attend the wedding ceremony at the church but not the reception. Ms Folbigg understood that her reaction to the conflict was to take action and express her distress through her behaviour rather than reveal the extent of her feelings and hurt.

Ms Folbigg then spoke about her lifelong need to hide her feelings. She was fearful that if she showed her feelings, there would be dire consequences. She had experienced this with her mother when she challenged her mother and attempted to assert control of her life. It ended up in her being vilified and abandoned.

Ms Folbigg was married in 1988 when she was aged twenty and Craig was twenty five.

They set up home in a rented flat at Georgetown in Newcastle. Ms Folbigg worked as a waitress at an Indian restaurant. She had interviewed successfully for the job and she stayed on in that job for a number of years. Craig continued working in a clerical role for BHP.

Decision to have children

Ms Folbigg said it was something that she felt was expected of her. She wanted to have her "own family base". At the time she had no concerns about body image issues. She had no concept or awareness of role modelling or even awareness of the absence of a close maternal figure in her life.

The subjective state was one of perceived independence, autonomy and competence at a time when there was an absence of any general parental role modelling regarding broader issues such as education, relationships and having secure engaged adult figures in her life.

With regard to leaving school, there was no support from guidance teachers at school and particularly during Year 12. There was no discussion from her parents about the wisdom of leaving six months before the HSC. Her grades were average. There was no aspiration to progress academically and no advice or assistance regarding a vocational pathway.

Ms Folbigg confirmed that she was told by her foster parents at the age of about twelve or thirteen that she was fostered. At some stage she believed she was adopted by them but later was aware that this had not occurred. Throughout her early years she was aware of comments from the foster family such as "We chose you", and "We saved you".

Craig was from a large family. She saw it as an inevitable and natural process that they would have children. They stopped contraception. They achieved pregnancy without difficulty.

Contact with her Biological Family

Ms Folbigg then digressed to tell me that there were other developments occurring in parallel regarding her biological family. Her eldest half-sister who shared the same mother was an older woman called Gaye. At that stage she was about forty two and Ms Folbigg was twenty. Her half-sister made efforts to trace her. Since Ms Folbigg was an ex-Ward of the State, she had to give permission for contact to occur. She said there was a trust issue but she was pleased that her half-sister had made an effort to find her. She was resentful however that she had to make the effort to travel to see her half-sister at Gosford rather than have them come to her at Waratah. Her half-sister Gaye was married with sons and a daughter.

There was also a younger half-sister called Lynne who was fifteen years older than Ms Folbigg. She was living with Gaye at the time. In previous years she had grown up in an orphanage and was a Ward of the State in the New Zealand system because she was abandoned by her biological father and by their mother when she was an infant.

Gaye was the only one of the three half-siblings who had experienced any time with their mother. Their mother's relationship with Gaye's father broke up when Gaye was fifteen. Lynne had no experience of being with their mother. Their mother had left Lynne's father who was unable to care for Lynne and placed her in an orphanage.

Despite this chaotic family history, the two older half-sisters painted a rosy picture of their mother. They did however talk about alcoholism, gambling and a lack of reliability. She was described as a flighty woman.

Ms Folbigg's mother, also called Kathleen, was aged forty two when she was born. There were photographs when her mother was more settled and married but that relationship with Gaye's father broke up when he cheated on their mother.

Over time Ms Folbigg met her mother's sisters, her two aunts. There were also five brothers in that family. She met one of them. Ms Folbigg said she maintained contact with her biological mother's family over many years but they dropped contact with her when her "situation" became apparent. She clarified that she was referring to the murder charges. In the interim they were supportive of her when she lost the first three of her children.

Ms Folbigg said she wished she had more support with her children when they were babies. She then spoke of being abandoned by her biological family and referred to them as being the same family who had abandoned her in the past, and in effect she had been abandoned twice.

Her two half-sisters hated her biological father for what he did to their mother. She referred to her biological father murdering her mother by stabbing her many times. She obtained no details about the murder from her half-sisters.

At around that time she did obtain further information through Craig's insistence that they pursue more detail about her biological mother. They went to Sydney to view the police records about the murder of her mother. She recalls her reaction as wanting to see what her biological father looked like particularly because she felt that she did not resemble her mother much. She hoped that she would see what his face was like despite the knowledge that he had murdered her mother. When they viewed the records, the photograph of his face was removed from the records.

At the time she had some assistance from a social worker involved with the records. She was not allowed to copy or photograph the records. When she asked why her father had murdered her mother, she was told that it was a crime of passion. She was told that he was a violent man and that he was an associate and worked for a known major criminal, Lenny McPherson, and that he was a standover man in the criminal group.

She said she also met her father's younger brother. He spoke more positively about her father and described him as a generous, gregarious man, but also as someone who was "not so nice".

She felt she had little reality insofar as knowledge of her father was concerned. I asked her whether she had any feelings that she could recall about receiving this information as it unfolded at the time. She said her chest would tighten and she became upset beyond simply having a pain. She knew that she blocked out her feelings. She was aware that she could protect herself this way. She had done this since she was a child. There were things missing and she felt she could not do anything about that. She was able to cry but she did not do that.

The birth of Caleb

Her recall is of enjoying the feeling of being pregnant and awareness of "a life within that was me". She was protective of the pregnancy. She stopped Craig from smoking indoors. She improved her diet. She has clear recall of feeling the first flutter of the baby and also the experience of the first ultrasound where she could see the heartbeat and where it was confirmed that all was healthy and well. Craig was keen to attend the ultrasound appointment with her, but in the end there was a work issue that interfered with the arrangement. Antenatal care was via the hospital in Waratah. It was a healthy pregnancy.

She said she had a hope that she would have her child and in that way have the child become part of her roots. She didn't feel that any of her family members were giving her support. When her baby was born, she focused on him as her future.

The emotional experience of having Caleb was described. She spoke of the distress of experiencing a first labour. She had an epidural anaesthetic that interfered with her ability to experience the physical aspects of the birth. She was not able to hold Caleb for hours after the birth. Caleb was delivered by forceps delivery because of the problems associated with the epidural and her inability to be aware of the need to push during delivery. She said she felt "ripped off". However when she was able to hold Caleb eventually, she was in tears and she recalls experiencing the feeling "I made you". She described being very protective of Caleb. She would look at his face repeatedly and say to herself, "I did it". She said she felt complete. She had a husband in her life, a home and a gorgeous baby.

At that point in the interview, Ms Folbigg lost composure. She became quiet and silent. She pointed to a packet of tissues I had placed on the desk. There were few tears. She appeared to be detached and stunned. Her response was consistent with a dissociated state.

When she regained composure, she said that her friends Tracey and Megan who were friends from her school years were present in her life at that time. Mostly however, it was Craig's family who were around her at the time. When Caleb was born, she said her parents came in to see her and were proud of their grandchild. Her mother visited her home a few times. Ms Folbigg said that she felt things may be coming together in their relationship. Perhaps she had met her mother's expectations.

Caleb was born in early February 1989. He died nineteen days later. Ms Folbigg said that she went from euphoria to crashing down. She had only begun to experience the very early stages of mothering.

I asked her about her reaction to his death. She said that finding him was bad enough. The realisation was that she had lost her family, her security and her trust in life. The experience of euphoria was so brief and ended so quickly. She did not attempt breastfeeding. She said she believed that having inverted nipples meant that she could not breastfeed. There was no encouragement from anyone to pursue breastfeeding.

Ms Folbigg then talked spontaneously about the results of an autopsy that showed that there was nothing unusual found.

I asked her about subsequent events. She said Craig took over the arrangement of the funeral. At the time she felt that she disengaged. She said, "The walls came up immediately". She said she avoided people and wouldn't engage or listen to them. She was reluctant to walk outside. She was overwhelmed by attempts at grief counselling. She dismissed talk about the need for counselling and the theories about the stages of grief. She found that the people she encountered were intrusive although they were wanting to help. These people included Craig's family, a Priest who attended on one occasion and told her, "Your child was chosen by God as an angel". She felt more distressed. Her recall of the funeral is of having Craig's large family present. She cannot recall whether her parents were there. She believes the service was brief and there was a gathering afterwards, possibly at a relative's home or at her home. She said she was in a state of numbness, disbelief and detachment.

In subsequent months her response to the grief was to displace feelings onto an activity. She said this was her normal way of coping with emotional distress. She decided that she should do up the house they had bought at Mayfield. They had bought the house before they were married. She felt she wanted to change things and to focus on external distractions and activities. She had relatives who were close by but she wanted to avoid them. She went on aimless walks. They had two dogs and a cat. She focused on the animals. Later she returned to work at the restaurant. She said she did feel the pain of grief but she experienced it privately at times. At other times she was numb.

She was aware of neighbours who had children. One of the neighbours was pregnant. When the baby was born she did engage with the neighbour and the baby. She focused on calming and settling the baby. It did set her off thinking about her own loss, but she would shut this down as best she could.

Caleb's ashes were left at the crematorium and interred in the Remembrance Wall. She said she never went there and she avoided thinking about going there. She compared this with Craig who would go there frequently. She explained this to herself as needing to accept that "everyone is different".

She spoke about Craig's loss of his mother when he was fifteen, and his expectation according to the values of his Catholic upbringing was that women should be subservient and he expected this from her. She said she found the experience of the neighbour's children and the baby next door ultimately as helpful. She saw Craig being notably positive with the little baby boy of the neighbours. She felt that she should emulate that.

In time she and Craig explored information about Sudden Infant Death Syndrome (SIDS) at Waratah Hospital. They did engage with grief and genetics counselling at the hospital. They asked questions about what had happened to Caleb. They were told there was no reason to expect that it could happen again with subsequent children. Ms Folbigg said her focus remained on completing the renovation of their home.

The birth of Patrick

They discussed another pregnancy towards the end of 1991 and she soon became pregnant. Both Ms Folbigg and her husband were keen to have another baby. She described the pregnancy as being fine. She had more confidence and was more familiar with what to expect during the pregnancy.

She was more anxious about ensuring that any risks associated with SIDS would be lessened. She bought better bedding and made more careful preparation of the nursery. She tried to be more involved with Craig. At the same time, she had increasing trepidation and was fearful of being so fully involved with the pregnancy because of the fear of losing a baby. She said she evaluated everything. She attended a different obstetrician.

She remembers encouragement from everyone, saying "This will be fine" but she felt she had to protect herself. I asked her what she meant by this. She said that with Caleb, she had allowed "my walls to drop, with Patrick I kept my defences up". Ms Folbigg said she was less emotional about the pregnancy and birth and more focused on controlling the environmental issues. She then talked about the suburb of Mayfield and its proximity to the BHP plant at Newcastle. She threw herself into monitoring information about environmental risks to her baby.

She went into labour at term. She got through the labour without an epidural. She was less fearful and more relaxed about being in labour. Patrick was delivered uneventfully.

She had a short hospital stay and then had a period at home when she was alone in the house. Craig went back to work. When she was alone, she was fearful and tried to cope by focusing on establishing a routine. She said she had fears in the early hours of the morning because it reminded her of when she found Caleb deceased. She would go in and check Patrick. At that stage there were no monitors available to her. She generally recalls feeling less emotional at first but then engaged more when there was meaningful eye contact with Patrick. She said it was profound and deep for her to feel that sense of connection. She experienced new things that were encouraging for her. She smiled when she talked about her subjective positive feelings.

