SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General (Qld) v Gilchrist* [2010] QSC 464
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **PHILLIP ARTHUR GILCHRIST** (respondent)
FILE NO:	BS 6933 of 2010
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court of Queensland
DELIVERED ON:	8, 10 November 2010
DELIVERED AT:	Brisbane
HEARING DATE:	8 November 2010
JUDGE:	Philippides J
ORDER:	**A continuing detention order is made pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003**
CATCHWORDS:	CRIMINAL LAW – JURISDICTION, PRACTICE AND PROCEDURE – JUDGMENT AND PUNISHMENT – SENTENCE – MISCELLANEOUS MATTERS – SEXUAL OFFENDERS – where Attorney-General seeks continued custody of respondent pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 – where respondent serving sentence for convictions of entering a dwelling and committing an indictable offence, two counts of indecent assault whilst armed with a dangerous weapon with circumstances of aggravation, and rape – where respondent had not undergone sexual offender program – where respondent claims to have no memory of convicted offences – where expert opinion that respondent is a serious danger to the community – where circumstances justify order for continued detention – whether respondent is a serious danger to the community in the absence of an order *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld), s 13
COUNSEL:	K Philipson for the applicant C Chowdhury for the respondent

SOLICITORS: Crown Law for the Attorney-General
Legal Aid Queensland for the respondent

Philippides J:

[1] The applicant, the Attorney-General, seeks an order pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 ("the Act"), that the respondent, Phillip Arthur Gilchrist, be detained in custody for an indefinite term for control, care or treatment.

[2] The respondent was born on 31 July 1961, and is 49 years of age.

[3] The respondent is presently serving a 13 year sentence imposed in 1998. His full-term discharge date is 17 November 2010. The sentence was imposed for offences committed on 17 November 1997 of entering a dwelling and committing an indictable offence, two counts of indecent assault whilst armed with a dangerous weapon with circumstances of aggravation, and rape. The respondent, armed with a knife, scaled a drainpipe and entered the bathroom window of the third floor unit of the victim at night, having disguised himself with a handkerchief covering his face. In sentencing the applicant, Forde J noted that the offences were similar in nature to previous offences, for which Demack J had suggested psychiatric treatment, and made the following comments:

> "This type of offence is chilling in nature in that others who are vulnerable living by themselves can be easy prey from someone such as yourself.
>
> You had a knife that you held at the throat of the complainant who resisted you; you had, in a premeditated way, arrived; you were wearing a condom; you had the complainant perform oral sex upon you and you upon her which are the subject of counts two and three, and then the rape occurred. When you went outside the complainant attempted to arm herself and threw some weights at you which hit you and she bit your finger and she screamed and others heard her and you jumped out the window and you were injured when you fell.
>
> …It was a protracted and persistent assault by you on her."

[4] The applicant has previous convictions for sexual offending on 16 March 1985 and on 10 April 1986. The March 1985 offence concerned the rape of a woman in a toilet block in Gladstone. The April 1986 offences relate to the respondent breaking into the flat of a young woman in the early hours of the morning, placing a knife to her throat, and forcing her to perform oral sex on him and raping her. On 11 November 1986, Demack J sentenced the respondent to a total period of seven years imprisonment and stated:

> "[The first offence]…occurred in a relatively public place, the degree of fear that you were able to induce…meant that you were undetected until you had committed the second offence, so that in itself is a very serious rape. The rape of the other victim was one that you appeared to have planned to some

> extent, that you thought about on a number of occasions during the evening before finally committing the burglary and then the rape. In itself this is a particularly serious rape, and if there were no mitigating circumstances in your case it would attract a sentence in double figures."

Background

[5] The respondent, who had speech difficulties as a child, attended a special school for his entire schooling. He was treated with Ritalin, being "hyperactive" and aggressive at school. In his youth, the respondent abducted an 11 month old baby one night after entering a house, undressed the baby and placed it under a sprinkler in an adjacent yard. He was institutionalised from about the age of 15 for four to six years, reportedly in a boys home and then in a psychiatric hospital in Tasmania (reportedly for conduct disorder), before moving to Gladstone with his family in 1981. The respondent has reported that while in the psychiatric facility he was physically and sexually abused by staff and other male patients. For most of his life, when not institutionalised, the respondent lived at home or in supported accommodation. He has only ever worked with the Endeavour Foundation and as a volunteer at church (he is a "born-again" Christian) and he had been on a disability support pension for intellectual disabilities.

