SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General (Qld) v Lawrence* [2018] QSC 218
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (Applicant) **v** **MARK RICHARD LAWRENCE** (Respondent)
FILE NO/S:	BS No 7468 of 2007
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	28 September 2018
DELIVERED AT:	Brisbane
HEARING DATE:	23 April 2018 and 27 July 2018
JUDGE:	Brown J
ORDER:	**The order of the Court is that:** **1. The decision made on 3 October 2008 that Mark Richard Lawrence is a serious danger to the community in the absence of a Division 3 order is affirmed.** **2. Mark Richard Lawrence is ordered to continue to be subject to the continuing detention order.**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where a continuing detention order under the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) was made with regard to the respondent on 3 October 2008, that has been affirmed by the Court on many occasions since – where the applicant seeks, at an annual review, an affirmation of previous orders, namely that the respondent continue to be subject to the continuing detention order – where the respondent submits

that the need to ensure adequate protection of the community can be met by the making of a supervision order – whether adequate protection of the community can reasonably and practicably be managed by a supervision order

Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld), s 13, s 16, s 28A, s 30

Attorney General (QLD) v Beattie [2007] QCA 96
Attorney-General v Francis [2007] 1 Qd R 396
Attorney-General for the State of Queensland v Lawrence [2017] QSC 61
Attorney-General v Lawrence [2016] QSC 58
Attorney-General (Qld) v Sutherland [2006] QSC 268
Lawrence v Attorney-General (Qld) [2017] QCA 27

COUNSEL: J Rolls for the applicant
B Mumford for the respondent

SOLICITORS: Crown Law for the applicant
Legal Aid for the respondent

[1] The Attorney-General applies for a review of the Continuing Detention Order of the respondent, Mr Mark Richard Lawrence. The Attorney-General seeks an affirmation of the previous orders made by this Court.

Background

[2] On 3 October 2008, Fryberg J ordered that the respondent be detained in custody for an indefinite term for control, pursuant to Division 3 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) ("**the Act**"). That order has now been reviewed on a number of occasions, the result of which has been that the respondent has remained the subject of a continuing detention order. The respondent has now been in prison for over 30 years.

[3] In a carefully set out judgment,[1] Atkinson J affirmed the order of Fryberg J made on 3 October 2008 and ordered that the respondent continue to be subject to the continuing detention order. Her Honour set out in detail the history of the respondent's detention orders, the medical evidence that had been obtained relevant to her Honour's decision in March 2016, as well as the respondent's criminal history including the index offence which brought him within the operation of the Act. I rely on those matters in her Honour's judgment and will not again reiterate those matters.

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1 *Attorney-General v Lawrence* [2016] QSC 058.

[4] In her judgment, Atkinson J found that the respondent had provided inconsistent information to various medical professionals and in evidence. Her Honour concluded:[2]

> "[193] Mr Lawrence has been distrustful and suspicious, has taken offence at personal slights and been prone to anger over many years. He is aware that if he reveals that he is developing deviant fantasies, this could lead to return to prison, an outcome he is desperate to avoid.
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> [194] This lack of trust in professionals and his suspicious querulousness was amply demonstrated in his oral evidence where he expressed disagreement with various statements made by Dr Madsen, Dr Lawrence and Dr Grant. This is of particular concern given that he would have to be fearlessly honest with Dr Madsen for him to be safely managed on a supervision order. I do not accept that he would be honest in these circumstances, given his demonstrated history of lying and suspiciousness and his knowledge that such disclosure would be likely to return him to prison.
>
> <u>The need to protect the members of the community from that risk</u>
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> [195] The risk to members of the community from Mr Lawrence is obvious and must be measured not only against the risk posed of his reoffending but also the risk posed by his reoffending; that is, of very serious, potentially fatal, harm. The need to protect the community from that risk is said by s 30(4)(a) of the [*Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld)] to be the paramount consideration. I am persuaded that the only way to protect the public from the risk posed by Mr Lawrence is to affirm the decision that he is a serious danger to the community in the absence of a Division 3 order and for him to be subject to a continuing detention order."

[5] The respondent appealed her Honour's judgment and the appeal was dismissed.[3] In dismissing the appeal, Fraser JA (with whom Morrison JA and Boddice J agreed) found no error in her Honour's analysis of evidence which concerned the critically important question of the extent to which the respondent entertained deviant sexual fantasies and his responses to them.[4] This was because relevantly, the psychiatrists' opinions about the efficacy of supervision orders were predicated upon the respondent disclosing the occurrence of sexually deviant fantasies and his responses to them.[5] No error was found

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2 [2016] QSC 58 at [193] to [195].

3 *Lawrence v Attorney-General (Qld)* [2017] QCA 27.

4 At [34].

5 At [35].

in her Honour determining that adequate protection of the community could not be reasonably and practically managed by a supervision order under s 30(3)(b) of the Act.[6]

[6] In the annual review of the continuing detention order in 2017, evidence was heard from a number of specialists, particularly Dr Aboud and Dr Beech, and from the respondent. Subsequently, the respondent's counsel indicated that, in light of the evidence given by psychiatrists and the evidence of the respondent, there was no opposition to the orders sought by the Attorney-General.[7] In his consideration of whether it was appropriate to affirm the 2008 order and order that the continuing detention order continue, Martin J considered the matters required by s 30(1) of the Act, particularly the matters in s 13(4) and the reports produced under s 28A. His Honour noted that there had been little change in the views previously expressed by the psychiatrists but that there was greater emphasis on the use of antilibidinal drugs as a means of dealing with the respondent's sex drive.[8]

[7] In that hearing, Dr Aboud considered that the fact that when the respondent committed the crime at Wolston Park, that it was a culmination and acting out of a very well formed fantasy to rape and kill from which he subsequently would masturbate thinking about what had happened, deriving sexual pleasure:[9]

> "… presents the foundations of the risk that I would not feel confident could be managed while he has an active sexual drive; sexual drive being the key moderator of the risk."

[8] Dr Aboud's opinion was that it was necessary for the respondent to commence a course of antilibidinal treatment before he could be considered for any form of release under supervision.[10]

[9] His Honour noted:[11]

> "On the current state of the evidence, if Mr Lawrence were to be released on some future review, it would be on the basis of him being subject to, among other conditions, some type of verifiable and effective antilibidinal drug treatment."

[10] His Honour noted at the time that there may be an issue as to whether the respondent could be relied upon to comply with a treatment regime if medication was taken orally, as there would be a high degree of reliance placed upon him self-reporting. His Honour

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6 At [35].

7 *Attorney-General for the State of Queensland v Lawrence* [2017] QSC 61 at [5].

8 [2017] QSC 61 at [17].

9 [2017] QSC 61 at [22].

10 At [23].

11 At [23].

noted that this raised issues of risk due to his unreliability and because when he had in the past undergone such treatment, he had stopped it because of the side effects of the drugs.[12]

[11] The evidence before me in this review grapples with the proposed regime as a result of the respondent commencing taking antilibidinal drug orally and an antidepressant in April 2018.

[12] The initial hearing took place on 23 April 2018 which was adjourned and continued on 27 July 2018 after the Attorney-General sought to present further evidence as to the cost of alternative treatments. At that further hearing, a report was also produced from Dr Robert Moyle and tendered by the Attorney-General. I address that below.

What the Court must decide

[13] The first question for this Court to determine is whether the Court should affirm the decision made on 3 October 2008 that the respondent is a serious danger to the community in the absence of an order. The making of that order was not contested by the respondent.

[14] The Court is still required to determine whether such an order should be made. The Court may affirm the decision only if satisfied in accordance with s 30(2) of the Act that the evidence is of sufficient weight to affirm the decision. That requires the Court to consider the matters set out in s 13(4) of the Act, as well as psychiatric reports provided pursuant to s 28A of the Act.

[15] At the hearing, the real dispute between the parties was, assuming the Court's jurisdiction under s 30(3) of the Act was enlivened, whether the respondent should continue to be subject to the continuing detention order or be released from custody subject to a supervision order.[13] Section 30(4) of the Act provides that, in considering whether to make a supervision order or an order that the party concerned continue to be subject to the continuing detention order, the paramount consideration is the need to ensure adequate protection of the community. The Court must consider whether adequate protection of the community can reasonably and practicably be managed by a supervision order and whether the requirements of s 16 of the Act can reasonably and practicably be managed by corrective service officers.

[16] The onus is on the Attorney-General to present evidence satisfying the evidential standard under s 30(2) of the Act which is of sufficient weight to satisfy the Court that it should affirm the decision that the prisoner is a serious danger to the community in the absence of a Division 3 order.

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12 At [23].

13 Section 30(3) of the Act.

[17] In determining the appropriate order to make under s 30(3) of the Act, the Court must bear in mind the considerations discussed in *Attorney-General (Qld) v Francis* where the Court of Appeal stated:[14]

> "The question is whether the protection of the community is adequately ensured. If supervision of the prisoner is apt to ensure adequate protection, having regard to the risk to the community posed by the prisoner, then an order for supervised release should, in principle, be preferred to a continuing detention order on the basis that the intrusions of the Act upon the liberty of the subject are exceptional, and the liberty of the subject should be constrained to no greater extent than is warranted by the statute which authorised such constraint."

[18] Updated medical evidence was provided to the Court. Dr Beech and Dr Aboud provided reports pursuant to s 28A of the Act. Dr Madsen, who is a forensic clinical psychologist and has been treating the respondent since June 2012, provided an updated report. Dr Arnold, provided a report based on her four consultations with the respondent. She was engaged to see the respondent for a psychiatric assessment and to determine treatment needs and in particular, to review the respondent's treatment on an antilibidinal medication.

[19] Evidence was also provided by officers of Queensland Corrective Services ("**QCS**").[15] The respondent also gave evidence.

Events since the last review

[20] On 11 April 2017, the respondent indicated to the Court that he wished to start antilibidinal medication.[16] The IOMS notes[17] record that the respondent subsequently attended a meeting on 13 April with his case work manager and stated that he wished to start medication as soon as possible. The IOMS notes record on 6 May 2017, that he is now taking prescribed medication "as directed by the courts, (50ml Androcur daily) and started 75ml of Effexor daily. Started 21/04/17 and has been referred to see two Psychiatrist (sic)". Unfortunately, Dr Arnold did not see the respondent until 11 May 2017, by which time he had commenced taking the antilibidinal medication.[18] No baseline blood tests were taken just prior to the respondent commencing taking the medication.

[21] The antilibidinal medication, Androcur, was prescribed by Dr Hayman. Following the taking of the medication, the respondent's testosterone levels were 1.7 nmoI/L on 30

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14 [2007] 1 Qd R 396 at [39].

15 Affidavit of S Simmons, filed 22 March 2018; Affidavit of J Monson, filed 27 July 2018.

16 [2017] QSC 61 at [24].

17 Affidavit of S Simmons, filed 22 March 2018, Exh SS-1.

18 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.1.1] and [7.1.2].

May 2017; 2.8 nmoI/L on 29 June 2017; 3.0 nmoI/L on 28 July 2017; 4.5 nmoI/L on 3 October 2017; 3.9 nmoI/L on 13 December 2017; 3.7 nmoI/L on 25 January 2018; 4.0 nmoI/L on 5 March 2018, 3.2 nmoI/L on 10 April 2018; 4.3 nmoI/L on 17 May 2018; 4.2 nmoI/L 31 May 2018; 5.0 nmoI/L on 18 June 2018; 3.6 nmoI/L on 2 July 2018; 3.5 nmoI/L on 20 July 2018.[19]

[22] Androcur is Cyproterone and is commonly referred to as such by Dr Beech and Dr Aboud.

[23] The respondent's dose of Androcur was originally 50mg but was increased to 100mg, and then to 200mg subsequent to the hearing in April 2018.