Ms Folbigg described a terrifying incident when Patrick was about four months old. By that stage he was in a bedroom away from the parental room because Craig snored loudly. She was prone to regular checking of the baby. Her anxiety settled a little by four months. She felt it would be safe. By that stage she was aware that she was bonded with Patrick. She felt that her positive dreams were now again coming to fruition.

She then said it was a shattering event. She checked on Patrick and found him in a limp state. She said she has no clear recall of what happened. She was told that she was seen on the floor rocking. She said she simply cannot recall those moments but from what people said she did, she was in a state of shock. An ambulance was called and Patrick was taken to hospital. He was given oxygen and he seemed to improve. She said she and Craig were encouraged at that stage, but later became aware that Patrick had suffered brain damage with visual impairment and seizures. Ms Folbigg said that she accepted that it was her duty to care for him.

Ms Folbigg said that Patrick died at the age of eight months. She said she had fought so hard to care for him. She developed a sleep problem following the death of Caleb. She would wake in the early hours of the morning and generally had patchy disturbed sleep. Patrick had seizures and because of this he was given anticonvulsant medication that meant that he could sleep for longer periods. This meant that Ms Folbigg could also sleep for longer periods.

She could not remember the funeral at all. Her sister Lea came from Melbourne to support her but she cannot recall much more. Patrick was cremated and his ashes were interred together with those of Caleb.

On further questioning about Patrick, Ms Folbigg spoke about the standout memories following Patrick's death. She said she remembers becoming severely depressed. She did not want people around. She lacked energy and she had no drive to do anything. She avoided children. They reminded her of the loss of her babies. She lost interest in family. She didn't want to interact with people or to communicate with them. She preferred being emotionally shut down and detached. She felt no-one could understand the distress she experienced.

She said she felt she had worked so hard to ensure that this would not happen. It left her feeling that her preparations were not good enough. She kept thinking that she must have made a mistake in her caring for Patrick. She was preoccupied with thoughts of how she had failed. She believed she had lived a life of failure. She believed she was not good enough. She recognised these feelings as existing since childhood. She felt she was not a good person.

It caused her to question the relationship that she had with Craig. She blamed herself and persisted with thoughts that there was something wrong with her. She thought that she might be genetically flawed. She described it as having "deep self-doubt". At the same time, she sought comfort in eating and experienced dramatic and substantial weight gain. She spent her time lying on the couch. She neglected domestic duties. Her weight increased to 90kg.

There was no counselling regarding SIDS deaths.

She took the baby items and packed them away out of sight. She avoided going to the cemetery. She kept pictures of both babies but had them away from central or direct view.

She was living in the same house with the same neighbours. She was able to keep up with them but stayed away from the babies and interacted preferably with the older

children. She was drawn to the experience of the camaraderie of their family life. After a while she re-engaged with Craig's family. She was able to spend time with them and later also to feel that she could engage emotionally to some extent. For a long time she had been in a state of emotional shutdown.

She is not sure when this happened but some months later she returned to her job at the Indian restaurant and found this comforting and distracting.

Ms Folbigg said her relationship with Craig was severely affected by what had happened. She was aware that his family had enveloped him and she felt out of place and dislocated from them. She wanted to have support from her own family. She saw Craig's family supporting him.

They were still in the Mayfield house and both she and Craig were back at work.

Ms Folbigg then spoke of a particular incident when she encountered Craig and her best friend from her earlier years, BJ, in a romantic clinch in their home. It was a devastating experience for her. It led to deep feelings of rejection and abandonment and betrayal. She felt physically unworthy and unattractive. She found Craig's response to be shameless and defiant towards her. It was a shattering experience to have her best friend engaged with her husband in this way. She experienced as it as deep betrayal and another fracture of her trust.

She described her reaction to this scenario. She became verbally abusive and kicked her friend out of the house but both she and Craig realised that her friend was too drunk to drive and she was forced to endure the friend's presence in the household. She felt devalued and rejected by her husband. It was overwhelmingly distressing for her. She said it changed their relationship and set off deep feelings of insecurity. These arose at a time when she was especially vulnerable. She had lost any semblance of self-esteem. She was preoccupied with her changed appearance and weight gain. She felt overwhelming feelings of vulnerability.

Her response to that dire situation was to focus on external events and to set distracting challenges. She decided that they should sell the Mayfield house and move to a different area. They moved to Thornton near Maitland and bought a house there. She liked the house and she liked living there.

There were other changes during those months. Craig left his job at BHP and by then was selling cars. From the time they were at Thornton, he secured a steady car sales job.

Ms Folbigg remained focused on external activities and distractions. Her long term friend Megan, who was then her best friend, worked with her husband who managed the store at BabyCo. Ms Folbigg was encouraged to work there. She was formally interviewed and appointed to the job. She said it seemed weird but she took comfort in being genuinely helpful to expectant parents. It was a way of facing her deep distress and demonstrating competence and prowess in dealing with the needs of expectant couples. She focused on her skills and developed them so that she became useful and expert. It helped her overcome her feelings of grief and vulnerability at the time.

She experienced the camaraderie of the work group. It was important for her to feel that once again she belonged somewhere. It provided her with significant comfort and support. At the same time their home at Thornton involved a well-functioning neighbourly group. They had social interactions and the environment appeared to her to be a step up socially.

During that time there was no talk about further children but over time they began to talk about babies more generally.

A younger cousin of Craig's came to stay with them. She liked having the young person in their home. He had a girlfriend. She liked taking a maternal role towards them and caring for them.

Her emotional state was suppressed. She focused on external activities and external sources of validation and gratification.

The birth of Sarah

Sarah's birth was not planned. She discovered that she was pregnant and her first reaction was to be distressed and contemplated termination of that pregnancy. She kept that secret from Craig but ended up discussing the pregnancy with him. He was shocked by the news of the pregnancy and distressed by the idea of facing a new baby in their lives and the fears associated with that. They both came to accept the pregnancy.

Ms Folbigg said she clicked into a role of being a perfectionist. She felt she had to do everything regarding the pregnancy and maintaining health to the utmost. She was unable to contain her distress. She began to focus on the extent of her fears and distress to the point where she experienced feelings of depression.

She became worried that her depressed state and anxiety could affect the health of her baby in utero. At that stage she had still been overeating and was living a life punctuated by escapism and watching excessive numbers of videos and escaping into books as she had done as a child. She said she was more worried because of how overweight and unfit she was. Her worry increased because of being pregnant. She became preoccupied with decreasing her food intake and increasing her fitness. Focus on these activities was consistent with numbing her emotions because of the distraction provided by these activities.

She continued working at BabyCo. She had access to the best equipment for the baby. It comforted her to feel that she had some control that way. She attended genetic counsellors on two occasions.

By that stage there was also new technology involving an apnoea mat that could detect cessation of breathing. She felt reassured by that technology. She consulted a private obstetrician in an attempt to access the best care she could. The pregnancy was untroubled. The birth was uneventful. They had to drive to John Hunter Hospital in Newcastle for the birth. The delivery was uncomplicated. As the pregnancy progressed, she felt that she had achieved more control because of the many things that she believed she had been able to change or control during the pregnancy.

Nevertheless Ms Folbigg said that she was full of fear with Sarah. She had trouble attaching and bonding and felt that she did not connect with her until Sarah was more than six months old. She was terrified of losing her. She said Sarah was an infant whose personality shone through. She found that it was Sarah who bonded with her primarily.

She struggled to have Craig engage in providing sufficient care for her and for Sarah. She implored him to step up with sharing childcare responsibilities. He emphasised that he had a need for regular sleep in order to function at work at Singleton where his job was. It involved a fifty minute journey. She deferred to his demand. She was however fed up with these arrangements. In contrast, Ms Folbigg said that Sarah was a joy to be with. As an infant she had enthusiasm and energy. As she bonded with Sarah, she was able to fantasise about Sarah's future as a "curious joy of a person".

Although it was her third child, Ms Folbigg said it was her first experience of a normal child beyond four months of age.

Sarah died at ten months of age. Ms Folbigg said that once Sarah activated her emotions (despite her deep reservations following the birth), she said she relished her but had persistent fear that she could lose her. She said she would become anxious or overwhelmed if Sarah was sleeping. She would tear up when she felt emotionally connected to Sarah.

At this stage in the interview Ms Folbigg became overtly tearful to the point of sobbing. She became overwhelmed. She needed a break in the interview and took at least ten minutes to settle. During this period, our interaction was superficial and chatty rather than part of an organised assessment consultation.

Ms Folbigg volunteered that she felt deeply distressed with thoughts of missing having her three children together as siblings during the period she was with Sarah.

In keeping with her pattern of emotional numbing when distressed, Ms Folbigg digressed to talk about external material.

Experiences as an Inmate

After a break, we spoke more generally about her experience of being in gaol. She said she had learned to cope with people leaving and that she found it best to keep her relationships with other inmates at a relatively superficial level. Her early experiences in gaol were very distressing but she learned to cope with the abusive comments by being aloof and emotionally numb. She said she had been physically threatened and physically assaulted.

She was assisted by always having a job in the gaol. At present she worked as an administrative clerk in the reception area. She performed the role of a sweeper. She had done that for five or six years and then she had to move to do something else to avoid a situation of conflict with another inmate. She is now back in that role and has been there for the past eight months.

She received psychiatric review and psychological treatment when she was in the Induction Centre over a period of about two and a half years. Things changed in the gaol with a number of inmates with child-related convictions who all ended up moving from the protected group into the general population. There were ten such inmates who were then integrated into a group of thirty other inmates.

Ms Folbigg is now off protection and lives in a small house with twelve other female inmates.

She had spent two years at a female unit at Cessnock Gaol. She had seen a psychiatrist regularly over a number of years but this had now stopped. She spoke about Dr Lisa Brown who had seen her for review at relatively infrequent intervals as the years progressed. She is able to self-refer to see a psychologist or a psychiatrist if needed but has not pursued this with any regularity in recent years. She is aware of her propensity to shut off emotionally and is aware that it is not healthy but it is sometimes necessary for her.

She has had treatment with antidepressant medications over the years and named a number of them including Luvox, Efexor, Cipramil and Zoloft. She is now off all medications. In the past she used tranquilising medication, Seroquel at doses of 25 to 50mg to assist her sleep. She has not seen a psychiatrist for over two years. Her contact with psychologists has helped her to deal with distressing anxiety and stress associated with life as a gaol inmate. She describes her current mood state as stable.

Ms Folbigg returned to talking about the loss of Sarah.

She said it was similar for her to the experience of losing Caleb. It came as such an overwhelming shock. She said she had just reached a stage of discussing the pros and cons of considering having a sibling for Sarah. She said there was in an inner feeling of not wanting to have to share her care of Sarah with another child. She had reached the point where she believed that if her child survived, she would probably not have more than one.

With the death of Sarah however, Craig became severely and deeply depressed. She felt that she could not help him. They would avoid each other. He worked at Singleton and left home early and came home late. He was closer to where the ashes of their children were interred. His way of grieving was foreign to her. She was intent on shutting down her distress. He seemed to be obsessed with his.

