SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Friend* [2009] QSC 135
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **ROY FRIEND** (respondent)
FILE NO:	883/06
DIVISION:	Trial Division
PROCEEDING:	Review hearing
ORIGINATING COURT:	Supreme Court of Queensland
DELIVERED ON:	2 June 2009
DELIVERED AT:	Brisbane
HEARING DATE:	14 April 2009
JUDGE:	Daubney J
ORDER:	**1. The respondent continue to be subject to the detention order made on 27 February 2008**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where respondent was to have access to psychiatric and psychological counselling – where significant limitations on the provision of the treatment program to the respondent were encountered – where delay in granting treating psychologist access – where treatment sessions were of inadequate duration and frequency – where no significant progress in the respondent's condition – whether the respondent is a serious danger to the community – whether the respondent should continue to be subject to a continuing detention order *Dangerous Prisoners (Sexual Offenders) Act* 2003 *Attorney-General v Francis* [2006] QCA 324, applied *Attorney-General v Friend* [2008] QSC 27, considered
COUNSEL:	J M Horton for the applicant

J H Allen for the respondent

SOLICITORS: Crown Law for the applicant

Legal Aid Queensland for the respondent

[1] On 2 June 2006 Moynihan SJA, on an application made by the Attorney-General pursuant to s 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 ("the Act") found that the respondent, Roy Friend, was a serious danger to the community (as that term is defined in the Act) and made a supervision order which enabled the respondent to be released from custody subject to a range of requirements specified in the supervision order.

[2] In February 2008, the Attorney-General applied pursuant to s 22 of the Act for recision of the supervision order on the ground that the respondent had breached a number of its requirements, particularly those which restricted his contact with male children. These contraventions were proved by admissions he had made to psychiatrists who had examined him, and his counsel at the hearing accepted that the admissions amounted to admissions of breaches of requirements of the supervision order.

[3] On 27 February 2009, Skoien AJ ordered that the supervision order which had been made on 2 June 2006 be rescinded and made a continuing detention order in respect of the respondent.

[4] The matter now before the Court is a periodic review, as required by s 27 of the Act which provides:

> "**27 Review – periodic**
>
> (1) If the court makes a continuing detention order, the court must review the order at the end of 1 year after the order first has effect and afterwards at intervals of not more than 1 year after

the last review was made while the prisoner continues to be subject to the order.

(2) The Attorney-General must make any application that is required to be made to cause the reviews mentioned in subsection (1) to be carried out."

[5] In relation to a review hearing, s 30 provides:

"**30 Review hearing**

(1) This section applies if, on the hearing of a review under section 27 or 28 and having regard to the matters mentioned in section 13(4), the court affirms a decision that the prisoner is a serious danger to the community in the absence of a division 3 order.

(2) On the hearing of the review, the court may affirm the decision 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 affirm the decision.

(3) If the court affirms the decision, the court may order that the prisoner -

(a) continue to be subject to the continuing detention order; or

(b) be released from custody subject to a supervision order.

(4) In deciding whether to make an order under subsection (3)(a) or (b), the paramount consideration is to be the need to ensure adequate protection of the community.

(4A) If the court makes the order under subsection (3)9b), the supervision order must include the requirements mentioned in section 16(1)(da) and (db).

(5) If the court does not make the order under subsection (3)(a), the court must rescind the continuing detention order."

[6] The respondent's relevant criminal history was usefully summarised by Skoien AJ in his reasons for judgment:[1]

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[1] *Attorney-General v Friend* [2008] QSC 27.

