SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General (Qld) v Stafford* [2019] QSC 238
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **SCOTT SHAMUS STAFFORD** (respondent)
FILE NO/S:	BS No 5194 of 2019
DIVISION:	Trial
PROCEEDING:	Originating application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	18 September 2019
DELIVERED AT:	Brisbane
HEARING DATE:	2 September 2019
JUDGE:	Burns J
ORDER:	**Being satisfied to the requisite standard that the respondent, Scott Shamus Stafford, is a serious danger to the community in the absence of an order pursuant to Division 3 of Part 2 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, the court orders that Scott Shamus Stafford 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 there is an application pursuant to s 5 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 for an order pursuant to Division 3 of Part 2 of that Act – whether the respondent is a serious danger to the community in the absence of a Division 3 order – where the court may order a continuing detention order or a supervision order pursuant to s 13(5) of the Act – whether the adequate protection of the community could be reasonably and practicably managed by a supervision order – whether the requirements under s 16 of the Act could be reasonably and practicably managed by corrective services officers *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) s 5, s

9A, s 13, s 16, s 27, s 28

Attorney-General (Qld) v Francis [2007] 1 Qd R 396; [2006] QCA 324, followed
Attorney-General (Qld) v Kanaveilomani [2013] QCA 404, cited
Attorney-General (Qld) v Phineasa [2013] 1 Qd R 305; [2012] QCA 184, followed
Attorney-General (Qld) v Sutherland [2006] QSC 268, cited
Fardon v Attorney-General (Qld) (2004) 223 CLR 575; [2004] HCA 46, cited
Kynuna v Attorney-General for the State of Queensland [2016] QCA 172, followed
Turnbull v Attorney-General (Qld) [2015] QCA 54,cited

COUNSEL: J Tate for the applicant
L Falcongren for the respondent

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

[1] The applicant Attorney-General for the State of Queensland seeks an order under Division 3 of Part 2 of the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) in relation to the respondent, Scott Shamus Stafford. The effect of such an order, if made, would be to detain the respondent in custody for an indefinite term for control, care or treatment[1]or release him from custody subject to a supervision order containing the mandatory statutory requirements and such other conditions as are considered appropriate by the court.[2]

[2] The parties, through their respective counsel, are at one in the proposition that there is acceptable, cogent evidence supporting a finding to a high degree of probability that the respondent remains a serious danger to the community in the absence of a Division 3 order. Where they are apart is on the question of the appropriate order. The applicant submits that the adequate protection of the community can only be ensured at this time by the making of a continuing detention order, but the respondent submits that this object can be achieved by the making of a supervision order for a period of 10 years.[3]

[3] The respondent is an Aboriginal man, aged 35 years of age, and without the benefit of much in the way of an education. He told one of the psychiatrists who examined him for the purpose of this proceeding (Dr Moyle) that he was born in Cherbourg, and was the sixth of 10 siblings. His family moved to Darwin when he was still very young, then to Cairns and, finally, to Yarrabah. There was a short period of time when his family moved to the ACT but they returned to Yarrabah when the respondent was about 12 years of age. On his return, he became increasingly involved with alcohol, drugs and other criminal activities. He lived on the streets at times but appears to have formed a relationship with a woman when he was about 16 years of age that lasted for some time. It was a tumultuous

1 Section 13 (5) (b).
2 Section 13 (5) (b). The mandatory requirements are set out in s 16.
3 A draft supervision order was in evidence: Exhibit 3.

arrangement but they had two children together, a girl and a boy. He suffers from diabetes (requiring injections of insulin), heart problems and obesity.

[4] The respondent has a history of serious sexual offending including multiple counts of rape and indecent treatment of children. Most relevantly, he was sentenced in the District Court at Cairns on 28 May 2013 to imprisonment for eight years and six months after pleading guilty to three counts of rape and nine counts of indecent treatment of children under the age of 16 years. His full time release date is tomorrow (19 September 2019). He is therefore a "prisoner" as defined by s 5(6) of the Act who is currently serving a term of imprisonment for a "serious sexual offence" which, by the Schedule to the Act, relevantly includes an offence of a sexual nature involving violence or an offence against a child.

[5] By way of background, the respondent's criminal record stretches back to his mid-teens and includes convictions for burglary, stealing, assaults with violence, sexual offences, drug offences, breaches of bail conditions, breaches of immediate release orders and probation orders, enclosed land offences, wilful damage and general dishonesty. Over a 15 year period between the ages of 13 and 28, the respondent was convicted of around 200 offences. So far as his convictions for sexual offences are concerned, they followed pleas of guilty in the District Court at Cairns on three separate occasions. I deal with each group of offences in order.