At one stage, Craig suggested that he bring the ashes of the three children home. She said that she didn't want them disturbed from where they were. Eventually however she consented to him bringing the ashes home in the hope that it would settle him. She wanted to have a special place built at the home to keep the ashes. They had an ebony table with a locked draw in it constructed. The ashes were interred there. She felt it did help Craig with his grief.

Once again, she dealt with her distress by making the decision to sell the home at Thornton. It had been fully renovated and there was no prospect to do further renovation work. She wanted to run away from the environment where Sarah died.

They bought a home at Cardiff which was closer to Craig's family.

When they were at Cardiff, she said it was not a good time for her. She had further weight gain and weighed 100kg or more. She felt severely insecure, unattractive and rejected by Craig.

The relationship reached what she described as "rock bottom". She ended up leaving Craig for a period of two months before returning to their home. She said she was trying to wake him up and to engage better with her. She was afraid that he would abandon her completely. She had some successful response from Craig in that it was clear that he wanted her back.

Despite the reconciliation, it did not fix the relationship in her opinion. There were three separations overall over the ensuing months. His comments to her about her weight were rejecting and cruel. He said that if she was not a Size 10, she was fat and that the marriage was over. He said he had three fat sisters and he didn't need a fat wife. It put her on a mission. She felt that she had made a vow to maintain and protect the marriage.
She underwent a weight loss program at Jenny Craig and lost a substantial amount of weight and was back to a Size 10. She felt it attracted Craig back to her and the relationship.

In the interim her relationship with her mother had improved but when she returned to Craig, her mother broke off the relationship with her totally.

There was another move of house. They rented a property at first at Singleton and then later bought an expensive house. She felt it was Craig's need to have this house and not hers. She was working hard at improving the relationship. She was planning and doing romantic things to ignite the relationship further. She was very focused on gaining approval and security.

It reached the stage when they were living in what she described as "this lovely big house and that it should have a family in it". Although neither discussed it openly, each thought that the other wanted to have a baby.

Craig took on finding experts who might advise them about all safety measures to ensure a healthy baby. She said she went along with this but was scared. She focused excessively on her preparation for pregnancy and focused on her health, her weight, the home and establishing a support group around her. Despite all of this, she said she felt filled with a deep sense of insecurity. At that stage she was thirty two years old.

She discovered a further distraction and became obsessed with the gym. She was obsessed with her weight and was obsessive with her exercise.

She was pre-occupied with her appearance. She found a group of women at the gym where she felt accepted and included. This was an important support for her. These were not Craig's friends in Singleton where he worked, but her own group at the gym. She said she now realised that she was focusing on whatever she felt she was able to control.

The birth of Laura

Ms Folbigg described the pregnancy as good and the delivery as uneventful except for fracturing her coccyx post-delivery. She had feelings of not wanting to bond because she was not game enough to attempt to bond. Although she had delivered the baby, she was terrified of losing her.

She felt that the possibility of losing a baby for the fourth time was so confronting despite the fact that everyone around her seemed to be so confident that this could not occur.

They had monitoring equipment and were meticulous with this until Laura was one year old. Throughout the first twelve months, Ms Folbigg said she remained terrified. When Laura turned one, they had an enormous party. She said it was more like a wedding than a first birthday party. After that, she began to allow herself to see a future.

She said Laura was a calm child and relished being with her. She said it was a wonderful feeling and she was able to share the joy with Laura. There were no tantrums and Laura was an easy child to manage. However she said she felt she was constantly on guard and by this stage it was her intrinsic way of being.

By then, despite the positive experience, she retained unrealistic thinking. She felt that if she wasn't perfect with Laura, that Laura would pick this up and would not continue to want to be with her as her mother. She clarified that, "not wanting to be with her", meant that she would die.

Ms Folbigg spoke about the monitor that they used. She found it to be evocative and created anxiety for her because there were repetitive false alarms. Craig on the other hand was reassured by having the monitor regardless of the false alarms that occurred regularly.

By this stage, Laura was over a year old and was developing well. She was walking, expressing some words and all of this was exciting and new for Ms Folbigg. Despite all the reassurance, Ms Folbigg said that she was always accompanied by a fear of not showing Laura her fear.

This constant state of anxiety precipitated increased thinking about her three other children. She began to pursue a spiritual answer as to why her three previous children had died. She became preoccupied with feelings of concern about why Laura had survived and the three children had died. She wanted to know what it meant. She felt guilty for surviving her deceased children. She felt that in this day and age, she should not still be here and have had her children die.

Ms Folbigg spoke about Craig's life and how it had turned out after they separated and divorced. She told me that he had remarried and has had another child. In contrast she said that if she wasn't in prison, she would never have children again. She questioned why she was even on the planet. She recognised that she was reliant on her need to cope by shutting down her emotions and focusing on "moving forward". She said the feelings of the guilt of surviving appeared in her diaries. She said she

blamed herself for everything that had happened. She said she expressed her search for answers by constantly self-blaming and looking for answers so that she could make things better.

The Diaries

Ms Folbigg spoke spontaneously about keeping diaries. She said she had kept diaries in exercise books from her teenage years. It was a way of communicating to no-one and keeping her feelings contained. She wrote in the diaries to express feelings without the expectation that the content would be read or shared.

She said she had an urge to do this from when she was young. There was no-one she felt that she could talk to about how she felt. She felt she couldn't intrude upon or burden her sister with her thoughts and feelings. She feared her mother's rejection and wrath. She had learnt to write things down as a way of coping and containing emotions. As a teenager, she had had the diaries and simply kept writing in new exercise books after each was filled.

As an adult, she continued this practice where she would fill a book and keep it in a drawer. She made no effort to hide her diaries because she simply viewed them as part of her life and not as something dangerous or secret. She seldom, if ever, would review the material in her diaries that were filled but she would read previous entries in her current diary in the course of making new ones.

I asked her specifically if she left her diaries out in order for her husband to find what she had written. She said it was not intended for her diaries to be read by others. Writing her diaries "was simply a way of getting things out".

Mental State Examination

Ms Folbigg presented as a middle-aged well-groomed woman dressed in prison greens. She wore some makeup and had attended to her eyebrows, although her nails were bitten. Her hair was pulled back.

Her affect was unusual. She related pleasantly but in a superficial talkative way in a setting where it was clear that evocative and poignant material had to be discussed. She was emotionally blunted for most of the assessment and at times her affect was inappropriately bland or focussed on factual material and lacked emotional content. At other times, there were moments where she lost composure in a significant way. At these times she could not hold back her tears. She wept and was distraught. At other times she was emotionally blunted to the point of being detached and dissociated.

Her mood state did not display overt depression. She gave a history of periods of depression consistent with adjustment to life events in the gaol setting. She also gave a history of significant depressive illness in previous years in the context of experiencing the deaths of her children, the unravelling of her relationship with her husband and the experiences of subjective abandonment and rejection as she experienced it.

Her thought processes were rational. There was no evidence of perceptual distortion, delusional material or hallucinations. There was no evidence of persecutory ideation. Her speech was organised and expressive. She expressed content without difficulty.

Her cognitive functioning suggested at least average intellect. She followed the questioning without difficulty. There was no suggestion of cognitive impairment.

She expressed adequate evidence of insight into her problematic life experience but this was not fully developed insofar as appreciating the probable causes for her lifelong experience of emotional disengagement in its various forms.

She showed adequate ability to reason and exhibited sound judgment. The content of her history was non-contradictory and consistent with other material that was available to me.

REVIEW OF DOCUMENTS

General comment

I have read the documentation provided. Much of it is useful by way of background information and also relating to information relevant to the trial.

The discussion that follows focuses on those documents that I found helpful in carrying out my task of conducting a psychiatric assessment and addressing the questions listed in the letter of referral.

Psychological report of Rozalinda Garbutt dated 4/2/2000

This psychological report was produced in 2000, well before the trial was concluded in early 2003. At the very beginning of the document in the "Summary of conclusions", Ms Garbutt states, "My opinion is dependent upon the elimination of natural causes to explain the deaths of the four Folbigg children". Ms Garbutt then goes on to advance an opinion to suggest a motive to support the allegations that Ms Folbigg murdered her children.

An extensive list of material considered is noted. It lists copies of diaries and personal correspondence written by Ms Folbigg. It includes consideration of the psychiatric condition, "Munchausen Syndrome by Proxy Syndrome" and goes on to describe the condition and then to express the opinion that Ms Folbigg was not suffering from "Munchausen Syndrome by Proxy Syndrome" at the time of the deaths of her four children.

In the assessment of the material considered by Ms Garbutt, is a description under point B on page 5 of the report that notes the following:

> *"Kathleen makes little attempt to generate sympathy from the police or family members she has contact with. Kathleen detaches herself from the incidents rather than encouraging ongoing support. For example, from the time that the ambulance arrived she physically distances herself in another room and resists*

> *attention. Kathleen discourages the SIDS support group's assistance and is hesitant to accept monitoring from doctors, including attending the Westmead Hospital. … Kathleen mentioned to very few people even the fact that she has had children, friends were even unaware that they had existed."*

My comment: These observations capture Ms Folbigg's description and presentation when I assessed her of chronic emotional numbing as the habitual way of attempting to cope with emotional distress. It appears that the phenomena were identified but possibly not properly understood by Ms Garbutt if one considers my assessment that is documented at the end of the report.

There are comments about diary entries that make references to supporting the opinion that Ms Folbigg was responsible for the deaths of her children.

The quotes from diaries are documented on pages 8 and 9 of Ms Garbutt's report and are not repeated in this report. The opinions expressed do not appear to have been canvassed with Ms Folbigg at any stage. The quotes can be interpreted very differently against the backdrop of the material that was elicited when I assessed Ms Folbigg, particularly her lifelong propensity to suppress distressing emotions, produce distracting external challenges and to attempt to problem-solve using simple practical proposals instead of showing ability to engage with distressing underlying emotions.

There are further comments about guilt and responsibility attributed to entries in the diaries that are assumed to support admissions of guilt and attribution of responsibility for the deaths once again in the absence of information derived from examination of Ms Folbigg.

An opinion is advanced in the summary of the diary entries referring to published research on filicides suggesting that Ms Folbigg's diary entries are consistent with the published material quoted in her report.

In the conclusion, Ms Garbutt once again notes that

> *"The question of a natural death is a debate open to medical experts. If natural causes is under question then this leaves accidental or homicide as the remaining modes of death".*

My comment: My view is that there is a lack of knowledge of Ms Folbigg's crucial early life history involving trauma and abuse. There is a lack of appreciation of the existence of long term psychiatric illness associated with childhood trauma and abuse. It appears that there is misinterpretation of clinical features that were neither recognised in the course of analysing the documentation and Police ERISP material that have led to an opinion that is not nearly as robust as it reads in the report, in my opinion.

Ms Garbutt's assessment appears to have occurred in the absence of a comprehensive psychological assessment of Ms Folbigg. The interpretation of Ms Folbigg's responses and reactions in the face of traumatic experiences is, at best, misunderstood. It is attributed to motives which were never explored directly with Ms

Folbigg. It arises from interpretations from Ms Folbigg's diary entries that were never the subject of direct inquiry with Ms Folbigg.