> "[4] First, Mr Friend was convicted in 1991 at Townsville of the offences of indecent dealing with a boy under 17 (5 charges) and indecent assault (16 charges). The offences occurred in 1987 and 1988. He was sentenced to 2 years' imprisonment.
>
> [5] The second set of offences was for possession of child abuse photographs in August 1997. Mr Friend was convicted and sentenced to 6 months imprisonment (suspended for three years).
>
> [6] The third set of offences concerned indecent treatment of a boy under 16. They were committed while Mr Friend was in the company of another child sex offender. In December 1997 they took the boy for a drive. The other man began sexually abusing the boy and insisted that Mr Friend do so also. Mr Friend briefly touched the boy twice on the genitals. The sentence imposed was 12 months imprisonment which was reduced on appeal to 3 months imprisonment. The sentencing Judge (Wall CDJ) recommended that Mr Friend undertake psychiatric and psychological treatment as considered appropriate and that he participate in the sexual offenders treatment program.
>
> [7] The fourth set of offences in April 2003 concerned indecent treatment of a boy under 16 (13 charges) and indecent treatment of a boy under 12 (2 charges). They occurred after Mr Friend had become acquainted with boys, generally between the ages of 4 and 16. He met and befriended them as part of his employment. His behaviour would normally involve brushing up against the boys and touching their genitals through their clothes, but pretending the contact was accidental. Later, he took some of the boys home and showed them pornographic videos and masturbated himself in their presence. He touched the penis of the boy under 12 by putting his hands inside the boy's pants."

[7] In the course of his reasons for judgment, his Honour then set out the evidence of the three psychiatrists who had seen the respondent, including the details of the admissions made which were agreed to be admissions of contravening conduct. One of the psychiatrists considered the respondent's then current risk of re-offending was "great"; another considered it "high", while the third thought it "moderate". His Honour noted:[2]

> "All agree that a proper course of psychiatric treatment and psychological therapy could reduce this to enable, in the opinions of Professor James and Dr Beech (and subject, no doubt, to re-evaluation in a year or so) his supervised release from prison. Professor Morris considered him to be suitable for that supervised release now. Each of them is of the opinion that Mr Friend presents as a very complicated clinical case."

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[2] At [35].

[8] His Honour then considered a proposed management plan for the respondent, noting that the treatment suggested fulfilled the statutory requirement for control of the respondent, care for him and treatment of him. He then weighed the evidence which had been adduced from the respondent and the respondent's brother as to their plans if the respondent were released. Skoien AJ then said:

> "[39] The doubts that I have about the desirability of Mr Friend's release from prison relate to: the justifiable suspicion that all three psychiatrists retain about Mr Friend's frankness about the motive behind the events of November 2007; the real possibility that the events displayed continued sexual interest in boys; the further real danger of his exposure to the stresses of life outside prison, including possibly, the effect of his continued unlawful sexual interests, leading to further suicidal thoughts, and perhaps even attempts; the fact that life outside prison will assuredly expose him to contact (either unsupervised or effectively unsupervised) with boys; the fact that a curfew would be of no practical assistance. To cloister him so as to remove the obvious stresses would necessitate, virtually, house arrest which would be tantamount to prison.
>
> [40] There is some doubt, as there must always be, of the efficiency of the treatment if administered in prison. In *Francis* the response of QCS left much to be desired. However the affidavit of Joel Smith, Principal Advisor, Sexual Offender and Dangerous Offender Unit, Probation and Parole Directorate is before me in which the assurance is given that proper therapeutic treatment can be given and will be made available. I cannot reject that evidence and I must accept that a private psychiatrist of dedication and ability would be assigned to provide treatment of the proper type, using proper skills and in proper quantity. I expect that psychological treatment, if required, will be given by Dr Whittington, with whom Mr Friend has seemingly built up a good rapport or by someone of equal competence. Equally, I accept that the same resources would be applied by QCS to meet appropriate conditions should Mr Friend be released under supervision."

[9] His Honour concluded[3] that there was a risk of contravention by the respondent during the course of the psychiatric treatment which was likely to have a temporary destabilising effect on him, and consequently concluded that this treatment needed to take place in prison. That conclusion founded the necessity for his Honour to rescind the supervision order, and make a continuing detention order in its place.

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3 At [43].

