SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney General for the State of Queensland v Bridson* [2010] QSC 411
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **WALTER FRANK BIDSON** (respondent)
FILE NO/S:	BS 5452 of 2007
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	7 October 2010
DELIVERED AT:	Brisbane
HEARING DATE:	7 October 2010
JUDGE:	Applegarth J
ORDER:	**The application is dismissed**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY- where respondent subject to a supervision order – whether respondent contravened the conditions of the order which required the respondent to abstain from illicit drugs and to take prescribed drugs as directed by a medical practitioner *Dangerous Prisoner (Sexual Offender) Act* 2003 (Qld), s 22 *Briginshaw v Briginshaw* (1938) 60 CLR 336 *Rejfek v McElroy* (1965) 112 CLR 517
COUNSEL:	B Mumford for the applicant DC Shepherd for the respondent
SOLICITORS:	Crown Law for the applicant Legal Aid Queensland for the respondent

HIS HONOUR: The applicant Attorney-General alleges the respondent contravened conditions of a supervision order made on 13 November 2008. The applicant alleges that on 12 August 2009 the respondent contravened conditions (xxiii) and (xxiv). Those conditions were, firstly, that he abstain from illicit drugs, and, secondly, that he take prescribed drugs as directed by a medical practitioner.

The essence of the allegation is that on 12 August 2009, the respondent took a prescription drug commonly known as Serepax. The drug which it is contended the respondent ingested is a benzodiazepine drug, Oxazepam. It is commonly prescribed as a short-term aid to sleep. It is only available as a prescription drug. It can be a drug of dependence when abused in our community. There is no evidence the respondent was prescribed such a sedative.

The respondent denies having consumed any such drug. He denies that he contravened the supervision order. If I find that the respondent contravened the supervision order, then unless he satisfies me on the balance of probabilities that adequate protection of the community can be ensured by the existing order as amended under ss 22(7) of the *Dangerous Prisoners (Sexual Offences) Act* ("the Act"), I must rescind the supervision order and make a continuing detention order.

The applicant accepts in the light of the evidence, including the evidence of two Court-appointed, examining psychiatrists, that if a contravention is proven, the risk of reoffending can

be managed within the community by the continuation of the supervision order.

Accordingly, the principal issue for my determination is whether the respondent contravened the supervision order in the respects alleged.

Section 22 of the Act relevantly provides that the section applies if the Court is satisfied “on the balance of probabilities that the released prisoner is likely to contravene, is contravening, or has contravened a requirement of the supervision order”. As the statute makes clear, the degree of proof is on the balance of probabilities.

In *Briginshaw v. Briginshaw* (1938) 60 CLR 336 at 350, Rich J stated that:

> "The nature of the allegation requires as a matter of common sense and worldly wisdom the careful weighing of testimony, the close examination of facts proved as a basis of inference and a comfortable satisfaction that the tribunal has reached both a correct and just conclusion."

The better known passage from that case is that of Dixon J at 362:

> "… [R]easonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved."

His Honour said:

> "The seriousness of an allegation made, the inherent unlikelihood of an occurrence of the given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal."

His Honour emphasised that it is not a matter of some intermediate standard between the satisfaction beyond reasonable doubt required upon a criminal inquest, and reasonable satisfaction in a civil case. His Honour said, "It means the nature of the issue necessarily affects the process by which reasonable satisfaction is attained."

Later, in Rejfek v. McElroy (1965) 112 CLR 517 at 521, it was emphasised that there remains two distinct standards:

> "But the standard of proof to be applied in a case and the relationship between the degree of persuasion of the mind according to the balance of probabilities and the gravity or otherwise of the fact of whose existence the mind is to be persuaded are not to be confused. The difference between the criminal standard of proof and the civil standard of proof is no mere matter of words: It is a matter of critical substance. No matter how grave the fact which is to be found in any civil case, the mind has only to be reasonably satisfied and has not with respect to any matter in issue in such a proceeding to attain that degree of certainty which is indispensable to the support of a conviction upon a criminal charge ..."

Against that background, I apply the standard set by the statute. The matter to be proved is to be proved on the balance of probabilities. I apply that standard in the context of proof of what is, by its nature, a serious allegation, namely contravention of a supervision order. I also do so in circumstances in which the consequence of

proving contravention of a supervision order is to place the onus upon a respondent of satisfying the Court of certain matters, failing which the supervision order is rescinded, and the respondent is required to be detained in custody for the period stated in the order. One only needs to say that to recognise the gravity of the consequences, or the potential gravity of the consequences, of a finding of contravention.

The fact that in this case, as matters have transpired, the applicant accepts that the consequence of a finding of a contravention in this case should not be a return to custody under a continuing detention order, does not, to my mind, substantially affect the proposition that proof of a contravention that in law exposes a respondent to such consequences is a serious matter requiring appropriate proof on the balance of probabilities.

Facts

The applicant was released pursuant to the supervision order made by Mullins J on 13 November 2008. His progress was uneventful and is documented in the material before me. He was subjected to many random breath and urine tests, as might be expected of someone with his past difficulties with alcohol. All of those tests were clear.

As at August 2009, the respondent was in accommodation in the community. He had in the past experienced difficulties, particularly the distress of his mother's passing and the

sadness and frustration that attended the fact that he was unable, because of the terms of his supervision order, to travel to Cairns to see her. However, he seemed to recover from that sadness and was living in conformity with the supervision order in the suburbs.

He generally kept to himself. He had a few church friends. He had little money to spend and he spent it on groceries, transport and taking care of his dog.

The department's records for 8 August 2009 record a random home visit conducted that morning. It records that there were nil issues and nil concerns. That visit was by a Mr Kevin Hallam.

On 9 August the respondent went to an Alcoholics Anonymous meeting. That was the only notable event for that day. On 10 August he reported to the Correctional Service Office by telephone. He disclosed to them that he was going to go to the Exhibition with a friend. He identified the friend by name. He was warned by an officer about behaviour. The records indicate that he was reminded that he had to abide by his conditions, especially not attending licensed premises.

He went to the Exhibition on 11 August 2010 with a friend. That female friend was simply a friend. Theirs was a platonic relationship and she was a supportive friend. He met his friend. They went to the Exhibition. At one stage they bought coffees. He finished his coffee. His friend did not

finish hers and she asked him if he wanted to drink the remainder of her coffee. He finished her coffee. He consumed other items at the Exhibition.

He particularly recalled drinking the cup of coffee because, as he says, he does not usually drink unsealed drinks in the area in which he lives. He did not trust the people who lived there. He said that there were a lot of junkies in the area and it was his habit only to drink from sealed containers.

He denies being under any particular stress. It was a happy outing for him with a friend and he never had any idea that his friend would become a partner.

He received a telephone call on the morning of 12 August. He was informed that a urine test would be conducted later that day, as it was around lunchtime by Mr Hallam who arrived with another officer at the respondent's residence.

The process by which the test was taken, helpfully described by Mr Hallam in his affidavit and in his oral evidence, involved taking a sample and then returning with the sample to the office.

I will deal later with what happened upon Mr Hallam's return to the place described in the evidence as the reporting office.

Importantly, the respondent says that prior to and during the test he felt well. He did not feel sluggish or tired. Mr Hallam in his evidence indicated that there was nothing abnormal about the visit or the respondent when the urine test was taken. He did not notice anything untoward in the respondent's behaviour.

In fact, after the test was taken, the respondent, who was minded to go to the Exhibition again, asked Mr Hallam and his associate if they would mind giving him a lift to the nearby station, and they agreed and dropped him off, and he went off to the Exhibition.

I refer to these matters because if the respondent had consumed Serepax tablets in the quantity that is possibly suggested by the test, the evidence is that one would have expected him to be exhibiting significant signs. However, he did not do so.

Mr Hallam returned with the sample and undertook, at the Wacol reporting house, a presumptive test on part of the sample which was put in a separate bottle. Mr Hallam split the urine sample that had been received and tested one bottle of it. The other bottle was sealed with evidence tape.

Mr Hallam conducted a presumptive test for certain drugs. All the drug tests were clear, but the test for benzodiazepine indicated that it was positive. As a result, Mr Hallam says he placed the other specimen jar that had been sealed in a

clip-seal bag, in the refrigerator. The remaining waste materials were put in a biohazard waste bin.

The fact of a positive test as a result of the basic presumptive test that was administered by Mr Hallam is consistent with that being a false positive. There is no dispute about evidence filed on 6 October 2010 on behalf of the respondent that in a similar urine sample testing exercise he has had the experience of the test being a false positive. He was assured and satisfied relatively recently that a urine sample that had been given returned a false positive but the more accurate test that was then conducted on the other sample showed that there were no such benzodiazepines in the urine sample.