The referral letter to psychiatrist, Dr Yvonne Skinner, dated 6 December 2002 and the report of Dr Skinner dated 22 January 2003

The referral correspondence asks in particular Dr Skinner's opinion as to "Whether an unbalance of mind arose from birth or lactation in the Accused, as opposed to any other abnormality or character defect".

I note the material provided to Dr Skinner that includes diaries and diary extracts that were proposed to be relied upon by the Crown.

The material included Kathleen Folbigg's DOCS file and statements from Ms Folbigg's family, her foster mother Deidre Marlborough and her foster sister Lea Brown and also a statement by Carol Newitt, the sister of Craig Folbigg.

Dr Skinner's report of 22 January 2003 is framed in accordance with the letter of instruction from the Office of the Director of Public Prosecutions.

Of importance, Dr Skinner reviewed as background the DOCS file. She noted that Ms Folbigg was born Kathleen Megan Britton on 14 June 1967. She noted that her mother was murdered by her de facto husband, Thomas Britton, who was convicted and incarcerated subsequently.

On 9 January 1969 when Ms Folbigg was aged nineteen months, she appeared at Minda Court as a neglected, destitute child and was made a Ward of the State. The information is that Ms Folbigg was placed in the care of Mr and Mrs Platt who were the maternal aunt and uncle of Ms Folbigg. It documents that the maternal grandmother was residing with the Platts and that there was "a very close bond of friendship" existing between all the persons because Kathleen had stayed with her maternal aunt and uncle for extended periods in the past and on one occasion for about five months".

The reason for the previous separation from her parents is not documented. In addition to the arrangement for her to be fostered by the Platts, Dr Skinner stated that a report by the DOCS District Officer noted that before she was murdered, the biological mother agreed to allow Mr and Mrs Platt to adopt the child and had signed a document to that effect. Dr Skinner noted however that later Ms Folbigg's biological mother declined to allow the adoption to proceed and withdrew the child from the care of Mr and Mrs Platt.

The important information that lay behind the circumstances of Ms Folbigg's life at the time are not documented. There is clearly a history of significant early life disruption of attachments and bonds in circumstances that are not clearly described in Dr Skinner's report.

Dr Skinner noted that Ms Folbigg had undergone a number of name changes. She was known to the Platt family as "Liza". Her further experiences as an infant and young child are documented by Dr Skinner. It appears that in January 1970 she was reported to be making good progress, to be speaking well and to be reasonably bright. In

contrast however, at a home visit in May 1970, Mrs Platt indicated that she was experiencing difficulties with Ms Folbigg.

An assessment by Mrs Platt that Ms Folbigg was of low intelligence, had difficulty in learning basic requirements of hygiene and acceptable manners, and had difficulties with behaviour including severe temper tantrums and aggression, is recorded. Further disturbed behaviour reported to consist of occasions of screaming and crying incessantly. It was also reported that at the age of no more than two and a half years, "She had a preoccupation with sexual problems".

She was taken to the Child Health section. A medical officer considered it likely that Ms Folbigg had been abused sexually by her father during infancy. Dr Skinner reported that,

> *"The assessing medical officer considered the possibility that the foster mother and maternal grandmother may have had a distorted impression of the child's behaviour. It was considered that the maternal grandmother was a particularly destructive influence on the child. It was recommended that the maternal grandmother should be separated from the family, or perhaps that Kathleen should be transferred to another foster situation."*

The information recorded by Dr Skinner is that the situation deteriorated and was noted at a home visit in June 1970 when the foster mother indicated that Ms Folbigg's behaviour was deteriorating. It states that, "It was felt that the point had been reached where Kathleen was such a disturbing influence in the home that the relationship between adult members was starting to suffer as well".

It records that on 11 June 1970, Mrs Platt contacted the office to say that the family were no longer able to care for Kathleen.

Formal psychological and education assessment was carried out on 29 July 1970 where it was noted that Ms Folbigg was assessed as having an IQ score of 77, indicating "Borderline Retarded". The record noted however that this was a doubtful assessment because of the observed state of disturbance of Ms Folbigg where little rapport was established during testing and Ms Folbigg remained remote during the contact, spoke little and did not respond to conversation or enter into shared activities. She was restless and inattentive, giving little impression of any desire to cooperate or please.

Dr Skinner recorded that "It was concluded that she was a very disturbed little girl who exhibited numerous behavioural difficulties, was aggressive to other children and did not respond to usual social and emotional demands placed on her at Bidura." At that stage it was considered that she did not seem suitable for foster placement because of her emotional management difficulties and that she required therapeutic treatment within a stable environment.

Dr Skinner quoted a DOCS report that described Ms Folbigg as follows, "a fair haired, delicate looking child with a pretty, but very emotionally flat face." She was described as unresponsive and withdrawn. She rarely smiled or spoke if shown individual attention. It was reported that she was reassured by being close to an adult, and

immediately screamed and became aggressive if this position was at all threatened by another child. She was seen by Dr Spencer at the Child Guidance Clinic who concluded that she was an emotionally disturbed child who would need specifically qualified foster parents. Kathleen was transferred from Bidura to Corelli another care facility. Her behaviour improved, she was less withdrawn and able to chat to her peers and staff. She was still considered aggressive with her peers.

My Comment: The description above is consistent to severe disruption of early developmental bonding manifested in a young child by clinical phenomena of indiscriminate attachment to adult figures and notable features described as anxious attachment behaviour.

Dr Skinner discussed further information following the placement with foster parents in the Marlborough household. There is a record of difficulty despite good progress overall in that Mrs Marlborough complained that she could no longer cope with Ms Folbigg and needed assistance. Following a home visit, it appeared that she had made the call when she was upset but overall was fond of the child and wanted to keep her. It appears that the record did refer to Ms Folbigg's difficulty tolerating the children of her foster sister, Lea Brown, who were being minded in the home. The aggression and distress appeared to arise from sibling rivalry and was exhibited in the form of temper tantrums. The experience of being fostered in the Marlborough household appeared to be satisfactory to the point where Ms Folbigg requested to have the name of her Birth Certificate changed to Kathleen Megan Marlborough in February 1984.

Dr Skinner obtained some history of Ms Folbigg's life as a foster child with the Marlboroughs and also notes that Ms Folbigg gained information about her biological mother. The material documented is consistent with what Ms Folbigg told me at interview.

Dr Skinner quotes Ms Folbigg's statement in a letter dealing with her memories of early life as follows:

> *"I don't have any flashes of this time except of fighting, crying, being scared but never allowing myself to show that. Even now I still regard some feelings as a form of weakness. And love was never said or shown from me."*

Dr Skinner quotes from a letter written by Ms Folbigg written on 19 June 1999,

> *"Mrs Folbigg described her feelings about her background; unwanted at birth. A father who was so selfish and unthoughtful that he took my mother from me and ruined my life from that one action. Shuffled about for whatever reasons".*

There is additional detail about Ms Folbigg's early life in the documentation provided to Dr Skinner. Dr Skinner has recorded it in detail. It is obviously indicative of significant early life and developmental hardship and impairment. There is corroborative information about psychological difficulties associated with developmental impairment in the DOCS records that includes assessments by DOCS workers, child health medical practitioners and assessment of intelligence presumably by a psychologist. The significance of all of this material is to shed light on the significant disruption of normal and healthy infant and childhood developmental

process and to note that the sequelae from this experience have persisted into adult life.

Dr Skinner quotes extensively from the statement of Craig Folbigg made to police on 19 May 1999. I have not seen this statement but the content is consistent with what Ms Folbigg told me when I assessed her. I note Craig Folbigg's description of Ms Folbigg's response to the deaths of their children that include comments of the relatively detached and disengaged nature of her responses after experiences of acute distress at the time of their deaths. It also notes that Ms Folbigg experienced extreme anxiety and depression when she was attempting to cope with their second child Patrick who had suffered brain injury after the event when he was four months old. His observations of his wife allude to his identification that her grieving responses were unusual and different from most other people. He contrasted the extent of his grief with the apparent ease with which his wife was able to start work at BabyCo and deal with babies and pregnant women as part of her job at the time.

The statement of Deidre Marlborough was discussed by Dr Skinner. It confirmed that Mrs Marlborough never had a close relationship with Ms Folbigg. It quotes Mrs Marlborough's opinion that Ms Folbigg always seemed to be a devoted mother to Patrick and her other children.

The statement of Lea Brown of 24 July 1999 is discussed by Dr Skinner. It includes Ms Brown's opinion that "Kathy dealt with the death of Caleb by putting up a wall, which no-one could get through." It includes positive comments about Ms Folbigg's response to the birth of each child sequentially.

Dr Skinner viewed the transcript of ERISP interview of Ms Folbigg dated 23 July 1999.

Dr Skinner commented on Ms Folbigg's responses to questions about the content of her diary in the course of the ERISP interview. She quotes Ms Folbigg as providing the following account,

> *"When asked what she meant by 'Obviously I'm my father's daughter', she replied that her natural father was 'just a total big loser'. She states that she was, 'thinking along the lines of I am a loser'."*

Dr Skinner commented,

> *"With respect to the diary entries discussed with her at the time of the interview, Mrs Folbigg appeared to explain these entries as writing her thoughts and feelings to ease her own feelings of frustration."*

Dr Skinner went only as far as assessing the content of the diaries for any evidence that might suggest psychosis, major mood disturbance or cognitive dysfunction. These were excluded as present in the writings.

Later, when Dr Skinner reviewed comments in the statement of Craig Folbigg about Ms Folbigg's mental functioning in the ten years associated with the deaths of their children, she quotes him as noting the different presentations regarding the extent of

her engagement with the children at various times. He commented upon her changed response to the children and at times her irritability. He noted periods when she was tired and grumpy from lack of sleep and other times when she was outwardly calm and comfortable with her situation.

Overall, Dr Skinner interpreted this information to exclude evidence of significant psychiatric illness over the extended period, and in particular, the absence of postnatal depression in relation to the birth of each child.

Further assessment of hospital notes and notes from the general practitioner produced comments to exclude any record of psychological problems or evidence to suggest any psychiatric illness associated with postnatal depression or psychosis.

Dr Skinner reported in keeping with what was asked of her. She excluded any evidence of psychiatric illness such as Postnatal Depression, Major Depressive Disorder, Bipolar Disorder, psychosis of any type and the absence of any psychiatric condition producing cognitive disturbance that could impair Mrs Folbigg's functioning to the point of having a psychiatric defence to the charges she faced. She dealt with the definition of infanticide and excluded this as an appropriate terminology because of the absence of a severe mental illness being implicated in the deaths of the children.

Dr Skinner did comment about the disrupted early life and emotionally disturbed childhood as follows,

> *"Kathleen Folbigg had an emotionally disturbed childhood, with her mother's death occurring when she was only about fifteen months old. She had an unsatisfactory foster placement, institutional placement and later a foster placement that proved more unsatisfactory. It would be expected that she might have emotional difficulties after these problems occurring during her childhood development. Most psychiatrists would agree that background history of such disturbance would lead to personality problems or possibly psychiatric disorder, but studies show that there is no recognisable link between such childhood emotional disturbance and a particular psychiatric disorder or psychological condition."*

In respect of the opinion of Dr Skinner regarding the link between significant early childhood developmental disruption and/or associated abuse, the studies quoted are, in my opinion, not current.