[10] After the respondent was retained in custody pursuant to the continuing detention order, the plan was for him to have the benefit of an appropriate course of psychiatric and psychological counselling. Indeed, Justice Skoien referred specifically in the passage I have quoted above to having been given an assurance that "proper therapeutic treatment can be given and will be made available". It is regrettable, to say the least, that what were described to me as administrative difficulties encountered within Queensland Corrective Services ("QCS") led to significant limitations on, if not hindrances to, the provision of the treatment program to the respondent. Mr David Whittingham, the consultant psychologist who had been treating the respondent prior to the making of the order on 27 February 2008 and who was supposed to have been given access to the respondent to continue his treatment regime while in continuing custody, stated in his report dated 11 February 2009:

> "I have seen Mr Friend for a total of 17 sessions, commencing on 13/06/08 to 06/02/09, with all sessions occurring at Wolston Park Correctional Centre. Sessions have varied in length from no contact, 15 minutes to 90 minutes dependent on operational issues in the centre including access difficulties, and visits coordination and occasional need to reschedule due to other commitments. On several occasions such disruptions have increased Mr Friend's distress regarding the treatment process and necessitated a more acute focus to therapy until his level of distress had reduced sufficiently to focus on the therapeutic tasks."

[11] It is also to be noted that it took some four months for the Department to facilitate access by Mr Whittingham to the respondent. The Director of the High Risk Offender Management Unit within QCS, who was called to give oral evidence before me, was unable to provide any explanation for this delay, beyond saying that she had correspondence with the relevant correctional centre and that approval for access by Mr Whittingham was ultimately approved. The respondent filed an affidavit before me in which he particularised the dates and duration of each of Mr Whittingham's visits to him – the shortest being of five minutes and the longest (on

one occasion only) of 60 minutes. When explored in evidence, it became clear that there was no inconsistency between Mr Whittingham's recollection of the duration of the visits and that of the respondent – the respondent was referring to the time they spent "face to face", while Mr Whittingham was referring to the time he was available to see the respondent after having passed through the necessary security checks. But even when Mr Whittingham was inside and available to see the respondent, further time would then elapse while the respondent was located and brought to him. Mr Whittingham described occasions of having to wait for 30 minutes before the respondent was brought to him, and referred specifically to one visit which he described as "a particularly poor occasion where [the respondent] and myself went to four different areas of the centre before we eventually saw one another for ... a very small period of time". This restriction of access occurred in a context where Mr Whittingham considered "face to face" sessions of a minimum of an hour's duration and on a weekly to fortnightly frequency where necessary to provide appropriate treatment to the respondent. Seventeen visits, most of significantly less than an hour's duration, over a period of some 60 weeks, was clearly inadequate for the purpose.

[12] Not all of the blame for that can be laid at the feet of QCS. There were several occasions when other professional commitments prevented Mr Whittingham from attending on the respondent. Mr Whittingham gave evidence, however, that he had since put new staffing arrangements in place which would increase his availability to visit the respondent. There were also, of course, periods of absence when Mr Whittingham was on leave.

[13] However, QCS' shortcomings in delaying the grant of access by Mr Whittingham for some four months and not facilitating the presentation of the respondent to Mr Whittingham for treatment sessions of appropriate duration and frequency cannot go unremarked. Such were the concerns in this regard raised during the hearing that, as I have said, the Director of the High Risk Offenders Management Unit was called to give evidence before me. I have already observed that this officer was unable to supply me with any sensible explanation for the past shortcomings to which I have adverted, but at least she proffered to the Court a "proposed regime" for the psychological and psychiatric treatment of the respondent if he is kept in detention. The Director of the High Risk Offenders Management Unit assured me when giving evidence about her authority to proffer and implement this "proposed regime", saying that:

> "... In terms of my role I will be able to oversee this and to make sure that it continues as per the plan and also offer myself as a point of contact if there are any difficulties."

[14] The terms of this "proposed regime" are set out in Annexure A to this judgment.

[15] Given the less than optimal circumstances of the treatment regime afforded to him while under the continuing detention order, it is hardly surprising that there has been no significant progress in terms of the respondent's condition. Indeed, as Mr Whittingham noted in his report, the disruptions appear to have contributed to episodes of elevated distress, which necessitated more acute therapeutic approaches.

[16] In his report dated 11 February 2009, Mr Whittingham described at length the respondent's presentation over the course of his treatment while under the continuing detention order, articulated the various bases for his assessment of the respondent's risk for sexual violence, described the psychological tests administered

and the various factors which he took into account when assessing that risk and also the plan proposed by him for future management. He considered the respondent to be in the "moderate" risk category, saying:

> "2. I note overall based on available information, on balance and review there appears evidence of several continuing stable dynamic risk factors according to the SONAR, and a slight reduction of the acute dynamic risk factors overall due to reduced substance use and victim access as outlined."

[17] He continued:

> "Mr Friend reports experiencing intense and recurrent suicidal thoughts at times at a level typical of individuals placed on suicide precautions. The potential for suicide should be evaluated immediately after the court process and appropriate interventions should be implemented without delay. Furthermore, concerns about his potential for suicide are heightened by the presence of a number of features, such as a lack of social support, social isolation, and hopelessness, that have been found to be associated with suicide risk. Mr Friend requires a careful follow-up regarding the details of his suicidal thoughts and the potential for suicidal behaviour is warranted after the court outcome is known, as is an evaluation of his life circumstances and available support systems as potential mediating factors.
>
> ...
>
> 4. Should Mr Friend remain in custody it would be prudent to increase frequency of psychological and support services and include appropriate regular psychiatric support. Mr Friend appears likely to remain a chronic risk of suicide and this risk may elevate significantly if certain conditions arise, particularly for example, continued detention. A suicide risk assessment should be done immediately when the court outcome is known and appropriate management instituted. I am happy to continue to see Mr Friend for psychological therapy and I believe this service should emphasise a continued focus on extant dynamic risk factors of immediate concern and the ongoing post traumatic symptomatology."

[18] Mr Whittingham confirmed in his oral evidence before me that his report was not, and did not purport to be, a risk assessment of recidivism, but focused on the treatment provided and to be provided. He also confirmed that he thought that the "proposed regime" (Annexure A) would go a significant way to overcoming the access problems he had encountered. He also confirmed that a weekly treatment regime was desirable, and achievable on his part.

[19] Evidence was also led from two psychiatrists who had examined the respondent in accordance with the requirements of s 29 of the Act.

[20] Dr Barry Nurcombe, who examined the respondent on 9 March 2009, provided a report dated 11 March 2009 in which, after outlining the respondent's personal and clinical history and his observations on examination of the respondent, he formulated his diagnosis in the following terms:

> "76. By definition, Roy Friend does not suffer from paedophilia. His sexual deviation involves post-pubertal male youth, predominantly between the ages of 14 and 16 years. He can be regarded as having ephebephilia or hebephilia, conditions referring to adolescents and not children."

[21] When Dr Nurcombe gave oral evidence before me, the following questions were asked and answers given:

> "Now, you've spoken a little about therapy and its role, if you like, in the contraventions. You also I think refer and Professor James refers to stress and anxiety also being triggers for possible re-offending? -- Yes.
>
> Is that the same – is that at the same source in terms of being a trigger that the therapy is? Are they the same thing is really what I'm asking? -- They interact, really. Therapy, inevitably, will raise issues to do with unresolved childhood sexual abuse – conflict. On the other hand there are particular factors that could occur in social relationships such as rejection and so forth that could also affect the danger of his re-offending, yes.
>
> So is it right to say, and correct me if I'm wrong, that although therapy targeted at the respondent's childhood sexual agues is one possible trigger for anxiety and stress it is not the only possible trigger? -- Correct.
>
> Now you also say in your report – I think its over the page – paragraph 100, page 92 of the bundle, you don't see any purpose in the respondent remaining in prison? -- Not therapeutically.
>
> I was going to ask you that. You're really referring to his therapeutic needs and interest; is that right? -- Yes, precisely."

[22] Dr Nurcombe also said in evidence:

> "Unfortunately, the therapy has been somewhat intermittent and variable in length and that has been a problem. Therapy needs to be consistent in its frequency and the duration of each session. That has not been the case according to Mr Friend's affidavit and I have no reason to question that."

[23] Indeed, under cross-examination, the doctor agreed with the proposition that 17 sessions over a period of about 60 weeks was "grossly inadequate", and said that he thought sessions of 50-55 minutes would be appropriate.