Because that indicative test is simply that, it is understandable that the sample was sealed up and placed in the refrigerator by Mr Hallam, to be sent for testing by the Forensic Toxicology Section of Queensland Health Forensic and Scientific Services.

Before I deal with the analysis undertaken there, it is important to note something about the records of the Queensland Corrective Services in relation to the respondent's urine and drug testing record, in respect of the sample taken on 12 August 2009, which are said to have been BZO positive. They record that the sample was taken by Heidi Bird at the Wacol District Office. No explanation was given as to why the department's records would record the test as having been

undertaken there instead of, as was the case, the sample having been taken by Mr Hallam and another officer, who was not Ms Bird, at the respondent's residence.

That unexplained entry raises a serious question as to whether there was some inadvertent mixing of samples that were taken, and that it was not the sample that was sealed up by Mr Hallam, but a sample like it, that was sent to the forensic centre for testing. This raises the possibility that what was in fact sent to the centre and identified as the sample taken from the respondent was a sample taken from someone else, possibly a sample taken by Ms Bird from someone at the Wacol office that same day.

I should note that there are possibilities that the sampling undertaken by Mr Hallam was inexact and there was some unfortunate contamination. Although those possibilities cannot be excluded, the suggested source of contamination, such as the thermometer, does not explain the presence of the level of drugs detected. Mr Hallam wore gloves. I do not place much store on the possibility of contamination as explaining the test results.

I turn to consider the evidence relating to the testing of the sample that was received by the forensic toxicology section. A sample was received and analysed by a laboratory technician there using a device that is described as immunoassay. That recorded a positive reading for benzodiazepines.

However, that was not the end of the matter and that test is not as certain as the further test that was undertaken, which Ms Hadley explained is a mass spectometry test. That further test, described in the confirmation report, was undertaken by another analyst and reported the existence of benzodiazepine in a quantity greater than 4,000. A later test was undertaken and it recorded that the actual level was 11,000 ng per mil.

Pausing there, the possibilities are that the sample that was tested and produced a recording of 11,000 was the sample taken from the respondent. Another possibility is that it was a sample taken from someone else that came to be wrongly labelled and identified as the respondent's sample because of some mishap at the Wacol office.

I next consider the significance of an analysis of 11,000 ng / mL, which is addressed in the report of Dr Hoskins, and in his oral evidence. He explained, very helpfully, that such a level is very difficult to explain from a single dose.

In his written report dated 25 November 2009, and on the stated assumptions and information upon which that report is based, he thought it conceivable but quite unlikely that the result reflected consumption of a single dose. He said if it were for a single dose, the specimen would have to have been collected no more than a few hours after ingestion, and even then it would be unusual. He thought it more likely that the result reflected multiple doses, but he could not say anything more, nor could anything more be said about the

quantity, frequency or duration of the use.

He added that Oxazepam is insoluble in water but soluble in alcohol. He says that when attempts are made to dissolve it in alcoholic beverages, or soft drinks, or coffee, the resulting mix is distinctly unpleasant to taste and very obvious.

Importantly, at paragraph 18 of his report he said:

> "Assuming they were not taking it regularly, a person who had consumed enough Oxazepam to achieve the urine results in this case would be noticeably sedated, noticeably to themselves and probably others."

He mentioned the possibility of undertaking hair specimen tests but the evidence before me indicates that those tests are not particularly conclusive.

Dr Hoskins gave informative oral evidence concerning the test result of 11,000 nanograms per millilitre and he explained that one could not convert that into a dosage. The reason he gave was that two individuals could consume the same quantity of the drug and both would provide a different urine specimen. He said that there can be a difference of more than a factor of 10 between the results, even if both individual's urines are -similarly concentrated.

He noted that when you add variability in urine concentration it is even more unpredictable and he emphasised that the variability by a factor of 10 can be based on interpersonal differences between individuals, including their metabolism.

A reading of the 11,000 milligrams per litre would not arise from a very small intake but he thought it might exist from a not necessarily high quantity.

He explained that such a level is much higher than one would ordinarily expect from a normal dose, but it could be a statistical outlier. The reading is well above what one would normally be looking for and above the level that is normally tested for in the laboratory. He said a possibility is that you have an individual who is an outlier. That possibility cannot be ruled out.

Another possibility was that the drug was consumed very recently and therefore the levels in the blood which contributed to the levels in the urine were very high.

Turning to Dr Hoskins' report and his important observation at paragraph 18 of his report that I earlier quoted concerning persons who were not taking the drug regularly, here there is no history of the respondent taking the drug. There is no history of him taking sedatives earlier in his life and there is certainly no history of him taking them in the weeks and months prior to this testing.