Dr Madsen

[24] Dr Madsen prepared a report dated 30 March 2018. Since his last report on 2 June 2017 had met with the respondent on five occasions, the most recent being 23 February 2018. Dr Madsen noted that the respondent had prepared an updated relapse prevention and re-integration plan document, which is fairly comprehensive. He stated that his impression was the respondent had been positively motivated in their sessions and that the additional work he had done on his new plan demonstrated a good understanding of the problems and challenges he is likely to experience in the future should he be reintegrated with the community. He added that it was also notable that the respondent has consistently verbalised his preparedness to comply with any recommendations and also cooperate with professionals involved with his care/management. Dr Madsen's report states:[20]

> "As regards to risk, of relevance is that Mr Lawrence is now a year older (56 years) and has in the last 12 months commenced biological intervention for specific factors related to his prior offending (i.e. sexual preoccupation; impulsivity). His self-report and presumably his test results for his testosterone level appear to indicate that this intervention has been successful (i.e. reduced testosterone, loss of sex drive and stable mood). Mr Lawrence's general presentation and documented day-to-day behaviour indicates that he is reasonably emotionally stable and is not obviously impulsive (i.e. is saving money, attends work, completed offence-related treatment activities, complies with prison rules/procedures and no documented adverse incidents or breaches). He continues to verbalise a motivation to comply/cooperate with professionals, and appears to have done so without difficulties over the last 12 months. Finally, as noted within earlier reports, Mr Lawrence does not attempt to justify his prior offending, nor seem to hold generalised negative attitudes and beliefs that would predispose him to antisocial/criminal activities in the future."

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19 Affidavit of A McLean filed 27 July 2018, Exh AM-1; T2-7/39-44.

20 Supplementary Affidavit of L Madsen, Exh LM-1 at p 2.

[25] Dr Madsen noted that if the respondent was to be reintegrated with the community, it would be important that he have access to psychological treatment/support on a more frequent basis as the process of returning to the community and adjusting will no doubt be challenging for him on a practical as well as an emotional level.

[26] Ms Jolene Monson gave evidence on behalf of QCS. She stated that it was anticipated that the arrangement whereby the respondent was treated by Dr Madsen would remain in place should the respondent be further detained or should he be released from custody subject to a supervision order.[21]

Dr Beech

[27] Dr Michael Beech gave reports pursuant to s 28A of the Act. He provided a report of 19 February 2018, a supplementary report of 20 April 2018, and a supplementary report dated 18 May 2018. Dr Beech had provided earlier reports in 2007, 2016 and 2017 in relation to the respondent.

[28] Dr Beech considers that the respondent has a sexual paraphilia of sexual sadism, which occurs in conjunction with an anti-social personality disorder and moderately high psychopathic traits.[22] Dr Beech's opinion is that the unmodified risk of violent sexual offending by the respondent is high, notwithstanding the progress that Dr Beech acknowledged that the respondent has made over the years.

[29] Dr Beech identifies three potential risk scenarios in the case of an unmodified risk:

(a) The first is that on release the respondent will be able to continue with his settled demeanour, and with assistance will slowly adjust to community living and make an uneventful transition;

(b) The second scenario is that over time he will become stressed, notwithstanding his attempts to settle and the supports he has in place. With that stress, and the exposure in the community to visual and sexual cues that enliven his sexual fantasies, he will become sexually preoccupied again. The more anti-social traits will come to the fore, and he will target a vulnerable person, possibly a child and indecently assault or rape them. The victim would suffer at least psychological damage and possibly physical injuries; and

(c) The third scenario is that the respondent's exposure to visual and other sexual cues will enliven the sexual sadism, and he will again covertly and quietly plan the sexual assault and killing of a targeted vulnerable adult female. He raises the possibility that despite the respondent's apparent settling and despite his disavowals, a variation of this scenario is that he has continued to harbour sexual fantasies. He notes that against the latter two scenarios, the respondent has denied

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21 Affidavit of J Monson, sworn 7 June 2018 at [45] to [46].

22 Affidavit of Dr Beech, filed 22 March 2018, Exh MJB-2 at p 13.

any ongoing sexual fantasies and has worked with Dr Madsen to look at managing stress generally.

[30] As to the respondent's assertion that he no longer has sexual fantasies, Dr Beech states that factors that might militate against the respondent's statements that he no longer had the sexual fantasies which drove his earlier crime which led to his killing a young woman are: the possibility that he is simply being untruthful about the cessation of the fantasies; the possibility that the fantasies have lessened in the absence of visual cues in prison, and the possibility that the fantasies are dormant and will return after exposure to the changes he might face once he is released. Dr Beech considers it is more likely that the fantasies have become dormant with the passage of time, increasing age and absence of arousal triggers.[23]

[31] As to the respondent having been on Cyproterone for the last 12 months, Dr Beech opines that the drug acts to reduce sexual urges and sexual arousal generally, and acts to reduce and supress deviant sexual fantasies. He notes in particular that, from the studies which have been done, the best treatment effects occurred where there was a duration of follow up greater than four years, ongoing psychological treatment and continued monitoring of treatment. The studies that Dr Beech reviewed found that it was failure to continue with treatment that was a strong indicator of recidivism. Dr Beech stated that the preferred treatment might be a gonadotrophin release hormone agonist and Cyproterone, but stated that, "nonetheless, studies have indicated that Cyproterone can be effective". He noted that the treatment effects are reversible one or two months after medication interruption. He concluded that:

> "It is therefore my opinion that on the current treatment risk of re-offending would be substantially reduced, that is the likelihood of reoffending would be substantially reduced, while on medication. It does not though disappear although it significantly lessens, … while on treatment."

[32] Dr Beech stated that the medication would require close monitoring and vigilance and consideration should be given to a higher dose than 50mg daily.

[33] In his report of 20 April 2018,[24] Dr Beech gave further evidence after having received updated medical records. Dr Beech also reviewed Dr Aboud's report dated 30 March 2018, noting that Dr Aboud opined that the risk was now reduced to below moderate and should be considered potentially manageable in the context of a supervision order. Dr Beech stated that he concurred with Dr Aboud that the likelihood of reoffending has reduced to below moderate. He states that, "to that I would add though that if Mr Lawrence were to reoffend, the offence might be catastrophic." He clarified his opinion in his first report as follows:

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23 Affidavit of Dr Beech, filed 22 March 2018, Exh MJB-2 at p 14.

24 Affidavit of Dr Beech, filed 23 April 2018, Exh MJB-1.

> "I believe that it should be stated that the likelihood of re-offending with medication, psychological intervention, and supervision has been reduced below moderate, below the risk of the average sex offender. The risk of harm though, if an offence were to occur, remains high. With treatment and supervision, Mr Lawrence should be seen as placed in the group of sex offenders who are at below average of risk of re-offending."

[34] He goes on to state:

> "However, as noted in my earlier report, for people with paraphilias treated with cyproterone, there is still a re-offence rate. Cyproterone suppresses testosterone levels, but does not ablate (sic) them. Normal people on cyproterone can re-elevate testosterone levels through masturbation. The half-life of cyproterone is such that if a dose is missed for one month or so, testosterone levels can return to normal. It is less successful, in some studies, for people whose deviant arousal is cued by visual stimuli (such as in Mr Lawrence's case). The medication would be expected to reduce sexual arousal, deviant sexual thoughts, and sexual preoccupation. It would not though reduce the non-sexual desires to dominate people. I believe that a preferable treatment would be cyproterone at a higher dose, and/or the addition to a gonadotrophin releasing hormone antagonist. It is imperative if Mr Lawrence is released on medication that it is overseen by an experienced psychiatrist, and I am concerned that his current medication prescription does not seem to have psychiatric input. It would be imperative, even within the limits of medication half-life, that the testosterone levels are regularly monitored (and that there is not an omission as it appears to have occurred in February 2018). It would be imperative that Mr Lawrence continue to see someone such as Dr Madsen, frequently and regularly, and that some form of diary is maintained."

[35] In a further report of 18 May 2018, Dr Beech provided a supplementary report about the different types of antilibidinal medications and their cost. In that report, he referred to a review of the pharmacological treatment of paraphilias which was annexed to his report, which noted that paraphilia is a chronic and, in most cases, lifetime disorder and that the gold standard treatment of severe paraphilia in adult males is anti-androgen treatment, especially GnRH agonists. A GnRH agonist is available in Australia called Goserelin. According to that review, the minimum duration of treatment necessary is three to five years. Dr Beech's report estimates that the cost for such Goserelin treatment would be in the order of $4,400 per year. The other anti-androgen medications available are Cyproterone (Androcur), which the respondent is already taking, and Medroxy-progesterone, referred to as Depot-provera. Depot-provera and Goserelin are long acting injectable forms of the medication. Depot-provera costs in the order of $30 to $100 per year, presuming injections are every three months. Dr Beech noted the various side effects, but stated that adverse side effects could be treated with the usual remedies. Dr Beech considered that the preferred treatment for the respondent, given his history of sexual sadism and his offences, would be Goserelin in combination with ongoing psychological treatment, possibly with adjunctive Cyproterone.

[36] Dr Beech gave oral evidence that Cyproterone is not as effective in its ability to reduce testosterone and the fantasies that you are aiming to reduce when compared to Goserelin, and that if you stop taking Cyproterone, it wears off over the course of about four weeks.[25] He also noted that a person taking Cyproterone could bring his testosterone levels back to a certain level by regular masturbation. He noted that Depot-provera reduces testosterone levels, but does not ablate sexual fantasies and may not be as effective as Cyproterone, though it has advantage of being in the form of an injection, which does not require supervision. Dr Beech stated that absent self-reporting, the way that one would detect whether or not the medication has been effective is to take regular and random tests of testosterone levels. In his view, treatment would be aiming for a level at less than 3.[26]

[37] Dr Beech in evidence also noted that while the risk of reoffending is considerably reduced by the medication Cyproterone, the respondent still has a domineering personality and when he gets anxious or stressed, he likes to dominate. That might not be necessarily sexual in nature but could translate into the committing of a sexual offence.[27] Dr Beech accepted however, that if one reduced the testosterone levels, then the aggression and desire to control things like that would be reduced, but not in the same way as you reduce the sexual arousal from it.[28] If the respondent feels he is losing control and becomes frustrated and depressed, Dr Beech stated that the dynamic is that to seek control over his life, the respondent may start to fantasise about controlling people and attack them.[29] He stated that the warning signs would be that the respondent would become resentful, truculent, uncooperative, irritable, and very negative.[30] He agreed however, that one might see nothing or might see some sort of disquiet.[31] Dr Beech accepted that QCS would not necessarily know that the respondent's crankiness or other display of disturbance was manifesting an escalation in risk. He agreed that QCS Officers would be able to detect matters such as the respondent being cranky, irritable and not cooperative, but not necessarily know what he is thinking about and whether he is starting to plan to act out a fantasy that he has developed in response to his frustration.[32] In his view, if the respondent was observed becoming cantankerous, it would be appropriate for QCS to restrict the respondent's movements, bring a curfew in and try to work with Dr Madsen to see how some of the frustrations could be alleviated

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25 T1-12/28-32.

26 T1-15/20-27.

27 T1-18/1-11.

28 T1-18/15-18.

29 T1-19/25-27.

30 T1-19/30-35.

31 T1-19/40.

32 T1-20/18-20.

and watch him more carefully.[33] The respondent has in the past not communicated his thoughts and remained secretive. Dr Beech opined that when the offence occurred back in 1983, which was while he was in a psychiatric hospital, presumably no one had any idea that he was fantasising about abducting someone and killing them as subsequently occurred.[34] Dr Beech, however, considered that in relation to the offence carried out in 1983, which acted out sexual fantasies with catastrophic consequences, that offence was most likely driven by sexual urges.[35]

[38] As stated above, while Dr Beech considers that it is possible that the fantasies that the respondent has had in the past have subsided over time, he does not think it is likely that they simply stopped one day.[36]

[39] In his view, the sexual fantasies are more likely to be dormant. In the absence of medication, Dr Beech stated that there is a risk that the respondent could see visual cues such as a crime show on television which could cause him to start to fantasise about them or become sexually aroused by them. The effect of medication is to make the cues less likely to conjure up any kind of mental phenomenon. It make sexual arousal much less likely to occur and to make it much more difficult to fantasise about what you would do.[37] Dr Beech considered that would occur on Cyproterone or some other drug that would lessen or reduce testosterone levels. He stated that injections are more consistent and have an effect to a greater degree.[38] He considered that it would also be easier to ensure that the respondent was being compliant with his medication if taken by injection.

[40] Dr Beech accepted however, that if the respondent was having weekly tests for his testosterone levels, there would be a point at which the levels would indicate that the respondent was not taking the oral medication or the medication was ceasing to have effect.[39]

[41] In the present case, no baseline tests were taken prior to the respondent commencing with medication. Thus the relationship between the respondent's testosterone level and sexual arousal is unknown. Dr Beech stated that the absence of base line tests was not of real importance if the level was below 3, but was important if the levels were at, say at 4.2 and it was necessary to ascertain whether that was significant in terms of sexual

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33 T1-20/30-33.

34 T1-20/41-46.

35 T1-18/23-24.

36 T1-24/17-24.

37 T1-25/5-14.

38 T1-25/15-19.

39 T1-26/15-21.

drive and presumably escalating risk.[40] Dr Beech stated that the available studies, which are limited, indicate that if you use a drug like Goserelin, the testosterone levels go down and sexual arousal and sexual fantasies both dissipate. On other medications, levels below 3 would not necessarily quell sexual fantasies or desires in the same way.[41]

[42] Dr Beech agreed that the current regime of anti-androgen medication, namely Cyproterone, would have the effect of supressing fantasies or urges or thoughts. In the studies that were available, there was about an 80 percent reduction, and because the fantasies or urges or thoughts are supressed, it would be less likely that he would act on any of them.[42] Dr Beech agreed that the most robust indication of an escalating risk would be disengaging from correctional services supervision and monitoring programs, disengaging from psychological therapy and intervention and discontinuation or poor compliance with the recommended risk management communication. He considers however, that the problem remains that there may not be any indication that any of this is going on at all.[43] He agreed however, that discontinuation or poor compliance with anti-androgen medication would be a strong indicator of escalating risk.[44] Dr Beech would expect that it is more the duration of a change in the respondent's attitude than a day to day change in manner which would be of significance.[45] Dr Beech stated that in those circumstances, intervention could be by a number of different means, such as watching him carefully, having a psychologist involved, increasing medication, or involving a psychiatrist. The aim of any intervention is, if the respondent is in a negative emotional state, to ensure that he is not fantasising sexually and using sex to cope with his problems and from there start to plan and act, or to ensure that he is not in such an irritable state that he might somehow, as he did in his early stages of offending with children, impulsively act that out.[46]

[43] When asked about the risk of the respondent deciding that he did not want to continue taking the medication, Dr Beech considered that the respondent would not necessarily simply say that he would not take the medication, but would more likely engage in more subtle conduct such as arguing with those who he sees as to when he sees them, what tests he gets done, what particular drug he takes and things of that nature.[47]

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40 T1-26/40-43.

41 T1-27/14-16.

42 T1-35/37-44.

43 T1-36/1-10.

44 T1-36/12-13.

45 T1-36/20-29.

46 T1-37/14-20.

47 T1-28/3-5.

[44] Dr Beech agreed in cross-examination that the respondent's plans and expectations on release are quite realistic.[48] He agreed that Cyproterone has the effect of reducing the respondent's sexual urges, his sexual arousal and his deviant sexual fantasies.[49]

[45] Dr Beech accepted that in addition to the management of the respondent's risk by medication, supervision and treatment, there are a number of relevant overlying factors which exist, namely: settling in the custodial setting, being placed in the residential facilities, employment and observations made in the Index Offender Management System notes that he has, for all intents and purposes, seemed to be a model prisoner.[50] He noted in particular that the respondent has built up a good relationship with Dr Madsen over six years, which would assist in the management.

[46] In his supplementary evidence given on 27 July 2018, Dr Beech commented that the readings of the respondent's testosterone levels have increased since the early levels, which were found to be below 3 in 2017 for unexplained reasons. The levels have been above 3 even though the respondent had his dosage increased to 100mg and then 200mg. Dr Beech noted that, even on 200mg, his levels of testosterone are hovering at around 3.5. Dr Beech said that there are at least six different reasons why the testosterone levels would go up. The most common reasons would be a lack of absorption, that the respondent is masturbating or that other medications may be interfering with the drugs.

[47] Dr Beech states that it is possible to increase the level of Cyproterone up to 300mg but that must take into account the fact that the respondent is already starting to get significant side effects on the increased dosage.

[48] Dr Beech stated that he did not consider that Depot-provera was as effective as Cyproterone, albeit it has the advantage of being an injection. It would however, ensure consistency of testosterone levels and is not affected by variables such as absorption. He does not consider Depot-provera could be used in conjunction with Cyproterone.

Dr Aboud

[49] Dr Aboud, by reference to previous psychiatric reports, summarised the respondent's position as follows:[51]

> "Initially, from 2006, the examining psychiatrists expressed concern that Mr Lawrence's risk of re-offending was very high, on account of his deviant sexual drive and psychopathic personality traits, and beyond the scope of safe community management. However, in more recent years, examining psychiatrists had increasingly considered that he had shown signs of

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48 T1-30/1-12.

49 T1-30/23-27.

50 T1-32/29-35.

51 Affidavit of Dr Aboud, filed 17 April 2018, Exh AA-3 at p 10-11.

> maturation in respect of his personality and that his libido was less strong. He had increasingly been thought to become less impulsive, and that his psychopathic personality traits were less evident. These considerations had been reflected in the assessment of his potential manageability on a supervision order, should he be released. Most recent psychiatric reports have highlighted the need for his risk of re-offending to be robustly managed with antilibidinal hormonal medication, and for this medication to be commenced and properly trialed in prison, prior to any consideration of release to a community setting."

[50] Dr Aboud considered that the respondent meets the criteria for a psychiatric diagnosis of antisocial personality disorder. He also noted that he had been assessed to have previously manifested a range of psychopathic traits, and while Dr Aboud considers that there has been moderation over time in the accentuation of these traits, the core psychopathic disposition remains. Dr Aboud opined that the respondent also meets the criteria for a diagnosis of the paraphilia sexual sadism. Dr Aboud noted that previous psychiatric reports have opined that the respondent also has likely paedophile tendencies and Dr Aboud considers that this may well be the case. He noted that the respondent has a low IQ. Dr Aboud agreed with other psychiatrists that the respondent appears to function at a higher level than the label attached to his rating of intelligence might suggest. He however stated that it might be that when tested in a less restricted environment than a prison institution, his intellectual limitations might become more evident.

[51] Dr Aboud stated in his report that:

> "It would appear that from an adolescent age Mr Lawrence came to maladaptively manage psychosocial stress, anxiety, low selfesteem, feelings of disempowerment, social isolation and interpersonal difficulties with intense sexual preoccupation and sadistic sexual fantasy. This is likely to have occurred as a result of his prejudicial childhood and his abnormal psychosocial maturation and development. He became secretive and untrusting of others, and such tendencies appear to continue to the current time. He has given varying accounts of the presence, absence and cessation of sadistic sexual fantasy…"

[52] Dr Aboud noted that the respondent presents with a number of particularly worrying risk factors for sexual and violent reoffending. Those factors include: the chronicity, diversity and specific nature of his sexual offending; his sexual deviance; his previous impulsivity; his breaches of criminal justice orders; his antisocial personality and psychopathic traits; and the limitations he experiences with insight and processing emotions such as empathy and remorse. Dr Aboud considered that there are positive developments in the respondent's favour, including that he has completed a range of sexual offender treatment programs and engaged in individual therapy with a skilled psychologist for the last 5 years. However, Dr Aboud considered that the respondent suffers from an unusual and highly concerning psychopathology, namely a combination of the paraphilia sexual sadism and an antisocial personality with some psychopathic

traits. Dr Aboud stated that given the respondent's past offending history, it must be recognised that should he reoffend there is potential for the offence behaviour to be very serious, namely the committal of a sexually sadistic murder.

[53] Dr Aboud used a number of tools in assessing the respondent's risk of reoffending. The actuarial assessments of sexual and violence recidivism, which largely rely on a number of historical factors, indicate that the respondent represents a high risk. The dynamic assessments however indicate that the risk is reduced. This reduction is on account of a number of different factors, namely: the softening of the psychopathic personality traits as part of the natural aging process; his settled custodial behaviour, reflecting improved impulse and emotional control; his participation in recommended psychological therapies, and significantly his ongoing commitment to individual psychologist treatment over several years; and his agreement to take prescribed antilibidinal medication and antidepressant medication since April 2017.

[54] Dr Aboud stated that it was now his opinion, that in circumstances of his continuing acceptance of recommended medications, the respondent's overall risk of both sexual violence and general violence would be reduced to below moderate and be considered potentially manageable in the context of a supervised order.[52]

[55] At the time Dr Aboud's report was provided, the respondent's available blood test indicated that the serum testosterone had been reduced to levels well below that of a typical male and significantly below his previously measured levels, and that in that period the respondent had described that he was no longer experiencing any sexual arousal or urge or desire to masturbate.

[56] In Dr Aboud's opinion, the respondent requires a clear and robust structure around his prescription, administration and monitoring of medications for the purpose of risk management. Medications would include the antilibidinal and would also to some extent include the antidepressant. He considers that the medication should be prescribed by a psychiatrist or there should be oversight of the medication by a psychiatrist and blood test results should be going to the psychiatrist. He also considers that there needs to be a close working relationship with the psychiatrist, Dr Madsen, the psychologist and with QCS.[53] In this regard, his view is similar to Dr Beech's view.

[57] Dr Aboud does not consider that the general practitioner should be the lead nor be the main medical professional who has responsibility for the oversight of the respondent's treatment. In that regard, he expressed concern that the psychiatrist, Dr Arnold, was introduced and then withdrawn from the process.[54] He stated that:[55]

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52 Affidavit of Dr Aboud, filed 17 April 2018, Exh AA-3 at p 21.

53 T1-41/10-19.

54 T1-41/23-25.

55 T1-41/40-43.

> "I think that was unfortunate because I would have thought that she still has a role, but it probably needed to be clarified that she had a primary role in relation to the antilibidinal, not a secondary role at all."

[58] Dr Aboud agreed with Dr Beech that there were risks in having the respondent take oral medication in terms of supervision and ensuring that he had taken the medication.[56] Dr Aboud also noted that if the respondent wished to bring up his testosterone levels, he could cease the medication and increase his levels of masturbation. Dr Aboud said, however, that one has to bear in mind that with low testosterone levels, certainly levels that are approaching 3.0nmoI/L or below, the desire to masturbate is negated. At 3.0nmoI/L or below, the level of testosterone is within the female range, and the male sex drive is about as low as one can reasonably reduce it. At such level, Dr Aboud stated that it is also very rare for a man to have an erection or sexual urges because the psychology and physiology of sexual drive are quite closely connected.[57] Dr Aboud expressed the view that it would be preferable for the respondent to have a serum testosterone level reduced to or below 3. He would have a concern if his level was between 3 and 4.5, even though that it is still quite low. At 5 or above, he would consider intervention was required.

[59] Dr Aboud considers that the most robust way of testing the respondent's compliance is by measuring his testosterone level. He said that while there would a lag, any lag time could be reduced by increasing the frequency of blood tests from monthly to a more frequent interim.[58]

[60] Dr Aboud described that the risk, if the respondent had an active sexual drive unmodified by an antilibidinal drug, arises from the fact that the respondent is a man with a personality disorder, some psychopathic traits, a history of giving confusing information about whether or not he was harbouring sexual deviant fantasies, a history of having sexual deviant fantasies of a sexually homicidal nature that date back to his teenage years, and the possibility that they are ongoing and secretly harboured with the potential for planning to act on them.[59] Dr Aboud would categorise the unmodified risk of the respondent as being very high. His view is that when one pays attention to the outcome, which could be a very severe outcome. The unmodified risk is not a manageable risk at all. He stated that so much of the respondent's management would depend on the respondent's self-report, which unfortunately has been demonstrated as unreliable.[60]

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56 T1-42/43-46 and T1-43/1-2.

57 T1-43/35-42.

58 T1-44/30-34.

59 T1-45/28-34.

60 T1-45/36-40.

[61] As to the antilibidinal medication the respondent was taking, Dr Aboud agreed with Dr Beech that the present prescribed dosage of 50mg of Cyproterone was too low. Dr Aboud agreed with Dr Beech that the GnRH agonist, which is Goserelin in Australia, has been the subject of studies which suggest that they are superior medications and have a more powerful impact of lowering testosterone levels. He agreed with Dr Beech that an injectable form of medication would be more favourable in managing the respondent. He considered that Depot-provera, which is given three-monthly and typically used as an oral contraceptive, is probably similar to that of Androcur in terms of its efficacy, but compliance could be guaranteed. He stated however, that even if the medication is given as a Depot-provera injection, it would still be very important to measure the testosterone levels. In particular, he points out that if somebody was compliant with the Depot-provera antilibidinal and had a testosterone level in the male range, then the treatment would be obviously ineffective.

[62] Dr Aboud considered that a safe level for the respondent's testosterone levels is below 3, given that he could not relied to self-report as to whether he was having fantasies or not and that it is unknown what testosterone level is needed to negate all sexual drive. He considered that while the levels of 3 to 4.5 are low, it is not the level that he hoped to see because he considered the management of the respondent on antilibidinal drugs is trying to achieve as close to a failsafe mechanism as possible, given the rather unusual and extreme nature of the respondent's sexual risk.[61]

[63] Dr Aboud considered that if one was to change the respondent from his oral medication to one of the two depot medications, it would be important for those types of medication changes to happen in a custodial environment. He considered that it could take several weeks if not a few months to change over from the oral medication to the depot medication which would require the ongoing measurement of the testosterone levels in order to hold them below 3. Dr Aboud considered that the prescription and oversight of the medication should be by a psychiatrist and one who has a record of assessing and managing people who have committed violent and sexually violent offences. Dr Arnold is such a doctor.[62]

[64] If the respondent wanted to stop taking the antilibidinal medication, Dr Aboud stated that stopping medications in people where their medication is part of a risk management process is a different to stopping medications when the medication is wholly about a person's health. A psychiatrist would take into account different considerations if the respondent, after his release in the community, stated that he did not want to take the antilibidinal medication anymore because of the side effects.[63] From a psychiatric point of view, reducing or stopping the medication should be the last resort, rather than the first action, and there may be other ways to manage the problem other than stopping the medication. He considered that if the respondent stopped taking the medication, the

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61 T1-48/41-45.

62 T1-50/1-6.

63 T1-47/24-45.

effect would be that his risk would increase, and would increase markedly after the time at which his testosterone levels were no longer reduced.

[65] Dr Aboud's opinion that the respondent presents a moderate risk in relation to reoffending of a sexual nature relies on the fact that he is taking an antilibidinal hormonal agent that is to a very large degree managing the key dynamic component of his risk, which is the respondent's capacity to marry up his physiological sexual urge with a sadistic sexual homicidal fantasy.[64] Dr Aboud's opinion is that there needs to be a sexual component for the respondent to reoffend. While his view differs from Dr Beech, he stated that it was impossible for him to say that the view of Dr Beech, that the respondent's need to dominate supports a non-sexual pathway towards sexual offending, was not open. Dr Aboud's view is based on the fact that it appears that all of the respondent's sexually violent offending has a sexual component.[65] Dr Aboud considers that Dr Arnold's view that the respondent's risk relates not only to his sexual behaviours, but also his ability to express anger and his lack of moral development and empathy so he can act against other people without any sense of right or wrong,[66] is a highly credible position. He considered that she was commenting on the respondent's personality structure and psychopathic traits as well as deviant aspects of his make-up. Dr Aboud however, considered that while those views are credible, he takes a different view and considers that the beating heart that manifests the respondent's risk is his sexual drive, particularly his sadistic sexual drive to rape and kill. The risk that manifested in 1983 was his sexual drive and particularly the sadistic sexual drive to rape and kill.[67] Dr Aboud considered that once the respondent's sexual drive is removed, he is potentially manageable, even though he still may not be honest with QCS.

[66] In response to questioning as to the ability of QCS officers to recognise escalating risk, Dr Aboud stated that the risk for sexual offending would be increased in the circumstances of psychosocial stressors, instability, interpersonal conflict, relationship difficulties, loneliness, isolation and negative effective states. He agreed with Dr Beech that there may be very little to notice, but stated that what QCS Officers may notice is a change in his behaviour, with him becoming less inclined to engage in activities that he had previously been prepared to engage in, avoiding responsibilities, or some other kind of change in him. He stated that whether QCS would identify that as a problem is questionable and it might be that those who have to work with the respondent need to be briefed as to what they need to report in terms of information to their line manager who would regularly inform and discuss the respondent's wellbeing with the psychologist, Dr Madsen. Dr Aboud considers that it would be very important that there was a regular dialogue between QCS and the treating psychologist.[68] Dr Aboud noted that it

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64 T1-51/10-15.

65 T1-51/34-42.

66 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.2.2].

67 T1-52/36-37.

68 T1-53/10-24.

would be a change in the respondent that was important. Determining the reason for the change is difficult because the respondent is prone to keeping information to himself. Dr Aboud also considers that the respondent is anxious that disclosures lead to negative impact for him. Dr Aboud considered that putting the respondent on a curfew and limiting his movements would be a useful risk management intervention in response to any significant change, even though it could make the respondent feel worse, and then feeding information to Dr Madsen. Dr Aboud considers that when the respondent is released he would probably be managed quite restrictively, and he would need to be on a supervision order for a minimum of 20 years.

[67] Dr Aboud stated that in terms of psychosocial stressors, the respondent's likelihood of acting on them in the sense of reoffending is linked to his sexual drive. There could, if those factors are recognised, be a broad supportive intervention in respect of them that would avoid the respondent going down a path of brooding, obsessively thinking and starting to become more pathological in his internal world. For the respondent to be likely to act on the sexual stressors in a sexual way, he would need a sexual drive, a libido that allows that negative disposition, that pathological internal thought to start to become sexualised into a maladaptive pattern of thinking that involves harming somebody sexually and killing them in order make him feel better about himself.[69]

[68] Dr Aboud considered that those psychosocial stressors could cause the respondent to want to stop taking the medication. That could also occur if his relationship with his female pen pal continued and he became frustrated at being on an antilibidinal medication and not being able to engage in a sexual relationship with her.

[69] Dr Aboud pointed out that for the respondent, psychosocial stressors are inevitably going to occur and it is about how they are managed and how the respondent is supported in managing them as opposed to trying to avoid their existence altogether. He considered that the respondent is going to have a whole range of problems if he is released from prison in negotiating day to day things, such as his living circumstances and what he is allowed to do and what he is not allowed to do and that between QCS officers, his case officer and his psychologist and his psychiatrist, he is going to need a lot of support.[70] Thus, while the respondent is voluntarily engaging in his medication and is of a fairly calm and accepting disposition in the prison, caution needs to be exercised given the environment that he is presently in at a time when he considers it is in his best interests to take that medication.[71]

[70] Dr Aboud considers that if the respondent's testosterone level got to a level of above 5, action such as incarcerating him for risk management purposes would be required until further measures could be taken to manage that risk.[72] In making that comment, Dr

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69 T1-54/35-46.

70 T1-55/30-36.

71 T1-55/40-46.

72 T1-58/1-12.

Aboud agreed that the increase in testosterone levels would not necessarily be due to anything done by the respondent. He agreed that a reasonable course of action would be, if the testosterone level was above 5, for the psychiatrist to increase his medication dosage. Dr Aboud considered that while he had nominated that the blood tests to check testosterone levels should be monthly, it would perhaps be appropriate that the levels be checked fortnightly or even weekly if there was some kind of increase in the respondent's testosterone levels.

[71] Dr Aboud considers that the psychiatrist should be the ultimate decision-maker as to the antilibidinal medication regime, including which antilibidinal the respondent is prescribed, the appropriate dosage, and the frequency of the testosterone test and the response if the respondent does not wish to take it.[73] The general practitioner should be involved. He considered that the psychiatrist, general practitioner and QCS would need to work together. The psychologist also needs to be involved.

[72] Dr Aboud stated that he considered that the SSRI antidepressant is being prescribed to the respondent because he recommended it based on a small body of evidence that demonstrates that they do have a purpose in the treatment of sexual offenders and in particular they reduce obsessive thinking. In this case that is directed to obsessive thinking associated with sexual fantasy.

[73] The respondent was cross-examined about being on the antidepressant and stated that he did not think that he needed to be prescribed it because he was not depressed. It is evident from Dr Aboud's evidence that that could well be the case, given the reason that Dr Aboud had recommended it was not to treat depression.

Dr Arnold

[74] Dr Arnold provided a report which was in evidence. She had been engaged by QCS after the previous review hearing following the agreement by the respondent to commence antilibidinal medication. The instructions provided for her to make an assessment, which would involve up to four consultations and to provide a report which includes progress with addressing treatment targets and progress and compliance with antilibidinal medication if relevant.

[75] Dr Arnold gave that report. She noted that the respondent gave her permission to liaise directly with his general practitioner, Dr Hayman, with whom she had some discussions about his management. She also noted that the respondent informed her that he was already taking Androcur (Cyproterone), as he had decided following the Court decision that he needed to take the medication so he organised an appointment and Dr Hayman had prescribed 50mg daily. He said that he was already referred to a psychiatrist at the time.[74] It was plain from the interaction of the respondent with Dr Arnold that he did

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73 T1-59/38-41.

74 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [3.3.1].

not understand why he was taking the antidepressant, although he had noted that Dr Aboud had said that he had to take an antidepressant.[75] I have referred to this earlier.

[76] The respondent told Dr Arnold that he had a friend in Hervey Bay that he had known for some time, who had said to him when he gets out of jail they could have sex and that feels good and he had masturbated to that thought. He stated that now he was on medication, the masturbation had stopped. He stated that he was not sure what will happen with the relationship but it is still a friendship. He stated he did not think about sex and that the woman in Hervey Bay knows the medication he is taking.[76]

[77] At the time that Dr Arnold saw him, the respondent's testosterone levels were 1.5nmoI/L on 17 May 2017, 1.7nmoI/L on 30 May 2017, and reportedly 2.8nmoI/L on 29 June 2017, which she was still to confirm with his general practitioner, Dr Hayman.[77] Dr Arnold considered by reference to those levels that the current dose of Cyproterone was adequate and his testosterone level was significantly sub-therapeutic.[78] Dr Arnold also stated that she understood that Dr Aboud directed the use of an intramuscular medication to achieve the same results stating that a three monthly injectable format would mean that there was more control over the medication and less for the respondent to make decisions about on a daily basis. Dr Arnold stated that as the respondent had already made the decision, to take Cyproterone as a daily oral dose, and this had quickly lowered his testosterone levels, that this would be the long term medication of choice. Her report states that she raised the other injectable form with the respondent and he agreed that it would seem unnecessary at present.[79] The respondent was cross-examined about this and appeared to suggest that he had sought the oral tablet and not the injectable form. He could not recall the discussion. It is unclear on the evidence how the respondent came to be prescribed the oral medication as opposed to an injection.

[78] In her report of 8 August 2017, Dr Arnold noted that she would continue to monitor his testosterone levels, monitor his other physiological parameters and also watch for medical complications of testosterone.[80] Unfortunately, however, her engagement was terminated, so that did not occur.

[79] Dr Arnold considered that the respondent's risk relates not only to sexual behaviours but his ability to express anger and his lack of moral development and empathy so he can act against other people without a sense of right or wrong. She states that this was

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75 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [3.4.1].

76 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [3.7.7].

77 T1-15/1-5.

78 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.1.3].

79 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.1.9].

80 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.1.10].

based on it being unclear from the information whether he raped his victims or used rape as a threat to terrify his victims and have power over them.[81]

[80] She noted the positive thing about his prognosis and risk behaviour was that over many years in the controlled environment of the prison, he has settled down and shows no signs of anger or impulsivity, has taken control in a positive way of the workplace and has the ability to work with a number of men in a productive way. She stated that it was unpredictable if he is able to generalise this to a less controlled environment. She considered that long rehabilitation is therefore necessary to slowly introduce him to the external world, should he be deemed fit for release.[82]

[81] While it is clear from the comments that the respondent made to Dr Aboud, Dr Beech and Dr Madsen that he was unhappy with Dr Arnold and had taken exception to things in her report, it is evident from his interaction with her that he did not initially appreciate her role and that he then took exception to her not returning to see him. Her engagement was terminated without any discussion with the respondent and in particular without him having the opportunity to discuss her report with him. While there is clearly now an issue as to trust, it may be that the relationship is salvageable. The respondent gave oral evidence that he was prepared to continue with Dr Arnold as his psychiatrist if that was appropriate, particularly given that Dr Moyle had indicated that he would not be able to take on the respondent as a patient.

Ms Monson

[82] Ms Monson gave evidence on behalf of QCS. She deposed to the fact that QCS is unable to manage the risk posed by the respondent if he is released under a supervision order. This is for a number of reasons including that:

(a) QCS cannot give medication and while it can encourage an offender to take appropriate medication, it cannot compel an offender to do so.

(b) QCS holds concerns that the respondent's sexually deviant fantasies and urges may persist and be undetected by staff.

(c) The constraints of GPS tracking may not be effective for offenders who have a demonstrated history of offending against a victim in a rapid and opportunistic manner in a public place or other location where they can have reasonable cause to be.

(d) While curfews can be imposed, offenders are given passes to attend in the appointments essential to their reintegration that occur during their curfew period, and QCS does not as a matter of course escort offenders when they are granted leave.

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81 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.2.2].

82 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.2.5].

(e) The sustainability of curfews is limited because it is expected upon an offender's release that the offender will require access to the community to fulfil other requirements and to service his general living means.

(f) The QCS contingency accommodation does not provide an intensive support program and generally does not include such activities as escorted leave.

[83] Ms Monson gave evidence that QCS will fund a psychiatrist to assess the respondent for antilibidinal medication and administer the medication, including regular blood tests to monitor his testosterone levels. QCS will not fund any medication for offenders and thus the cost of any antilibidinal medication will have to be borne by the respondent. QCS will also fund a psychologist and anticipates that Dr Madsen would continue to see the respondent. QCS will continue to liaise with any treating psychologists regarding the nature and effectiveness of treatment.

[84] In her affidavit filed 27 July 2018, Ms Monson states that QCS cannot ensure that the respondent takes oral medication.[83] She considers the most effective way to ensure the respondent's compliance with antilibidinal medication is for it to be administered by injection. She attaches a report by Dr Moyle following the high risk offender management unit engaging Dr Moyle to meet with the respondent to review the respondent and his antilibidinal medication regime for the purpose of providing ongoing psychiatric oversight, recommendations and reviews of medication, with administration to be undertaken in conjunction with a general practitioner. Dr Moyle provided a report indicating that he was not prepared to accept being retained to provide the psychiatric oversight and to manage the respondent's antilibidinal medication regime.

[85] Ms Monson deposes that for QCS to be effective as possible in supervising the respondent and managing his risk, a regime must be established between QCS and the respondent's treating psychiatrist to include a good working relationship, and cooperation between the two parties with very clear communication.

[86] In cross-examination, Ms Monson:

(a) agreed that it would be up to a treating psychiatrist to determine which medication was more effective for the respondent;

(b) accepted that, in relation to her concern that QCS would have no control over which medical practitioner the respondent attends upon to obtain his medication or the type of medication, a provision could be included in a supervision order that he attends upon a medical practitioner and that he not change the medical practitioner without first notifying QCS;

(c) accepted that all medical practitioners could work together with QCS by a process requiring the respondent to disclose aspects of his treatment to QCS, and for the respondent to permit those treating practitioners, be they general practitioners or psychiatrists or psychologists, to provide information to QCS and that those

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[83] At [14].

practitioners be entitled to exchange information between them as part of managing the risk the respondent presents; and

(d) accepted that a way of controlling the respondent to ensure that he takes his medication is to ensure that he gets medication from Dr Hayman or someone at that clinic, and in the event that he fails to do so, ensure that be reported to QCS, or by an alternative condition that the respondent go to a pharmacist to be dispensed with the Androcur and the pharmacist could report a failure to QCS. She is unaware whether such a facility is available.

[87] Ms Monson also accepted that it was possible that QCS could request the respondent's treating practitioner to initiate a blood test, albeit that they would be guided by the treating medical team. She accepted that the results from any blood test could, by the terms of the supervision order, be disclosed not only to the respondent's medical practitioners, but to QCS. She also agreed in cross-examination that while she had stated that QCS had not obtained any pathology results from Dr Hayman, QCS had not requested those results. She also accepted that disclosure, not only of tests being carried out to ascertain the testosterone levels but also of the medication regime, could be the subject of disclosure requirements in a supervision order.

[88] Ms Monson confirmed that QCS would be willing to speak to Dr Arnold and ascertain whether she is prepared to re-engage with the respondent.

[89] Ms Monson confirmed that the respondent did not have any disciplinary issues within the prison as far as she understood, had employment and was in a residential facility. The respondent's current behaviour is regarded as being able to be managed in a less secure environment.

Mr Mark Lawrence

[90] The respondent gave evidence and was cross-examined.

[91] The respondent deposes to the fact that he has been in low security custody after being placed in Sir David Longlands Correctional Centre since 2006 when he was granted low classification. He has undertaken a number of sexual offender programs in relation to cognitive skills, anger management and stress management. He has worked in the light fabrication workshop since 2008 and progressed to a leading hand, which is the highest level. He deposed to his good behaviour since being at Wolston Correctional Centre since his arrival.

[92] He stated that he is willing to undergo further courses and professional counselling to assist him to live in the community. He confirmed that he will comply with the conditions of a supervision order. He stated that he is willing to continue on the medication prescribed for the reduction of his sex drive and that he will not do anything to jeopardise his stay in the community. He attached the Future Release and Relapse Prevention Plan, which was provided to Dr Beech and Dr Aboud, both of whom said that the plan was appropriate. He also deposed to the fact that he has spoken with the Salvation Army who confirm that they will support him up on his release.

[93] The respondent deposed to his last blood test result for testosterone being 3.7, which he considered was well below the range of which he stated was the target. He was particularly cross-examined about his blood tests and how many blood tests he had obtained. He stated, notwithstanding that there were no results between 28 July 2017 and 3 October 2017, that he had blood tests in that time. He also indicated that he had a blood test on 31 October 2017 and 13 December 2017, but did not know where the November 2017 test result was, but stated that he definitely had a test in November. He also claimed that he had a blood test in February 2018, even though he only had results from 25 January 2018 and 5 March 2018. He could provide no explanation for the lack of results. The respondent's notes upon which he was cross-examined reflect that he understood that he would have a blood test on the 30th of every month.[84] He did have blood tests on 28 August 2017, although he was not able to identify whether one of them was for testosterone, and on 29 September, his notes reflect the fact that his testosterone levels had not been checked for 2 months. On 3 October he had a blood test. There is also reference to him having chased up blood tests. I consider that the respondent's evidence that he had tests monthly was generally self-serving, given that he was aware that he did not have monthly results and his notes reflect that he had not had tests every month.

[94] The respondent was also cross-examined about taking an antidepressant and the fact that he had stated that he did not have depression and did not feel he needed an antidepressant. He accepted that he has said that. The matter is of no significance since it appears he was not prescribed an antidepressant for depression. Dr Aboud's evidence was that the antidepressant was not prescribed for depression but rather was a second prong of the medication which he was given. It is apparent from Dr Arnold's report however, that the respondent did not understand why he was taking the antidepressants, but referred to the psychiatrist Dr Aboud saying he had to take the antidepressant.[85]

[95] The respondent was candid in agreeing to cross-examination enquiring that he was taking the antilibidinal medication to lower his testosterone levels to obey what the two psychiatrists had said in the Court hearing last year.[86] He stated that he did not think he needed to take it, but he had to take it. He identified the benefits of the medication as being that he cannot masturbate and cannot get an erection and that there were bad benefits because he gets hot sweats and starts shaking.[87] He stated that Dr Beech was saying that the medication can stop fantasies and "all that kind of stuff" and "which I don't think about". He was asked in cross-examination, if he did not have fantasies, what was the medication doing? He stated that he was in a no-win situation because he had to take medication to be released and if he did not take it, he would not get

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84 Affidavit of M Lawrence, filed 19 April 2018, Exh MRL-3, entry of 12 June, p 3.

85 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [3.4.1].

86 T1-33/15-19.

87 T1-33/20-34.

released.[88] He stated in cross-examination that did not perceive he had a sexual deviance anymore and that it had gone.[89] When asked whether he was receiving treatment for a condition that he did not think he had, he agreed, "in a way, yes".[90] He stated that the only reason that he was taking the medication was so he could get his freedom back.[91] When it was put to him that once he was out of prison, he would not need to take the medication anymore, he said that, "I will still take the medication if that is part of my order. I would not deviate from that in any way, shape or form".[92] He stated that if it was part of the order, he would obey it because that is what people want and he was willing to obey that. It was put to him, "It's what the people want, you said, not what you want?", to which the respondent replied, "It's about the safety of community, isn't it?". When it was put to him that he did not have a sexual deviance, then "what's to protect?", he stated, "Some people can change and you – and after 34 years in jail, you're saying that I can't change?".[93] He agreed that the fantasies he used to have were dangerous fantasies and stated that he had changed that through therapy and through the work he had done in prison.[94] When asked what Dr Arnold was referring to when she stated "Does not have visual fantasies. He says just thoughts", he could not remember what they were or describe the distinction between the two.[95] He stated that he did not have even thoughts these days and that violence did not pop into his head anymore.

[96] The respondent agreed in cross-examination that his female friend in Hervey Bay who had stated that when he got out of jail, they could have a sexual relationship. He stated that while he was on medication, he did not think he could have a sexual relationship with her, but stated that he would like to have a sexual relationship with her if things worked out that way. He stated that he intended to pursue the friendship with the person in question, and that he had told her he was on and antilibidinal medication.

[97] He agreed that some three or four years ago he saw Dr Hayman about Viagra, and asked about Viagra because he could not get erections. He stated that he did not go to get Viagra, because you could not get it in jail, but he was discussing it for outside when he got released.[96] It was also put to him that he had told Dr Arnold that Dr Hayman had

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88 T1-33/45-46; T1-34/1-2.

89 T1-34/5-10.

90 T1-34/22-23.

91 T1-34/29-30.

92 T1-34/34-36.

93 T1-34/6-7.

94 T1-35/25-29.

95 T1-36/25-32.

96 T1-38/30-46; T1-39/1-5.

done base line tests through Prison Health.[97] He did not agree with that. This is in reference to 7.1.2 of Dr Arnold's report. However, it is not recorded that that was a comment by the respondent and 3.3.2 Dr Arnold states, "I asked him if he had obtained any blood tests and he said not but he had some blood tests about 12 months ago".[98]

[98] He stated that he had objected to Dr Arnold's report and also he did not think much of Dr Arnold because "when people say they're going to come back and see you, they don't turn up, they should be keeping their appointments with their patients".[99] He stated that he would be treated by Dr Arnold if that was the only person who they could get to treat him.[100] That is inconsistent with previous statements that he did not want her again. It was also evident that he took exception to Dr Arnold because she asked about his past, rather than treating him, which he considers is about his future. He accepted however, that he can see that he has to stay on the medication for treatment because of his offences in the past.[101] He stated that the difficulty of Dr Arnold wanting to know about his past offences was that some of it was lies. I consider that his evidence that he was prepared to be treated by Dr Arnold involved a level of self-interest to assist his case.

[99] He stated that he had asked that his dosage of Cyproterone be increased following the previous hearing in April 2018, because Dr Beech and Dr Aboud had said that the dosage was too low. He noted that on 200mg, there are a lot more symptoms in terms of side-effects. He agreed that he had told Dr Moyle that 200mg was "wrecking him".[102] He also agreed that he had said that Dr Hayman hasn't got a clue about how to manage this as he is just a GP and doesn't specialise in this medicine.[103] He stated the reason for his comment was that Dr Hayman doesn't understand why his levels are where they are, because of the increase in his dosage.

[100] He agreed that he had taken Androcur in the 1990s but he had stopped it because of the side-effects and "in prison, people gig you about your breasts and all that kind of stuff", and he "didn't understand the side effects" and he wasn't getting any blood tests and he wasn't seeing a psychiatrist.[104] He agreed that he was having similar side effects to the drugs now. He stated that he considers that the side effects are worse on his present dosage than they were in the 1990s. The respondent, when asked whether he would be willing to take the medication, notwithstanding the physical symptoms he was presently

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97 T1-39/5-26.

98 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [3.3.2].

99 T1-42/11-12 and 41-42.

100 T1-42/45-46.

101 T1-43/20-23.

102 T1-46/34-35.

103 T1-46/43-36.

104 T1-47/24-29.

suffering from the medication, confirmed that that was the case. The respondent also confirmed that he understood that the supervision order that he may be placed on could be for a long period of time, and that he could be subject to having the medication for a very long time and that he would still be willing to take it.[105]

[101] Overall I consider that the respondent was reasonably candid in the evidence he gave, although some statements were self-serving and exaggerated when he considered it would assist in his application. While he gave his assurance that he will continue to take the antilibidinal medication for as long as he is subject to an order to do so, I find that he does not consider he needs to take it, save to ensure his release. He could, however, identify the reason he was taking it. His pragmatic approach to taking the medication highlights that he needs to be in a stable treatment regime prior to his release and to be engaging with the psychiatrist who has oversight of the treatment regime upon his release.

Dr Moyle

[102] QCS produced a report by Dr Moyle at the 27 July hearing. QCS contacted Dr Moyle in order to ascertain whether he would be prepared to undertake supervision of the respondent on his medication. Dr Moyle produced a 42 page report in response, even though that apparently was not requested. However, it is evident from the letter of 19 April 2018 that Dr Moyle may well have been confused, given the nature of the letter that was written to him, about his role. As it turns out, he provided a lengthy report and he was provided with considerable information by way of psychiatric reports.

[103] The respondent was prepared to proceed with the hearing, notwithstanding the considerable report that had been provided by Dr Moyle and which the respondent had only been provided with the day before. An affidavit attaching the report was not, however, provided by Dr Moyle and the report was annexed to Ms Monson's affidavit.

[104] Dr Moyle indicates that Dr Arnold had a very fine appreciation of the respondent's personal needs, in paragraph 7.1.12, regarding his need to gain a sense of identity and meaning. He considered that the tests carried out by Dr Hayman were appropriate. Dr Moyle on his interview with the respondent formed the view that he had no commitment to be treated with antilibidinals once he was released into the community. He regarded the respondent's sole goal was to be released from gaol, not to calm or prevent fantasy-driven arousal or masturbation. He raised the need for a therapeutic relationship to be established between a psychiatrist and the respondent. In particular Dr Moyle considers that the treatment contact with Dr Arnold had left the respondent angry when he saw her, like others, not living up to their obligations and considers that he needed to be assured that that was not due to her disliking him. He noted that Dr Arnold was quite able to take responsibility from his care and was prevented from doing so with a consequent negative effect on their therapeutic relationship. He agrees that Dr

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105 T1-51/1-10.

Madsen's treatment has been effective and longstanding, but in the respondent's case, the most effective treatment biological treatment in conjunction with a psychologist.

[105] While Dr Moyle considered that the respondent may have entered into treatment as a result of being coerced to do so in order to be released from prison, he did not consider that he is unable to consent to treatment. Dr Moyle considered that if the respondent consented willingly, voluntarily and without coercion to treatment to lower the sexual deviant fantasies spontaneously, that would be appropriate. He considers it is necessary to develop a therapeutic relationship with Dr Arnold while in custody to overcome any concerns about the treatment's utility. Dr Moyle was not prepared to take on the respondent for a number of reasons, including a misconception of the role he was being asked to undertake, which he understood was to oversee Dr Arnold.

[106] Dr Moyle, like Dr Beech, considered that the respondent should be treated with Goserelin, although he states that he "should have available to him the use of the most powerful antilibidinals, albeit at some cost that is unable to be met by individuals". He does not however state alternative drugs cannot be effective to treat the respondent. While he states that the respondent does not willingly consent to treatment of a paraphilia and sees it as a way to illicit release from custody, prevents his re-integration into society, I am not entirely convinced that is a correct perception. The respondent's evidence displayed some understanding of the effect of the treatment and the perceived benefits. However, I find that the respondent did not understand its use from a therapeutic point of view. That may have arisen at least in part from the fact that he did not have ongoing interaction with Dr Arnold and did not appreciate the effect of Dr Aboud and Dr Beech's reports.

[107] The respondent undertaking the treatment was in response to evidence that had been given in the Court stating that the only way that he could be released and his fantasies could be said to be controlled, given his lack of self-reporting, was by engagement with antilibidinal treatment. While it is apparent that he may not fully understand the basis of the treatment, he took steps willingly to undertake the treatment and has maintained taking the medication including increasing the dosage of it, and was able to identify some benefits. That is supported by the report of Dr Arnold.[106]

[108] While Dr Moyle is an eminently qualified psychiatrist to express opinions about the respondent and his treatment, given the lateness of the report being provided, the confusion as to the purpose of the report and as to the instructions, I accept Dr Moyle's evidence as to the importance of the therapeutic relationship between a psychiatrist, psychologist, general practitioner and the respondent and that a psychiatrist should be involved in his treatment while on the antilibidinal medication. I give less weight to the other views expressed by Dr Moyle than to those of Dr Beech and Dr Aboud, who were engaged to provide the s 28A reports and gave oral evidence.

Consideration

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106 Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [4.8.1].

Is the respondent a serious danger to the community?

[109] The first question that must be determined is whether or not the Court should affirm the decision that the respondent is a serious danger to the community in the absence of a Division 3 Order.[107] The Court can only affirm the decision if it is satisfied by acceptable cogent evidence and to a high degree of probability that the evidence is of sufficient weight to affirm the decision. The respondent does not dispute that there is such evidence and the decision should be affirmed. I must have regard to the factors in s 13(4) of the Act and the reports produced under s 28A of Act in determining this question.

[110] Having regard to the psychiatric evidence of Dr Aboud and Dr Beech, which I have discussed in some detail above,[108] I find that there is a moderately high to high risk of reoffending by committing a serious sexual offence if the respondent was to be released without a Division 3 Order and without continued treatment with antilibidinal medication.

[111] The respondent has been diagnosed with having the sexual paraphilia of sexual sadism, and an antisocial personality disorder with psychopathic traits, which according to Dr Beech perpetuates the risk posed by the respondent. That view is supported by Dr Aboud. Dr Aboud considers that the respondent may well have paedophile tendencies which have been identified in previous psychiatric reports. Dr Beech and Dr Aboud have both noted the respondent's progress in recent years and both consider that there has been a reduction of risk having regard to the dynamic risk factors with a moderation in his psychopathic traits and his anti-social personality disorder. However, Dr Beech still considers that unmodified by a Division 3 Order, the respondent continues to pose a high risk of violent sexual offending and has described three risk scenarios if the respondent is released without any Division 3 Order which I have set out above. Dr Aboud, while acknowledging the positive steps taken by the respondent and his progress in his therapy with Dr Madsen, considers that he still presents with a number of particularly worrying risk factors for sexual and violent offending. He notes that the respondent suffers from unusual and highly concerning psychopathology and considers that, given his past offending, it must be recognised "that should he reoffend there is

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107 Section 13(2) provides that the prisoner is a serious danger to the community if there is an unacceptable risk that the prisoner will commit a serious sexual offence if released from custody or if released from custody without a supervision order being made. "Unacceptable risk" requires a balancing of competing considerations where the Court is required to make a value judgment of what risk should be accepted against the serious alternative of the deprivation of a person's liberty: *Attorney-General (Qld) v Sutherland* [2006] QSC 268 at [30] per McMurdo J. To determine whether a risk is unacceptable one must take into account and balance the nature of the risk and the degree of likelihood of it eventuating with the seriousness of the consequences if the risk eventuates: *Attorney General (QLD) v Beattie* [2007] QCA 96 at [19] per Keane JA There must be a sufficient likelihood of the occurrence of a risk which, when considered in a combination with the magnitude of harm that may result and other relevant circumstances, makes the risk unacceptable: *Nigro v Secretary to the Department of Justice* (2013) 41 VR 359 at [6]; Bowskill J in *Attorney General for the State of Queensland v Fisher* [2018] QSC 74.

108 Although I have regard to all of their evidence and the evidence put before me.

potential for the offence behaviour to be very serious, namely the committal of a sexually sadistic murder".

[112] While the respondent has given evidence that he no longer has sexually violent fantasies, his evidence as to when he stopped having such fantasies is unreliable given the inconsistent versions he has relayed to psychiatrists in the past and the fact that he believes that discussing them may harm his chances of release. Given his psychopathic traits, trusting him to self-report would be unwise,[109] particularly because he is untrusting of others. Both Dr Beech and Dr Aboud consider that the respondent's sexual fantasies are more likely to have become dormant and there remains a risk that they could re-enliven in particular circumstances and give rise to future sexual offending. I accept that that is the more likely scenario, particularly given the role of sexual fantasies in the lead up to his 1983 offending and post that conduct and his paraphilia.

[113] In his report of 21 November 2016, Dr Aboud noted the uncertainty surrounding the respondent's current sexual drive and current presence of sadistic sexual fantasies because of the respondent's unreliable self-reporting. He stated:

> "At this time, I believe that the only prudent decision is to assume that his sexual drive and sexual deviance are both in fact ongoing entities. As such, in the absence of adequate management of these factors, his risk of reoffending would not, in my view, be considered manageable in a community environment."

[114] Dr Aboud expressed the view at the time that if the respondent was to accept antilibidinal hormone medication and had a reduced testosterone level, he would consider his future sexual risk would be reduced, and if he accepted an SSRI antidepressant, it would likely decrease his potential for impulsivity and he would gain greater self-control, also reducing his future reoffending risk.

[115] Dr Aboud considers that if the respondent continues to accept the recommended medications (presently an antilibidinal medication together with the antidepressant), his overall risk of both sexual and general violence would be reduced to below moderate and could be considered potentially manageable in the context of a supervision order. Dr Beech agrees that on the current treatment the respondent's current risk of reoffending is substantially reduced and his risk is reduced below moderate with medication, psychological intervention and supervision. Both psychiatrists warn however that if the respondent were to reoffend, the offence might be catastrophic. Both Dr Aboud and Dr Beech consider that the respondent would have to be closely supervised and monitored if he were to be released, even on medication.

[116] While Dr Beech and Dr Aboud differed as to whether the respondent's sexual offending was primarily driven by his sexual drive or was also driven by a non-sexual pathway

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[109] Affidavit of Dr Arnold, filed 22 March 2018, Exh JA-2 at [7.2.1]; Affidavit of Dr Aboud, filed 17 April 2018, Exh AA-3 at p 17.

due to his personality and desire to dominate and control, both considered that the unmodified risk posed by the respondent was moderately high to high. Dr Aboud did not consider the view of Dr Beech, that there was a risk of the respondent re-offending through a non-sexual pathway which could be with violence or against a child, as a view that could not be reasonably held. Dr Beech's view was supported to some extent by the observations of Dr Arnold. I cannot discount it as a potential risk, although I consider that there is less of a risk of the respondent reoffending by committing a serious sexual offence through the non-sexual pathway. Both considered that the risk remains that the respondent would have violent sexual fantasies of raping and killing a woman and would act upon them as he did in 1983. That potential risk, if it becomes reality, could have catastrophic consequences.

[117] While the respondent's offending was a considerable time ago, the nature and pattern of that offending does support the views expressed by Dr Beech and Dr Aboud as to the risk of the respondent reoffending by committing a serious sexual offence. The respondent's criminal history extends beyond the 1983 offence. Prior to 2000, it extends to offending against children before he was an adult and to the rape and sexual assault of a prisoner in 1999.

[118] That is not to say that the respondent has not made considerable positive advancements in his rehabilitation that has had some effect on his risk of reoffending. The evidence shows that the respondent has taken significant steps in his own rehabilitation by participating successfully in sexual offender programs, anger and stress management programs and by undertaking educational courses. He has been employed in the prison since 2008 where he progressed to the position of leading hand and has conducted himself as a model prisoner in the low security section of the prison. He has made considerable progress in addressing aspects of his behaviour and learning techniques of avoidance with Dr Madsen, as is evidenced by Dr Madsen's report. He has developed a Future Release and Relapse Prevention Plan which is realistic and sought to take a number of steps to prepare for his release such as seeking support from the Salvation Army. Dr Madsen has noted the progress of the respondent in his reports and that there has been a reduction in some factors contributing to the risk posed by the respondent, although he notes that the issue of deviancy remains and is unlikely to change. The respondent's positive changes through his treatment with Dr Madsen was a matter considered by both Dr Beech and Dr Aboud in forming their opinions as to the risk of the respondent committing a serious sexual offence.

[119] Balancing all of the evidence and the different competing considerations, I am satisfied that the weight of evidence demonstrates that, unmodified by a Division 3 Order, there is an unacceptable risk that the respondent will commit another serious sexual offence which could potentially be against children or be against a woman with violence. If he does reoffend against a woman, there is a real risk of catastrophic consequences.[110] The respondent poses an unacceptable risk of committing a serious sexual offence and there

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[110] If the respondent was to re-enliven his sexual fantasies and act upon them it could result in death, as it did to the female in-patient at Wolston Park.

is a clear need to protect the community from that risk. While age, and the rehabilitation courses and treatment undertaken by the respondent have had a positive effect, his diagnosis and the potential for him to reoffend resulting from his acting out sexual fantasies as he did in 1983 or to a lesser extent, through a non-sexual pathway described by Dr Beech particularly having regard to the various stressors which the respondent will inevitably face upon his release which could act as triggers to re-enliven his developing sexual fantasies or the need to control and dominate which may manifest through sexual offending, pose an unacceptable risk. Although the antilibidinal medication reduces the risk of the respondent's reoffending, his taking of that medication needs to be closely monitored and supervised. There is acceptable cogent evidence which satisfies me to the high degree of probability required that the respondent remains a serious danger to the community in the absence of a Division 3 Order.

What Order should be made under s 30(3) of the Act?

[120] Having made that determination, the Court's discretion is enlivened under s 30(3) of the Act, which is the more difficult question in the context of the present case.

[121] In making a determination under s 30(3) of the Act, as to whether to order that the respondent continue to be subject to the continuing detention order or be released from custody subject to a supervision order, the paramount consideration is to be the need to ensure adequate protection of the community. If I am satisfied that adequate protection of the community can be ensured by a supervision order, then I should order the respondent's release on supervision rather than order his continued detention.[111]

[122] The respondent has taken a number of steps to demonstrate that he can be released under a supervision order as well as taking antilibidinal medication. Unfortunately for the reasons set out below I am persuaded that the risk of reoffending posed by the respondent cannot presently be managed through a supervision order.

[123] The respondent is a complex man and the evidence of the psychiatrists and the limitations of the role that QCS can have upon his release under a supervision order demonstrate that he would be complex to manage under a supervision order.

[124] Neither Dr Aboud nor Dr Beech consider that the respondent could reliably self-report if he is having sadistic sexual fantasies, which he has acted upon in the past in killing the young woman at Wolston Park. Dr Aboud also reported that the respondent has had sexual fantasies about raping a male, which he did in 1999 (although the respondent was found guilty of the offence, he continues to maintain it was consensual). That is

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111 *Attorney-General v Francis* [2007] 1 Qd R 396 at [39]; *Attorney-General (Qld) v Yeo* [2008] QCA 115; *Attorney-General (Qld) v Lawrence* [2010] 1 Qd R 505; *Attorney-General (Qld) v Ellis* [2012] QCA 182; *Attorney-General (Qld) v Fardon* [2013] QCA 64.

supported by the analysis carried out by Atkinson J of his inconsistent accounts to psychiatrists.[112]

[125] Given the unreliable nature of the respondent's self-reporting and his psychopathology, Dr Beech and Dr Aboud recommended last year that he take antilibidinal medication to reduce the risk of him sexually reoffending, in response to which the respondent gave evidence that he would be willing to engage in such treatment. That was referred to by Martin J in his judgment. As discussed above, the respondent immediately approached his general practitioner to take the medications recommended by Dr Aboud, rather than waiting for QCS to engage a psychiatrist. The respondent does have a tendency to act impulsively and to try and take control of situations. Following the initial hearing of this matter in April 2018, where issues were raised by Dr Beech and Dr Aboud as to his testosterone levels and their opinions were that the safe level would be 3.0nml/L or below, the respondent again went to his general practitioner to get him to increase the antilibidinal medication.

[126] While the respondent's results were below 3.0nmoI/L when he first took his medication last year, they have not been below 3.0nmoI/L this year. There are divergent opinions about the medication the respondent should be prescribed. Dr Beech considers that he would be best treated by Goserelin, given his paraphilia. That view is supported by Dr Moyle. Cyproterone, which the respondent is presently taking, according to Dr Beech suppresses sexual drive but does not ablate it. The testosterone levels may be increased through masturbation, although there are a number of reasons as to why the levels may increase. If Cyproterone is not taken for approximately one month, the levels of testosterone will increase to normal. While the respondent gave evidence that he can afford Cyproterone or Depot-provera, he cannot afford Goserelin.

[127] Dr Aboud agreed that there are studies which support GnRH agonist as being a superior medication. He also agreed that an injectable form would be able to guarantee the respondent's compliance. He did not appear to consider Cyproterone could not be effectively used. He emphasised that regardless of the form of medication used, it is the effect on the testosterone level which is critical and must be monitored.[113]

[128] Dr Aboud considered that the respondent's offending is driven by his sexual drive and if his testosterone level is reduced below 3.0nmo/L, his sexual drive would be reduced such that even if he had sadistic sexual fantasies, he would be unlikely to act on them. Dr Aboud considered that he would also be unlikely to have any desire to masturbate, which could increase his testosterone levels. That appeared to be accepted by Dr Beech. Although Dr Arnold was not cross-examined, and her views as to Goserelin and Depot-Provera as alternative treatments are unknown, she had at least expressed the view that Cypotrerone was appropriate at the time she saw the respondent, although that must be

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112 [2016] QSC 58 at [183] to [188].

113 T1-46/14-24.

balanced against the fact that she had limited results which showed low testosterone levels and was expecting to be supervising the respondent on his treatment in the future.

[129] The practical advantage of the respondent being prescribed Depot-provera or Goserelin is that given they are administered by injection, supervision of his medication is easier than if he is taking oral medication, and it also appears that they are able to regulate testosterone levels more consistently as they are not subject to as many variables as the oral medication which can affect the absorption of the drug. It is also easier for QCS to manage supervision of the respondent, given they cannot supervise him taking the oral medication on a daily basis.

[130] I presently must make a determination on the basis of the respondent continuing to take the oral medication on a daily basis if not twice daily. While the evidence of Dr Beech is that it would take a month to reverse the effects of the antilibidinal medication and for the respondent's testosterone levels to return to his normal testosterone levels, the level at which the risk of the respondent's reoffending could start to escalate could be less than his normal level, depending on the level of testosterone which needs to be present in the respondent in order for his sexual drive to be reactivated. Dr Aboud considered that a level of 5.0nmoI/L or above would ring alarm bells. Both Dr Beech and Dr Aboud consider above 4.0nmoI/L would be concerning. It is in this regard that the absence of baseline testing before the commencement of the medication is significant.

[131] Dr Beech and Dr Aboud both states that they consider that the testosterone level of the respondent needs to be 3.0nmoI/L in order to reduce his risk of reoffending to below moderate, particularly given the absence of any baseline tests before he started taking the medication. The respondent is presently seeking to deal with a higher dosage of Cyproterone to try and achieve that level, but it had not been achieved by the time of the 27 July hearing and his levels remained above 3.0nmoI/L.

[132] While it was submitted by the respondent's counsel that he could have his medication adjusted to achieve such levels, I consider that it would be necessary for the relevant medication level to be established while in custody, particularly given the possible side effects which may need to be managed. Presently, the effect of the respondent's testosterone levels being above 3.0nmoI/L on his sexual drive is unknown. Without the respondent's sexual drive being effectively suppressed, the risk of him re-enlivening sadistic sexual fantasies and reoffending cannot be effectively managed by a supervision order.

[133] The three-pronged treatment regime recommended by Dr Beech and Dr Aboud, which involves a psychiatrist such as Dr Arnold being engaged to determine, monitor and oversee his treatment on the antilibidinal medication, needs to be in place before the respondent is released under a supervision order to ensure his manageability, particularly if the respondent is to continue on oral medication which is liable to fluctuate for a number of reasons. While it was submitted on behalf of the respondent that conditions could be put into place to ensure communication between the medical professionals who need to be involved and regular blood tests could monitor the testosterone levels, that can only be done when the respondent is on a stable medication

regime supervised by a psychiatrist, where a psychiatrist is satisfied that the respondent's testosterone level is at a level which can adequately manage the risk of the respondent's reoffending. In that regard it is significant that Dr Aboud has identified a number of matters which may increase the risk of the respondent reoffending when he transitions from the prison into the community. Dr Arnold and Dr Madsen have identified that that transition needs to be carefully managed. If the respondent had to transition from jail after thirty-four years and deal with an unstable medication regime which has not been adjusted to achieve the target testosterone levels at which the risk of the respondent acting on sexual fantasies has been safely reduced as well as dealing with any side effects and all of the stresses to which he will be exposed and having to build a relationship with a treating psychiatrist, the instability that the respondent will be exposed to and his potential responses is not manageable on a supervision order and the adequate protection of the community cannot be ensured. The complexity of the respondent's diagnosis and his personality and his secretive nature and slow ability to build trust with people is such that he needs to have the relevant treatment regime in place before he can be managed under a supervision order to ensure the adequate protection of the community, rather than him being released while the determination of the appropriate level of medication and the necessary testosterone level being achieved is a work in progress. A psychiatrist and Dr Madsen need to be actively involved in establishing that regime.

[134] Having reviewed the evidence, it is apparent that there was an unfortunate chain of circumstances which led to the respondent being prescribed the antilibidinal, Androcur, by his general practitioner before Dr Arnold had reviewed the position and discussed it with the general practitioner. It was then unfortunate that her position was terminated, apparently on the basis that the general practitioner was monitoring the medication. It is apparent from the evidence of Dr Beech and Dr Aboud that the respondent's treatment process, using antilibidinal medications, needs to be undertaken with a combination of different professionals involved in a coordinated way. That has not occurred, with the result that a stable treatment regime has not been established.

[135] It was submitted on behalf of the Attorney-General that the respondent had prematurely approached the general practitioner to get the medication before Dr Arnold was engaged and had brought the relationship with Dr Arnold to an end. That does not appear to be entirely borne out by the evidence. The respondent had agreed in evidence in the review last year that he would undertake such treatment and the IOMS notes reflect the fact that he was eager to undertake it and had discussed it with his case management officers following the court hearing. He did so through his general practitioner. It appears that QCS may not have informed the respondent that Dr Arnold was to be engaged and terminated Dr Arnold's services without informing the respondent that they were going to do so. After that time, the respondent indicated that he did not wish to be attended by Dr Arnold in the future and wished to be assigned a different psychiatrist. That however is explained, in part, by the fact that he never had the opportunity to discuss with Dr Arnold a report that she prepared which he considers

contains misinformation. [114] The respondent had also commented to Dr Madsen and other psychiatrists that Dr Arnold simply had not come back which, to a person who is naturally suspicious and untrusting, easily undermines trust in a relationship. The combination of both circumstances would appear to have contributed to the respondent's position. However, he was not responsible for bringing the relationship to an end. It was plainly a result of a misunderstanding. QCS understood that the medication was being administered by Dr Hayman and did not understand the role which Dr Arnold was to have in that treatment process, nor does it appear that Dr Arnold necessarily understood her role fully.

[136] As discussed above, Dr Beech raised the prospect of the respondent still being at risk of offending even if on antilibidinal medication at the appropriate level, because of his personality traits which seek to control and dominate. He considered that the respondent's offending in the early part of his life in relation to children may be due in part to those features of his personality and that if he upon his release became frustrated, depressed and stressed and felt a lack of control, that may cause him to sexually reoffend. Dr Beech pointed out that it would be difficult to determine whether he posed such a risk unless he communicated how he was feeling to someone such as QCS or his psychologist. Dr Aboud did not adopt that view, although he considered such a position was a reasonable one to adopt. Dr Aboud did however consider that it was important to manage the effect of psycho-stressors and instability and other matters identified on page 16 of his March report upon the respondent as those matters could increase the risk of his sexual offending. While both Dr Beech and Dr Aboud stated that it may be difficult to detect whether the respondent was experiencing those stressors, particularly for QCS, both considered that changes in his disposition such as his becoming querulous, cantankerous and non-cooperative over some time would be observable and steps could then be taken to impose restrictions and contact the respondent's psychologist to provide supportive intervention.

[137] They considered that the provision of support to the respondent is important to reducing the triggers that could lead to the respondent's reoffending. The Attorney-General submits that that is not manageable by QCS under a supervision order, particularly given the evidence that the respondent is non-trusting and secretive and seeks to avoid disclosing things that may harm his position. There is no doubt that it would raise challenges for QCS and, as Dr Aboud indicated in his evidence, the case workers and QCS officers would need to be trained as to signs they would need to look out for and to inform Dr Madsen. I do not consider that on the evidence before me it would not be possible for QCS to manage this aspect of the respondent's risk under a supervision order. That is supported by the fact that the respondent has particularly through his treatment with Dr Madsen learnt about the importance of communication and taking steps to avoid negative thoughts and manage anger. The IOMS notes of the interactions with his case worker also indicate that he is communicating in a more open way and

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[114] T2-42/11-45.

dealing with matters which do not go the way or at the pace he would like in a calm and more patient manner.

[138] The primary tool in managing the respondent's risk of reoffending is, however, the maintenance of his testosterone levels at a low level which would curb any sexual drive and ability to act on such frustrations and stressors by sexually reoffending, together with the treatment regime involving a psychiatrist and psychologist.

[139] I am presently not satisfied that adequate protection of the community can be assured if he is released on a supervision order. One of the most significant triggers for the respondent reoffending would be if his sexual fantasies and/or his sexual sadism became enlivened through him being exposed to the stressors described by Dr Aboud and visual or other sexual queues and the opportunity to access potential victims which cause him to become sexually pre-occupied which could cause his anti-social personality traits to come to the fore or him to plan a sexual assault. Given the complexity of the respondent's psychopathology, that risk of sexual reoffending can only be reduced to below moderate if he is on antilibidinal medication together with psychiatric and psychological intervention and under supervision. The assessment by Dr Beech and Dr Aboud that the respondent's risk is below moderate is dependent on such a regime being put in place. Although the respondent has endeavoured to create such a regime by going to his general practitioner to take the recommended medications, I accept the evidence of Dr Aboud and Dr Beech that the prescribing and monitoring of the medication needs to be undertaken by a psychiatrist in conjunction with a psychologist and the general practitioner. As Dr Arnold's role in that regard did not continue, such a regime has not been in place. That is not to say that the respondent's general practitioner has not discharged his role entirely appropriately and professionally, but his supervision alone is not sufficient. A psychiatrist such as Dr Arnold needs to be re-engaged to coordinate and monitor the treatment regime with both the respondent's general practitioner and his psychologist Dr Madsen. The psychiatrist can observe how the respondent is responding and modify the treatment as appropriate to achieve the desired testosterone levels, as well as make any changes to a different medication if he or she considers that that is the appropriate treatment.

[140] In addition, if the respondent is prescribed oral medication and his taking the antilibidinal medication on a daily basis is necessary to maintain his testosterone levels at the necessary levels, there is presently no mechanism by which QCS can reasonably and practicably manage a supervision order which requires him to take medication on a daily basis. QCS does not give prisoners in the precinct medications nor is there a nurse who can administer the medications as occurs in prison. The evidence on behalf of QCS is that they could not reasonably and practicably supervise the respondent taking the medication orally. I accept that to be the case but consider that it may not be an insurmountable problem, given that it may be possible for his general practitioner or a local pharmacist to supervise the taking of the medication each day who has authority to notify QCS should that not occur. Ms Monson accepted such a regime, if in place, could be managed. There is, however, no evidence presently before me upon which I can be satisfied that such a system can be put in place and that the supervision of the

respondent taking oral medication can be reasonably and practicably managed by QCS. Without such a system being put in place, there is a significant risk that he may not take the medication and that QCS may not detect it. There are a number of matters which have been identified which may lead him to stop taking the medication, whether because of the side effects, because he considers he does not need to take the drugs because he is presently not having sexual fantasies, his increasing anxiety and frustration as he exposed is to various psycho-social stressors upon his release, or because his relationship with his female friend in Hervey Bay continues and he desires to have sexual contact with her.

[141] While that may be alleviated by a condition requiring the respondent to have regular blood tests and for him to give authority for the results to be given to his general practitioner, psychiatrist and QCS, the increase in those levels may be due to a number of factors and not only because the respondent has stopped taking the medication.

[142] While regular blood tests on a weekly basis will detect rising testosterone levels to alert medical practitioners and QCS that something may be going awry with the medication, an indicated increase in testosterone levels could be due to a number of reasons and his failure to take the medication may go undetected.

[143] In my view, that risk cannot be alleviated by seeking to impose a condition upon the respondent that he maintain his testosterone level at 3.0nmoI/L as suggested on behalf of the Attorney-General. That would involve the Court in imposing a condition with which the respondent may not be able to comply due to factors outside his control. A condition may however be imposed upon him that he must take the medications prescribed to him in order to maintain his testosterone levels at the level required by psychiatrists. Thus a regime needs to be in place to supervise the taking of that medication. Such an order does have a coercive element insofar as if the respondent does not consent to continuing the treatment, that may result in him being in breach of the order. Dr Moyle has discussed the ethics of treatment being imposed by a coercive order of the Court, rather than as a result of a treatment regime agreed to by the respondent. However, the question of whether he would undertake treatment is and will remain a matter for the respondent, even if the ramifications of him deciding that he does not wish to continue with such treatment would mean that he may be in contravention of the order. While this matter is a difficult issue, the primary consideration as to whether a prisoner may be released under a supervision order is whether the adequate protection on the community is ensured. It is not uncommon that onerous conditions are imposed in order for the Court to be satisfied that that protection is ensured. The respondent would be able to make an application for a variation of the order under s 19 of the Act if circumstances changed, or he wished to have the condition varied or removed.

[144] It is not appropriate for this Court to determine nor direct the appropriate antilibidinal treatment for the respondent. That is a matter within medical expertise. The Court must determine whether the presently proposed treatment regime ensures the adequate protection of the community. Even if a psychiatrist determined that Depot-provera was a more appropriate treatment for the respondent and the respondent was willing to take

Depot-provera, he would need to be subject to such a treatment regime while in custody to safely transition to the different treatment and to see whether it reduced his testosterone levels to what is regarded as a safe level before the Court could consider whether it is satisfied that by his engaging in such treatment, the adequate protection of the community is ensured. That said, while the taking of oral medication poses issues in terms of manageability under a supervision order, it may be a possibility, particularly if the treatment regime is established while the respondent is in custody and a therapeutic regime with a psychiatrist is engaged, for such a regime to be established and managed under a supervision order to ensure the adequate protection of the community.

[145] If the treatment regime is established while the respondent is in custody, the treating psychiatrist will also be in a position to inform the Court about how the medication regime he or she has put in place can be maintained and supervised if the respondent were to be released under a supervision order.

[146] Despite the respondent's efforts to place himself in a position where he could be released under a supervision order by treatment with antilibidinal medication and an antidepressant prescribed while in custody, an appropriate treatment regime was not put in place while he was in custody to satisfy the Court that the risks posed by the respondent can presently be reasonably and practicably managed. While the protection of the community must be adequate, not failsafe, I am not satisfied that adequate protection of the community could be presently assured by a supervision order on the present state of the evidence, given the risks of the respondent reoffending and the real potential for that reoffending to have catastrophic consequences, for the reasons outlined. That said, I do not discount the possibility that such a regime can be put in place in the future.

[147] I am persuaded that the only way to protect the public from the risk posed by the respondent is to affirm the decision that he is a serious danger to the community in the absence of a Division 3 order and for him to be subject to a continuing detention order.

Orders

(1) The decision made on 3 October 2008 that Mark Richard Lawrence is a serious danger to the community in the absence of a Division 3 order is affirmed.

(2) Mark Richard Lawrence is ordered to continue to be subject to the continuing detention order.