[24] He also thought that if the respondent was released under a supervision order, and with a regular and predictable therapy regime, the risk of re-offending would reduce from "moderate" to "low" after some six to 12 months.

[25] On 16 March 2009, the respondent was examined by Dr Basil James, who provided a report dated 30 March 2009. After reviewing the respondent's history, setting out the observations on examination, and referring to collateral documentation, such as Mr Whittingham's report, Dr James said:

> "1. I had previously expressed the opinion (report of 14/01/2008, para numbered 3 on page 11), that there was some validity in Mr Friend's own contention that any attempt to treat his Paedophilia behaviourally without addressing his Borderline Personality Disorder is unlikely to be successful.
>
> I continue to hold this view, and in my opinion, for the reasonably foreseeable future, the main risk for Mr Friend acting out his paedophilic inclinations is inversely related to the degree to which he has attained a stable improvement in his Personality Disorder.
>
> I also expressed the view (page 10 of the same report) that the treatment of a Personality Disorder of the chronicity and intensity exhibited in the case of Mr Friend, would need, inter alia, to be prolonged (not less than two years), and quite intense (not less than once a week)."

[26] Dr James concluded:

> "4. It is my concluding and considered view that Mr Friend's underlying disorder (i.e. his Borderline Personality Disorder) has not yet changed sufficiently to enable him to experience a consistent and a coherent sent of Self; and thus to experience the sense of agency necessary for him to be assured of the requisite level of choice and control, particularly under stress.
>
> I consider it highly likely that if he were at this point to be released from the secure environment of the prison, he would experience periodically dissolution of his sense of his Self and would be at high risk of re-offending.

> 5. Should the Court decide that Mr Friend continue to be detained in prison, it would be my opinion that the treatment programme already initiated should be continued and intensified.
>
> The reports both of Mr Whittingham and of Mr Friend himself suggest that much greater benefit would be likely if the logistics required for the therapy could be more assuredly arranged. It is important to appreciate that for the success of the psychotherapy to be maximised, the regularity and (as far as possible) absolute predictability of treatment sessions is of the essence. The sense of constancy (which would also preferably include a constancy of the physical setting) comprises what is technically known as "The Frame", within which is evolved the necessary affective ambience necessary for therapeutic work to be most effective, particularly in the treatment of Borderline Personality Disorder. In my opinion, this regularity should be seen to be as important psychotherapeutically as is the regularity of insulin in the treatment of Diabetes."

[27] In evidence before me, Dr James confirmed that he regarded the respondent as presenting a "therapeutically challenging case". In terms of the treatment which had been provided, Dr James said:

> "Given the nature of Mr Friend's disorder I think that treatment was, in a logistical sense, inadequate. There were insufficient sessions at an inadequate frequency, they were irregular, unpredictable and with varying durations. All of those I think militate against success and indeed those very features can sometimes stir up and aggravate the underlying condition."

[28] Dr James was asked about the living arrangements proposed for the respondent if he were released at this stage under a supervision order, also having regard to the care and support which would be provided for the respondent by the respondent's brother, and said that, notwithstanding the positive aspects of this support, the need for the respondent to undergo psychotherapy and the expectation that this would, at times, generate quite intense anxiety, led Dr James to consider that this external support would be inadequate in circumstances when the respondent developed anxiety between his sessions. In terms of oversight by a psychiatrist, Dr James said:

> "Availability for – to deal with crises quite apart form the sexual abuse. The condition from which Mr Friend suffers, that is to say, borderline personality disorder, is a very distressing experience. Very difficult to treat and requires a considerable amount of time. I would say that his disorder is quite severe. It has become – the severity of it has become apparent to me over time and the people with this kind or condition often become

> extremely distressed, and I think I have included in 1 or at least – of my reports the DSM definition of borderline personality disorder. It does include – and Mr Friend's history includes – quite serious suicidal attempts at times. So it is a very serious disorder. It can have serious exacerbations during treatment, quite apart from the sexual abuse issue and some sense of containment, I think, is of value."