He did not present as someone who would have taken such a dose.

There was no suggestion that he was noticeably sedated. That said, the possibility exists as an alternative that he was something of a statistical outlier and that he gave the urine

sample that was tested as having 11,000 nanograms but was not as affected as one might expect for someone without a tolerance to this drug to be.

The possibility exists that he may have taken a relatively small amount the day before, but for the reasons given concerning interpersonal variations, gave a sample that still produced a notably high reading.

That evidence requires consideration of two possibilities. The first is that he self-administered the drug either shortly before or the day before the test was taken. Another possibility is that he did not voluntarily ingest it, that it was taken up when he drank coffee or somehow otherwise ingested it.

The possibility of having consumed it in coffee was mentioned by the respondent when he first became aware of this test result. He did not put it forward then or now as a high probability. This scenario was not particularly pressed by counsel on his behalf.

The lady who he went to the Exhibition with was not called as a witness. There is a recording of what she said in an interview. Leaving aside the admissibility of that as proof or lack of proof of matters in that interview, she denied having, as it were, spiked the coffee with any such drug. She was not called as a witness. One might say if she had done anything of the kind, one would have expected her to deny it.

But apart from her denial when interviewed and the absence of any evidence from her admitting that she did put a drug in the coffee, there are other factors that tell against this as a real possibility.

The first is the taste and the lack of any detection of the drug in the coffee remnants that the respondent consumed. The second is the question of why this friend would put the drug in her coffee to start with rather than ingest the tablet in the normal way. If she intended to spike the respondent's coffee, then why would she want to do this?

The evidence of the respondent does not suggest that he was out of this lady's presence such that she had an opportunity to take the top off the lid of the coffee (if it had a lid on it) and put a Serepax tablet in the coffee prior to his return where he drank the balance of it.

It is possible that the coffee did have a Serepax tablet in it, but I regard that matter as highly improbable.

I then come to the question of the probability that the respondent self-administered this drug, which I accept is an illicit drug within the meaning of the supervision order because it is capable of being abused if not taken in accordance with prescriptions.

In assessing probabilities, one has to first consider the inherent probability or improbability of the respondent having self-administered this drug.

One consideration is to pose the question of why he would do such a thing. There is nothing in the records or in the evidence at all to suggest that he was in an agitated state such that he would administer a sleeping tablet to himself or other kind of sedative. There is nothing noted in his record indicating that he needed sedation. On the contrary, as I've already noted, there were no concerns reported.

He had not resorted to sedatives or prescription drugs leading up to or immediately following the death of his mother. Within the limits of the supervision order he appeared to be coping well.

It might be said, or speculated, that going to the Exhibition was inherently stressful and that he may have wished to sedate himself from what would otherwise be an anxious experience.

As against that it is submitted, and I accept, that such a course is improbable in circumstances in which the respondent might expect to be drug-tested and expect any drug consumption to be detected.

The record indicates that he was warned about the dangers of consuming alcohol. He was warned of the presence of police. It would be odd for him to self-medicate and, in fact, overmedicate and bring himself to the attention of the authorities at the Exhibition.

It would be equally ill-advisable for him to take a drug without a doctor's prescription in circumstances in which he would have fully expected to be tested in circumstances in which the supervising authorities knew he was going to the Exhibition.

It would be improbable for him to do so in circumstances in which he may expect a call the next day as, in fact, happened.

There does not appear to be any particular trigger for the respondent to self-medicate. In other cases the Court encounters individuals who breach conditions requiring them to abstain from illicit drugs notwithstanding the grave consequences that can be associated with a contravention of a supervision order. But often in those cases it is apparent from the evidence that there is some trigger for the consumption, some particular event, or some particular state of affairs that prompts resort to self-medication, with cannabis or some other drug.

Here one does not have such a thing. The respondent was compliant with the orders and coping reasonably well with them.

In short, it seems inherently improbable that the respondent would self-medicate. He had no particular reason to do so, so far as I can see, and the chance of detection was a very real one.

The second matter which tells against a finding of a

contravention is that the respondent did not present as one would expect him to present if he had the kind of levels of drug detected in the sample that was tested. He simply did not present in the way that Dr Hoskins said someone with that level of drug would be expected to present.

On the contrary, he presented as being alert and of his normal character. This was not simply a case in which he was passive and in which some sedation might have gone undetected by Mr Hallam and his associate. The respondent was keen to go out, and went out, accompanied by Mr Hallam and his associate.