The report of Dr Bruce Westmore, psychiatrist, dated 16 June 2003

This report describes three dates when Dr Westmore assessed Mrs Folbigg in the gaol. He saw her originally on 13 September 2002, subsequently on 21 January 2003 and further on 11 June 2003.

His report of 16 June 2003 was written in the context of guilty verdicts and noted that Ms Folbigg maintained her innocence in relation to these offences. The report produced is clearly within the context of the guilty verdicts. The attention of Dr Westmore was drawn to attempting to gain deeper and clearer understanding about the pathogenesis of Ms Folbigg's offending conduct. The report quotes questions put

to Ms Folbigg based on the assumption that she had killed her children that clearly Ms Folbigg was unable to answer.

My reading of this report is that if one suspends any view as to whether or not Ms Folbigg did murder her children, her answers to direct questions about her diary entries, dealing with her feelings of anger and her expectations of parenthood, she gave credible and consistent answers that would not necessarily be consistent with an admission or acknowledgment that she had killed her children. Ms Folbigg spoke candidly about the troubled relationship with Craig and her state of distress within that relationship over some time.

The remainder of the examination confirmed the absence of any major depressive disorder, psychotic illness or other overtly disabling psychiatric illness at the time of examination.

I note Dr Westmore's reporting of documents concerning Ms Folbigg's experiences as a foster child of the Marlborough family. The reporting appears to be of relatively untroubled experiences and not consistent with other material and the history I obtained directly from Ms Folbigg. The significant early life experiences were not explored.

Dr Westmore's opinions and conclusions are difficult to consider because they are all based on the acceptance of the verdicts following the trial.

He does acknowledge that her early life experiences are likely to have influenced her personality development. Her personality functioning however whereby he did observe that

> *"Ms Folbigg was a very controlled woman, probably over controlled in view of the serious circumstances in which I was assessing her. She rarely showed emotional distress, or indeed, any emotional response, this despite the very traumatic nature of the charges against her and later, the outcome of the court case".*

His interpretation of this observation was to extrapolate how individuals who are over-controlled may be prone to episodes of extreme anger. He further extrapolated how these features were expressed in the diary entries and that they have been an outlet for her to express her internal feelings of anger, frustration and homicidal impulses and thoughts.

Dr Westmore than went on to make some speculative comments about how these observed features may have expressed themselves in a way that resulted in the murder of Ms Folbigg's children.

Report of Dr Michael Giuffrida, psychiatrist, dated 27 August 2003

This report was prepared for Ms Folbigg's Legal Aid solicitor as part of the pre-sentencing hearing.

Dr Giuffrida had an extensive contact with Ms Folbigg in his role as a Visiting Medical Officer to Corrections Health where he saw her for assessment, diagnosis and treatment on a number of occasions.

He then saw her subsequently in the capacity of an expert witness for the purpose of providing this report. Dr Giuffrida listed the documents available to him, and in particular, a copy of Ms Folbigg's DOCS file.

He quotes the reason for the report being a request to submit a report to assist in determining whether at the time of the commission of the offences, he believes that there were any psychiatric or psychological mitigating factors, or special defences relevant to Ms Folbigg.

The report is comprehensive. Much of the material speaks for itself. In particular it provides a description of her personal circumstances following the breakup of her marriage to Craig and the expectation of divorce. She was not as yet incarcerated and was living with a friend in rented accommodation in Singleton where she had been since she left her husband some three years previously. She had been working on a casual basis as a waitress for the previous four years.

Later following the conviction, Dr Giuffrida saw Ms Folbigg in gaol. There were concerns about her personal safety and about suicidality. She was at risk resulting from abuse and threats by other inmates.

In his assessment Dr Giuffrida noted the absence of severe depressive illness, severe mood disorder, psychosis or cognitive impairment related to the offences.

In his examination of 22 May 2013, he noted,

> *"Remarkably calm and detached and able to speak at length without distress at any point, strikes me as being affectless in this situation. Spoke clearly and coherently without any hint of thought disorder, delusional ideas or particular preoccupation other than details of her offences. I found her remarkably lacking in expression of grief in relation to these."*

He stated that his earliest impression of Ms Folbigg was that she suffered no psychiatric disorder and there was nothing to indicate any underlying personality disorder apart from the apparent detachment regarding the death of her children.

Dr Giuffrida addressed with Ms Folbigg the way she reacted to her particular circumstances and the frequent observations that were made by others that she appeared remote and detached. He noted that Ms Folbigg agreed that she did come across as being emotionally detached, but explained that this was more the result of the deaths of her children together with her most recent conviction of their deaths.

She said that she had always coped with conflict and crises by being emotionally detached. She commented that her mother and her foster sister always said that she built a brick wall around her emotions. She said, "I never had the justification to lower it".

Dr Giuffrida went through the detail of Ms Folbigg's experience of the birth, lives and deaths of all of her children. He elicited information that was consistent with what I elicited when I assessed Ms Folbigg. He identified the longitudinal history of exposure to the deaths, the grief of the loss of the babies and also the cumulative effect of the trauma, the breakdown of her relationship with her husband and the development of increasingly dysfunctional behaviour on her part where she gained large amounts of weight, became obsessed with regaining control of her life and also descriptions of significant periods of emotional numbing, avoidance of interactions with people and detachment from her feelings.

My reading of Dr Giuffrida's report documents repeatedly many instances of Ms Folbigg's difficulty in maintaining engagement with painful emotions. It describes clearly the habitual patterns of emotional disengagement, involvement in displacement activities and emotional defensiveness to remain detached from the sources of her emotional distress.

In the context with the questions asked of Dr Giuffrida to consider what, if any, effect psychiatric and psychological disturbance may have had upon Ms Folbigg's conduct in relation to the deaths of her children, in the context of having been found guilty at court, he assessed Ms Folbigg against that backdrop.

He specifically addressed the content of the diaries but once again with the perspective that the verdict represented what she had done. He elicited history from Ms Folbigg that she had recurrent episodes of depression and a prevailing pattern of depressive mood over a number of years. He described symptoms of pervasive depressed mood, worse in the evenings and associated with loss of interest and anhedonia. It was said to be associated by impaired sleep and a disturbance in appetite with a marked increase in consumption and major weight gain at times of up to thirty kilograms or more. Associated with each of the episodes of depression were intense feelings of worthlessness, loss of self-esteem and a sense of failure as a mother. There was also a decrease in energy, motivation and drive and social withdrawal to the extent that she avoided most basic activities in order to survive. There was an absence of self-harm or suicidal ideation according to his record.

Dr Giuffrida reviewed the DOCS files. He clearly appreciated and extracted the information of the significant and severe disruption in Ms Folbigg's early life. The review of the DOCS file is dealt with in detail.

It notes the names that differed over the years. At one stage she was Kathleen Donovan, at another she was known as Liza Platt and later as Kathleen Marlborough. The dealings before the Minda Children's Court as a destitute toddler were noted. The fostering by her mother's sister and her husband, the Platts, and the breakdown of that arrangement in due course, were all noted, as was consistent with Dr Skinner's review of the documents.

The extent of Ms Folbigg's disturbance in terms of observable behaviour when she was a month short of her third birthday was noted in May 1970. By then her foster parent, Mrs Platt, was having difficulties with Kathleen. She was thought to be of low intelligence and was not learning to cope at basic requirements of hygiene and acceptable manners and behaviours. She was described as having severe temper

tantrums, being extremely aggressive, particularly towards other children who visited the home, and she was seen to have

> *"a preoccupation with sexual problems and had been seen on a couple of occasions trying to insert various objects into herself".*

There were occasions when she would scream and cry incessantly and cause embarrassment in the home and outside because of her behaviour.

Referral to a Dr Spencer at the Yagoona Child Health Clinic on 21 May 1970 resulted in a description of Liza Platt as

> *"virtually uncontrollable and a disruptive influence on the marriage of Mrs Platt."*

The record confirms that she indulged in excessive sex play and masturbation. It prompted the very significant comment in Dr Spencer's report where he stated,

> *"The social history is well known to you and seems that Liza was misused by her* father *during infancy."*

This material is detailed in Dr Giuffrida's report but is reiterated because it is clearly highly significant in gaining an understanding of the psychological vulnerabilities, the personality development and the psychological defences and patterns of behaviour that have become habitual features of Ms Folbigg's interactions with others.

It is consistent with her current presentation and was observed by Dr Giuffrida and all the other psychiatrists who assessed her to demonstrate affective disturbance with obvious emotional detachment, inappropriate affective expression in terms of numbing and distancing and reliance on avoidant and displacing patterns of behaviour so as not to deal with emotional distress.

Further, the extent of Ms Folbigg's impaired functioning as a child is captured in the attempt at intelligence assessment where she scored in the *"Borderline retarded"* range which clearly is not accurate given her subsequent intellectual performance. It was suggested (correctly in my opinion) that her poor performance resulted from her disturbed state and her inability to engage in the testing and in the process overall. She was described as speaking little and remote during the assessment. She did not respond to conversation or enter into shared activities. Her response to testing was not maximal. She was restless and inattentive and gave little impression of any desire to cooperate or please. Dr Giuffrida quoted other comments about the assessment of Ms Folbigg at the time that are consistent with Dr Skinner's report.

Dr Giuffrida noted some improvement sufficient to result in suitability to be fostered by the Marlborough family. There are also subsequent notations in the DOCS file about engagement with that family over the years. Dr Giuffrida also noted a significant report of 22 October 1974 when Ms Folbigg was seven years old and in Second Class. Her IQ was assessed at 110 which put her in the Above average to Superior range.

There are other intercurrent notations in the DOCS file about patchy relationships, social disengagement, loss of interest in outside activities and inability to sustain

friendships. Later reports in 1978 and 1979 noted that Ms Folbigg was found to be inattentive, disruptive and defiant at school. There were stealing charges and appearances before the Worrimi Children's Court in December 1982 where she was admonished and discharged on two stealing charges. There are no subsequent offences until she came into the criminal justice environment in relation to those charges for which she was convicted.

Dr Giuffrida addressed the extracts from Ms Folbigg's diaries. His general impression having read all the material was that Ms Folbigg was at the time a greatly tormented and exceedingly disturbed woman. He noted throughout the diaries was a prevailing theme of intensely depressed mood, expressions of worthlessness and low self-esteem and repeated references to feelings of rejection and abandonment by her husband Craig and her family and friends. He quoted some comments that he interpreted as showing intense ambivalent feelings about pregnancy and motherhood. He stated,

> *"It would seem clear that Ms Folbigg was in fact tortured by feelings of guilt, shame and remorse, although she did everything she could to suppress and contain these feelings".*

Dr Giuffrida dealt with diagnosis and unlike Drs Skinner and Westmore, he identified a history of pervasive depression throughout her marriage that he felt was confirmed by numerous reference to her depressive mood and associated symptoms as recorded in her diaries. He described this as Chronic Dysthymia that sometimes intensified and was accompanied by biological features of depressive illness at some points in her life.