[29] When asked about the desirability or necessity for the respondent to continue to be detained while his therapy continues, Dr James said:

> "I think the point clearly at issue is whether this treatment is better delivered while Mr Friend remains in custody or whether it's better or reasonable to contemplate it happening when he's released. One – one tends to think of imprisonment in terms of its restrictiveness and punitiveness and so forth but it – it does actually offer a stability and security. Very frustrating sometimes I acknowledge, but it – it does have that sort of consistency which can actually aid the therapeutic process, at least for a period of time, in my view."

[30] When asked whether the respondent's suicide risk had any relevance, Dr James said:

> "If he's retained in prison that will be extremely frustrating and disappointing and that will be very stressful for him. And that will occur fairly rapidly as a response. If he's released I think the stressors will be rather different. I've alluded to the stressors that are likely to emerge during therapy with relatively limited support. So I think that there would be concern given Mr Friend's past suicidal inclinations whether he remain in prison or not. I think that vigilance – 24-hour-a-day vigilance is likely to be greater and more protective within the custodial setting than convoluted ways in which he would actually go about – or, he did not about attempting to kill himself involving a victim, the police, etcetera. So I think that the greatest stability would be advantageous if he were for a while still in custody as the treatment begins and unfolds."

[31] Dr James said that he thought it would be reasonable to review progress and expect to see real progress within a 12 month period.

[32] By s 30, the first inquiry is whether I should affirm the decision that the respondent is a serious danger to the community in the absence of a Division 3 order. I may only affirm that decision if I am satisfied –

(a) by acceptable, cogent evidence, and

(b) to a high degree of probability

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

[33] By reference to s 13(1) and (2), the question whether a prisoner is a serious danger to the community is determined by whether there is an unacceptable risk that the prisoner will commit a 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.

[34] The expert psychiatric and psychological opinion evidence before me is acceptable and cogent evidence that, at the present time, and in the context of the respondent's past treatment regime, there continues to be an unacceptable risk that the respondent will commit a serious sexual offence if released from custody. For the reasons addressed above, little has changed in this regard since the last occasion the respondent was before the court. Notwithstanding the somewhat lesser assessment of the likelihood of the respondent re-offending by one of the psychiatrists, the weight of the evidence is, in my view, sufficient to persuade me to the necessarily high level of probability of such an event occurring as to lead me to conclude that the decision that the respondent is a serious danger to the community in the absence of a Division 3 order should be affirmed.

[35] The next question, then, is whether the respondent should be continue to be subject to a continuing detention order or whether he should be released from custody subject to a supervision order. In that regard, by s 30(4), the paramount consideration is the need to ensure adequate protection of the community.

[36] In *Attorney-General v Francis*[4] the Court of Appeal recognised[5] that there may be some instances in which "a dangerous prisoner has such clear and pressing prospects of rehabilitation that the court's choice of an order under s 13(5)(a), rather than under s 13(5)(b), will turn on the answer to the factual question whether further treatment, necessary to ensure adequate protection to the community, is likely to be available or effective only while the prisoner remains in detention".

[37] The present is, it seems to me, such a case. When the matter was before Skoien AJ, his Honour, when considering the risk to the community while the treatment for this respondent was being undertaken, thought that the risk of him contravening was greater during the course of the temporary, but likely destabilising, psychiatric treatment.[6] His Honour then concluded that the question as to where such treatment should take place admitted of only one answer, namely "in prison".

[38] On the basis of the evidence to which I have referred above, I find myself compelled to reach the same conclusion. Notwithstanding the offers of support for the respondent by his brother if the respondent were released into the community, and notwithstanding even the relatively circumscribed environment of the particular living community into which the respondent would be released if a supervision order were made, the evidence both of Mr Whittingham and Dr James, and also to some extent of Dr Nurcombe, paints the picture of a man for whom there are clear prospects of rehabilitation (in the sense of significantly lessening the risk of recidivism), but who needs to undergo a properly monitored and administered course of treatment in order to achieve that result. Regrettably, lapses in the treatment regime to date have meant that this level of rehabilitation has not yet been

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4 [2006] QCA 324.

able to be achieved. The rehabilitation treatment, however, also clearly carries further risks of trauma or destabilisation for the respondent such that, in my view, the administration of this further treatment, which is clearly necessary to ensure adequate protection to the community, is likely to be effective only while the prisoner remains in detention.

[39] Accordingly, I will order that the respondent continue to be subject to the continuing detention order made on 27 February 2008.

[40] It is to be hoped that the treatment to be provided to the respondent, facilitated by the "proposed regime" in Annexure A, will yield the beneficial outcome opined by Dr James and Dr Nurcombe. By s 27(1), the next review of the continuing detention order is to occur within a year of the current review. In the course of argument, and subsequently while reflecting on my decision in this matter, I gave consideration as to whether it would be appropriate for me to direct that the next review occur at some time earlier than one year. The consensus of opinion between Dr James and Dr Nurcombe, however, tends to suggests that a review in, say, six months time may be too early, and there is no point in me presently making a direction that such a review be convened if, as appears likely to be the case, it would be premature.

[41] I note also that s 28(1) allows the respondent to make application for review of the continuing detention order at any time "if the court gives leave to apply on the ground that there are exceptional circumstances that relate to the prisoner". I have already referred to the difficulties encountered in the treatment of the respondent to

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5 At [30].
6 [2008] QSC 27 at [43].

date as a consequence of the "administrative difficulties" encountered within QCS. I have also recorded the "proposed regime" now offered on behalf of QCS, and the assurances given by the manager of the relevant unit with respect to its implementation. Having received that assurance, it is unnecessary for me presently to venture a view as to whether a failure on the part of QCS to implement that proposed regime would constitute the sort of "exceptional circumstances" referred to in s 28(1), or to say anything further on this aspect.

[42] The only order will be that the respondent, Roy Friend, continue to be subject to the continuing detention order made on 27 February 2008.

Annexure A

PROPOSED REGIME
PSYCHOLOGICAL AND PSYCHIATRIC TREATMENT OF MY ROY FRIEND

This document sets out a proposed regime for the continuation of treatment of Mr Roy Friend in the event he were detained by order of the Supreme Court pursuant to the Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld).

Psychological

1. The services of Mr David Wittingham (psychologist) will be continued, at the expense of Queensland Corrective Services (**QCS**).

2. Mr Wittingham will be provided with the evidence of the hearing on 14 April 2009 concerning the treatment which the Respondent ought to receive.

3. The frequency and duration of sessions to be conducted by Mr Wittingham will be at his discretion, but not more frequent than weekly.

4. With respect to access by Mr Wittingham to the Wolston Correctional Centre (**the Centre**):

   (a) The Director (high risk offender management unit) will advise the Centre's General Manager of Mr Wittingham's role with respect to Mr Friend and the need to facilitate Mr Wittingham's entry to the Centre for the purpose of seeing Mr Friend;

   (b) The Centre has advised that the Manager of Offender development (MOD) will remain as the point of contract for any problems experienced by Mr Wittingham. In addition to overseeing the negotiated expected session times.

   (c) Mr Wittingham's retainer from QCS will permit him to allocate sufficient time to travel to the Centre, attend a full sessions and allow time for him to gain access and for administrative procedures to be completed;

   (d) if Mr Wittingham provides a schedule of session times and dates to the MOD, he will be placed on the Centre's "Visit List";

   (e) Mr Wittingham will be asked by the MOD to prepare a schedule of proposed schedule times and dates at which he intends to see Mr Friend;

   (f) QCS will request progress reports to be provided by Mr Wittingham after completion of 12 sessions of treatment including as to any difficulties experienced in gaining access to the Centre.

Psychiatric Oversight

5. Mr Friend will be referred to Prison Mental Health. A summary of the evidence given during the hearing on 14 April 2009 will be provided, and specifically:

(a) the need for the treating psychiatrist to consult with Mr Wittingham, including with respect to Mr Friend's medication;

(b) the existence of a suicide risk;

(c) the desirability of consistency and the treatment to be provided.

6. Mr Friend must give authority to Prison Mental Health to provide a progress report concerning the Respondent, which is to be provided at a time Prison Mental Health considers appropriate.