It is, of course, possible that the respondent consumed the drug, but had some extreme tolerance to it such that, notwithstanding the levels that were found in his urine, he did not present with any of the symptoms of sedation or behaviour akin to drunkenness. That must be a possibility in the sense that anything is possible. But it seems on any assessment of possibilities, an extremely unlikely scenario.

Next, there is the respondent's denial. It might be said, “Well, of course, he would deny it”. But he has denied it on oath and he was not cross-examined.

I accept that no one can say what was going on in the respondent's mind on or about 12 August 2009 and what matters in his life might have prompted him to resort to such a drug. However, in circumstances in which there is no evidence indicating any trigger to take drugs, and in circumstances in

which the evidence indicates that the respondent was not expressing any concerns, it would be a significant thing to simply reject the respondent's denial in circumstances in which he was not tested under cross-examination to explore matters that could explain his self-medicating, and to test him concerning matters that he relies upon in support of the proposition that he simply would not have risked the matter in the circumstance.

I readily accept that it is not every assertion in an affidavit that should be accepted. The absence of cross-examination does not require me to accept the respondent's denial. The absence of cross-examination does not require me to accept his denial where there is contradictory evidence, and here there is the evidence in the form of the drug testing which, if accepted, would require me to not accept the respondent's denial.

However, this is not simply a matter in which there is the evidence concerning the drug testing and the respondent's denial.

Overall I have to balance the probative value of the test result against a number of other matters.

On one side of the balance is the inherent improbability that he would take the drug knowing that he was likely to be detected. On the same side of the balance is the absence of any identified reason for him to do so. On the same side of the balance is his sworn denial which was not tested in

cross-examination.

As against that is the fact of the drug analysis. However, the probative value of that evidence is diminished somewhat by questions raised concerning the continuity of the sample taken by Mr Hallam with the sample that was ultimately tested at the Queensland Health Clinical Forensic Medicine Unit.

That question mark concerning the possibility of samples being mixed or wrongly labelled is a real one coupled with the record that I've earlier identified concerning the entry in the department's books as to the sample that was taken on the day and by whom it was taken.

I have, since the matter was heard, considered the transcript of the evidence given by the different witnesses concerning the process of sealing and whether much could be placed upon the fact that the photograph of the sample that was tested at the forensic medicine unit does not show any signs of the type of tape that Mr Hallam says he placed over this sample. I do not think any great store should be placed upon the fact that those photographs do not reveal remnants of tape.

However, there is at least a doubt concerning the possibility that the collecting of samples at the Wacol office and their being placed in the refrigerator may have permitted some mixing of the samples and that the sample that was subsequently tested by the forensic medicine unit was not, in fact, the sample taken from the respondent.

Ultimately, then, it is a matter of the reliance that can be placed upon those test results as against the other matters. This is a serious allegation and, in all the circumstances, I do not have the satisfaction referred to by Dixon J in *Briginshaw v Briginshaw* that the contravention has been proved.

Accordingly, I decline to find that the applicant contravened his supervision order as alleged.

Had I reached the conclusion that the respondent did contravene the order as alleged, then I would have proceeded to consider whether he discharged the onus of proving that the protection of the community could be adequately served by a supervision order.

I would have found that the respondent had discharged that onus on the balance of probabilities. As I said at the outset, the applicant fairly acknowledged that the respondent had done so.

Because it is unnecessary for me to reach a finding in relation to this aspect, my comments can be relatively brief.

For the reasons that I have already given, the respondent does not have a history of contravening the supervision order. If he did take a Serepax tablet as alleged, it would have been an unfortunate lapse but not a relapse.

The evidence given by Dr Beech and Dr Sundin well satisfies me that any such contravention was not indicative of an increase in the risk posed by the respondent.

What is more, since that time, the respondent has progressed. He has been subject to many more urine and breath tests and they have all been clear. The respondent has continued with appropriate relationships with psychologists and with Alcoholics Anonymous. He would have well and truly satisfied me on the balance of probability that the adequate protection of the community would be served by a continuation of his supervision order, and in those circumstances, I would have made an order that the supervision order continue.

However, in circumstances in which I have declined to find that there was a contravention, the supervision order continues in its existing terms. Anything else?

MR MUMFORD: Nothing, thank you, your Honour.

MR SHEPHERD: Thank you, your Honour.

HIS HONOUR: Thank you for your assistance.