His view was consistent with Drs Skinner and Westmore concerning the absence of any psychotic illness affecting Ms Folbigg.

Dr Giuffrida expressed strong opinions about Ms Folbigg being unable to bond with her children. I am concerned however that these views and the views expressed subsequently in the remainder of the report are much influenced by the acceptance that Ms Folbigg killed her children, resulting in Dr Giuffrida attempting to unravel the psychological processes that could account for a woman with her personality functioning and variable depressive illness carrying out these acts.

Dr Giuffrida excluded evidence that was consistent with a severe or pervasive personality disorder and in particular the absence of the usual features of Borderline Personality Disorder and/or psychopathy.

Throughout Dr Giuffrida's report, he documents the remarkable extent of emotional detachment and affective blandness inconsistent with the significant experiences of the loss of four children sequentially. He does at some point consider the possibility of Post Traumatic Stress Disorder in relation to these circumstances and then goes about describing the absence of the usual features of Post Traumatic Stress Disorder.

Absent from his assessment however is the full consideration of the obvious and preceding history of severe trauma and probable abuse that Ms Folbigg was exposed to from the very early period of her life and throughout the period when she was

rejected at foster homes, institutionalised and further struggled to establish secure emotional bonds with her long term foster family.

The possibility of a pre-existing disabling Chronic Post Traumatic Stress Disorder with marked features of detachment, dissociation, emotional distancing and affective blunting in response to any potential triggering event was not considered. This is discussed later in the body of this report. Despite identifying the extent to which Ms Folbigg was a highly disturbed young child when she was in the care of DOCS and when she was in the care of the Marlborough family, the distinct probability that she was suffering trauma-related psychiatric illness, currently identified as Complex Post Traumatic Stress Disorder, was not considered in Dr Giuffrida's assessment despite its detailed content and identification of the diagnostic features that one would associate with this condition.

Dr Giuffrida went as far as to identify the significance and seriousness of the early childhood experiences and probable sexual abuse. Dr Giuffrida referred to abundant evidence in the literature of early childhood development affecting children who are neglected and who suffer serious sexual and physical trauma and neglect who go on to suffer profound disturbance of personality development. He identifies that it was very likely that Ms Folbigg failed to experience any true bonding or attachment to her own mother. He appreciated the seriousness of these disruptive influences on Ms Folbigg's development in her early life and subsequently and he noted the clear evidence to support the suggestion that she was sexually abused probably as an infant.

Without identifying the sequelae to the significant and prolonged trauma in the early life of Ms Folbigg, he appears to have formulated this in terms of personality characteristics and not associated it with the features that are commonly observed in abused children who develop Complex Post Traumatic Stress Disorder as a pervasive long term psychiatric disorder.

[redacted]

[redacted]

The affidavits of Megan and Collin Donegan and Karren Hall

These are noted. They essentially speak for themselves and require no further comment from me.

Documents relating to a number of people who witnessed Kathleen Folbigg after the death of her children

These documents are from Melissa Anne Smith - a neighbour, Carol Ann Newitt - the sister of Craig Folbigg and three friends from the gym, Jan Bull - an instructor, Debbie Goodchild and Judith Patterson. These are descriptions from people who know Ms Folbigg but who are not expert in psychiatric or psychological evaluation. The content of these statements speak for themselves.

Extracts of evidence from the following people from the trial

These extracts of evidence are from ambulance officers, David Hopkins, Deborah McDermid, Brian Wadsworth and Kathleen Coyle. Their descriptions are unremarkable in my opinion.

Similarly the evidence of Stephen Saunders, police officer is noted without comment.

The clinical file of Singleton Heights Medical Practice.

The records were reviewed. They are consistent with general practice notes. There is nothing remarkable contained in these notes.

Justice Health medical records

There are considerable notes in this file. The important information concerning Ms Folbigg's psychiatric state is that she was seen primarily by the same consultant psychiatrist, Dr Lisa Brown who monitored her mood state and her adaptation within the gaol environment.

Treatment for subjective reporting of depressive symptoms and sleep disturbance is noted sporadically over the years. The extent of the depression and sleep disturbance appears to be consistent with a reactive state in the course of making adjustments to serving a long sentence.

What is notable in this material is the relative lack of engagement with Dr Brown over time in that the notes are purposeful and descriptive but do not include any recording of the development of any psychological material that might indicate some form of therapeutic relationship that goes beyond reporting of symptoms and monitoring the effects of medication. The significance therefore is that the extent of Ms Folbigg's habitual emotional distancing and numbing is consistent with her longterm exhibiting of her personality functioning.

File of documents comprising scientific literature

I have reviewed this material superficially. I have not gone through a careful assessment of each scientific paper. It is notable that some of the studies may have some relevance to those offences for which Ms Folbigg was convicted but, in the context of providing this report, under pressures of time, I cannot extract any compelling or significant information to address those questions that are asked of me in the referral correspondence.

The various documents relating to diary entries and transcripts of diary entries

I have perused these documents but have not had the opportunity to go through them in any detail with Ms Folbigg. Without raising particular entries with her and eliciting contextual comments, it is difficult not to make assumptions or reach opinions that may be significantly skewed or misinterpreted.

Examination of this material sufficient to form any meaningful view about their relevance would take far more time and discussion with Ms Folbigg than I was able to expend in the course of carrying out this assessment and producing this report.

YOUR QUESTIONS

1. ***History taken by you***

   This documented in the body of the report.

2. ***Diagnosis***

   The significant information available about Ms Folbigg's early life points strongly to a subjective experience of severe disruption of the fundamental early life necessity for attachment, nurture and security.

   Coupled with this background history is a history strongly indicative of early childhood abuse, sexual and physical violence and the tragic outcome resulting in the killing of her mother by her father in a violent stabbing.

   There is suggestion that the extent of disruption within the first two years of Ms Folbigg's life and before the time that her mother was murdered, was so severe that the DOCS file records that she spent at least five months in foster care with her maternal aunt, Mrs Platt. I have no further detail about the reasons for this but a separation of a small child from her mother at that early age necessitating fostering by an aunt and uncle, suggests that the child's experience within the parental home was significantly problematic.

   Subsequent developmental experiences after the murder of her mother were not settled, secure or nurturing. The extent of early childhood hardship continued in many ways and although she was fostered eventually at the age of three, her experience within that foster home was not one of significant attachment,

engagement, security and emotional warmth to have assisted her to overcome whatever trauma and developmental disruption occurred in her earlier years.

The clinical features exhibited by Ms Folbigg when I saw her, observed by every other psychiatrist who has examined her and confirmed in the history she gave at assessment, are all consistent. Ms Folbigg has lifelong symptoms of emotional detachment, emotional numbing, difficulty trusting, engaging with others and experiencing periods of severe detachment to the point of dissociation.

Her longterm history is one of emotional withdrawal from those around her, disengagement from potential figures of attachment, brittle relationships and significant emotional dysregulation.

There is a history of chronic depression with periods of severe overt major depressive symptoms that included sleep disturbance, appetite disturbance, socially avoidant behaviour and a form of eating disorder that functioned as a displacement activity.

Ms Folbigg's subjective experience was not one filled with overt expression of psychiatric symptoms. Instead she has lived a life where she accepted as her baseline experience the experience of emotional numbing with an emphasis on self-reliance and persistent difficulties with attachments and trust.

My assessment of Ms Folbigg is that she has features that are consistent with those seen in abused children and are described diagnostically as features consistent with a diagnosis of Complex Posttraumatic Stress Disorder. Ms Folbigg does not report symptoms of re-experiencing trauma, nightmares and flashback experiences in relation to the original trauma. My understanding is that she was exposed to trauma at a stage of her life when she was preverbal and has not articulated her experiences of the trauma in a verbal description. She has expressed the effects of trauma through her lifelong pattern of distancing, emotional numbing, detachment and dissociation.

These features of psychiatric symptoms associated with early life trauma have been observed clearly in the course of her life from the stage when she came to the notice of authorities as a toddler.

These features have been noted consistently since then and are described by her in her subjective account of her developmental history, her history of relationships as they occurred in later life and particularly in her subjective experience in her marriage and as a mother.

It is inevitable that Ms Folbigg has been affected by the trauma of her early childhood experiences so as to reflect this in her personality. Her personality functioning is based on creating an external picture of wellbeing. She has the advantage of being physically attractive and intelligent. She has probably conducted herself in relation to others in a manner that has avoided criticism, humiliation and judgment particularly in her adolescence and early adult years.

She however subjectively describes herself as "a shell of a person". She has been plagued with self-doubts, low self-esteem and anxiety about being accepted generally and particularly in relationships.

Her insecurities were clearly articulated in her description of her marriage and demonstrated in her conduct within the marriage where her focus was abnormally upon her insecurities, her need to be reassured by her husband that she was desirable and attractive and conversely her self-loathing and low self-esteem when she lost control of her eating patterns and gained substantial weight.

My understanding of her personality functioning is that she has many vulnerabilities but does not exhibit pervasive and severe dysfunction to the point of being able to diagnose a personality disorder. She clearly has deep-seated personality vulnerabilities particularly in establishing and maintaining relationships. She functions more effectively as an isolated and guarded individual.

The history is that Ms Folbigg has had episodes of significant mood disturbance sufficient to make a diagnosis of Persistent Mood Disorder (Dysthymia) and at times has had episodes of Major Depressive Disorder during times of particular hardship.

In my opinion the significant and pervasive psychiatric diagnosis is that of Complex Posttraumatic Stress Disorder for the reasons I have described above.

Ms Folbigg has had the extraordinary and added trauma of the deaths of four children. The questions that remain about the cause of death of her four children are not for me to address. It is apparent that whatever the facts are, Ms Folbigg has been through sequential traumas. She has been through the experience of conviction and incarceration that further adds to her burden of emotional distress.

3. Prognosis

Ms Folbigg has a guarded prognosis for the complex reasons I have articulated in my answer to the previous question.

4. Please advise whether our client's treatment to date has been appropriate

Your client has had very little psychiatric treatment for the deep-seated pervasive Complex Posttraumatic Stress Disorder that comprises her significant psychiatric condition. She has had supportive treatment at various times by her general practitioners and in the gaol environment she has had access to appropriate psychiatric and psychological treatment. At present she is receiving no psychiatric or psychological treatment and she takes no medication.

5. What is your experience in treating and assessing individuals exposed to traumatic instances or circumstances?

My experience in this regard is extensive. I have had longterm exposure to the treatment of service personnel who have been exposed to cumulative severe trauma causing longterm disabling posttraumatic stress disorder. I have assessed

hundreds of individuals over the years with this diagnosis in relation to workplace trauma.

I have also over many years been involved in assessing adults who were sexually and physically abused as children. I have done this in the course of my psychotherapy practice and treated many individuals with such backgrounds.

In more recent years I have conducted many medicolegal assessments of individuals who were sexually abused as children. I have in the course of these assessments elicited the clinical features associated with such abuse and have assessed the impairment arising from early trauma associated with physical and sexual abuse.