[6] The respondent has been evasive about his sexual history to the various clinicians. He reported a relationship with a woman he met at a sheltered workshop and that they had gone to church together. He reportedly still kept in contact but the relationship was not a sexual relationship.

The respondent's reported disabilities

[7] The respondent claims that as a result of his fall on the occasion of the offending on 17 November 1997, he suffered head injury with consequent memory loss and additionally suffered other physical injuries to his back and legs, requiring the use of crutches, walkers and wheelchairs over the last 14 years.

[8] The evidence indicates that following the fall on 17 November 1997, the respondent managed to run away from the scene of the crime and he returned to his house and went to bed. The following morning he was able to walk to the Royal Brisbane Hospital. The Hospital records do not indicate that he sustained a significant head injury. The respondent sustained a fractured navicular bone of the right foot and undisplaced fractures of the lateral processes of lumbar vertebrae. His lower leg was placed in a cast and he was discharged to the watchhouse the day after the incident. The respondent claims that as a result of the fall, his right foot was twisted inwards so he walked on the side of his foot and as a result of those injuries he had a prosthetic device. The respondent reported that he is able to mobilise for periods without a wheelchair by use of crutches or other such means.

Report of P Piscitellu, Psychologist, 29 May 2006

[9] The respondent undertook four hours testing over two days and his scoring showed that he was functioning in the average range with a lower score in areas associated with verbal comprehension, processing speed and some aspects of memory functioning. His overall IQ score was 106.

Neuropsychological Report of Ms Anderson, 27 October 2010

[10] Ms Anderson reported substantial concerns about the validity of the respondent's complaints of memory problems, as there was no objective evidence of brain injury. Moreover, his level of deficit and reported amnesia was well out of proportion to what would be expected. Further, it was extremely uncommon to encounter people with significant disturbance of long-term memory following a head injury and it was usually indicative of non-organic features to the presentation. She had similar concerns about the respondent's reported physical impairment, noting his reported symptoms provided a significant basis for him avoiding responsibility for his actions and avoiding treatment, as he advocated that he was no longer a risk given his immobility.

[11] Ms Anderson administered a number of measures of test validity due to serious concerns about the validity of the respondent's presentation. The respondent's performance was consistently in the extremely low range. Ms Anderson opined that the results of the tests raised serious concerns about the respondent's level of application to the tasks at hand, which was consistent with clinical observation.

[12] Ms Anderson noted that on formal measures of test validity, the respondent consistently performed in the invalid range, his responses were random, meaning they could not be relied upon as being consistent measures of his underlying cognitive ability and that assisted in explaining the great deal of variability that had been reported in previous psychological test results.

[13] It was difficult for Ms Anderson to provide any useful information as to the extent to which the respondent's behaviour was deliberate, but whether it was conscious or unconscious, it appeared to have been used to obtain various gains throughout his incarceration, including avoiding work and responsibility and therapy. She opined that his physical condition may serve the same purpose and she supported further assessment of any possible underlying condition because he seemed to use it as evidence to suggest he is not a significant risk in the community. Given his avoidance of therapy and accepting responsibility, it was Ms Anderson's view that his future behaviour was not predictable.

Report of Dr Douglas, Psychologist, 1 November 2010

[14] Dr Douglas produced a report dated 1 November 2010 after seeing the respondent on 21 October 2010. Dr Douglas raised doubt with regard to the respondent's likely overall level of intellectual functioning because of several notable issues. She noted

that while the respondent was assessed in 1986, revealing a Full Scale IQ of 77 and an overall memory quotient of 70 (both Borderline level of functioning), no mention was made as to whether any tests of effort were administered at that assessment. Yet, she noted that an assessment was undertaken in 2006, which revealed a notably higher Full Scale IQ at 106 (Average range). She opined that an improvement in intellectual function by 30 points over that period was unlikely.

[15] Dr Douglas reported that the respondent's overall level of intellectual functioning fell within the Low Average range, which was consistent with premorbid expectations. She reported the respondent's overall verbal comprehension skills to be intact and to fall within the range expected of a man of his age and demographic background (also Low Average range).