[6] On 22 January 2007, the respondent pleaded guilty to one count of indecent treatment of a child under the age of 16 years and one count of entering a dwelling with intent by break at night. The victim was a 14 year old girl who was known to the respondent and resided with her parents in Yarrabah. At about 2.30 am on 27 January 2006, the respondent broke into a dwelling when the victim was asleep in her bedroom. Her father and mother were asleep in another bedroom. The victim awoke when she felt someone touching her on her vagina. She saw the respondent leaning over her bed, and heard him say something to her. She screamed for her father and, with that, the respondent ran from her room. Her father took the victim to the police station, and identified the respondent as someone he knew was a friend of his son. The respondent was apprehended and interviewed by the police. He gave a largely false account. When sentenced by his Honour Judge Griffin QC, it was accepted that the respondent touched the victim "on the outside of her genital area" and that, when he did so, he had a "very drunken intent". He was sentenced to two years imprisonment for the enter dwelling with intent by break at night offence and 12 months imprisonment for the indecent treatment offence, each of which was suspended after serving eight months for an operational period of two years;

[7] Only a few days before he pleaded guilty to the offences before Griffin QC DCJ, the respondent committed the same offences against a different child complainant, and in very similar circumstances. On 3 September 2007, he pleaded guilty to one count of indecent treatment of a child under the age of 16 years and one count of entering a dwelling with intent by break at night. The offences were committed in the early hours of 19 January 2007. Again, the family of the victim, a 12 year old girl, was known to him. The respondent gained entry to the family home through an unlocked window and found the victim asleep in her bedroom. She awoke to him lying on the bed next to her with his erect penis exposed. She took fright and ran from the room. When interviewed by police, he again gave a largely false account but did say that he had consumed three to four casks of wine since the previous morning as well as four to five "cones" of marijuana. The

respondent was sentenced by his Honour Judge White to three years imprisonment for the enter dwelling with intent by break at night offence and two years imprisonment for the indecent treatment offence, with a parole eligibility date of 22 March 2009;

[8] As earlier mentioned, on 28 May 2013, the respondent pleaded guilty to three counts of rape and nine counts of indecent treatment of children under the age of 16 years. Some of the counts charged circumstances of aggravation involving a child under 12 years old or a child under the respondent's care. These offences are referred to in the material as the "index offences". The circumstances were as follows:

(a) *Rape* x 3: The three counts of rape constituted one episode of offending on 19 March 2011. The sentencing judge, his Honour Judge Harrison, recounted the facts:

> "These charges involve you going into the bedroom of a 15 year old girl and raping her on three separate occasions. Earlier that evening you had been a guest in her grandmother's home where the young girl was staying at the time. You had been one of a group of people who'd been there playing cards and drinking. The house was shut after everybody left and everyone else went to bed. You somehow managed to get back in by knocking on the door and someone there let you in and you then proceeded, at sometime around 4 a.m., into the bedroom of this 15 year old.
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> You then took advantage of her and committed three separate rapes. The first involved the insertion of your tongue in her vagina, which comes within the extended definition of rape. On the second occasion, you placed your penis inside her vagina and on the third occasion you penetrated her vagina with one of your fingers.
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> When you first went in there you tried to take her shorts off. She told you to get off. She told you to go and get her phone and a drink. You said you'd get them for her but you returned a short time later and pushed her back down on to the bed and lay on top of her. Then, importantly, you told her you had a knife and you threatened to stab her with the knife if she didn't let you do it.
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> There's no proof that there was a knife but I view very seriously the threat that you did make to the effect that you had one and to the effect that you would stab her if she did not go along with what you intended to do. Obviously there will have to be a substantial sentence imposed because of that offending";

(b) *Indecent treatment of children under 16, child under 12 years, under care* x 2: These offences occurred sometime between late 1999 and 2004. The victim was one of the respondent's younger brothers who was aged between five and 10 years of age at the time. The respondent rubbed his penis on his brother's buttocks outside of his shorts and then removed his own shorts, exposed his penis, and rubbed his brother's hand on it;

(c) *Indecent treatment of child under 16, child under 12 years* x 2: The victim was the respondent's younger sister who was between 10 and 11 years of age at the time. Although it is not clear, it is likely that these offences took place between October 2000 and October 2001. The offending involved the respondent getting into his sister's bed and rubbing his penis against her buttocks on the outside of her shorts. He also lifted her t-shirt, rubbed her breasts and rubbed her genitals underneath her

underwear;

(d) *Indecent treatment of child under 16 (expose), child under 12 years*: This offence took place between early 2004 and early 2007. The victim was the respondent's niece. She was between four and seven years old. He exposed his penis and masturbated whilst his niece was watching;

(e) *Indecent treatment of child under 16 (expose)*: The victim was the same younger brother as is referred to in (b) above, although he was approximately 13 years of age at the time of the offence. The respondent masturbated in front of his brother;

(f) *Indecent treatment of children under 16, child under 12 years*: The victim was the same niece as is referred to in (d) above. She was four or five years old at the time. The respondent touched his niece on the vagina through the outside of her clothing. She slapped his hand and walked away; and

(g) *Indecent treatment of children under 16* x 2: These offences again involved the same niece. She was then about nine or 10 years old. 26. The first offence occurred when she was asleep at night. She awoke to the respondent beside her bed. One of his hands was up her shorts and he was touching her on her genitals through her underwear. The second offence involved the respondent entering her bedroom, standing beside her and masturbating while she was sleeping. He then pulled down his shorts, lay beside her and continued to masturbate whilst she slept. After a period of time, his niece awoke, and the respondent ceased masturbating.

[9] When sentencing the respondent to an effective head sentence of imprisonment for eight years and six months, Harrison DCJ, made it clear that the offences summarised in (b) and (c) of the preceding paragraph most likely occurred when the respondent was under 17 years of age and, as such, he was dealt with for those offences as a child. The balance of the offences occurred when the respondent was an adult. The respondent's "serious addiction to cannabis" and "problems with alcohol" were noted along with a diagnosis reported by Dr Maguire, psychiatrist, on 28 June 2012 to the effect that he suffered from paranoid schizophrenia manifesting in "delusional beliefs and auditory hallucinations".

[10] For the purposes of this application, the respondent was examined by three psychiatrists: Drs Moyle, Timmins and Harden. Each provided a written report and gave evidence at the hearing.

[11] **Dr Moyle** examined the respondent on 9 July 2018 at the Capricornia Correctional Centre to assess his risk of sexual recidivism in relation to a possible application under the Act. Dr Moyle also took into account a large volume of documentary material including documents relating to his criminal history, time in custody and treatment. He offered this summary of his observations and assessment of the respondent:

> "Mr Stafford is a 34 year-old coming to the end of an 8 1/2 year sentence for rape with additional sentences for many teenage crimes against children of various ages, many prepubertal. Some of these offences occurred after he had first been convicted and sentenced in January 2007 for some sexual offences, and the offences for which he was convicted late in 2007 occurred prior to his first conviction for sexual offending. However, offending in 2010 and 2011 by indecent treatment of children would be a second series of offences that lead up to the rape offences in March 2011,

The earliest offences involved people he knew – a niece, his sister and a brother. The brother was as young as four years old, when he would masturbate, or rub up against the boy, as he would do touching behaviours with the sister and the niece. The rapes were an escalation of the prior sexual offences. He remembers this index offence clearly with me, describing in detail his thinking at the time and how he had a powerful sexual arousal when intoxicated with alcohol and marijuana and, despite some vague awareness that he should not do it, he climbed into bed with the girl and, once he had done that, after she told him to go, he stopped at the door then decided he was going to go to jail anyway because he had already fondled her in bed, threw her out of the bed onto the floor, and raped her, leaving after the grandmother came. He was caught after he failed to provide a fare to the taxi that drove him to Garbutt. He acknowledged not only the rape but the prior sexual offending. He would have been well motivated when he remembered all the prior offending, in the records of interview with police.

…

By my count, in the years from 13 to 28 - i.e. 15 years - he was convicted of 204 offences, appeared in Court on 21 occasions, and was only 13 when first convicted to custodial sentences but he did not seem to return to a pro-social lifestyle. To me, he recounts an excitement-filled life where drugs and alcohol leave him feeling positive and without a fear of death, despite his current obesity, diabetes and heart problems, and his history of what was diagnosed back in 2006 and 2007 as Paranoid Schizophrenia and treated with antipsychotics effectively. He now presents off medicines, by his account, for psychosis. It is not uncommon for people who abuse marijuana, and alcohol in particular, to have some paranoid jealousy, and it does sound like the first partner he had, the woman who became his "missus" when she was 15 and he was 16 and he started having an enjoyable sexual life, may not have been cheating on him but he was already abusing drugs and alcohol. He could and would drink three casks of wine a day and still remain functional. This extreme tolerance makes it clear he had Drug and Alcohol Use Disorders.

However, he did not develop commitment or responsibility for caring for his own and others' needs. Many crimes from 12, 13 until 23 were simply taking from others what he wanted, although he does report a three day period of working removing barnacles from a ship before his preference for drinking to intoxication ended that job prematurely. He was paid well. Otherwise, he lives according to his urges of the moment.

…

He does not deny always knowing what he is doing is wrong by common standards but he justifies his behaviour on grounds of chasing excitement and sex when he can get it, and enjoying the use of alcohol and drugs. He believes that he can be released at the end of sentence and therefore no restrictions are likely to be placed upon him. I discussed with him at the start the nature of the interview and that it is to inform the Attorney-General, who will decide on whether to proceed with an application subject to the [Act].

In custody, he was repeatedly in the Detention Units and has been offered opportunities to engage, in prior custodial sentences and current custodial sentences, in sex offender programs. He has chosen not to do so. His behaviour was escalating

> and his drug abuse, and alcohol abuse in particular, is not subsiding with age. He fully intends to live a street life on release, as it is the life he enjoys. He has a limited social support network, no clear plans on how to do anything but approach a shipyard with the hope that he might get some work there in future. Without that, he will live on the benefits, buy cheap clothing so he has enough money left over for his alcohol and possible drug use/cigarette use.
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> …
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> In programs, he has failed to learn or complete the programs. He simply expects to be able to live his life as he has in the past, assuring us that he knows what he did was wrong and he will not do it again. He has made no plans to form a stable, pro-social network of acquaintances who might influence him, and sees himself as uninfluenced by others, a man who likes to live life on his own how he wants to live it. He has characteristics of irresponsibility, impulsivity, but no significant hostility towards women, simply a desire to have sex when he wants to have it. Those elements of the sex offender programs he has attended have been incomplete, as has been his attendance in alcohol and drug programs.
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> …
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> Therefore, diagnostically, I do not believe that the sexual offending relates to his past diagnosis of Paranoid Schizophrenia but may represent the serious Antisocial Personality Disorder and the drug and alcohol abuse, in the sense that he does not respect the rights of others, never has, that he chases excitement, is impulsive and lives an irresponsible lifestyle, without need for close intimate relations with others, and gaining sex as he wishes, although he knows that it is wrong to do so, against the expressed wishes of a partner.
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> The diagnosis is Antisocial Personality Disorder, Drug and Alcohol Use Disorders, plus or minus Drug-Induced Psychosis or Paranoid Schizophrenia, and the possibility of childhood ADHD coming into adulthood and the possibility of some paedophilic sexual interests enacted on, render him, clinically, a high risk. He does not listen to his own doubting moral statements when he tells himself what he is doing is probably wrong and simply, knowing he is going to jail means he does not consider the child and would just simply take his sexual urges to their logical conclusion against anybody who might attract him in the vicinity at the time, without significant consideration of the effects on the victim. He has led a life of antisocial offending."

[12] Dr Moyle administered a number of risk assessment tools and the results of those, combined with his clinical assessment, led him to the following opinions on that topic:

> "My assessment of him leads to diagnoses of Antisocial Personality Disorder; Drug-Induced or Paranoid Schizophrenia, in remission; Drug and Alcohol Use Disorders, in remission in custody; possible Paraphilias of paedophilic nature; and possible childhood ADHD that may be related to his difficulties at school, his subsequent wagging and choosing the impulsive, active lifestyle with peers.
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> …

I have used clinical judgment as well as actuarial assessments and structured clinical judgment and, on all measures, his risk of reoffending is very high on release without addressing those factors that make the risk high that are amenable to alteration.

The most significant factor that is able to be changed is drug and alcohol use. He has no commitment to do so, The new aspect that is amenable to change is that he develops a pro-social lifestyle, working on skills and getting work, an income, and putting money aside to try and assist his own children's development Next is his learning to problem-solve rather than act impulsively. There is nothing in my assessment of him to say that he is so unintelligent or has such poor cognitive function that he cannot learn, but many people with psychopathic scores on a PCL do seem to have difficulty learning and behaving in ways that respect the social norms of our society. He can learn through good interventions with psychologists over a long period of time to look at his attitudes, his problem-solving, his impulsive wishes and, with good moral development therapy, can learn the norms of moral thinking, if he so chooses, and would then be free to choose whether to offend or not. At the moment, he seems driven by the impulse of the moment and the needs of the moment, such as, if he is hungry or has needs for items to survive, he will simply steal them. He tried to put a stop to that sort of behaviour several years ago, and it may be that he is more amenable to that now.

Some attempt to engage him with his cultural group may allow a sense of belonging that he does not seem to have had with other than his antisocial cousins and peers, who enjoy drinking and offending. Learning to develop a pro-social network may take time but he needs the opportunity. Mr Stafford needs to learn not to demand in an intimidating way from others, to steal, and develop problem-solving skills to stop him from reacting to the impulse of the moment, especially if he is jealous or suspicious of others' motives, to step back and look at the alternative explanations and strategies.

In his current state of mind, this is unlikely, I suspect it will take at least a year or two to even start to develop these skills, with intense therapy,

It is my opinion that, if released from custody, in his current frame of mind he is at a much higher than average risk of reoffending in a sexual way or a violent way, that he is vulnerable to cause deterioration to his health with his smoking and drinking and the poor attendance on his diabetic needs consequent upon this, and he may not remember to take treatment for his illness. He has low motivation for change.

Therefore, in dealing with the reasons for the [Act] - i.e. for control, treatment and rehabilitation — it is my opinion that Mr Stafford, in his current state of mind, will not exercise control over his risk factors on release. He is determined not to. I cannot see any Supervision Order preventing him going his own way if he wishes. He has limited respect for authority and profound respect for his own wishes to be met when he wants them met. While his nature can be pleasant, there is no sign that he has empathy or understanding of normal social awareness and moral decision-making and, where he does have some doubts, that is readily overcome by a combination of intoxication and a sense of giving up and doing what he wants anyway, without consideration of the rights of others.

…

> Therefore, as well as attending and completing sexual offender programs and substance abuse programs, as well as transitional programs, and encouragement to involve himself was culturally relevant or socially relevant others, I believe he will need individual treatment prior to any consideration of release in the community. He should also have his state of mind treated over time by a psychiatrist and consider use of antiandrogen treatment of sexual arousal and adhere to medical treatment should psychosis appear. It may also need craving inhibitors to help him withstand the urge for substances. I recommend getting the full records of the Prison Metal Health Services to consider before concluding on his mental health needs.
>
> I think the risk is high, should he be released from custody, that he will reoffend sexually when he wishes to do so and the opportunity arises to do so."

[13] In oral evidence, Dr Moyle confirmed his opinion that the risk of serious sexual reoffending on the part of the respondent was high. He also confirmed his opinion that the respondent "will not exercise control over his risk factors on release", and whether he is on a supervision order or not. Under cross-examination, Dr Moyle agreed that the consumption of alcohol and cannabis were significant risk factors and that abstinence would go to reduce his overall risk. However, his motivation to do so was doubtful. Even if he was motivated to abstain, Dr Moyle expressed concerns about how reliable that would be given his "level of impulsivity". Nonetheless, based on the contents of an exit report prepared by Ms Lavers (a psychologist who engaged the respondent in one-on-one counselling), he hoped that the respondent's motivation to adhere to the conditions of a supervision order might be increasing. If the progress he has made in that regard continues, his risk profile could reduce over time to "moderately high", but he would remain a high risk "at the moment". Otherwise, he would require intensive, daily NDIS support in the community and "that could possibly lower the risk" as could strict enforcement of any supervision order along with close monitoring of him for "signs that he's distressed".

[14] **Dr Timmins** was appointed by the Court under s 8 of the Act to undertake a risk assessment in relation to the respondent. She assessed the respondent on 17 June 2019 at the Townsville Correctional Centre. Like Dr Moyle, she also had regard to the large volume of documentary material relating to the respondent including documents concerning his criminal history, time in custody and treatment.

[15] In her report dated 26 July 2019, Dr Timmins expressed the opinion that the respondent is suffering from Paedophilia (non-exclusive, attracted to males and females); Exhibitionism (possible rape fantasies); Antisocial Personality Disorder; Psychopathic Traits; and Polysubstance Use Disorder (alcohol and marijuana).

[16] Dr Timmins recorded that the respondent had "struggled to complete required programs to address his offending with long periods spent in the Detention Unit". She regarded his insight into his offending pathways as "relatively poor with few, if any, plans to manage his sexual offending, use of substances or his mental health in the community". There had been suicide attempts whilst in custody, reports of paranoid thoughts and auditory hallucinations since 2006 (although neither symptom persisted at the time when Dr Timmins saw him) and an admission to a psychiatric hospital in Townsville in 2012 "for a couple of months". He had been under the care of the Prison Mental Health Service for the two month period receding his examination and was prescribed Olanzapine 20 mg at

night. His behaviour in custody has been, at times, sexually inappropriate (e.g., masturbating in view of female custodial corrections officers).

[17] Dr Timmins offered, relevantly, the following opinions:

> "[The respondent] has evidence of an Antisocial Personality Disorder, psychopathic traits and a Substance Use Disorder, mainly alcohol and cannabis use. He appears to have few plans to manage either of these issues in the community which at the very least would make it more difficult for him to manage his risk of reoffending in a sexual manner.
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> Mr Stafford has a high sex drive with multiple and frequent partners. He has struggled to manage his sex drive in the community. He has a history of following women home which has culminated in three Rape charges which form part of his offences for this current incarceration.
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> His victims are likely to be underage children, both males and females, either known or unknown to him. There is also a risk towards young adult females with whom he finds sexually attractive. He may follow them home and either watch them, or actively approach them through entering their homes. He is likely to be opportunistic in his offending, whereby he may meet a child, or young adult female and have an urge to have sex. Alternatively, he may masturbate in front of under age children.
>
> He may or may not be distressed with a relationship break-up or other personal stressors at the time. He may or may not be intoxicated. He is likely to not desist with his behaviour even if the victim does not consent. He is at risk of escalating to penetrative sexual offences, with the potential for a high degree of psychological and physical harm to the victim.
>
> He shows poor insight into his substance use, mental health issues, capacity to cope with stress and his sexual offending. He is emotionally immature. He tends to externalize blame to others, and avoids taking responsibility for his own behaviour. He appears to manipulate and avoid programs by either changing his protection status or complaining of suicidal thoughts, voices and excessive concerns about what other people think of him.
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> He has struggled to complete programs with long periods spent in the Detention Unit - some of these appear to be related to mental health issues, others appear to have an element of secondary gain, either to move units due to perceived safety concerns; or possibly to avoid recommended programs.
>
> He has few supports in the community. He has few, if any, plans to manage his criminal behaviour, substance use, mental health issues or sexual offending risk in the community.
>
> I am of the opinion that Mr Stafford will be at a **HIGH** risk of re-offending in a sexual manner if released into the community without a supervision order.
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> …

> His risk may be modified by a community supervision order under the Dangerous Prisoner (Sex Offender) Act 2003. He would most likely fall into a **MODERATE to HIGH** risk category.
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> The duration of a community order would need to be at least 10 years for the adequate protection of the community. [The respondent] is still relatively young and has a number of outstanding treatment needs relating to his risk of sexual offending which are important to address. If released he is likely to require significant time and support in order for him to learn to ameliorate his risk of sexual re-offending in the community." [Emphasis in original]

[18] When giving evidence at the hearing, Dr Timmins said that she did not consider the existence of a supervision order would reduce the respondent's risk of offending very significantly. She explained that this was because "he is not part of affecting reduction in his risk at all"; he was "not an agent of reducing the risk he poses to the community". Dr Timmins highlighted the respondent's failure to complete a drug and alcohol intervention program or a sex offender program. She stated that he had been "poorly compliant with his mental health medications and treatments" and that he therefore had "a number of outstanding needs". She noted that the respondent was "still engaging in sexual behaviour in custody" and, accordingly, that he is a person with "a high sex drive" without "any understanding or any sort of internal controls" over it. Nor does he have "any sort of clear plans for how to manage any of this" if he is released to the community where he will be exposed to drugs and alcohol that have the potential to increase his sex drive and reduce his impulse control. In short, she said, "I think you have a concerning picture". In cross-examination, Dr Timmins agreed that one-on-one counselling was a treatment option that needs to be seriously considered for the respondent. Alcohol and cannabis were significant risk factors for him, but it was difficult to say whether he was motivated or not to abstain from the consumption of those substances. Indeed, she did not think that the respondent was motivated at the present time to address any of his issues. It is important for him to stay on his prescribed medication and give himself the best chance to complete the available programs. He remains highly impulsive and, as such, it would be difficult for those responsible for supervising him to foresee trouble; she did not think that there would be "many warning signs".

[19] **Dr Harden** was also appointed by the Court under s 8 of the Act to undertake a risk assessment. He examined the respondent at the Townsville Correctional Centre on 1 July 2019, had regard to the documentary material to which I have already made reference and administered a number of risk assessment tools.

[20] The following opinions were expressed by Dr Harden:

> "At the time of this assessment [the respondent] was a 36 -year-old indigenous man serving his second period of incarceration for sexual offences. His history of sexual offending dates back to when he was 15 years of age with the most recent offences committed when he was approximately 27 or 28 years of age. There have been at least 6 victims of the sexual offending all of them under 16 years of age.
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> Some of the victims would have been prepubertal at the time of the offending, albeit the offences committed when he was younger (mid-adolescence) himself and some of the victims would have been post-pubertal (for example the recent 15 year old). It

seems likely he does have a paedophilic orientation, particularly given the recurrent offending and the lack of any adult victims. He denies such sexual interests.

He undertook a preparatory program successfully in custody but was unable to complete a more significant intervention program due to mental health symptoms. He is now undertaking individual treatment and reportedly is compliant with this.

He appears to have no significant internal controls with regard to sexual behaviour as evidenced by his exposure of himself to female correctional staff as acknowledged to myself at interview.

He has an extensive and serious criminal history dating back to 13 years of age with no significant pause apart from periods of incarceration. He has a history of severe alcohol and marijuana use once again only punctuated by periods of incarceration.

He appears to have come from a functional family and other family members do not have the same extensive history of criminality. He denies any substantial history of abuse or neglect as a child.

He gives a history of childhood learning disorders with regard to mathematics but on more recent testing appears to have more significant deficits in the language area and has, on that most recent testing, a mild intellectual disability.

He has been diagnosed with a psychotic illness, namely paranoid schizophrenia, from approximately 2006 or 2007 onwards and has been on an antipsychotic treatment, much of that involuntary because of compliance issues, since that time. This illness appears to have been characterised almost solely by auditory hallucinations and anxiety but these [constellation] of symptoms were significant enough to interfere with his ability to complete the group sexual offending program. Dr Moyle in his report appropriately casts into question whether there is a psychotic illness or some other explanation for this constellation of symptoms.

In the absence of more collateral information from recent years regarding his mental health treatment and involuntary treatment this question remains open.

He has a severe Antisocial Personality Disorder with significant psychopathic features that are likely to interfere with treatment and rehabilitation. He appears to have no significant strengths in that he has a limited relationship with family members, no significant work experience, no other prosocial contacts or structures and his previous time in the community seems to have been characterised by offending, substance use and living off government allowances or the charity of others.

It may be that with some additional support structures (which may be accessible to him via the NDIS now that he has a formal finding of mild intellectual disability and below average adaptive function) things may improve.

He claims that he undertakes a full range of activities of daily living in custody without assistance. It is not clear to me from the data what his capacity is in terms of independent living in the community. There has been no suggestion that he is not capable of appropriate self-care in the community but this bears further

examination."

[21] Dr Harden considered that the respondent met the diagnostic criteria for Antisocial Personality Disorder (severe, with Psychopathic features); Paedophilia, Nonexclusive (provisional); Polysubstance Abuse (in remission due to incarceration); Schizophrenia – Paranoid Type; and Mild Intellectual Disability. He made provisional diagnoses of Paedophilia, Nonexclusive and Schizophrenia – Paranoid Type.

[22] As to the question of future risk, Dr Harden stated:

> "The actuarial and structured professional judgement measures I administered would suggest in my opinion **that his future risk of sexual reoffence is well above average (high)**. My assessment of this risk is based on the combined clinical and actuarial assessment. This assessment takes into account all information made available to myself.
>
> The critical issues for this man are his substance misuse, intellectual disability, possible psychotic illness, severe antisocial personality disorder with psychopathic features and probable paraphilia.
>
> Any future offence is likely to occur while intoxicated and be oriented towards younger victims. It is less likely that physical violence will occur during the offending. Physical injury of the victim is less likely. Psychological trauma of the victim is very likely.
>
> In my opinion the monitoring and supports associated with a supervision order reduce his risk of recidivism to moderate/average or lower. This is predicated upon his being able to cope practically in the community with the level of self- care and self-management required on a supervision order." [Emphasis in original]

