SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v LKR* [2018] QSC 280
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **LKR** (respondent)
FILE NO:	6692 of 2018
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court of Queensland at Brisbane
DELIVERED ON:	30 November 2018 Orders made 26 November 2018
DELIVERED AT:	Brisbane
HEARING DATE:	26 November 2018
JUDGE:	Applegarth J
ORDER:	**The Court, being satisfied to the requisite standard that the respondent is a serious danger to the community in the absence of a Division 3 Order, orders that pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, the respondent be detained in custody for an indefinite term for control, care or treatment.**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where the respondent is due to be released from custody after serving a lengthy term of imprisonment for offences including a rape in 2013 to which he pleaded guilty – where the respondent previously served lengthy terms of imprisonment for other serious sexual offences committed in 1999 – where the respondent concedes that an order should be made under s 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, but does not concede that the order should be a continuing detention order – where the applicant denies that he committed the rape offence in 2013 to which he pleaded guilty – where the applicant refuses to undertake a high

intensity sexual offenders program – where the psychiatric evidence is that the respondent should not be released until he has completed such a program in custody so as to develop a suitable risk management plan – whether the court can be satisfied at this stage that a supervision order will provide adequate protection of the community

Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld) s 13

Attorney-General (Qld) v Beattie [2007] QCA 96 cited
Attorney-General (Qld) v DBJ [2017] QSC 302 cited
Attorney-General (Qld) v Fardon [2011] QCA 111 cited
Attorney-General (Qld) v Francis [2007] 1 Qd R 396; [2006] QCA 324 cited
Attorney-General (Qld) v Lawrence [2009] QCA 136; [2010] 1 Qd R 505 cited
Attorney-General (Qld) v Sutherland [2006] QSC 268 cited
Nigro v Secretary to the Department of Justice (2013) 41 VR 359; [2013] VSCA 213 cited
Turnbull v Attorney-General (Qld) [2015] QCA 54 cited
Yeo v Attorney-General (Qld) [2012] 1 Qd R 276; [2011] QCA 170 cited

COUNSEL: J Tate for the applicant
K E McMahon for the respondent

SOLICITORS: Crown Solicitor for the applicant
Legal Aid Queensland for the respondent

[1] The applicant seeks an order under Part 2 Division 3 (s 13) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, and submits that adequate protection of the community can only be ensured at this stage by the making of a continuing detention order under s 13(5)(a) of the Act.

[2] The respondent concedes that an order should be made under s 13, but does not concede that the order should be a continuing detention order. Despite expressing some ambivalence to the examining psychiatrists about his release, his instructions were to contest the application for his continued detention.

[3] The psychiatric reports are to the effect that the respondent should not be released until he has completed the High Intensity Sexual Offenders Program (HISOP). The respondent is reluctant to participate in HISOP because he contends that he is not guilty of the index offences. HISOP in prison would be conducted in a group and the applicant says that he is fearful of risk of assault by prisoners if he participates.

[4] The respondent's refusal to acknowledge that he committed all of the offences to which he pleaded guilty, and to participate in a HISOP which will address the causes of his sexual offending, means that a suitable release risk management plan cannot be developed. The applicant submits that, in the absence of such a plan and an informed

basis to assess his risk if released under such a plan, there is insufficient information at this point to conclude that a supervision order will provide adequate protection of the community.

[5] The central issue for determination by the Court, assisted by the medical evidence given at the hearing, is whether a supervision order, which included a requirement to participate in an individual intensive treatment program in the community and which contains stringent conditions, is likely to reduce the risk of serious sexual reoffending to an acceptable level.

Overview of the facts

[6] The respondent was born on 18 January 1973, and therefore is 45 years of age.

[7] On 28 August 2014, he pleaded guilty in the District Court at Brisbane and was convicted on counts of rape, attempting to pervert the course of justice, unlawful entry of a vehicle for committing an indictable offence at night, stealing and possession of a Schedule 1 dangerous drug. The respondent was sentenced on 20 February 2015 to five years six months imprisonment for the rape. For the remaining indictable offences, he was sentenced to concurrent terms of imprisonment ranging from 3 to 12 months imprisonment. A period of pre-sentence custody in the order of 619 days was declared as time already served. An immediate parole eligibility date was fixed. On present calculations, the respondent is due for release on 11 December 2018.

[8] The respondent committed other serious sexual offences in early 1999 for which he received lengthy terms of imprisonment.

[9] The psychiatric assessments undertaken indicate the respondent's unmodified risk of sexual re-offence is at the "high" range.

[10] The expert evidence of Dr Brown, Dr Beech and Dr Harden is to the effect that there is insufficient information to formulate a suitable release risk management plan that would provide adequate protection of the community. It is therefore difficult to express an opinion about the extent to which a supervision order will reduce the risk of offending. In the circumstances, the court cannot be satisfied that a supervision order will provide adequate protection of the community.

The statutory scheme

[11] The objects of the Act and its scheme are well-established and it is not necessary to quote the terms of s 13 and other provisions.

[12] The first enquiry is whether or not the respondent is a serious danger to the community in the absence of a Division 3 Order. The statutory test is whether there is an unacceptable risk that the respondent will commit a serious sexual offence if released

without a Division 3 order.[1] That matter must be proven by sufficient cogent evidence, and the Court is required to consider each of the matters stated in s 13(4). If satisfied to the high degree of probability required that, if released without a Division 3 order there is an unacceptable risk that the respondent will commit a "serious sexual offence", then the second inquiry is as to the kind of s 13 order to be made. In considering these matters, the paramount consideration is to ensure adequate protection of the community.

[13] The applicant must establish that adequate protection of the community cannot be ensured by a supervision order.[2] In *Attorney-General (Qld) v Lawrence*, Chesterman JA (with whom Muir JA and Margaret Wilson J agreed) addressed the relevant onus of proof:

> "[I]n cases where the Attorney-General contends that the community will not be adequately protected by a prisoner's release on supervision the burden of proving the contention is on the Attorney. The exceptional restriction of the prisoner's liberty, after he has served the whole of whatever imprisonment was imposed for the crimes he committed, and for the protection of the public only, should not be imposed unless the inadequacy of a supervision order is demonstrated. The liberties of the subject and the wider public interest are best protected by insisting that the Attorney-General, as applicant, discharges the burden of proving that only a continuing detention order will provide adequate protection to the community."[3]

[14] Ultimately, it must be open to conclude that, "a supervision order would be efficacious in constraining the respondent's behaviour by preventing the opportunity for the commission of sexual offences."[4] It has been said:

> "The means of providing the protection, and avoiding that risk, is a supervision order. When a court is assessing whether a supervision order can reasonably and practically manage the adequate protection of the community, it is necessarily assessing the protection the order can provide against that risk. Before making the order a court has to reach a positive conclusion that the supervision order will provide adequate protection."[5]

[15] In considering whether a risk is unacceptable it is necessary to 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.[6] There must be a sufficient likelihood of the occurrence of the risk which, when considered in combination with the

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1 *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) ("The Act") s 13 (2).
2 *Attorney-General (Qld) v Lawrence* [2010] 1 Qd R 505; [2009] QCA 136 at [38] – [39]; see also *Yeo v Attorney-General (Qld)* [2012] 1 Qd R 276; [2011] QCA 170 at [73].
3 [2009] QCA 136 at [38].
4 *Attorney-General (Qld) v Fardon* [2011] QCA 111 at [29].
5 *Turnbull v Attorney-General (Qld)* [2015] QCA 54 at [36].
6 *Attorney-General (Qld) v DBJ* [2017] QSC 302 at [13] following *Attorney-General (Qld) v Beattie* [2007] QCA 96 at [19].

magnitude of the harm that may result and any other relevant circumstance, makes the risk unacceptable.[7]

[16] A relevant consideration is whether the respondent is likely to comply with the requirements of a supervision order. If the respondent is unlikely to comply with the requirements of a supervision order, and the result of such of such non-compliance would present an unacceptable risk of the commission of a serious sexual offence, then a supervision order is most unlikely to be made. Ultimately, the Court must be satisfied that adequate protection of the community can be reasonably and practicably ensured by a supervision order. However, this does not entail proof that a supervision order is unlikely to be contravened, even in some trivial way. Many supervision orders contain numerous and exacting requirements which are designed to reduce risk and encourage positive behaviour by the respondent. Non-compliance with a particular provision may not, in itself, signal that the respondent has become an unacceptable risk of committing a serious sexual offence. Instead, it may alert the authorities supervising the respondent to a problem which needs to be addressed. Therefore, whilst I do not have to be satisfied to a high degree that every requirement in the supervision order is likely to be complied with over a period of many years, I have to consider whether the respondent is likely to comply with it.

[17] There is an implicit requirement in s 13 that a continuing detention order should only be made where the applicant proves that the community cannot be adequately protected by a supervision order.[8] A supervision order need not be risk free; that would be an impossible bar.[9] The starting position for a s 13(5) order is a supervision order. For that starting position to be displaced, the applicant must prove a continuing detention order is an appropriate order.[10]

[18] In deciding whether adequate protection of the community can be provided by a supervision order the court is assisted by the opinion of psychiatrists about the level of risk associated with a supervision order, and the respondent's likely compliance with it. However, the choice in a case such as this between a continuing detention order and a supervision order is a matter for the Court. As McMurdo J stated in *Attorney-General for the State of Queensland v Sutherland*:

> "…the assessment of what level of risk is unacceptable, or alternatively put, what order is necessary to ensure adequate protection of the community, is not a matter for psychiatric opinion. It is a matter for judicial determination, requiring a value judgment as to what risk should be accepted against the serious alternative of the deprivation of a person's liberty."[11]

[19] In summary, the applicant bears the onus of demonstrating that a supervision order will afford inadequate protection to the community.[12] Before a supervision order, rather

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7 *Nigro v Secretary to the Department of Justice* (2013) 41 VR 359 at [6] cited in *Attorney-General (Qld) v DBJ* [2017] QSC 302 at [14].
8 *Attorney-General (Qld) v Sutherland* [2006] QSC 268 at [27].
9 *Attorney-General (Qld) v Francis* [2007] 1 Qd R 396; [2006] QCA 324 at [39].
10 *Attorney-General (Qld) v Lawrence* [2010] 1 Qd R 505; [2009] QCA 136 [31].
11 [2006] QSC 268 at [30].
12 Section 13(7); *Attorney-General (Qld) v Lawrence* [2010] 1 Qd R 505; [2009] QCA 136 at [28].

than a continuing detention order, is made, the Court should be satisfied that its likely effect will be to reduce the risk of sexually offending to an "acceptably low level."[13]

Criminal history

[20] The following parts of these reasons in relation to the facts (which are not in dispute) are drawn heavily from the written submissions of the applicant and the respondent.

[21] The following table sets out the respondent's relevant Queensland criminal history:

Date	Description of Offence	Sentence
Brisbane District Court 12/04/2000	• Enter dwelling at night with intent & uses actual violence & break • Attempted rape • Sexual assault whilst pretending/is armed including oral contact with genitalia/anus • Stealing (3 charges) Above charges refer to Indictment No. 2055/99 • Enter dwelling at night with intent & uses actual violence & break • Rape • Stealing Above charges refer to Indictment No. 2056/99	On each charge: Conviction recorded Imprisonment 6 years On each charge: Conviction recorded Imprisonment 2 years Sentences to be served concurrently with each other but cumulatively with sentenced imposed on Indictment No. 2056/99 On each charge: Conviction recorded 7 years imprisonment Conviction recorded 2 years imprisonment Sentences to be served concurrently Declare that time spent in pre-sentence custody be deemed as time already served under this sentence: 372 days
Brisbane District Court 20/02/2015	• Rape • Attempting to pervert justice • Unlawful entry of vehicle for committing indictable offence at night • Stealing • Possess dangerous drug – schedule 1 The above refers to Indictment No. 762/14	Conviction recorded Sentenced imprisonment 5 years 6 months On all charges Conviction recorded Sentenced imprisonment: 12 months Conviction recorded Sentenced imprisonment 3 months All terms of imprisonment to be served concurrently Declare that time spent in pre-sentence custody be deemed as time already served under this sentence: 619 days

[13] *Attorney-General (Qld) v Beattie* [2007] QCA 96 at [19].

		Parole eligibility dare: 20/02/15
	The following Magistrates Court matters were heard by the District Court: • Unlawful possession of suspected stolen property (2 charges) • Trespass – entering or remaining yard or place or business (2 charges) • Assault or obstruct police officer (2 charges) Above refers to Indictment No. 1813/14	Summary offences dealt with under s 651CC: On all charges: Conviction recorded Not further punished

[22] His pattern of offending demonstrates a significant and high risk of future re-offending. The respondent's relevant criminal history began in 1991 when he was aged 18 and continued until his current incarceration. His criminal history includes offences relating to possession of drugs, property, assaults (including serious assaults) as well as breaches of probation and court based orders.

The January 1999 sexual offences

[23] On 12 April 2000, the respondent pleaded guilty in the District Court at Brisbane to offences on two indictments. The first indictment charged the respondent with counts of housebreaking, rape and stealing. The offences were alleged to have occurred on 21 January 1999.

[24] The second indictment charged the respondent with counts of housebreaking, attempted rape, indecent assault and three counts of stealing. The offences were all alleged to have occurred on 30 January 1999, nine days after the offences alleged in the first indictment. At the time of the commission of the second set of offences, the respondent was on bail in respect of a separate, unrelated matter (possession of weapons, shortening of firearms and possession of dangerous drugs) for which he was ultimately convicted in February 1999.

[25] As at 21 January 1999, the adult female victim, a single parent of two children, lived in the downstairs part of a split level house. On the evening of 20 January, she took her children to their father's address. In the late evening, she watched television upstairs with the owners of the house. She retired to bed at around 12:30 am. She awoke during the night with the respondent laying on top of her, moving about.

[26] The victim asked the respondent who he was and what he was doing, to which he replied, "I saw you earlier tonight upstairs". The respondent was lying between her legs and his erect penis penetrated her vagina. When the victim began to scream, the respondent placed a piece of cloth over her mouth. He continued to move his penis in and out of her vagina. Following intercourse, the respondent decamped from the room

and left via the rear access to the residence. Following the rape, the victim discovered her purse had been stolen. Police were called.

[27] Some nine days later, on 30 January 1999, the respondent offended again.

[28] On the evening of 29 January 1999, the two adult female victims (referred to as victim A and victim B) were staying with a family member in Redcliffe. They played board games and watched television with friends until 3:45 am. The victims then retired to separate beds in the same bedroom.

[29] Victim A reported that at about 4:30 am, she was woken by the respondent, who touched her shoulders with his hands. She tried to push him away. The respondent then said, "Shut up. I've got a knife. Lie still". Victim A saw the knife and the respondent put it on the middle of her throat. It was at that time that victim B woke to find victim A making an odd noise. The respondent said to her, "I'll kill you if you scream".

[30] He took off victim A's boxer shorts and underwear and started to touch her vagina with his fingers. He then touched and digitally penetrated her vagina. Victim A was crying, asking the respondent to stop. She told him words to the effect of, "If you just leave now, I won't tell anyone". He told her to shut up and pressed the knife further towards her throat. He then placed a pillow over victim A's head. He then placed his body between her legs and told her to spread her legs. She asked him to put a condom on. The respondent said he did not have one. The respondent then took the knife away from victim A's throat and started to lick her vagina.

[31] Victim B, who by this stage was also crying, said to the respondent, "Don't do that". The respondent then got up and said to her, "I'll fuck you instead", and told her to take off her pants. She said that she couldn't because she was menstruating at the time. The respondent then said, "Well, what am I going to do with you?" She said that he could touch her breasts. The respondent said, "No. I want you to suck my dick". He still had the knife. Victim B said she did not want to. The respondent then grabbed the victim's head, directed it towards his pelvis and made her put his penis in her mouth. The respondent held the knife at the back of her head. He started moving her head forward with his hand onto his penis. This continued for some time until he ejaculated into her mouth.

[32] The respondent then pointed the knife at victim A and said, "You're so lucky that your friend is here or else I would have raped you". After working out his exit, he threatened the two women that if they called the police, he would come back and kill them. Notwithstanding these threats, the women called police. Victim B vomited and kept the contents, which she gave to the police. When police arrived, victim B also noticed her bag containing her wallet, an airline ticket and passport had been stolen.

[33] Police located the respondent only three houses away later that same morning – a police dog tracked the respondent's scent from spermatozoa found in vomit kept by the victim B. When police arrived, the respondent ran from the scene. However, when police searched his residence they located personal effects of the victim of the offence committed on 21 January and that of victim B. The respondent's DNA was located in

stains on the mattress from the first set of offences, and spermatozoa found in victim B's vomit. The respondent's fingerprints were located inside both houses where the crimes were committed. Two of the victims identified the respondent from a photo board. On 1 February 1999, the respondent contacted police and turned himself in.

[34] The sentencing judge noted that the guilty pleas were in the face of an "overwhelming Crown case." He also noted that the offences were committed at a time when the respondent was suffering the intoxicating effects of medication, specifically, Temazepan (which he was misusing and abusing). It was accepted that the respondent had little, or no, memory of the offences.

[35] The respondent was ultimately sentenced to a global period of 13 years imprisonment.

[36] On counts 1 and 2 on the first indictment (the housebreaking and rape offences), the respondent was sentenced on each count to a period of seven years imprisonment. On the remaining stealing count, he was sentenced to a period of two years imprisonment. On counts 1 to 3 on the second indictment (the housebreaking, attempted rape and indecent assault with circumstances of aggravation offences), the respondent was sentenced on each count to a period of six years imprisonment. On the remaining counts, the respondent was sentenced on each count to a period of two years imprisonment. Those sentences were ordered to be served concurrently with each other, but cumulatively upon the sentences imposed on each separate indictment. A period of pre-sentence custody in the order of 372 days was declared as time already served.

Index offences – June 2013

[37] On 28 August 2014, the respondent pleaded guilty and was convicted in the District Court at Brisbane on counts of rape, attempting to pervert the course of justice, unlawful entry of a vehicle for committing an indictable offence at night, stealing and possession of a Schedule 1 dangerous drug. On 20 February 2015, the respondent also pleaded guilty and was convicted of a number of summary offences that included possession of suspected stolen property, trespass and obstruction of police in the performance of their duties.

[38] The victim was the respondent's eight year old niece. He was 40 years old at the time of these offences. The respondent had been staying at his brother's home and helping with the family mowing business.

[39] Early in the morning on 1 June 2013, the respondent entered the bedroom of the victim that she shared with her 11 year old step-sister. He went into the room with a pair of black handled scissors that had been taken from a knife block in the kitchen, a mobile phone that was used as a torch and a cup of water.

[40] The respondent poured water over the victim. He then used the scissors to cut away the victim's pyjama bottoms and he penetrated her vagina with his finger. He also took a number of photographs of the victim's vagina. The older child, who was sleeping on the upper bunkbed, observed some of the respondent's conduct.

[41] The following morning, the respondent told the victim's parents that the victim had urinated in bed during the previous night, and that he had cleaned it up. The victim, however, made an early preliminary complaint to her step-sister. The victim informed her step-mother and the police were called. A subsequent medical examination found a small one to two millimetre puncture to one of the internal structures of the child's vagina.

[42] As part of their investigation into the respondent, the police took possession of his vehicle, and took it to an impounding yard. The respondent broke into that yard by climbing over the fence, broke into the vehicle and took evidence (specifically, the mobile phone and other effects incriminating him in the rape).

[43] Police later located a plastic bag buried near a tree in the respondent's garden which contained a mobile phone, adaptor and battery. A further examination of the phone was conducted. Stored on the phone were a number of photographs of the victim's vagina exposed with part of her pink and white pants also visible. Police also located a backpack in the garage. Inside were clothing, three knives and a quantity of jewellery in a plastic container.

[44] An arrest warrant was issued for the respondent on 4 June 2013. He was at large until 11 June 2013, when he was arrested by police following a lengthy pursuit. He was only stopped when a police dog bit him on the ankle, and continued to struggle until he was handcuffed. When police searched the respondent, they located a black wallet and a clip seal bag containing 0.249 grams of methylamphetamine.

[45] On 20 February 2015, the respondent was sentenced to five years six months imprisonment for the rape. For the remaining indictable offences, he was sentenced to concurrent terms of imprisonment ranging from 3 to 12 months imprisonment. A period of pre-sentence custody in the order of 619 days was declared as time already served. An immediate parole eligibility date was fixed.

Programs in prison

[46] During his earlier imprisonment, the respondent completed the following programs:

- Cognitive Skills, on 15 September 2000;
- Substance Abuse Educational Program, on 8 February 2001;
- Violence Intervention Program (VIP), on 16 September 2001;
- Substance Abuse: Preventing and Managing Relapse, on 18 November 2002;
- Anger Management (completed via participation in the VIP);
- TAR-Get (Though Alternatives and Replacements – Group Therapy);
- Getting Started: Preparatory Program (GS:PP), on 17 March 2009; and
- New Directions – Medium Intensity Sexual Offending Program (MISOP), on 9 December 2009.

[47] Between 9 February and 17 March 2009 the respondent participated in the GS: PP at the Capricornia Correctional Centre, attending 12 sessions. In an exit report detailing the respondent' participation in the GS: PP, program facilitators noted that he reinforced

that he lacked memory of the offences, although he accepted responsibility for them. He was considered to be an active participant who was compliant with group expectations and requirements.

[48] During the GS: PP, the respondent provided a detailed account of his offending behaviour and events preceding the sexual offences. He reported that he had been devastated over the breakup of his marriage, and this sent him into a spiral of depression, drug and alcohol abuse, violent behaviour, and mental health issues. During this time, the respondent said he assaulted police, threw his television out of a window, and set fire to his car. The respondent reported that on 29 January 1999 he was intoxicated and walking home after having dinner with his sister. He said he walked past a house where there was a large party being held. He said he was invited into the house, he began to drink, and when offered two pills (which turned out to be Rohypnol), he took them.

[49] He remembers going downstairs to where the two victims were sleeping, and he attempted to have sexual intercourse with one of them. The respondent reported that her friend saw this and allegedly said, "Don't, she is a virgin, take me instead". The respondent otherwise cannot remember the sexual activity that took place. All he can recall is waking up in the bushes the following morning. He failed to mention the first set of offences that occurred a week earlier. Program facilitators recommended the respondent participate in the MISOP in order to further address his sexual offending.

[50] Between 1 July and 9 December 2009 the respondent participated in the MISOP at the Townsville Correctional Complex, attending 35 sessions. He was temporarily suspended from the group for two sessions due to breaching group guidelines around confidentiality. In an exit report detailing the respondent' participation in the MISOP, program facilitators noted that he initially presented as a defensive, judgmental participant. He also maintained his position that he could not recall his offending due to his substance use at the time. His recall of the offending and the events preceding it was consistent with those previously given during the GS: PP.

[51] Program facilitators indicated the respondent had started to develop a sound level of insight into his own feelings and behaviours that contributed to his offences. It was further noted he struggled to identify and explore his emotions. In conclusion, program facilitators recommended the respondent complete the Staying on Track: Sexual Offending Maintenance Program to further consolidate gains made during the MISOP.

[52] Despite having completed these programs, the respondent went on to commit the index offences.

[53] During the current period of imprisonment, he has so far refused offers to participate in the Getting Started: Preparatory Program on 4 February 2016, 7 March 2016, and 24 August 2017. He did however complete a Low Intensity Substance Intervention on 24 March 2016.

Parole

[54] The respondent was granted parole in his previous custodial episode on 26 February 2010 and was returned to custody on 2 November 2011. Dr Brown describes his reoffending pathway whilst on parole:

> "[The respondent] wrote a persuasive parole application in 2009 and secured his release, however he was unable to be truthful with his parole officer about the difficulties he was having with his daughter and partner. He began using drugs again when his relationship failed and his living situation became compromised such that he did not maintain his parole status. He was released from prison having served full time and therefore did not successfully establish himself in the community with parole support.
>
> On release he again fell into drug use and acquisitive crime, his stated reason being unmanageable pain. He began a relationship and reports low sex drive owing to physical health problems, however, somewhat incongruously he did appear to maintain a sexual relationship with his girlfriend and alleges that he had pictures of her genitals on his phone. On the day of the sexual assault against his niece he was intoxicated. Although he denies the offence, he attempted to pervert the course of justice and there is significant evidence against him. When challenged on such evidence he explains it away and believes that at the ages of eight and eleven his nieces framed him and were able to give matching evidence when subject to intense police questioning.
>
> Since his incarceration for crimes against his niece he has lost motivation to obtain release via the Parole Board. He denies the offence and has refused to participate in sex offender treatment."

Psychiatric reports and risk assessments

Dr Karen Brown, Consultant Psychiatrist (8 March 2018)

[55] Dr Brown was instructed to assess the respondent's risk of sexual recidivism in relation to a possible application made under the Act. Dr Brown undertook an examination and interviewed the respondent on 4 January 2018 and 8 February 2018 at the Wolston Correctional Centre. The report is based on these interviews, as well as the respondent's criminal history, extracts from the files of the Office of the Director of Public Prosecutions and Queensland Corrective Services, and transcripts of relevant proceedings.

[56] Dr Brown's report details the respondent's psychological and psychiatric history, sentencing comments, prison conduct, family history, education and vocational history, social history, sexual history, the offences, the respondent's participation in treatment programs and his plans upon release. These factors informed Dr Brown's assessment of the respondent's risk of sexual recidivism.

[57] Dr Brown provides this formulation:

> "Based on the offending history he has demonstrated evidence of sexual sadism and also engaged in sexual activity with a child. However, in both cases there is a lack of evidence to confirm that his behaviour was primarily driven by longer standing deviant sexual urges. It is possible that his offending on both occasions represented opportunistic and grossly antisocial sexual gratification when severely intoxicated and disinhibited. However a more thorough exploration of possible sexually deviant interests is required.
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> …
>
> [The respondent] was heavily influenced by his Uncle who belonged to a motorcycle club and who strongly encouraged him to sell drugs to his friends. Use of drugs and low level crime became normalised and even glamorised in his household and he quickly became a drug user himself in particular of amphetamine and cannabis. Despite this he was able to complete an apprenticeship and maintained employment as a car mechanic for most of his adult life when not incarcerated.
>
> He has historically exercised power and control in longer term relationships. He has had several sexual partners during the course of his life, some more casual than others. When not in a relationship he sought sexual intimacy with old partners as a way of coping and re-establishing himself as dominant and in control. When his ex-defacto left him and took his children he likely struggled with the loss of control and he was unable to appropriately deal with feelings of powerlessness and rejection, leading him to emotionally and physically intimidate his ex-partner (for example by threatening suicide). His use of substances markedly escalated and his behaviour became regressed such that he was unable to problem solve in a prosocial manner. The assault of his boss destroyed his previously very good work record and likely depleted his self-esteem.
>
> Over the period that the first sexual offences were committed [the respondent] would have likely felt extremely angry with his ex-partner who he blamed for his failed family and work life. He sought help from doctors and was prescribed psychotropic medications, although he was not considered to have a major mental illness requiring hospitalisation. His attempt to take back control of his children only served to distance them further when his partner applied for a Domestic Violence Order. His feelings of loss, rage and entitlement were the likely precursors to his offending which manifested when he was disinhibited by substances."

Diagnosis

[58] Dr Brown diagnosed the respondent as suffering from:

- Antisocial Personality Disorder; and
- Substance Misuse Disorder (in remission in a controlled environment).

Actuarial Assessment

[59] Dr Brown assessed the respondent on a number of risk assessment tools, with the following results:

- Static 99-R: the respondent scored 6, placing him in the "well above average" risk range;
- Psychopathy Checklist (PCL-R): scored 22/40 indicating some psychopathic traits, but falling short of the formal cut-off for a diagnosis of Psychopathy;
- Risk for Sexual Violence Protocol (RSVP): under this guided clinical assessment protocol Dr Brown considers the respondent's risk of serious sexual offending in narrative form against these criteria:
  - Sexual Violence History;
  - Psychological Adjustment;
  - Mental Disorder
  - Social Adjustment; and
  - Manageability.
  - Historical Clinical Risk Management (HCR-20): in particular, on the evident risk factors Dr Brown notes:

> "His current plans do not explicitly include release from prison and he remains ambivalent about the challenges of community living on release.
>
> He may have exposure to family members and friends that use drugs and he has a network of drug dealers. Other destabilisers include physical health problems, unregulated pain and rejection from some family members including his twin brother. One son has no contact with him at present and has a criminal history. His relationship status is unclear at present. He maintains contact with his daughter, one son and his sisters. He has grandchildren who he would like to see. His older sister has offered support and accommodation on release.
>
> [The respondent] is currently non-compliant with the recommendation to participate in sex offender treatment. He appears ambivalent about release. Stressors on release will include others he associates with using drugs, relationship difficulties with his partner or family, financial stress and overcoming institutionalisation / the stigma associated with offence."

Risk

[60] As to risk, Dr Brown reports:

> "There are several risk factors that remain inadequately addressed including his attitude to women and relationships (and lack of self-awareness in relation to this), his failure to take responsibility for his offences (despite apparently doing so in his written material and during previous programs) and his profound addiction to substances.
>
> With regard to his potential release into the community, [the respondent] has encountered negative attitudes from others in relation to his offending and may face rejection from family members and potentially his partner. He is institutionalised. He has a number of physical health problems which currently prevent him from working, which was previously a protective factor. He is ambivalent about his release.
>
> [The respondent] does not fully accept responsibility for his sex offending. On release he is likely to eventually associate with those that use or sell

drugs, either through family members or friends and to form casual and more long-term sexual relationships which could negatively impact on his judgement across a range of domains. Problems with relationships (family, friends or girlfriends), unregulated pain or general stress associated with reintegration into the community will increase his risk of low mood and feelings of hopelessness, drug use and future physical or sexual violence.

Persons at risk of physical assault include friends and family members or romantic partners. Also at risk are those in positions of authority, acquaintances and other prison inmates. Based on the history persons at risk of sexual assault would include adult women (either known to him or strangers), and children (relatives or other children he may have access to).

Recommendations

It is my view that should [the respondent] be released without any type of supervision in the community the risk to others of both physical violence and sexual violence would be high. A return to the community with restrictions and monitoring similar to that of the Parole Order in 2010 would not be sufficient to reduce the risk of recidivism to a manageable level.

It is my view that [the respondent] should participate in the high risk sex offender program (HISOP) prior to release and demonstrate during that program an improvement in:

(a) self-awareness with regard to sexual deviance and behaviour in relationships,

(b) coping strategies when relationships don't go well or breakdown

(c) ability to accept responsibility for his offending on more than just a superficial level.

If he is unable or unwilling to complete the HISOP in a group then another option would be the provision of a similar program on a 1:1 basis with an appropriately trained psychologist. In addition a comprehensive addiction treatment program should be undertaken."

Dr Michael Beech, Consultant Psychiatrist (7 November 2018)

[61] Dr Beech was appointed by the Court under s 8 to undertake a risk assessment in relation to the respondent. He assessed the respondent on 5 October 2018 at the Wolston Correctional Centre and reported on 7 November 2018.

Diagnosis

[62] Dr Beech diagnoses the respondent as suffering from:

- Antisocial Personality Disorder (with associated significant narcissistic traits); and
- Substance Misuse Disorder (in remission in a controlled environment).

Actuarial Assessment

[63] Dr Beech assessed the respondent on a number of risk assessment tools, with the following results:

- Static 99-R: the respondent scored 6, placing him in the "much higher risk of reoffending' category;
- Hare Psychopathy checklist (PCL-R): scored 26/40, placing him on the cusp of Psychopathy; and
- Risk of Sexual Violence Protocol (RSVP): Dr Beech noted the presence of the these factors:
  - the persistence of offending
  - diversity of offending
  - the use of physical coercion
  - denial
  - attitudes that condone violence (possible)
  - problems with self-awareness
  - problems with stress
  - psychopathy
  - mental illness (ASPD)
  - problems with substance use
  - violent or suicidal ideation (past)
  - problems with intimate relationships
  - non-sexual criminality
  - problems with treatment (refusal)
  - problems with supervision (breaches of probation and parole)

Risk

[64] As to risk, Dr Beech reports:

> "In my opinion, the current risk for further sexual violence in the community is high, and much above the risk of the average sexual offender. The respondent has a significant personality disturbance and he has struggled on his releases into the community, on parole and on his full-time release. He has entered into dysfunctional relationships, returned to substance use, and has had emotional difficulties. I think it is highly likely that he uses sexual violence to manage these personal difficulties. I think that he has limited insight in to this and few if any strategies to manage it. On release, I think that he will again struggle, and he will revert to former patterns, and ultimately this will lead to some form of sexual offending
>
> One scenario is that on release, having learned from his incarceration and taken some benefit from earlier programs, he will be able to find family support and settle down. He will eschew difficult personal relationships and instead he will find employment and stability. He will stay away from substances. He will find psychological counselling in uses (sic) to manage his stress. The difficulty with this scenario is that many of these factors are not yet in place, and I think that he has limited self-awareness for this.

> The second scenario is that he will struggle in the community and return to substance use. He will have financial difficulties and he will return to general offending to manage. In an intoxicated or even non-intoxicated state, during the course of a burglary, he will break into a residence and find a sleeping adult woman. He will use the opportunity to commit further sexual offences. He will use threats of physical coercion to force the woman to engage in sexual acts, and she will suffer psychological and emotional harm.
>
> The third scenario is that he will opportunistically offend against a child. It is difficult to explore this scenario further because of his denial and his lack of involvement in any sexual programs that would explore this.
>
> I agree with Dr Brown that the respondent would be better served by completing a high intensity sexual offender program. In the absence of such a program, it is difficult to know what risk management strategies should be put in place for him.
>
> In my opinion, a supervision order would act to reduce the risk, but given the lack of details about his reasons for offending, the supervision order would need to contain general restrictions that would have to remain in place for several years, with continuing severe restrictions.
>
> The supervision order, with compulsory counselling, might detect the early signs of emotional decompensation and put strategies in place to manage this. It is difficult to know though how it would avert a more determined and premeditated assault on a child such as occurred in 2013, other than by placing restrictions on his contact with children generally.
>
> In the absence of an intensive exploration and the development of a comprehensive risk management strategy, it is difficult to know to what extent a supervision order would reduce the risk."

Dr Scott Harden, Consultant Psychiatrist (12 November 2018)

[65] Dr Harden also was appointed by the Court under section 8 to undertake a risk assessment in relation to the respondent. Dr Harden assessed the respondent on 9 August 2018 at the Wolston Correctional Centre and reported on 12 November 2018.

Diagnosis

[66] Dr Harden diagnoses the respondent as suffering from:

- Antisocial Personality Disorder;
- Paedophilia (non-exclusive) Provisional diagnosis; and
- Polysubstance Abuse (in remission).

Actuarial Assessment

[67] Dr Harden assessed the respondent on a number of risk assessment tools, with the following results:

- Static 99-R: the respondent scored 5, placing him at the "Moderate-High" (above average) risk category;
- Stable 2007: scored 16/24, placing him in the "High Needs Group" in relation to dynamic risk factors;
- Hare Psychopathy Checklist (PCL-R): scored 24/40, indicating elevation; and
- Sexual Violence Risk (SVR-20): scored positively on 12/20 items, with three further potential positives. An overall categorisation of "High" risk for future sexual violence risk.

Risk

[68] Dr Harden's assessment of risk is:

> "[The respondent] was a 45 year old man of indigenous heritage who had committed two groups of sexual offences. The first group of offences was against adult women in their own home at night by breaking into their homes and sexually assaulting them using threats and weapons. The second sexual offence was against an eight-year-old girl under circumstances where there was easy access to her as a victim.
>
> There is no other clear information to be certain of the presence of a paraphilia. The photographs of the eight-year-old female's genitalia on his phone, are however suggestive of a paedophilic interest.
>
> Effectively he denies committing any of the offences. When pressed he reluctantly admits that he might've committed the first set of offences. He has refused to undertake any further sexual offending treatment during his period in custody. He has limited or no insight into his psychological functioning with regard to sexual offending.
>
> He appears to have little or no concern for his previous victims and minimises and distorts any potential risk of future offending.
>
> He has a long and robust history of polysubstance abuse probably with a preference for amphetamines but also marked use of opiates. This has included lots of stealing and also dealing in drugs to maintain his substance use in the past. It has also resulted in relationship breakdown, loss of employment and estrangement from support structures."[14]
>
> […]
>
> "The actuarial and structured professional judgement measures I administered would suggest that when considered as it et al as he (sic) **his future risk of sexual re-offence is high (well above average) in the absence of a supervision order**. My assessment of this risk is based on the combined clinical and actuarial assessment.
>
> He is effectively untreated and requires either completion of the high-intensity sexual offenders program or individual treatment that reaches that standard of contact hours (300 hours plus).

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[14] Dr Harden's Report dated 12 November 2018, 19.

> Prior to this treatment it is not clear to me to what extent his risk would be reduced by a supervision order in the community as not enough is understood about his offending patterns and pathways.
>
> Once he has undertaken appropriate treatment supervision and intervention consistent with a supervision order in my opinion will reduce the risk to moderate by decreasing his capacity for use of substances, monitoring his activity and enforcing further treatment intervention.
>
> **Recommendations**
>
> I recommend he undertake the High-Intensity Sexual Offending Program in custody prior to consideration of release.
>
> If he were to be released:
>
> I recommend that he be placed on a supervision order for a period of 10 years."

Clinical recommendations

[69] The ongoing treatment and management of the respondent, whether in custody or in the community, was discussed by each of the reporting psychiatrists. The clinical views of the psychiatrists are highly relevant because of the respondent's Antisocial Personality Traits, Substance Use Disorder and refusal to undertake available sexual offender programs.

Dr Brown

[70] Dr Brown reports:

> "Any release plan should take into account that [the respondent's] self-report is not always reliable and should include the following:
>
> 1. Ongoing psychological therapy with a focus on sex offender treatment maintenance.
> 2. Drug and alcohol addiction support
> 3. A comprehensive testing plan to ensure abstinence from drugs
> 4. Referral to psychiatrist as required to address adjustment or depressive disorders.
> 5. Management of pain, ideally by a pain management specialist.
> 6. Reporting of romantic relationships and other significant associations.
> 7. Monitoring of movements and night- time curfew
> 8. Structured day (ideally work but other activities as his physical health will allow)
> 9. No unsupervised contact with minors, no overnight stays in a residence with minors
>
> Depending on [the respondent's] future level of engagement, use of anti-libidinal medication may be an option (given the seriousness of offending), however I note that [the respondent] is currently undergoing investigations

> of his prostate which, depending on the outcome and his associated treatment needs, may complicate this option. A high dose SSRI may be another anti-libidinal strategy which may also lead to an improvement in his mood stability and assist with stress management, however I am aware that he has not responded particularly well to antidepressants in the past. Further information about his current medical diagnoses and treatment (in particular corrective services medical notes) would assist with future psychiatric assessments."

[71] Dr Brown's Addendum Report dated 1 October 2018 states:

> "It will be important to treat [the respondent's] various medical conditions as adequately as possible in the future so as to reduce his level of stress and associated risk of relapse to substance use. This will likely require a combination of medical and allied health support. He is at risk of abusing and diverting prescribed opiates in the future.
>
> In my previous report I noted that consideration may need to be given to the use of anti-libidinal medications as part of [the respondent's] future management. Should this arise it would be important that his treating specialist had access to his medical records. Anti-libidinal medications are most useful for those who have committed serious sexual offences with ongoing high or distressing sex drive and/or intrusive sexually deviant thoughts that cannot be managed with psychological intervention alone. When used, these medications should form part of a risk management plan along with psychological and other supportive strategies. At the time that I interviewed [the respondent] he had not yet engaged with longitudinal psychological interventions and as such the understanding of his sexual drives and motivations for offending remained poorly understood. It is my opinion that engagement in such longitudinal assessment and treatment would be the first and most important step required to better understand [the respondent's] risk factors for sexual offending recidivism and to inform his future risk management plan."

Dr Beech

[72] Dr Beech's opinion is:

> "… a supervision order would act to reduce the risk, but given the lack of details about his reasons for offending, the supervision order would need to contain general restrictions that would have to remain in place for several years, with continuing severe restrictions,
>
> The supervision order, with compulsory counselling, might detect the early signs of emotional decompensation and put strategies in place to manage this. It is difficult to know though how it would avert a more determined and premeditated assault on a child such as occurred in 2013, other than by placing restrictions on his contact with children generally.
>
> In the absence of an intensive exploration and the development of a comprehensive risk management strategy, it is difficult to know to what extent a supervision order would reduce the risk."

Dr Harden

[73] Dr Harden reports:

> "I recommend he undertake the High-Intensity Sexual Offending Program in custody prior to consideration of release.
>
> If he were to be released:
>
> I recommend that he be placed on a supervision order for a period of 10 years.
>
> I would recommend that he be required to be abstinent from alcohol and drug use and undergo an appropriate random testing regime.
>
> I recommend that he have no unsupervised contact with persons under the age of 18 years.
>
> I would recommend that he have ongoing psychological, drug and alcohol and psychiatric (as indicated) treatment to address his risk issues."

Oral evidence of the psychiatrists

[74] Dr Brown explained that, at this stage, it is only possible to make a provisional, rather than a definitive, diagnosis of paedophilia. This is due to a lack of evidence. There are a number of possible reasons as to why there was an offence involving a child, including the possibility of intoxication rather than an enduring paedophilia. For a formal diagnosis of paedophilia one would expect to see more evidence of a sustained interest in sexual activity with children. However, there was evidence of such an interest in the photographs that were taken during the event.

[75] Another matter about which there is a lack of evidence, and which might be assisted by the respondent undertaking a HISOP, is the possibility of sexual sadism. Violence was associated with the offences and this raises the question of whether the respondent has an enduring interest in gaining sexual pleasure from harming or hurting others.

[76] Dr Brown noted that the respondent's sexual offending is "quite diverse" with the early offences involving adult female strangers and the later offences involving the child victim known to the respondent. This diversity made it difficult to predict future behaviour. According to Dr Brown, there is a "very poor understanding" as to what prompted the applicant to continue offending. Both he and professionals that are involved in his care and treatment lack this understanding, and that lack of understanding is due, in part, to the applicant's reluctance to complete a sex offender treatment program. The nature of his offending and its severity necessitated a HISOP with its longer, more intense course of treatment that would allow for adequate exploration of potential deviance and factors involved in his offending. It would also allow him to gain a better insight and understanding of his offending cycle. The HISOP would allow treating staff to better understand these matters and to develop coping strategies to thereby reduce his risk. The HISOP needed to be done in custody.

[77] Under cross-examination, Dr Brown acknowledged that the respondent's unmodified, relatively high risk would be reduced by a supervision order which, in its initial stages, would involve release to the Wacol Precinct and a 24 hour curfew. However, once that high level of supervision was relaxed somewhat, the risk would increase. Although Dr Brown gave a number of risk-reducing strategies in her report, in her opinion there are "too many unanswered questions in relation to this man being in the community". Because his risk is not fully understood, Dr Brown thought it difficult to make statements about whether his risk would be at a certain level at a particular time in the community with particular restrictions. More information was needed about what his risks really are so that they might be reduced. A risk reduction plan needed to be individualised and it was not possible to complete a proper risk reduction plan, and in that process make an informed assessment of risk, until he had completed the HISOP.

[78] Dr Brown's evidence, like that of Dr Aboud and Dr Harden, was that a group program was likely to be more effective than a one-on-one program. The evidence showed that a group program produced the best results. Further, it was possible for the respondent to participate in such a program even where he denied his guilt for one of the offences.

[79] Dr Brown emphasised that there was not a signature pattern of offending. The issue remains that "we don't understand why he committed that offence" and that there is not enough "information about the antecedents and the behaviours associated with that offence" to confidently predict [risk] in the future.

[80] Finally, Dr Brown remarked upon the fact that the applicant's parole was revoked. In Dr Brown's opinion, this demonstrated that he was not able to maintain adherence to quite a simple set of rules associated with his parole order. This made her concerned that he would not adhere adequately to a supervision order.

[81] Dr Beech also remarked upon the difficulty presented by having so little information from the respondent or from any programs that he had done about the factors that led him to his offending, including the emotional factors, psychological factors and environmental factors. It was clear that the respondent struggles in the community, in relationships, regresses, uses substances and at some point used sexual violence as a way of coping with his negative emotional experiences.

[82] Because not enough is known about his reasons for offending, not enough is known about the strategies that could be put in place. Not knowing much about the "trajectory of the offending in the first place", any supervision order would involve severe restrictions with curfews in place, restriction on his movements and restricted access to people generally. The highest level of supervision would need to remain because one does not know how the risk might be lessened in the community. Whilst a supervision order would provide some security, according to Dr Beech a "more individualised program" would identify factors that have to be closely monitored.

[83] Dr Beech identified one of the important parts of the HISOP, towards its end, as the development of a relapse prevention program. Presently, the respondent's plan to live with a family member, not use drugs and find a job showed a "quite low-level insight about the difficulties he would face in the community when you look at what happened

when he was released on parole and when he was released at his full time [discharge date]".

[84] Dr Beech's evidence is that if the respondent was to remain in prison and do the HISOP then he would be better informed and people who were supervising him would be better informed about how to manage the risk.

[85] Dr Beech identified the concern that there was no pattern, particularly in circumstances in which the respondent denied some of his offending. Those denials might be challenged within the group process in which the respondent would have the benefit of hearing other people's accounts of their offending. A group program was likely to be more effective than individual counselling.

[86] As to the absence of a pattern of offending, the respondent's early offending involved breaking into women's homes when he was intoxicated and distressed, raping them and running off. His 2013 offending was "very concerning" because it was against that pattern, involved a child and seemed much more premeditated. Because the respondent now denies that offence, the psychiatrists do not know what he was thinking or feeling at the time, Dr Beech observes, and this makes it much more difficult to provide a prognosis.

[87] Dr Harden gave evidence to like effect about the need for information and that, being effectively untreated, the respondent required a HISOP. Dr Harden explained that the individual treatment mentioned in his report was really "a fall back position", and that to match the HISOP would require 300 hours plus of contact hours. This would a "Herculean" individual treatment effort. The available evidence suggests that group programs are more effective than individual treatment. The HISOP is not available in the community. Dr Harden agreed that without the HISOP, it is difficult to know the degree of risk reduction that would be achieved by even intensive supervision in circumstances in which he has been untreated, has denied the index offence and not enough is known about it.

[88] Dr Harden also considered the respondent's breach of parole on previous occasions raised a question about compliance with a supervision order. Even if the respondent continues to deny guilt for the index offences, a HISOP would have some benefit, since there is the prospect of learning more about the antecedents to the offending, for example, he might talk about how he felt that day or what happened in the week before the offence. These antecedents might be disclosed without him having to directly say that he committed the offence.

[89] Notwithstanding that a supervision order would include stringent conditions and itself involve some treatment, Dr Harden adhered to the view that the respondent should complete the HISOP prior to release.

Disposition

[90] Having regard to each of the matters stated in s 13(4) and, in particular the risk assessments to which I have referred, I am satisfied to the high degree required that the

respondent presents an unacceptable risk of committing a serious sexual offence if released from custody without an order being made under s 13. The evidence is cogent and satisfies me to a high degree of probability.

[91] The respondent concedes that an order should be made. The issue is whether the order should be a continuing detention order or a supervision order.

[92] The respondent is entitled to deny that he committed some of the sexual offences to which he pleaded guilty, and to refuse to participate in the HISOP. However, his failure and refusal to address the causes of his sexual offending impedes the development of an informed plan to address the risk of his re-offending upon release into the community. That, in turn, means that the extent to which any supervision order will reduce his risk of re-offending to an acceptably low level is uncertain. The respondent's refusal to engage in sex offending programs in custody and to address the truth about his offending against his niece in 2013 provides a poor basis to conclude that participation in an individual treatment program in the community will adequately address his high risk of sexual re-offending and provide the respondent with (to quote Dr Brown):

> "(a) self-awareness with regard to sexual deviance and behaviour in relationships,
>
> (b) coping strategies when relationships don't go well or breakdown
>
> (c) ability to accept responsibility for his offending on more than just a superficial level."

[93] Until the respondent does these things it is difficult to say what risk reduction strategies should be implemented under a supervision order, and questionable whether the respondent would comply with them to a satisfactory extent.

[94] Even strict conditions in a supervision order do not mean that it is likely that the respondent will be disposed to comply with them, not relapse into drug abuse and opportunistically commit another serious sex offence.

[95] The extent to which any supervision order will reduce the high risk of the respondent re-offending to an acceptably low level is quite uncertain, principally because of the respondent's refusal to admit the full extent of his sexual offending and to do enough to address it. The level of risk on a supervision order cannot be adequately assessed. This is likely to be the case for as long as the respondent fails and refuses to address his offending and fails to undertake programs in custody which would allow a sound risk reduction strategy to be developed and successfully implemented.

[96] Because the risk of re-offending on a supervision order cannot be adequately assessed, the applicant has discharged the onus of establishing that adequate protection of the community cannot be ensured at this stage by the adoption of a supervision order.

[97] The respondent is a serious danger to the community in the absence of a s 13 order. At this time, adequate protection of the community can only be ensured by a continuing

detention order under s 13(5)(a) of the Act. The respondent is detained in custody for an indefinite term for control, care or treatment.