SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Barney* [2020] QSC 120
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **STEVEN PAUL BARNEY** (respondent)
FILE NO/S:	BS No 11432 of 2018
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court of Queensland at Brisbane
DELIVERED ON:	15 May 2020
DELIVERED AT:	Brisbane
HEARING DATE:	12 May 2020
JUDGE:	Davis J
ORDER:	**The court being satisfied that Steven Paul Barney is a serious danger to the community in the absence of an order made under Division 3 of Part 2 of the Dangerous Prisoners (Sexual Offenders) Act 2003, orders that the respondent be released from custody and from that time be subject to the requirements of the supervision order which is attached as Schedule A to these reasons for a period of five years until 15 May 2025.**
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 applicant applies for an order under Division 3 of Part 2 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 – where both parties join in the submission that the adequate protection of the community can be ensured by the respondent's release on a supervision order for a period of five years – where the evidence is that the respondent requires a high level of support if he is to be released – where suitable supported accommodation has been sourced – whether the adequate protection of the community can be ensured by the release of the respondent on a supervision order

Corrective Services Act 2006, s 4
Dangerous Prisoners (Sexual Offenders) Act 2003, s 3, s 5, s 8, s 9A, s 11, s 12, s 13, s 13A, s 16

A-G (Qld) v Beattie [2007] QCA 96, followed
Attorney-General for the State of Queensland v DXP [2019] QSC 77, followed
Attorney-General for the State of Queensland v Fardon [2019] QSC 2, followed
Attorney-General for the State of Queensland v Francis [2007] 1 Qd R 396, followed
Attorney-General for the State of Queensland v KAH [2019] 3 Qd R 36, cited
Attorney-General for the State of Queensland v Lawrence [2011] QCA 347, considered
Attorney-General for the State of Queensland v Newman [2019] 2 Qd R 1, cited
Attorney-General v Phineasa [2013] 1 Qd R 305, followed
Attorney-General for the State of Queensland v Travers [2018] QSC 73, cited

COUNSEL: J Rolls for the applicant
J Briggs for the respondent

SOLICITORS: GR Cooper, Crown Solicitor for the applicant
Legal Aid Office Queensland for the respondent

[1] The respondent is presently in custody under an interim detention order made under s 9A of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (the DPSOA). That order is to expire at 10.00 am on 15 May 2020.

[2] The applicant has filed an application seeking orders under s 13 of the DPSOA for the continued detention of the respondent[1] or alternatively that he be released under supervision.[2]

Statutory scheme

[3] Section 3 of the DPSOA prescribes the objects of the legislation as follows:

> "**3 Objects of this Act**
>
> The objects of this Act are—
>
> (a) 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
>
> (b) to provide continuing control, care or treatment of a particular class of prisoner to facilitate their rehabilitation."

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1 *Dangerous Prisoners (Sexual Offenders) Act 2003*, section 13(5)(a).
2 Section 13(5)(b).

[4] The objects of the DPSOA are fulfilled by a scheme providing for the detention of prisoners beyond the expiry of their sentences, or alternatively their release upon supervision.

[5] By s 5, the Attorney-General may apply for both an order under s 8 of the DPSOA and also an order under Division 3 of Part 2. Division 3 of Part 2 provides for final orders. Applications can only be brought under s 5 against a "prisoner".

[6] Section 5, which authorises the application for orders and which contains the definition of "prisoner", is, relevantly, as follows:

> "**5 Attorney-General may apply for orders**
>
> (1) The Attorney-General may apply to the court for an order or orders under section 8 and a division 3 order in relation to a prisoner.
>
> (2) The application must—
>
> (a) state the orders sought; and
>
> (b) be accompanied by any affidavits to be relied on by the Attorney-General for the purpose of seeking an order or orders under section 8; and
>
> (c) be made during the last 6 months of the prisoner's period of imprisonment.
>
> (3) On the filing of the application, the registrar must record a return date for the matter to come before the court for a hearing (preliminary hearing) to decide whether the court is satisfied that there are reasonable grounds for believing the prisoner is a serious danger to the community in the absence of a division 3 order. …
>
> (6) In this section—
>
> ***prisoner*** means a prisoner detained in custody who is serving a period of imprisonment for a serious sexual offence, or serving a period of imprisonment that includes a term of imprisonment for a serous sexual offence, whether the person was sentenced to the term or period of imprisonment before or after the commencement of this section."

[7] The definition of "prisoner" in s 5(6) introduces the concept of "a serious sexual offence". That term is defined as follows:

> "***serious sexual offence*** means an offence of a sexual nature, whether committed in Queensland or outside Queensland—
>
> (a) involving violence; or
>
> (b) against a child; or

(c) against a person, including a fictitious person represented to the prisoner as a real person, whom the prisoner believed to be a child under the age of 16 years."

[8] Section 8 provides for a preliminary hearing. It is in terms:

"**8 Preliminary hearing**

(1) If the court is satisfied there are reasonable grounds for believing the prisoner is a serious danger to the community in the absence of a division 3 order, the court must set a date for the hearing of the application for a division 3 order.

(2) If the court is satisfied as required under subsection (1), it may make—

(a) an order that the prisoner undergo examinations by 2 psychiatrists named by the court who are to prepare independent reports; and

(b) if the court is satisfied the application may not be finally decided until after the prisoner's release day –

(i) an order that the prisoner's release from custody be supervised; or

(ii) an order that the prisoner be detained in custody for the period stated in the order."

[9] The term "prisoner", as used in s 8 is defined differently to the definition in s 5(6). In s 8, the term "prisoner" has the same meaning as that defined for the purposes of the *Corrective Services Act* 2006.[3] The distinction is, though, not relevant here.[4] The respondent was, at the time of filing of the application, a "prisoner" under s 5 as he was "serving a period of imprisonment for a serious sexual offence".[5] At the time of the final hearing, the respondent was in the custody of the Chief Executive, Corrective Services, and therefore a "prisoner".[6]

[10] Section 8 introduces the notion of "serious danger to the community". This term is defined in s 13 which is the pivotal section in Division 3 of Part 2. Section 13 is in these terms:

"**13 Division 3 orders**

(1) This section applies if, on the hearing of an application for a division 3 order, the court is satisfied the prisoner is a serious danger to the community in the absence of a division 3 order (a serious danger to the community).

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3 *Dangerous Prisoners (Sexual Offences) Act* 2003 (Qld) s 2 and the dictionary which is the Schedule to the Act.

4 See *Attorney-General for the State of Queensland v Newman* [2019] 2 Qd R 1.

5 Section 5(6).

6 *Corrective Services Act 2006*, s 4, sch 4 (dictionary); *Dangerous Prisoners (Sexual Offenders) Act* 2003, s 2, dictionary.

(2) A prisoner is a serious danger to the community as mentioned in subsection (1) if there is an unacceptable risk that the prisoner will commit a serious sexual offence—

(a) if the prisoner is released from custody; or

(b) if the prisoner is released from custody without a supervision order being made.

(3) On hearing the application, the court may decide that it is satisfied as required under subsection (1) only if it is satisfied—

(a) by acceptable, cogent evidence; and

(b) to a high degree of probability;

that the evidence is of sufficient weight to justify the decision.

(4) In deciding whether a prisoner is a serious danger to the community as mentioned in subsection (1), 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 the prisoner;

(c) information indicating whether or not there is a propensity on the part of the prisoner to commit serious sexual offence sin 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.

(5) If the court is satisfied as required under subsection (1), the court may order—

(a) that the prisoner be detained in custody for an indefinite term for control, care or treatment (continuing detention order); or

(b) that the prisoner be released from custody subject to the requirements it considers appropriate that are stated in the order (supervision order).

(6) In deciding whether to make an order under subsection (5)(a) or (b)—

(a) the paramount consideration is to be the need to ensure adequate protection of the community; and

(b) the court must consider whether –

(i) adequate protection of the community can be reasonably and practicably managed by a supervision order; and

(ii) requirements under section 16 can be reasonably and practicably managed by corrective services officers.

(7) The Attorney-General has the onus of proving that a prisoner is a serious danger to the community as mentioned in subsection (1)."

[11] Orders which can be made under s 8 include orders that a prisoner undergo psychiatric examination. The evidence so obtained is then relied upon by the Attorney-General on the application brought under s 13. Relevantly to examinations ordered under s 8, are ss 11 and 12 which are in these terms:

"**11 Preparation of psychiatric report**

(1) Each psychiatrist examining the prisoner must prepare a report under this section.

(2) The report must indicate—

(a) the psychiatrist's assessment of the level of risk that the prisoner will commit another serious sexual offence—

(i) if released from custody; or

(ii) if released from custody without a supervision order being made; and

(b) the reasons for the psychiatrist's assessment.

(3) For the purposes of preparing the report, the chief executive must give each psychiatrist any medical, psychiatric, prison or other relevant report or information in relation to the prisoner in the chief executive's possession or to which the chief executive has, or may be given, access.

(4) A person in possession of a report or information mentioned in subsection (3) must give a copy of the report or the information to the chief executive if asked by the chief executive.

(5) Subsection (4) authorises and requires the person to give the report or information despite any other law to the contrary or any duty of confidentiality attaching to the report.

(6) If a person required to give a report or information under subsection (4) refuses to give the report or information, the chief executive may apply to the court for an order requiring the person to give the report or information to the chief executive.

(7) A person giving a report or information under subsection (4) or (6) is not liable, civilly, criminally or under an administrative process, for giving the report or information.

(8) Each psychiatrist must have regard to each report or the information given to the psychiatrists under subsection (3).

(9) Each psychiatrist must prepare a report even if the prisoner does not cooperate; or does not cooperate fully, in the examination.

12 Psychiatric reports to be given to the Attorney-General and the prisoner

(1) Each psychiatrist must give a copy of the psychiatrist's report to the Attorney-General within 7 days after finalising the report.

(2) The Attorney-General must give a copy of each report to the prisoner on the next business day after the Attorney-General receives the report."

[12] Section 16 deals with the contents of supervision orders. It provides relevantly as follows:

"**16 Requirements for orders**

(1) If the court or a relevant appeal court orders that a prisoner's release from custody be supervised under a supervision order or interim supervision order, the order must contain requirements that the prisoner—

(a) report to a corrective services officer at the place, and within the time, stated in the order and advise the officer of the prisoner's current name and address; and

(b) report to, and receive visits from, a corrective services officer as directed by the court or a relevant appeal court; and

(c) notify a corrective services officer of every change of the prisoner's name, place of residence or employment at least 2 business days before the change happens; and

(d) be under the supervision of a corrective services officer; and

(da) comply with a curfew direction or monitoring direction; and

(daa) comply with any reasonable direction under section 16B given to the prisoner; and

(db) comply with every reasonable direction of a corrective services officer that is not directly inconsistent with a requirement of the order; and

(e) not leave or stay out of Queensland without the permission of a corrective services officer; and

(f) not commit an offence of a sexual nature during the period of the order.

(2) The order may contain any other requirement the court or a relevant appeal court considers appropriate—

(a) to ensure adequate protection of the community; or

(b) for the prisoner's rehabilitation or care or treatment."

[13] By s 13A of the DPSOA, the court must, if making a supervision order, set the period of supervision. Section 13A provides:

"**13A Fixing of period of supervision order**

(1) If the court makes a supervision order, the order must state the period for which it is to have effect.

(2) In fixing the period, the court must not have regard to whether or not the prisoner may become the subject of—

(a) an application for a further supervision order; or

(b) a further supervision order.

(3) The period can not end before 5 years after the making of the order or the end of the prisoner's period of imprisonment, whichever is the later."

History

[14] The respondent is an Indigenous man born in December 1956 and is currently 63 years of age. He has been convicted of various sexual offences dating back decades. His criminal history is not limited to sexual offending and is not limited to Queensland, having also been convicted in the Northern Territory and New South Wales.

[15] The respondent's first conviction for an offence of a sexual nature was in this court on 16 March 1977 when he was convicted of break and enter a dwelling house with intent in the night time and attempted rape. He was then sentenced to four years' imprisonment.

[16] Over the following 40 years, the respondent was regularly before the courts and convicted of sexual offences, primarily offences of indecent treatment and wilful exposure.

[17] In Queensland, he was convicted in 2004 in the Mount Isa Magistrates Court, in 2005 in the Hervey Bay Magistrates Court, in 2006 in the Maryborough District Court, in 2008 in the Gympie District Court, 2009 in the Maryborough District Court, in 2012 in the Brisbane District Court and again in 2012 in the Brisbane Magistrates Court, in 2013 in the Brisbane Magistrates Court, in 2014 in the Wynnum Magistrates Court, in 2015 in the Brisbane Magistrates Court and again in 2015 in the Wynnum Magistrates Court and on 26 July 2017 in the Brisbane District Court.

[18] In New South Wales courts, he was also convicted of various offences of wilful exposure and like offences between December 1986 and 2001.

[19] In the Northern Territory, he was convicted in December 1996 of the offence of indecently exposing himself to a child.

[20] The respondent was sentenced to terms of imprisonment in 1977, 1996, 2006, 2008, 2009, 2012, 2013, 2014, 2015 and 2017. The offences were of a sexual nature and many involved children. Apart from the attempted rape conviction in 1977, none of the sexual offences involved physical contact or violence. They consisted of him exposing his victims to his genitals and acts of masturbation.

[21] The convictions in the Brisbane District Court on 26 July 2017 are of particular significance to the present application. On that day he was convicted of one count of indecent treatment of a child under the age of 16 and two counts of indecent acts in a public place. The offences occurred between 10 and 19 July 2016.

[22] Two of the counts occurred on trains. On both occasions, mothers had taken young children onto the train and the respondent had exposed and handled his penis in front of the children. The children involved on the first occasion were aged 13 and 10. The child involved in the second offence, which occurred on 18 July 2016, was a four year old.

[23] On 19 July 2016, the respondent exposed and handled his penis in front of a female bus driver.

[24] The convictions on 26 July 2017 left the respondent liable for the activation of a suspended sentence that had been imposed in the Wynnum Magistrates Court on 22 October 2015 for similar conduct. Judge Rackemann imposed an effective head sentence of two years and six months, activated the suspended period of imprisonment and set a parole eligibility date of 26 July 2017, being the date his Honour imposed the sentences.

[25] Despite making application for parole, the respondent did not achieve his release.

[26] Doctor Eve Timmins, a consultant psychiatrist, was retained by the applicant to prepare a risk assessment with a view to ascertaining whether an application ought to be made under the DPSOA. She interviewed the respondent on 17 May 2018.

[27] The applicant resolved to bring an application for Division 3 orders which was filed on 22 October 2018. On 6 November 2018, I made orders under s 8 of the DPSOA setting the application for hearing on 29 January 2019 and appointing psychiatrists, Doctors Ness McVie and Scott Harden, to examine the respondent.

[28] Both doctors interviewed the respondent and prepared reports in preparation for the hearing set to occur on 29 January 2019.

[29] On 18 January 2019, the respondent was interviewed by a psychologist, Dr Forster, to assess the suitability of the respondent to commence a preparatory sexual offender treatment program. The psychologist made observations of the respondent which raised concerns as to the respondent's cognitive functioning. These concerns were passed to Doctors Timmins, McVie and Harden and the general opinion was that the issue ought to be further investigated.

[30] The Division 3 application was adjourned and a report was commissioned from Dr Michelle Andrews, a clinical psychologist and neuropsychologist.

[31] The respondent's full time release date from the sentences imposed by Judge Rackemann was 30 January 2019. Once the application was adjourned, it was obvious that the proceedings would not be completed before the expiry of those sentences. The respondent is still in custody as a result of a series of interim detention orders made under s 9A of the DPSOA.

[32] Doctor Andrews interviewed the respondent on 8 March 2019 and prepared a report. Supplementary reports were then obtained from Dr Timmins (report dated 2 May 2017), Dr Harden (16 May 2019) and Dr McVie (10 May 2019).

[33] An issue which arose was that the respondent clearly needed supported accommodation if released on supervision. An occupational therapist, Dr Kieran Broome, was retained to assess these needs and a report was provided by him on 26 June 2019.

[34] In the usual course, a prisoner released on supervision would initially reside at the Wacol Precinct. The expert evidence suggested that the precinct would be an unsuitable residence for the respondent, given his need for support.

[35] On 22 April 2020, Queensland Corrective Services identified a supported accommodation facility which was considered suitable. On or about 23 April 2020, the respondent expressed a desire to live at that facility if released. The applicant then contacted the three psychiatrists and the occupational therapist to ascertain their opinions on whether the accommodation sourced would be suitable. They opined that it was suitable.

The position of the respective parties

[36] In reliance upon the medical evidence (which I analyse below), the applicant submits that she has proved "by acceptable, cogent evidence" and "to a high degree of probability"[7] that the respondent is a serious danger to the community in the absence of a Division 3 order. The applicant, though, does not press for a continuing detention order and accepts that the adequate protection of the community will be ensured by the release of the respondent on a supervision order for a term of five years.

[37] The respondent concedes that the Crown has proved to the requisite standard that he is a serious danger to the community in the absence of a Division 3 order but resists the making of a continuing detention order. He joins in the submission of the applicant that the adequate protection of the community can be ensured by his release upon a supervision order for a period of five years.

The psychiatric evidence

[38] Doctor Timmins was the first of the three psychiatrists to interview the respondent and provide a report.[8] She identified alcohol abuse as an issue. She recorded the respondent's long criminal history and the fact that alcohol and other substance abuse played a part in the offending.

[39] Doctor Timmins' diagnosis was that the respondent was suffering from an antisocial personality disorder with the presence of psychopathic traits. She also diagnosed alcohol dependence (in sustained remission in a controlled environment). She opined that the respondent did not have a psychotic illness or major mood disorder but suspected paedophilia (non-exclusive, directed towards females) and a fetish pertaining to female underwear but could not positively diagnose those things. As to the assessment of risk and recommendations, Dr Timmins' view was as follows:

> "In summary, I am of the opinion that Mr Barney's risk of sexual reoffending is HIGH if released into the community without a supervision order in place.
>
> He has few plans for his release. Those he does have are not likely to maintain enough support so that his risks are decreased. He is likely to quickly return to substance use and sexual offending behaviour. In addition he has very little desire to address his risk factors or sexual offending behaviour.
>
> He is likely to initially return to alcohol use, and subsequently sexual offending if he becomes bored, frustrated or suffer a

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7 Section 13(3).

8 Exhibit ET-2 to the Affidavit of E Timmins sworn 2 August 2018 (CFI 3).

> significant loss. His offending is likely to be against young female children, but could be young adult females. He has only one contact offence of Attempted Rape in 1977. It is unlikely he will offend with a contact offence. He is more likely to continue his current pattern of offending with exposing himself and masturbating in public.
>
> While there is not a high degree of harm to victims when compared to a rape offence his offending is persistent and frequent. There is likely to be a large number of victims and Mr Barney has little remorse or understanding as to the effect of his offending on others.
>
> He has poor insight and a high level of denial of his offending behaviour. He is largely untreated having refused to engage in any treatment programs for his sex offending or substance use. He has attempted to manipulate the situation, using his medical issues as a way to avoid these programs. As such he has not completed any Sex Offender programs.
>
> Ideally he should have engaged and completed the recommended Sex Offender and Substance Use programs in custody. Despite his reported issues with his memory I do think he has the capacity to complete the programs, he just does not want to.
>
> If the court is of a mind to release Mr Barney he will require a significant amount of support on release given he has no community supports and no feasible plans for his future.
>
> Given other forms of community order have failed to assist with his recidivism Mr Barney will need an intensive order with the ability to monitor his movements and use of electronic devices, limit his access to alcohol and other such substances, assist in engaging with treatment and appropriate community supports.
>
> 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 risk category.
>
> The duration of a community order would need to be more than five years given that Mr Barney is likely to find it difficult to engage in treatment and previous community orders have failed to address his recidivism. A period of eight to 10 years may be the most appropriate for the adequate protection of the community."[9]

[40] Doctor McVie's first report is dated 21 December 2018.[10] She also identified substance abuse as a risk factor. She diagnosed the respondent as follows:

> "Diagnostically, he could be said to meet criteria for a diagnosis of antisocial personality disorder, polysubstance abuse and possibly alcohol dependence, paranoid personality disorder and a paraphilia, exhibitionism."[11]

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9 Report of Dr Timmins, pages 259-260.
10 CFI 14.
11 Report of Dr McVie, page 17.

[41] As to risk, Doctor McVie said this:

> "Risk assessment indicates he currently would present a high risk of reoffending in a similar manner (exposing to female children and adult women in public places) if released from custody. Being on the Child Sex Offender Register with those reporting obligations does not appear to have decreased this risk for this man. The combination of a score of 4 on the Static 99R and a score of 17 on the Stable, indicates Mr Barney has a high level of treatment needs."[12]

[42] Doctor McVie's recommendations were these:

> "Mr Barney needs to complete specific programs to address both his sexual offending and his alcohol abuse. He needs a detailed relapse prevention plan in relation to his alcohol use. Homelessness and alcohol intoxication have been identified as clear precipitants for his more recent sexual offending behaviour.
>
> He requires further assessment of other treatment needs related to his sexual offending as outlined in the risk assessment above.
>
> He may benefit from programs with culturally appropriate content.
>
> Management planning may be assisted by formal neuropsychology testing and MRI brain to determine the level of his cognitive deficit, if present most likely related to chronic alcohol abuse.
>
> The level of risk of his committing similar offences is high if he is discharged from custody without further assessment and treatment. A supervision order could decrease his risk to moderate, if it was supported by a tightly structured individual treatment program."[13]

[43] Doctor Harden's first report was dated 15 January 2019.[14] Perhaps unsurprisingly, Dr Harden, like Doctors Timmins and McVie, identified alcohol and substance abuse as significant risk factors. He diagnosed the respondent as follows:

> "**Diagnoses**
>
> Exhibitionism
>
> Paedophilia. While there may be some debate about this it seems clear that a significant number of offences seem to be committed in the presence of prepubertal children to a much greater than chance degree. Most sexual offenders who suffer from exhibitionism target post pubertal females for exposure.
>
> Antisocial personality disorder
>
> Alcohol abuse and dependence."[15]

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12 Report of Dr McVie, page 17.
13 Report of Dr McVie, page 17.
14 CFI 15.
15 Report of Dr Harden, page 15.

[44] Doctor Harden was more sceptical than Doctors Timmins and McVie as to any beneficial effect of a supervision order upon the respondent's risk of committing a serious sexual offence. As to risk, Dr Harden opined:

> "**Risk statement**
>
> The actuarial and structured professional judgement measures I administered would suggest that his future risk of sexual reoffence 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.
>
> A supervision order in my opinion will do little to further reduce any risk currently as he is unlikely to comply with the strictures of such an order, in particular abstinence from substance misuse.
>
> If he were released from custody without constraints he would immediately resume his [offending][16] soon after committing another offence most likely exhibitionism in front of female young people."[17]

[45] Doctor Harden's recommendations were as follows:

> "**Recommendations**
>
> I would recommend he cease alcohol use permanently.
>
> I recommend he have no contact with females under 18 years of age.
>
> I recommend that he undertake the intensive sexual offending program for indigenous males or alternatively the high-intensity sexual offending program in custody prior to any consideration of release.
>
> Although he has substance abuse treatment needs it is likely that successful completion of the intensive sexual offender programs will deal with this issue to the extent of planning to manage risk of sexual recidivism associated with substance misuse."[18]

[46] The results of Dr Andrews' neuropsychology assessment are the subject of her report of 8 April 2019.[19] She examined the respondent and administered a number of clinical tests designed to assess the respondent's cognitive functioning. Doctor Andrews found that the respondent suffered impairment but not consistently across the range of cognitive functioning.

[47] Doctor Andrews found:

> "Across broader neuropsychology assessment he demonstrated age appropriate performance on tasks assessing:

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16 This word seems to have been accidentally omitted from the report.
17 Report of Dr Harden, page 16.
18 Report of Dr Harden, page 16.
19 Exhibit MA-2 to the Affidavit of M Andrews sworn 7 June 2019 (CFI 37).

- Word knowledge and semantic verbal fluency
- Expression and comprehension of simple information facilitated by repetition
- Basic auditory attention
- Basic working memory/mental manipulation
- Simple gross motor speed
- Visual constructional skills, visual concept formation and problem solving."[20]

And:

"Mr Barney demonstrated a mild level of difficulty on a task of letter fluency and on a visual memory (recall of previously exposed material and recognition) task.

Generally, across the assessment he demonstrated moderate (borderline range) to severe impairments (extremely low range) in the following areas compared to similar aged peers:

- Verbal memory; impairments in encoding information, learning or acquisition of new information and recall and recognition of previously learnt information. He is easily overwhelmed by larger amounts of information, and he does not benefit from cueing or repetition.
- Processing Speed; psychomotor speed and cognitive processing speed (ie tasks without a motor component)
- Complex attention and working memory; Mr Barney demonstrates attentional fluctuations throughout the assessment. His attention was easily drawn to information or stimuli that were most salient indicative of some mild stimulus bound response tendencies (ie acting or talking without specified goals when his attention is drawn to a stimulus). He also demonstrated difficulties with self-monitoring and error detection on some tasks.
- Executive Functions; Mr Barney demonstrated impairments in verbal planning and organisation, strategy use to reach a goal, maintenance of and shifting of attention, inhibition of responses, mental flexibility, abstract thought, verbal reasoning and efficient problem solving."[21]

And:

"Mr Barney's neuropsychology assessment results indicate that he has selected impairments across multiple areas of cognitive functioning inclusive of verbal memory, attention/complex

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20 Report of Dr Andrews, page 17.
21 Report of Dr Andrews, pages 17-18.

> attention, processing speed and executive functions. He has areas of relatively preserved functioning in the domains of visuospatial skills, immediate-auditory attention, simple working memory/mental manipulation and simple gross motor speed. However, it should be noted that even within these domains, as the attentional load and processing requirements increase Mr Barney's performance deteriorates quickly."[22]

[48] To all the psychiatrists and to Dr Andrews, the respondent reported that he suffered from emphysema. Clinical observations were made by the doctors that the respondent did have some difficulty with breathing. Dr Andrews explained in her report that emphysema is a form of Chronic Obstructive Pulmonary Disease (COPD). As COPD interferes with airflow into the body, sufferers experience reduced oxygen levels across time. This, she explains, can cause neurological damage and adversely affect cognitive functioning.

[49] COPD does not though, Dr Andrews explained, adversely affect all cognitive functioning uniformly but tends to have more effect upon cognitive domains including "attention, processing speed, memory and executive function". These are the areas where Dr Andrews found the respondent deficient so she:

(a) diagnosed mild neurocognitive disorder due to another medical condition (emphysema); but

(b) did not diagnose vascular dementia or mixed pathology dementia.

[50] As to the impact of the respondent's cognitive deficits upon risk of future sexual offending, Dr Andrews observed:

> "Currently Mr Barney benefits from a high level of structure and supervision in custody. Having external structure and supervision (whether this be in custody or in the community) reduces reliance upon his own cognitive recourses to plan and implement appropriate boundaries around his daily life and behaviours. External support and supervision will likely be the most effective mechanism in reducing or containing his risk of reoffending and managing his risk of returning to substance abuse."[23]

[51] The significance of Dr Andrews' report is obvious. Therefore, steps were taken to have the three psychiatrists consider Dr Andrews' report and provide supplementary opinions.

[52] Doctor Timmins provided a supplementary report bearing the date 2 May 2018, but that must be a misprint. The report was obviously authored on 2 May 2019.[24] Doctor Timmins confirmed her earlier diagnoses but, considering Dr Andrews' findings, Dr Timmins added a further diagnosis of "mild neurocognitive disorder". She confirmed her view that the risk of sexual offending is high if the respondent is released without a supervision order but that risk would fall to moderate under a supervision order.

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22 Report of Dr Andrews, page 18.

23 Report of Dr Andrews, page 20.

24 Exhibit AD-2 to the Affidavit of A Dalley sworn 17 June 2019 (CFI 36).

[53] Doctor Timmins emphasised that upon release the respondent "will require a significant amount of support". In relation to the duration of a supervision order, she observed:

> "The duration of a community order would need to be more than five years given that Mr Barney is likely to find it difficult to engage in treatment and previous community orders have failed to address his recidivism. A period of either to 10 years may be the most appropriate for the adequate protection of the community."[25]

[54] Doctor McVie, after considering Dr Andrews' report and her finding that the cognitive deficits could be linked to emphysema, thought there might be other explanations for the deficits.[26] Doctor McVie pointed to the respondent's early life boxing career and his history of alcohol and other substance abuse. As to risk, she opined:

> "Risk assessment indicates he presents a high risk of reoffending in a similar manner (exposing to female children and adult women in public places) if released from custody without supervision and treatment. Being on the Child Sex Offender Register did not alter his behaviour."[27]

And:

> "The level of risk of his committing similar offences is high if he is discharged from custody without supervision and treatment. A community supervision order could decrease his risk to moderate to low, if it was supported by a tightly structured individual treatment program. There should be a low tolerance for any non-compliance with conditions of any supervision order."[28]

[55] Doctor McVie thought that the respondent was capable of living independently in the precinct but advised that an occupational therapist may assist in planning for the management of the respondent on supervision.

[56] Doctor Harden considered Dr Andrews' report and in his supplementary report of 16 May 2019,[29] he opined that:

(a) Compliance with a supervision order is within the respondent's cognitive capacity.

(b) There is a danger that the respondent will not comply and will return to alcohol use.

(c) The supervision order ought to be structured so as to decrease the chance of the respondent becoming intoxicated.

(d) "The most likely kind of sexual offending at risk of reoffence is exhibitionism while intoxicated with alcohol".

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25 Supplementary report of Dr Timmins, page 5, which confirms her earlier report.
26 The report is Exhibit AD-5 to the Affidavit of A Dalley sworn 17 June 2019 (CFI 36).
27 Supplementary report of Dr McVie, page 5.
28 Supplementary report of Dr McVie, page 5.
29 Exhibit AD-6 to the Affidavit of A Dalley sworn 17 June 2019 (CFI 36).

(e) The respondent ought to have no contact with females under 18 years of age.

(f) The respondent's risk of re-offending without supervision is high.

(g) The respondent's risk of re-offending if on supervision is moderate.

[57] No doubt, in response to the views of Dr McVie, the respondent's case was referred to an occupational therapist, Dr Kieran Broome. After an extensive assessment Dr Broome, in his report of 26 June 2019,[30] concluded:

> "• Mr Barney would not be able to reside independently at the Wacol Precinct, due to difficulties with household chores and difficulty attending appointments. He would be able to reside at the Wacol precinct if appropriate visiting supports were provided.
>
> • Mr Barney would not be able to reside independently in the community, due to difficulties with household chores, difficulty attending appointments and difficulties with household maintenance. He would be able to reside in the community if appropriate supports were provided.
>
> • Mr Barney requires support with at least weekly cleaning, main meal preparation, taking out/in rubbish bins, heavier laundry, large shopping trips, household maintenance, transport (if suitably close public transport is not available), health management and establishment of financial supports (eg direct debit of recurring payments). Two accommodation scenarios are mostly likely to be appropriate;
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> o *Living in the community (eg rental, public housing or hostel accommodation) with support services*. Mr Barney's age (62 years) and indigenous heritage allow him to meet minimum and maximum age limits for both the National Disability Insurance Scheme (NDIS) and My Aged Care. It is unlikely that he would be accepted into the National Disability Insurance Scheme, as his primary cause of functional impairment (COPD) is typically considered by the NDIS to be a health-related rather than disability-related concern. My Aged Care is likely to be a more feasible option. He will require a support worker at least twice a week (once for cleaning and taking in/out of bins, and once for shopping and taking in/out of bins, as well as regular monitoring of his health and safety and reporting to a case manager). This is likely to take at least 1.5 hours per visit due to the tangential nature of conversation when inquiring into his health, combined with time completing or assisting with household tasks. He will also require prepared meals (eg Meals on Wheels). Monitoring by a case manager, nurse navigator or social worker would help to establish financial matters, assist in organising, supporting, and reinforcing health care, and monitoring medication compliance. He would also require

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30 Exhibit KB-2 to the Affidavit of S Barney sworn 17 July 2019 (CFI 40).

> referral to a multidisciplinary allied health team (dietitian, occupational therapist, physiotherapist) for nutrition, falls risk, mobility and functional management.
>
> o *Living in residential aged care.* Residential aged care will provide the relevant services listed above. Residential aged care placement may be more difficult to source. Mr Barney may experience better outcomes in residential aged care due to regular monitoring, a structured routine, support from a diversional therapist to engage in leisure, and typically limited access to alcohol. At the culmination of the occupational therapy assessment, residential aged care was the accommodation option preferred by Mr Barney." [31] (emphasis added)

[58] The psychiatrists were briefed again, this time to comment upon Dr Broome's report. It is unnecessary to analyse the opinions received from the psychiatrists other than to observe that there was an acceptance that the precinct was an unsuitable residence for the respondent.

[59] Armed then with the mounting body of expert opinion to the effect that the respondent should be housed in an aged care facility if released, the Aged Care Assessment Team was engaged.[32] That team assessed the respondent as requiring aged care at "level 3" which provides a level of support providing meals, food preparation, personal care, domestic assistance, nursing, transport and social support. Such a facility was identified. The psychiatrists and Dr Broome all assessed that facility as suitable to house the respondent.[33]

Consideration and determination

[60] The assessment of risk involves consideration of at least two elements:

1. The likelihood of the happening of the relevant event (here the relevant event is the commission by the respondent of a serious sexual offence); and

2. The consequence of the relevant event occurring.[34]

[61] Therefore, when the consequences of an offender committing an offence are grave, the risk might be unacceptable even though the likelihood of an offence being committed is low. This was the position in *Attorney-General for the State of Queensland v Lawrence*.[35] There, the prisoner had not offended for years and the likelihood of doing so was diminishing with time. However, the risk, if it eventuated, was of a violent sexual assault of a life threatening severity. Therefore, the risk was unacceptable.[36]

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31 Report of Dr Broome, page 7.
32 A Commonwealth government scheme.
33 See Affidavit of A Dalley sworn 8 May 2020 (CFI 72).
34 *A-G (Qld) v Beattie* [2007] QCA 96 at [19] and *Attorney-General for the State of Queensland v Lawrence* [2011] QCA 347 at [90].
35 [2011] QCA 347.
36 *Attorney-General for the State of Queensland v Lawrence* [2011] QCA 347 at [97].