[23] In oral evidence, Dr Harden agreed there was no real difference between his diagnostic formulation in this case and that separately expressed by Drs Moyle and Timmins. Where there was a difference of opinion was whether the strictures of a supervision order, as implemented in routine practice, reduce the risk of reoffending; Drs Moyle and Timmins were not of the opinion that there would be much of a reduction whereas Dr Harden considered that a supervision order would reduce the respondent's future risk of sexual reoffence from high to "around the average range". There was, however, a critical assumption underpinning Dr Harden's opinion – that the respondent would "prefer not to return to custody" because, if that was so, there would be an ongoing incentive to abide by the conditions of a supervision order. However, Dr Harden stated that "there may be an issue with that in this man" and that he otherwise had a "constellation of very severe risk factors". When cross-examined, Dr Harden agreed that "there are questions about his level of motivation about staying out of custody and unanswered as yet". Further, he agreed that this was a "serious problem" and that if the respondent is not sufficiently deterred from drinking alcohol by the prospect of going back to jail, then it would only take him drinking and an opportunity to arise for him to commit an offence. Dr Harden further explained that there are "a whole lot of things at play"; the respondent has a "very difficult personality", he is "a bit impulsive", and his views might "change from day to day depending on his emotional state". Furthermore, he is not someone who would necessarily provide warning signs that he is likely to relapse into alcohol use or offending

behaviour or both.

[24] The objects of the Act are to provide for the continued detention in custody or supervised release of a particular class of prisoner to ensure adequate protection of the community and to provide for the continuing control, care or treatment of such prisoners to facilitate their rehabilitation.[4]

[25] To those ends, the Act provides for the continued detention in custody or supervised release of prisoners but only if the court is satisfied that they represent a "serious danger to the community" in the absence of an order providing for their continuing detention or supervision under Division 3 of Part 2 of the Act.[5] The Attorney-General may apply for such an order,[6] and bears the onus of proving that the subject of any such application is indeed a "serious danger to the community".[7]

[26] A 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 without a supervision order being made.[8] A "serious sexual offence" means an offence of a sexual nature involving violence or against a child.[9]

[27] On the hearing of the application, the court may decide that a prisoner poses a serious danger to the community only if it is satisfied by acceptable, cogent evidence, and to a high degree of probability, that the evidence is of sufficient weight to justify the decision.[10]

[28] The paramount consideration in deciding whether to make a continuing detention order or a supervision order is the need to ensure adequate protection of the community.[11] In addition, the court must consider whether adequate protection of the community can be "reasonably and practicably managed by a supervision order" and whether the requirements for such orders specified in s 16 can be "reasonably and practicably managed by corrective services officers".[12]

[29] Section 13(4) provides that, in deciding whether a prisoner is a serious danger to the community, the court must have regard to the following:

> "(aa) any report produced under section 8A;
>
> (a) the reports prepared by the psychiatrists under section 11 and the extent to which the prisoner cooperated in the examinations by the psychiatrists;
>
> (b) any other medical, psychiatric, psychological or other assessment relating to

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4 Section 3.
5 Section 13(1).
6 Section 5(1).
7 Section 13(7).
8 Section 13(2).
9 Section 2 and the Schedule to the Act, being the Dictionary. See also *Attorney-General (Qld) v Phineasa* [2013] 1 Qd R 305; [2012] QCA 184 at [23]-[45] per Muir JA; *Kynuna v Attorney-General for the State of Queensland* [2016] QCA 172 at [56] per McMurdo P.
10 Section 13(3).
11 Section 13(6)(a).
12 Section 13(6)(b).

the prisoner;

(c) information indicating whether or not there is a propensity on the part of the prisoner to commit serious sexual offences in the future;

(d) whether or not there is any pattern of offending behaviour on the part of the prisoner;

(e) efforts by the prisoner to address the cause or causes of the prisoner's offending behaviour, including whether the prisoner participated in rehabilitation programs;

(f) whether or not the prisoner's participation in rehabilitation programs has had a positive effect on the prisoner;

(g) the prisoner's antecedents and criminal history;

(h) the risk that the prisoner will commit another serious sexual offence if released into the community;

(i) the need to protect members of the community from that risk;

(j) any other relevant matter."

[30] Section 13(5)(a) then goes on to provide that, if the court is satisfied that a prisoner is a serious danger to the community in the absence of a Division 3 order, the court may order that the prisoner be detained indefinitely for control, care or treatment pursuant to a continuing detention order[13] or released pursuant to a supervision order subject to such requirements as the court considers appropriate.

[31] The correct approach to a consideration of the issues arising under these provisions was explained by McMurdo J (as his Honour then was) in *Attorney-General (Qld) v Sutherland*[14] as follows:

> "No order can be made unless the court is satisfied that the prisoner is a serious danger to the community. But if the court is satisfied of that matter, the court may make a continuing detention order, a supervision order or no order.[15] There is no submission here that if the prisoner is a serious danger to the community, nevertheless no order should be made. As already mentioned, it is conceded on behalf of the prisoner that I could be satisfied in terms of s 13(1) and that a supervision order would be appropriate.
>
> The court can be satisfied as required under s 13(1) only upon the basis of acceptable, cogent evidence and if satisfied 'to a high degree of probability that the evidence is of sufficient weight to justify the decision.' Those requirements are expressed within s 13(3) by reference to the decision which must be made under s 13(1). They are not made expressly referable to the discretionary decision under s 13(5). The paramount consideration under [s 13(6)] is the need to ensure adequate protection of the community. Subsection 13(7) provides that the Attorney-General has the onus of proving the matter mentioned in s 13(1). There is no express requirement that the Attorney-General prove any matter for the making of a continuing detention order, beyond the proof required by s 13(1). So s 13 does not expressly require, precedent

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13 As to which, see *Attorney-General (Qld) v Francis* [2007] 1 Qd R 396; [2006] QCA 324 at [29].