I would consider my experiences as a clinician with regard to assessing individuals exposed to traumatic instances or circumstances has been comprehensive and advanced given the extent of my involvement in assessing and also treating individuals with trauma related illness.

6. **Please read the diary material provided to you. In light of your diagnosis, if any, and your experience with the treatment and assessment of individuals exposed to traumatic instances, in your opinion, are the diary entries influenced or impacted by any psychological illness from which Ms Folbigg was suffering at the time of her writing them?**

As a general comment I am strongly of the view that Ms Folbigg has amongst many other difficulties, a clear diagnosis of Complex Posttraumatic Stress Disorder. If one understands and appreciates the extent to which this has shaped her life (since the onset occurred so early in her life) then one can understand that the diary entries need to be assessed in the context of the existence of this diagnosis and the deep-seated psychological (but very private) subjective experiences of Ms Folbigg.

Although I have perused the diary entries, I have not had the opportunity to go through them in detail with Ms Folbigg. One must be aware of the need to address specific entries with her and to make sense of the meaning of the diary entries within the proper contextual setting in which they were created.

I can appreciate that the entries that are documented in the material from the trial remain open to further explanation and interpretation rather than to be assessed on their face. In my opinion, one can understand that the meaning of the diary entries is more likely than not to have been impacted by the psychological illness from which Ms Folbigg was suffering at the time of creating these entries.

7. **What is survivor guilt?**

Survivor guilt is a phenomenon seen most commonly in the setting of a complicated grief reaction. The term refers to the subjective experience of the bereft person in relation to maintaining life in the context of having those to whom they are bonded and attached or with whom they share other close relationships, having been killed.

Individuals suffering survivor guilt that I have assessed and seen over the years have experienced a range of subjective experiences. Some have been in close proximity to mass killings, e.g. the bombings of civilians in Bali and other locations in Indonesia who I have seen as part of my forensic practice. I have seen military personnel who have survived incidents where their comrades did not. I have seen police officers who have been involved in fatal situations involving their colleagues. I have seen survivors of fatal motor vehicle accidents who have survived when other family members have not. Whilst the causes for survivor guilt may vary, there are a number of shared emotions that have emerged in the course of assessing and treating individuals who suffer survivor guilt.

8. **Do you have experience in treating individuals labouring under survivor guilt? If so, please detail that experience**

As indicated above, the experiences are varied. I do have experience of treating a number of individuals experiencing survivor guilt. Some of the shared features include incessant questioning about why the patient had survived when others did not.

It may go further than that with regard to questioning whether there was anything that the person did to either cause the death of people close to them or failed to do in protecting those people.

The guilt aspect is often deep-seated and difficult to resolve in treatment. The experience is often complicated by further exacerbation of the trauma of the lethal incident or in other cases where there have been a number of past traumas exacerbating and triggering of those traumas as part of a posttraumatic stress disorder condition.

Further to experience of survivor guilt is often the associated complicated grief condition where there is lack of resolution of the grief with persistent unshiftable feelings of self-blame, complicated grief that goes on to become overt major depressive disorder and feelings of diminished self-worth and shame as part of the longterm picture.

9. **Taking into account your answers to question 7 and 8 above, in your opinion, were Ms Folbigg's entries in her diaries, influenced by "survivor guilt"? Please provide reasons for your answer**

It is difficult to answer this question comprehensively. I have not gone through Ms Folbigg's diary entries in sufficient detail to have an emphatic view about whether or not they were influenced by survivor guilt.

My view at this point is that it is possible and even likely that Ms Folbigg was writing personal entries to herself, in much the same way as she has made diary entries for a large part of her life so that her private thoughts and feelings were articulated in terms of self-blame, assuming responsibility for the deaths of her children and talking about her feelings and general actions in self-deprecatory ways.

10. Insofar as your diagnosis differs from Drs Skinner or Westmore, please advise why if you are able. In this regard, from what we can gather on the face of the reports, we can advise that neither Drs Westmore nor Skinner had access to our client's clinical treatment notes

The differences in my diagnostic views about Ms Folbigg as compared with those of Drs Skinner or Westmore arise in significant part because we have looked at different aspects of Ms Folbigg's presentation and were asked to address different issues.

Dr Skinner's assessment was essentially aimed at establishing whether or not Ms Folbigg suffered from a severe psychiatric condition that may have influenced her behaviour in relation to infanticide. The assessment therefore was to exclude those features of psychiatric illness that may be associated with severe psychiatric illness in the first 12 months following the birth of a child. Dr Skinner further looked at Ms Folbigg's psychiatric history overall and quite correctly excluded major psychosis, schizophrenia or bipolar disorder or any other severe brain injury or psychiatric condition that could account for Ms Folbigg being implicated in the deaths of her children on the basis of the presence of those disorders.

Dr Westmore conducted a similar assessment with regard to the presence or otherwise of severe psychiatric illness that could account for homicidal acts by Ms Folbigg in relation to her children. Insofar as their respective opinions are concerned about severe psychiatric illnesses (psychosis and severe mood disorder), my assessment is consistent in that I can concur that I found no evidence to support a view that Ms Folbigg has suffered from psychotic illness, severe mood disorder consistent with homicidal conduct or any other brain injury that might affect her conduct so as to carry out homicidal acts.

Although Drs Skinner and Westmore commented upon the strange interaction they had with Ms Folbigg, and in the case of Dr Skinner, carefully documented the early developmental disruption and exposure to trauma, there was no assessment or consideration in their reports of the existence of a severe life-affecting condition such as Complex Posttraumatic Stress Disorder.

My assessment of Ms Folbigg, looking at her habitual ways of relating, her communication patterns, her subjective emotional connection with those around her and her habitual ways of dealing with emotional distress and trauma, demonstrated to me the longterm existence of what I believe to be her primary psychiatric diagnosis, Complex Posttraumatic Stress Disorder.

You advise me that neither Drs Westmore nor Skinner had access to your client's clinical treatment notes. My view is that the significant history regarding her underlying primary psychiatric condition is contained in the DOCS records primarily.

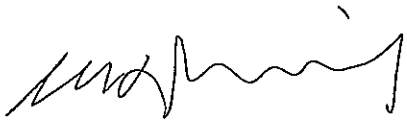
11. Any further comments you wish to make

I have had a limited opportunity to interview Ms Folbigg at assessment. I have combined the material that I elicited at assessment with the documentation

provided and, to the best of my ability, I have assessed that material so as to arrive at my diagnostic opinion.

Thank you for asking me to assess your client and to provide this report.

Yours faithfully,



DR MICHAEL DIAMOND
Consultant Psychiatrist

Encl.

ADDENDUM: After completing this report under pressure of time constraints, I received a bundle of material of 332 pages containing the DOCS material on 16 April 2019. I am able to confirm that the information I have quoted from the reports of Drs Skinner, Westmore and Giuffrida is verified in the source documentation.

CERTIFICATE – EXPERT REPORT

I refer to my report dated 8/4/19 which is attached to this certificate and certify as follows:

1. I was provided with a copy of the Uniform Civil Procedure Rules 2005 – Expert in Schedule 7 Witness Code of Conduct a copy of which is annexed to my report
2. I have read the Expert Witness Code of Conduct.
3. I agree to be bound by the Expert Witness Code of Conduct.

Dated: 15.4.19

Sign:

Name: MICHAEL DIAMOND

EXPERT CERTIFICATE

S177 EVIDENCE ACT 1995

The Expert Certificate is given by me pursuant to s177 of the Evidence Act that the defendant proposes to tender this Expert Certificate concerning my attached report dated which is signed by me as an expert and:

- States my name and address;
- States that I have specialised knowledge based on my training, study or experience as specified in the report attached to this certificate; and,
- Set out an opinion that I hold, and which is wholly or substantially based on that knowledge.

Dated: 15 APRIL 2019.

Signed:

Name: MICHAEL DIAMOND

(2) An expert witness must exercise his or her independent, professional judgment in relation to such a conference and joint report, and must not act on any instruction or request to withhold or avoid agreement.

5 Experts' reports

(1) An expert's report must (in the body of the report or in an annexure to it) include the following:

(a) the expert's qualifications as an expert on the issue the subject of the report,

(b) the facts, and assumptions of fact, on which the opinions in the report are based (a letter of instructions may be annexed),

(c) the expert's reasons for each opinion expressed,

(d) if applicable, that a particular issue falls outside the expert's field of expertise,

(e) any literature or other materials utilised in support of the opinions,

(f) any examinations, tests or other investigations on which the expert has relied, including details of the qualifications of the person who carried them out,

(g) in the case of a report that is lengthy or complex, a brief summary of the report (to be located at the beginning of the report).

(2) If an expert witness who prepares an expert's report believes that it may be incomplete or inaccurate without some qualification, the qualification must be stated in the report.

(3) If an expert witness considers that his or her opinion is not a concluded opinion because of insufficient research or insufficient data or for any other reason, this must be stated when the opinion is expressed.

(4) If an expert witness changes his or her opinion on a material matter after providing an expert's report to the party engaging him or her (or that party's legal representative), the expert witness must forthwith provide the engaging party (or that party's legal representative) with a supplementary report to that effect containing such of the information referred to in subclause (1) as is appropriate.

6 Experts' conference

(1) Without limiting clause 3, an expert witness must abide by any direction of the court:

(a) to confer with any other expert witness, or

(b) to endeavour to reach agreement on any matters in issue, or

(c) to prepare a joint report, specifying matters agreed and matters not agreed and reasons for any disagreement, or

(d) to base any joint report on specified facts or assumptions of fact.

New South Wales Consolidated Regulations

UNIFORM CIVIL PROCEDURE RULES 2005 - SCHEDULE 7

SCHEDULE 7 – Expert witness code of conduct

(Rule 31.23)

(cf SCR Schedule K)

1 Application of code

This code of conduct applies to any expert witness engaged or appointed:

(a) to provide an expert's report for use as evidence in proceedings or proposed proceedings, or

(b) to give opinion evidence in proceedings or proposed proceedings.

2 General duty to the court

(1) An expert witness has an overriding duty to assist the court impartially on matters relevant to the expert witness's area of expertise.

(2) An expert witness's paramount duty is to the court and not to any party to the proceedings (including the person retaining the expert witness).

(3) An expert witness is not an advocate for a party.

3 Duty to comply with court's directions

An expert witness must abide by any direction of the court.

4 Duty to work co-operatively with other expert witnesses

An expert witness, when complying with any direction of the court to confer with another expert witness or to prepare a parties' expert's report with another expert witness in relation to any issue:

(a) must exercise his or her independent, professional judgment in relation to that issue, and

(b) must endeavour to reach agreement with the other expert witness on that issue, and

(c) must not act on any instruction or request to withhold or avoid agreement with the other expert witness.