[16] With respect to the respondent's reported head injury suffered in 1997, Dr Douglas could find nothing in the nature of the injury to suggest that it was responsible for his lack of memory for the crimes he had committed. She stated that the respondent's reported history of "an evolving loss of memory" was notably inconsistent with the expected pattern of memory functioning following a head injury, and she noted that psychiatric examiners had also detected inconsistencies in the respondent's presentation of these claimed memory losses which do not fit with organic brain dysfunction.

[17] Dr Douglas was of the view that there was no reason why the respondent could not participate in a sexual offenders treatment programme. She noted the respondent to be of Low Average cognitive capabilities and intact comprehension skills, but with notably poor memory attentional and speed of information processing skills. She could not, however, see anything in this pattern of data that would render the respondent unable to understand the nature of his offences or to be unable to actively participate in appropriate treatment programmes.

Evidence of Dr Harden, Psychiatrist

[18] Dr Harden interviewed the respondent on 9 October 2009. He noted that the respondent was a poor historian with allegedly patchy recollection. In relation to the current offences, the respondent claimed severe memory loss, yet was able to recall in detail the differences between his view of events and other material. He claimed that the offences occurred because of being involved in looking at pornographic material.

[19] Dr Harden noted that the respondent expressed no emotional identification or empathy towards the victims of the offences, displaying a great deal of denial and that he appeared to have very significant minimisation of his offences and externalisation of responsibility. The respondent claimed poor memory, lack of intellectual ability, and problems with mobility and he had no real insight into his sexual offending.

[20] Dr Harden administered a number of assessments. On the STATIC 99, the respondent scored 7, which placed him in the high risk category relative to other

male sex offenders. (Based on review of other risk factors, Dr Harden believed that accurately represented the respondent's current risk). On the Stable 2007, the respondent scored 16 out of 24, placing him in the high needs group in terms of a sexual offender's dynamic risk. He scored highly in areas such as lack of concern for others, impulsiveness, poor problem solving skills and deviant sexual preference. Dr Harden noted that combining those scores put the respondent in the highest risk category in terms of recidivism rates. On the Sex Offender Risk Appraisal Guide, the respondent scored 17, which placed him in category 6, with a 58% rate of violent re-offending at 7 years and 76% rate at 10 years. On the Hare Psychopathy Checklist, the respondent scored 24, which was mildly elevated, but his scores were very elevated on characteristics associated with affective deficits of psychopathic personality traits. On the SVR-20 (Sexual Violence Risk), the respondent scored 8 out of 20 which placed him in the high risk category. Dr Harden also diagnosed personality disorder with antisocial and dependent features. He concluded that based on combined clinical and actuarial assessment the respondent's future risk of sexual re-offence was high.

[21] Dr Harden gave evidence as to the respondent's risk of re-offending as follows:

> "The real reason [the respondent] falls into the high risk group actuarially is because he's committed serious sexual offences before, has been sanctioned for them, has been released and has recidivated, which pushes [his] risk up very substantially. The dynamic variables in [the respondent] are hard to assess because of the lack of reliable information. One of the frustrations I think in assessing [the respondent] is that I have to regard much of the information he gives as either lacking in detail or unreliable both with regard to the offence history, his sexual behaviour and also potentially with regard to his level of physical disability, as has already been discussed. So, in summary with [the respondent], we have a man who is a high risk sexual offender who has undertaken very violent sexual offences requiring significant planning and organisation against very challenging targets."

[22] Dr Harden noted that the respondent contended that his difficulties with mobility significantly reduced his risk. However, Dr Harden gave evidence that in his view, the respondent remained in the high risk category, notwithstanding his claimed physical disability, observing:

> "I don't think on the information we have available currently, which is that he uses a wheelchair and is able to mobilise without one, [that] there is a substantial decrease in his risk, but I take more the line other psychiatrists have that … it may change the nature of what he might do in response to his sexual offending. The reason I say this is his previous offences required a fair degree of planning and, really, a great deal of effort to undertake them, and certainly there has been described cases, although no systematic literature, of individuals who are disabled or even wheelchair-bound committing sexual offences."

[23] Dr Harden noted that the respondent had few or no internal or external resources to assist him. Dr Harden's evidence was that "in terms of things that might reduce his risk, [the respondent] has almost nothing", observing that:

> "While incarcerated [he] avoided undertaking any specific intervention to reduce his risk. At interview he claims not to have an understanding of the offences at times, although he does seem to take some responsibility for

> them. He does not seem to see the need for risk reduction strategies in the community apart from very simplistic approaches such as avoidance of pornography and involvement in his church…"

[24] Dr Harden noted that the respondent maintained that there was no point in doing sexual offender programs, as his memory was too poor to make use of them, and it appeared that he had convinced the program staff of that despite his intellectual function testing showing his IQ was in the average range. Dr Harden considered that the respondent used his avowed intellectual difficulties as a general purpose excuse for not taking responsibility for his actions or attempting to obtain a more independent lifestyle. Dr Harden was of the view that on the evidence of the two neuropsychological reports, the respondent's cognitive abilities were greater than he portrayed and he was in fact capable of undergoing a sexual offenders program. In Dr Harden's opinion, the most appropriate program was the High Intensity Sexual Offender Program because it was designed for people who fell into the respondent's risk group.

[25] Dr Harden was of the view that the respondent should be required to undergo treatment before release into the community because that would enable more effective design of interventions to assist his integration into the community. Additionally, Dr Harden stated "his grave concern" that otherwise there will have been nothing that will have changed upon the respondent's release into the community.

Evidence of Dr Beech, Psychiatrist

[26] Dr Beech provided a risk assessment report after interviewing the respondent on 18 August 2010. The respondent told Dr Beech that he was "mentally disabled", had deficits in "verbal comprehension" and "information processing" (which words he had read from a piece of paper he had) and that he believed that his sexual and physical abuse in the psychiatric hospital were factors that led to his sexual offending in the 1980's. Dr Beech noted that the respondent gave a vague and inconsistent chronology of his life which seemed due to poor motivation and recollection.

[27] As to the assessment tools administered by Dr Beech, on the Hare Psychopathy Checklist Revised the respondent scored 23/29, which although a high score was not in the realm of psychopathy, it reflected a significant disturbance in his ability for empathy, remorse and the ability to take personal responsibility for himself and his behaviour. On the STATIC-99, he scored 7, which placed him in the high risk of sexual re-offending category. Dr Beech opined that continuing risk factors for the respondent were the chronicity of sexual violence for the offences in 1986 and 1997, the use of severe physical coercion in the commitment of sexual violence, his minimisation or denial of sexual violence, and problems with self awareness, stress and coping, intimate relationships, planning and treatment and problems which had arisen from his childhood sexual abuse.

[28] Dr Beech's opinion was that the respondent's history suggested significant anti-social personality traits with an elevated psychopathy score, juvenile delinquency,

adult sexual criminality and earlier breaches within custody; much information pointed to a passive, dependent, avoidant manipulative personality style. Dr Beech thought it was difficult to say whether or not the respondent had a specific sexual deviance, but remained concerned that his thoughts reflected a form of sexual sadism, although he could not assign that sexual deviance from the material and interview largely because of the fact that the respondent was uncommunicative and guarded.

[29] Dr Beech noted that the respondent wore a prosthetic boot on his right leg and physical examination revealed what seemed to be bilateral talipes equiovarus (in turned feet so that the soles pointed inwards), which the respondent attributed to his fall on the day of the 1997 offences. Dr Beech noted that the respondent repeatedly referred to his disabilities, both physical and mental, and the injuries from the fall and used those as reasons for his poor memory, his offending and his current difficulties.

[30] Dr Beech also noted that the respondent's current physical disability seemed odd and had the appearance of foot and leg contractures seen in disuse atrophy. He had grave concerns that the respondent's physical impairment had arisen from an exaggeration of a relatively minor injury. Dr Beech noted that the respondent was able to run from the scene after injuring himself and walk to the hospital the following day, and that investigations showed only a broken navicular bone in his foot and a fracture of the lateral spinal processes, none of which would account for his current deformity.

[31] Dr Beech was similarly unconvinced of the respondent's memory difficulties. Dr Beech noted that on mini Mental State Examination the respondent scored 28/30, which indicated that there were no gross cognitive disturbances and there was no objective evidence of a separate memory disorder. Dr Beech thought both disorders were used to avoid work, responsibility, and rehabilitation through a sexual offender program.

[32] Dr Beech reiterated in oral evidence that the risk of the respondent re-offending was high. Dr Beech also modified the views in his report to the extent that he indicated that he had underestimated the respondent's level of intelligence. He had thought it was in the borderline category, but was now satisfied on the basis of the psychological testing, that it was in fact in the low average intelligence range. He noted the importance of that conclusion was that it had consequences for the respondent's ability to offend in a more organised fashion than Dr Beech had given credit for. As for the respondent's claimed physical disability, Dr Beech was concerned that it was feigned and that through disuse had resulted in some objective signs of disability. That could recede if he were released into the community and started to exercise again. In that respect, Dr Beech saw the fact that the respondent was in a wheelchair as having the potential to lull a victim into a false sense of security.

[33] Given the respondent's lack of cooperation in revealing his sexual thinking and motivation, Dr Beech was not able to offer an opinion of what conditions could

adequately reduce the risk posed by the respondent to an acceptable level. He considered that the conditions required would in fact be tantamount to detention in the community.

[34] Dr Beech considered that in the light of Dr Douglas' report, it was clear that the respondent had the ability to undergo a mainstream sexual offender program and the most suitable one was the high intensity program. Given the respondent's lack of insight into his offending and poor relapse strategies, he required a high level of treatment.

Evidence of Dr Grant, psychiatrist

[35] Dr Grant noted that the respondent was difficult to interview and described multiple physical problems developing after the 1997 offences, which he attributed to the fall and injuries he suffered thereby. He claimed to have sustained a head injury in the fall that was responsible for the fact that he now had very little recollection for past events, or his offending behaviour. However, Dr Grant noted that the history of the injury and the assessment subsequently did not support the respondent's claim of having suffered a significant head injury.

[36] Dr Grant noted that the respondent presented vehement denial when confronted with police interview material and that he claimed that the interviews as documented must have been falsified. The respondent indicated that, whilst "accepting responsibility" for his offences, at the same time he disputed his involvement and the accuracy of the evidence against him.

[37] Dr Grant considered that there was a vague history of possible Childhood Attention Deficit Hyperactivity Disorder but diagnosed the respondent as having a personality disorder with dependent and passive aggressive traits. In his opinion, it was also likely that the respondent suffered from the sexual paraphilia of sadism. However, he was unable to make a definitive diagnosis because the respondent had been uncommunicative about his sexual thinking and motivation. (Dr Grant opined that the motivation for the offending included an element of enjoyment of inflicting pain and distress which suggested the paraphilia of sadism).

[38] Dr Grant obtained the following results using risk assessment instruments. On the STATIC-99, the respondent scored 6 taking his juvenile offences into account, placing him in the high risk group and if the juvenile offences were not taken into account, the level of risk was moderate to high. On the HARE PCL-R, he scored 22/40, meaning he had some significant personality traits but fell short of a diagnosis of psychopathic personality disorder. On the HCR-20, he scored 10/20 on historic items, 7/10 on clinical items and 7/10 on risk management items, which placed him in the high risk group for re-offending. On the Risk for Sexual Violence Protocol (RSVP), which was the newest and most comprehensive risk assessment instrument, the respondent was a high risk of sexual re-offending. Dr Grant opined that the respondent's risk assessment was in the high risk category on the basis of the structured risk instruments as borne out by the clinical risk assessment. Dr Grant

considered it troubling that a man with such severe planned offending was so much in denial and had so little concern for his victims.

[39] In regard to future risk, the respondent said he did not see himself being a risk to society at all. Part of the reason given by the respondent was that he was confined to a wheelchair or use of a walker, that his religious beliefs would protect him from further offending, and that he would mobilise church support to make sure he did the right thing. Dr Grant noted that the respondent seemed to have no definite plans as to where he would live or what he would do if released from prison. The respondent had written to a number of church places seeking accommodation but had been unsuccessful, and he hoped to get assistance from "Bridge the Gap" to find accommodation. He expected to continue on the disability support pension and believed he would need quite a lot of medical and social assistance when released.

[40] Dr Grant opined that the respondent's physical handicaps did not reduce his high risk of sexual re-offending, commenting that it might alter the nature of the re-offending but not the level of risk.