[62] In this matter, the converse applies. Where the seriousness of the predicted event is low, risk may be acceptable even in the face of some realistic likelihood of it occurring.

[63] Under the DPSOA, the relevant consideration is not risk of any offending, or even risk of sexual offending, but offending by commission of a "serious sexual offence" which relevantly here is "an offence of a sexual nature involving violence" or "an offence of a sexual nature against a child".[37]

[64] In *Attorney-General v Phineasa*,[38] the Court of Appeal considered the notion of "violence" in the definition of "serious sexual offence" in the DPSOA. There, Muir JA said:

> "[38] As I trust emerges from earlier discussion, the 'violence' referred to in the definition of serious sexual offence is force significantly greater in degree than mere physical contact or even, at least as a general proposition, acts such as pawing, grasping, groping or stroking. The language of sections 8 and 13, in particular, is inconsistent with the application of the Act to sexual offences other than of a very serious kind where offending against adults is concerned. Those sections are addressing conduct of such a nature, that the risk that a prisoner, assumed to be a member of a particular class, might engage in it and harm a member or members of the public if released from custody or if released without a supervision order, is regarded as unacceptable. Consequently, the 'violence' contemplated by the Act (excluding for present purposes threats and intimidation) would normally involve the use of force against a person to facilitate the 'rape' of that person within the meaning of s 349 of the *Criminal Code* or which caused (or in the case of predicted conduct would be likely to cause) that person significant physical injury or significant psychological harm."[39]

[65] Here, the respondent has not committed a sexual offence involving physical contact with a victim since his conviction in 1977. In the following 43 years, his sexual offending has been confined to exposing himself to women and girls (and like offences). The view of the psychiatrists is that his likely reoffending will be similar type offences. That behaviour, to an adult woman, is not a "serious sexual offence" as defined, but it is if the target is a child.

[66] Therefore, the relevant risk is that the respondent will expose himself to a child. In the absence of a supervision order that risk is high. The psychiatric evidence is unanimous to that effect. I accept the evidence of the psychiatrists, which I find to be cogent. I find to a high degree of probability that the respondent is a serious danger to the community in the absence of an order under Division 3 of Part 2 of the DPSOA.

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37 *Attorney-General for the State of Queensland v Travers* [2018] QSC 73 at [30] followed in *Attorney-General for the State of Queensland v Fardon* [2019] QSC 2 at [19].

38 [2013] 1 Qd R 305.

39 *Attorney-General v Phineasa* [2013] 1 Qd R 305, 314 at [38].

[67] The next question is whether a supervision order or a continuing detention order ought to be made. In context, that is resolved by determining whether a supervision order will provide adequate protection of the community against the risk of the respondent exposing himself to girls.

[68] There is no doubt that if the respondent was living independently in the community the relevant risk would be unacceptable and a supervision order would not provide adequate protection of the community. That is, though, not contemplated.

[69] The respondent would not, by the terms of the proposed supervision order, be at liberty to live at a place of his choosing. He "… must live at a place approved by a Corrective Services officer".[40] That place will be a level 3 aged care facility. Living at such a facility is necessary because of the cognitive impairments being experienced by the respondent. Because of those impairments, he needs, and will be provided with, support to assist with day to day living. That environment will, itself, instil a degree of control. As recommended by the psychiatrists, the supervision order will contain a prohibition against contact with children.

[70] The proposed supervision order will provide adequate protection to the community and the release of the respondent on supervision ought therefore be preferred to the making of a continuing detention order.[41]

[71] It is necessary then to determine the length of the supervision order. Applegarth J, in *Attorney-General for the State of Queensland v DXP*,[42] posed the question under s 13A of the DPSOA in this way: "… In considering the period of the [supervision] order, the court makes a current assessment of future risks and asks when will the respondent reach a point at which he will be an acceptable risk without a supervision order".[43]

[72] After initial disagreement, the psychiatrists all now substantially agree that point will be five years hence.[44] I accept that evidence. The supervision order should be for a duration of five years.

Orders

[73] The court being satisfied that Steven Paul Barney is a serious danger to the community in the absence of an order made under Division 3 of Part 2 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, orders that the respondent be released from custody and from that time be subject to the requirements of the supervision order which is attached as Schedule A to these reasons for a period of five years until 15 May 2025.

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40 Proposed condition 10.
41 *Attorney-General for the State of Queensland v Francis* [2007] 1 Qd R 396.
42 [2019] QSC 77, following *Attorney-General for the State of Queensland v KAH* [2019] 3 Qd R 36.
43 At [29].
44 Fifth supplementary affidavit of Amelia Dalley; sworn 8 May 2020, exhibit bundle pages 5, 7 and 9.