14 [2006] QSC 268.

15 *Fardon v Attorney-General (Qld)* (2004) 223 CLR 575; [2004] HCA 46 at [19], [34]; cf in relation to s 30 *Attorney-General (Qld) v Francis* [2007] 1 Qd R 396; [2006] QCA 324 at [31].

to a continuing detention order, that the Attorney-General prove that a supervision order would still result in the prisoner being a serious danger to the community, in the sense of an unacceptable risk that he would commit a serious sexual offence. However in my view, such a requirement is implicit within s 13.

The paramount consideration is the need to ensure adequate protection of the community. But where the Attorney-General seeks a continuing detention order, the Attorney-General must prove that adequate protection of the community can be ensured only by such an order, or in other words, that a supervision order would not suffice. The existence of such an onus in relation to s 13(5) appears from *Attorney-General v Francis*[16] where the Court allowed an appeal from a judgment which had made a continuing detention order upon the primary judge's view that the Department of Corrective Services would not provide sufficient resources to provide effective supervision of the prisoner upon his release. The Court found an error in that reasoning because of the absence of evidence that the resources would not be provided.[17] The Court observed:[18]

> '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 principal, 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.'

Thus the absence of evidence of the inadequacy of resources was important because that matter had to be proved, as a step in persuading the court that only continuing detention would suffice.

The Attorney-General must prove more than a risk of re-offending should the prisoner be released, albeit under a supervision order. As was also observed in *Francis*, a supervision order need not be risk free, for otherwise such orders would never be made.[19] What must be proved is that the community cannot be adequately protected by a supervision order. Adequate protection is a relative concept. It involves the same notion which is within the expression 'unacceptable risk' within s 13(2). In each way the statute recognises that some risk can be acceptable consistently with the adequate protection of the community.

The existence of this onus of proof is important for the present case. None of the psychiatrists suggests that there is no risk. They differ in their descriptions of the extent of that risk. But 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 judgement as to what risk should be accepted against the serious alternative of the deprivation of a person's liberty."[20]

[32] As earlier stated, it was not in issue on the hearing of the application that the respondent is a serious danger to the community in the absence of a Division 3 order. Rather, for the

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16 [2007] 1 Qd R 396; [2006] QCA 324.
17 Ibid [37].
18 Ibid [39].
19 Ibid.
20 [2006] QSC 268 at [26]-[30]. See also *Attorney-General for the State of Queensland v Kanaveilomani* [2013] QCA 404 at [118]-[120] per Morrison JA; *Turnbull v Attorney-General (Qld*) [2015] QCA 54 at [36]-[37] per Morrison JA.

respondent, it was submitted that the adequate protection of the community could be ensured by his release subject to a supervision order.

[33] I have no doubt that the respondent is a serious danger to the community in the absence of an order under Division 3 of the Act. Each of the reporting psychiatrists expressed the opinion that the respondent's unmodified risk of the commission of a serious sexual offence was high. He has a number of serious mental health issues, little in the way of treatment, a perfunctory insight into his offending behaviour or the need to address the causes of it, next to no motivation to change (if not a determination not to change) and, as Dr Harden said, a "constellation of very severe risk factors". This all amounts to the "concerning picture" spoken of by Dr Timmins.

[34] On the face of things, the more difficult question in this case is whether the adequate protection of the community can be reasonably and practicably managed by a supervision order. That is because of the difference in the *written* opinions of the psychiatrists regarding the extent to which a supervision order would reduce the risk to the community represented by the respondent: Drs Moyle and Timmins do not consider that a supervision order would have any significant reducing effect on the risk whereas Dr Harden expressed a contrary view.

[35] The applicant of course bears the onus of demonstrating that a supervision order would afford inadequate protection to the community and, in the end, I am satisfied that this is so. In coming to that conclusion, I was very much assisted by the oral evidence of each of the psychiatrists. In particular, it became clear that Dr Harden's opinion as to the reducing effect on risk of a supervision order was dependent on the "critical assumption" I discussed earlier (at [23]), that is to say, that the respondent would "prefer not to return to custody" and, if that is so, there would be an ongoing incentive for him to abide by the conditions of a supervision order. To my mind, it would be folly to make such an assumption in this man's case, at least at this time. Indeed, as Dr Moyle opined, it is more probably the case that the respondent is determined not to exercise control over his risk factors if he is released.

[36] It follows that I am satisfied by acceptable, cogent evidence and to the high degree of probability required by the Act that the respondent is a serious danger to the community in the absence of an order pursuant to Division 3 of Part 2 of the Act. I am further satisfied that the adequate protection of the community or the requirements of s 16 of the Act cannot be reasonably and practicably managed by a supervision order. Accordingly, it will be ordered that the respondent be detained in custody for an indefinite term for control, care or treatment.