[41] In his report, Dr Grant noted the uncertainty as to the respondent's intelligence level and cognitive abilities. Dr Grant noted that the claimed memory problems were the chief reason why the respondent had not undergone further sexual offender treatment programs. After having the benefit of Dr Douglas' report, Dr Grant gave additional oral evidence that he ruled out memory deficits arising from the alleged head injury. Dr Grant considered that the evidence indicated that the respondent was of low average intelligence and had sufficient intellectual ability to undertake a sexual offenders program. Indeed, Dr Grant was of the view that the psychological testing revealed that the respondent had the capacity to undergo the mainstream high intensity program, which Dr Grant considered to be the most appropriate for the respondent. Dr Grant's clinical opinion was that the respondent presented as a high risk of re-offending if released without first undergoing a sexual offender treatment program. In his view, the respondent was an untreated serious sex offender who had no real understanding of his sexual offending behaviour or its origins, or how to avoid re-offending, and had no appropriate relapse prevention strategies.

Whether a Division 3 order should be made

[42] If the Court is satisfied that a prisoner is a serious danger to the community in the absence of a Division 3 order, it can make final orders that the prisoner be detained in custody for an indefinite term for control, care or treatment (continuing detention order) or be released from custody subject to the requirements it considers appropriate (supervision order): s 13(1) and (5). Section 13(2) provides that a prisoner is a serious danger to the community if there is an unacceptable risk that the prisoner will commit a serious sexual offence if released from custody; or if released from custody without a supervision order being made.

[43] Section 13(4) provides a list of factors to which the Court must have regard when deciding whether a prisoner is a serious danger to the community, including:

- reports prepared by psychiatrists under s 11 and the extent of prisoner co-operation during the examination;
- other medical, psychiatric, psychological assessments relating to the prisoner;
- information indicating whether or not there is a propensity on the part of the prisoner to commit serious sexual offences in the future;
- the pattern of offending behaviour on the part of the prisoner;
- efforts by the prisoner to address the cause or causes of the offending behaviour and his participation in rehabilitation programs;
- whether or not the prisoner's participation in rehabilitation programs has had a positive effect on him or her;
- the prisoner's antecedents and criminal history;
- the risk of the prisoner committing another serious sexual offence if released into the community;
- the need to protect members of the community from that risk;
- any other relevant matter.

[44] The risk assessment reports indicate that the respondent is an untreated violent sex offender with limited insight and empathy, a very limited relapse prevention plan and a high risk of sexually re-offending. He has an extensive offending history and the index offences were pre-meditated and very similar to his previous offences, including breaking into a female's home and using a weapon to threaten her to comply with his direction to perform oral sex and then raping her.

[45] The respondent has resisted undergoing a sexual offender program, claiming that he has memory problems as a result of a head injury sustained in a fall during the incident the subject of the index offences. The expert evidence is that there is no objective evidence to support such injury. There are also similar concerns about the extent of the respondent's physical injuries, given the lack of pathology or history to explain his current level of disability. The consensus of the expert opinion is that the respondent uses his alleged disabilities and memory problems to avoid responsibility for his actions and to avoid treatment and other educational and rehabilitative programs. Further, the expert opinion is that the respondent's physical difficulties would not stop him from violently sexually offending.

[46] The expert evidence was all to the effect that the respondent presented as a serious danger to the community in the absence of a Division 3 order and I am so satisfied. There is ample, acceptable, cogent evidence which establishes to a high degree of probability that there is an unacceptable risk that the respondent would commit a serious sexual offence if released from custody even under a supervision order.

[47] The united effect of the evidence is that the respondent is capable of undertaking a sexual offender program and that to reduce the risk of re-offending he should undergo such treatment prior to release into the community. Counsel for the respondent conceded that, given the nature of the oral evidence, it was difficult to contend that a supervision order ought to be made. That concession was properly made on the basis of the expert evidence that the risk posed by the respondent could not be sufficiently mitigated by the imposition of a supervision order.

[48] Accordingly, I find that the respondent is a serious danger to the community in that there is an unacceptable risk that he will commit a sexual offence if released from custody, at least without some further treatment. In the circumstances, a continuing detention order is made pursuant to s 13(5)(a).