New South Wales Consolidated Regulations

UNIFORM CIVIL PROCEDURE RULES 2005 - REG 31.27

Experts' reports

31.27 Experts' reports

(cf SCR Part 36, rule 13C; DCR Part 28, rule 9C; LCR Part 23, rule 1D)

(1) An expert's report must (in the body of the report or in an annexure to it) include the following:

(a) the expert's qualifications as an expert on the issue the subject of the report,

(b) the facts, and assumptions of fact, on which the opinions in the report are based (a letter of instructions may be annexed),

(c) the expert's reasons for each opinion expressed,

(d) if applicable, that a particular issue falls outside the expert's field of expertise,

(e) any literature or other materials utilised in support of the opinions,

(f) any examinations, tests or other investigations on which the expert has relied, including details of the qualifications of the person who carried them out,

(g) in the case of a report that is lengthy or complex, a brief summary of the report (to be located at the beginning of the report).

(2) If an expert witness who prepares an expert's report believes that it may be incomplete or inaccurate without some qualification, the qualification must be stated in the report.

(3) If an expert witness considers that his or her opinion is not a concluded opinion because of insufficient research or insufficient data or for any other reason, this must be stated when the opinion is expressed.

(4) If an expert witness changes his or her opinion on a material matter after providing an expert's report to the party engaging him or her (or that party's legal representative), the expert witness must forthwith provide the engaging party (or that party's legal representative) with a supplementary report to that effect containing such of the information referred to in subrule (1) as is appropriate.

New South Wales Consolidated Regulations

UNIFORM CIVIL PROCEDURE RULES 2005 - REG 31.23

Code of conduct

31.23 Code of conduct

(cf SCR Part 39, rule 2; DCR Part 28A, rule 2; LCR Part 38B, rule 2)

(1) An expert witness must comply with the code of conduct set out in Schedule 7.

(2) As soon as practicable after an expert witness is engaged or appointed:

(a) in the case of an expert witness engaged by one or more parties, the engaging parties, or one of them as they may agree, or

(b) in the case of an expert witness appointed by the court, such of the affected parties as the court may direct,

must provide the expert witness with a copy of the code of conduct.

(3) Unless the court otherwise orders, an expert's report may not be admitted in evidence unless the report contains an acknowledgment by the expert witness by whom it was prepared that he or she has read the code of conduct and agrees to be bound by it.

(4) Unless the court otherwise orders, oral evidence may not be received from an expert witness unless the court is satisfied that the expert witness has acknowledged, whether in an expert's report prepared in relation to the proceedings or otherwise in relation to the proceedings, that he or she has read the code of conduct and agrees to be bound by it.

MON

7578

Michael Diamond

MB ChB, FRANZCP

ASSOCIATED CONSULTANTS

MICHAEL DIAMOND MB ChB, FRANZCP
PAUL FRIEND FRANZCP
ELIZABETH O'BRIEN MB BS, DPM, FRANZCP
JULIAN SHORT MB BS, FRANZCP
PETER ANDERSON BA, MB BS (Hons), FRANZCP
RALF ILCHEF MB BS, FRANZCP
ANTHONY SAMS BMed, FRANZCP, FAChAM
ANTHONY SAMUELS MB BCh, MCrim, FRANZCP
MURRAY WRIGHT MB.BS, FRANZCP
JENNY JORDAN MB, MICGP, FRANZCP
PETER YOUNG MB BS, FRANZCP
MELISSA BARRETT MB BS, FRANZCP
AMANDA BRAY MB BS, FRANZCP
HELEN PROSKURIN BA, MB BS, FRANZCP
MARY-ANNE FRIEND MB BS (Hons 1), FRANZCP

1 BERRY ROAD
ST LEONARDS NSW 2065
AUSTRALIA
Telephone: (02) 9906 2333
Facsimile: (02) 9438 5497

CURRICULUM VITAE

NAME: Dr MICHAEL DIAMOND

DATE OF BIRTH: 29 February 1952

PROFESSIONAL QUALIFICATIONS

1976 MB ChB, University of Cape Town

1984 FRANZCP - Fellow of the Royal Australian and New Zealand College of Psychiatrists

CURRENT POSITIONS

- **Consultant Psychiatrist in private clinical practice**
- **Forensic and Medico-legal Psychiatry Practice** with experience in all jurisdictions.
- **Medical Council of New South Wales:**
  - Medical and Psychiatric Consultant to the Council.
  - Involved with hearings concerning professional conduct, impaired practitioners and suitability for registration matters.

- **State Insurance Regulatory Authority – SIRA**
  (Previously Motor Accident Authority NSW):

  - Dispute Resolution Services – Decision-Maker, Appointed March 2018
  - Medical Assessment Service – Assessor in Psychiatry
  - Medical Review Panel – Member/Chair of Panels
  - Trained in MAA/SIRA Permanent Impairment Guidelines
  - Trained in AMA Guides to the Evaluation of Permanent Impairment
  - Member of Working Party – Guidelines for Management of anxiety following motor vehicle accidents

- **Nursing and Midwifery Council NSW:**
  Impaired Registrants Panel

- **Psychology Council NSW:**
  Impaired Registrants Panel

- **Control Risks Group:**
  Forensic Psychiatry Consultant

- **Beyondblue:**
  Expert Reference Group – Doctors Mental Health Program

MEMBERSHIPS

- **RANZCP Section of Forensic Psychiatry**
- **RANZCP Section of Psychotherapy**
- **Medico Legal Society of New South Wales** President 2014 - 2016
- **Academy of Forensic Sciences –** Member

OTHER EXPERIENCE

- **New South Wales Police Force:**
  - Consultant to the State Protection Group both as a trainer and during operational incidents involving hostage negotiation, witness protection and tactical issues.
  - Consultant to State Crime Command – matters concerning extortion, murder investigations, kidnapping, serial crimes.

Consultant to Counter-Terrorist and Special Tactics Command.

- **Federal Attorney-General's Department:**
  Protective Security Coordination Centre, Counter-terrorist Plan:
  Consultant to National Counter-Terrorism Committee - NCTC
  Negotiator Training. 1991 – 2007

- **Justice Health NSW:**
  Visiting Medical Officer. 2002- 2007

- **Royal Australian and New Zealand College of Psychiatrists:**
  Vice Chairman, NSW Branch Committee. 1993 to 1999
  Examiner RANZCP. 1992, 2004

- **Director of Post-Graduate Education in Psychiatry:**
  The Academic Mental Health Unit, South Western Sydney Area Health Service, Liverpool, NSW 1991-1995

- **Member of Ministerial Commission by the Minister for Justice, New South Wales:**
  Inquiry into suicide and self-harm in New South Wales prisons.
  March – July 1993.

- **Member, Royal Australian and New Zealand College of Psychiatrists Psychotropic Drugs Committee:** 1990-1992.

- **Chairman, Medical Advisory Committee, Northside Clinic:** 1988-1991.

- **Psychiatric Consultant, Health Care Complaints Commission**, assisting investigations from time to time.

- **Hospital Contribution Fund**
  Ramsay Health Care
  Consultant

- **Member, NSW Mental Health Expert Working Group**
  "National Health Goals and Targets".

REFEREES

Dr Murray Wright
Telephone: (02) 9391 9027

Dr Elizabeth O'Brien
Telephone: (02) 9906 2333

Mr Andrew Dix AM
Telephone 0419 478 915

CARDILLO GRAY PARTNERS

PO Box 409
Newcastle NSW 2300

Level 1, Cnr of Auckland & Hunter Streets
(Entry via Auckland Street)
Newcastle NSW 2300

P: 02 4910 0677 | F: 02 8287 2506

law@cardillograypartners.com.au
www.cardillograypartners.com.au

ABN: 83 144 875 755

Our Ref: SG: 89829
Email: stuart.gray@cardillograypartners.com.au

25 March 2019

Dr Michael Diamond
1 Berry Road
ST LEONARDS NSW 2065

Dear Doctor,

Re: Kathleen Folbigg
DOB: 14 June 1967

We advise that we act on behalf of Ms Kathleen Folbigg in relation to the Inquiry into her convictions. Thank you for agreeing to examine Ms Folbigg and provide us with a report regarding same in due course.

Procedural matters

We draw your attention to the following Court Rules, copies attached:

1. UCPR 31.23 Code of conduct
2. UCPR 31.27 Experts' Reports
3. UCPR Schedule 7 - Expert witness code of conduct

Please note that in order to be admissible at the hearing your report should comply with the following matters:

1. Address your report to this Firm and refer to these instructions;

    a. Your report must state:
    b. Your name and address;
    c. The matters set out in UCPR 31.27 - that as an expert you have specialised knowledge based on your training, study or experience, which is set out in the Report; and sets out the opinion that you hold as an expert, and which is wholly or substantially based on that specialised knowledge.

2. Attach a copy of this letter, the letter of instruction and its attachments (we will arrange for a copy of the attachments to be annexed to avoid such cumbersome exercise having to be undertaken by you) to your report;

3. Complete and attach the Certificate - Expert Report;

4. Complete and attach the Expert Certificate, s177 Evidence Act.

Client Details

Name:	Kathleen Folbigg
D.O.B:	14 June 1967
Address:	Silverwater Women's Correctional Facility
Phone Number:	(02) 9289 5920
Email address:	N/A
Injuries:	Psychological

Attached Documents

We *enclose* for your information the following documents:

1. 'Other Documents' Index (4 pages).
2. 'Other Documents' Material (1324 pages).
3. Kathleen Folbigg's Diaries dated 4 June 1996 to 6 June 1997, transcribed.
4. Report of Dr Betts dated 18 April 2014.
5. Kathleen Folbigg DHS - Individual Prescribing History dated from 01/01/1991 to 13/11/2018 inclusive.
6. Affidavit of Megan Donegan dated 18 February 2019.
7. Affidavit of Colin Donegan dated 11 March 2019.
8. Affidavit of Karren Hall dated 28 February 2019.
9. Bundle of scientific literature.

Questions

In preparing your report we would be pleased if you would address the following:

1) History taken by you.

2) Diagnosis.

3) Prognosis.

4) Please advise whether our client's treatment to date has been appropriate.

5) What is your experience in treating and assessing individuals exposed to traumatic instances or circumstances?

6) Please read the diary material provided to you. In light of your diagnosis, if any, and your experience with the treatment and assessment of individuals exposed to traumatic instances, in your opinion, are the diary entries influenced or impacted by any psychological illness from which Ms Folbigg was suffering at the time of her writing them.

7) What is survivor guilt?

8) Do you have experience in treating individuals labouring under 'survivor guilt'? If so, please detail that experience.

9) Taking into account your answers to questions 7 and 8 above, in your opinion, were Ms Folbigg's entries in her diaries, influenced by 'survivor guilt'? Please provide reasons for your answer.

10) Insofar as your diagnosis differs from Drs Skinner or Westmore, please advise why if you are able. In this regard, from what we can gather on the face of the reports, we can advise that neither Drs Westmore nor Skinner had access to our client's clinical treatment notes.

11) Any further comments you wish to make.

We undertake to be responsible for your professional fee and look forward to receiving your medico legal report in due course.

Would you please address your tax invoice as follows:

Kathleen Folbigg
CO/ Cardillo Gray Partners
PO Box 409
Newcastle NSW 2300

Our client is currently funded through Legal Aid and upon receipt of your invoice we will endeavour to arrange payment for you as soon as possible.

Should you have any questions or wish to discuss this matter please do not hesitate to contact us on (02) 4910 0677.

Yours Faithfully
CARDILLO GRAY PARTNERS

Stuart Gray
Partner

Encl.: