SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Pilot* [2012] QSC 235
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **LOMAX DOUGLAS PILOT** (respondent)
FILE NO:	10523/09
DIVISION:	Trial Division
PROCEEDING:	Application
DELIVERED ON:	31 August 2012
DELIVERED AT:	Brisbane
HEARING DATE:	15 December 2011, 12 March 2012, 5 April 2012, 18 June 2012
JUDGE:	Dalton J
ORDER:	**The respondent be detained in custody for an indefinite term for control, care and treatment.**
CATCHWORDS:	CRIMINAL LAW – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – application pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) for the respondent to be detained in custody indefinitely for control, care or treatment – where the respondent has an acquired brain injury and long-standing mental illness – where the evidence of psychiatrists is that the respondent requires 24 hour per day supervision and support if he were to be released from jail – where there is no funding from the State to support this level of supervision – where an alternative solution proposed on behalf of the respondent was found to be inadequate *Dangerous Prisoners (Sexual Offenders) Act* 2003 *Attorney-General v Francis* [2007] 1 Qd R 396 *Attorney-General for Queensland v Lawrence* [2008] QSC 230 *Attorney-General (Qld) v Saunders* [2011] QSC 228 *Attorney-General (Qld) v Sybenga* [2009] QCA 382 *Raymond Yeo v Attorney-General (Qld)* [2011] QCA 170

COUNSEL: JW Selfridge for the applicant
N Weston for the respondent

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

[1] Lomax Douglas Pilot is a young Aboriginal man. He was born on 30 May 1986 and is currently aged 26. On 9 December 1996, when he was aged 10 years old, he fell from a mango tree.[1] He fractured his skull and suffered brain contusions in the fall.[2] He was admitted to hospital with a Glasgow Coma Score of 4.[3] Magnetic resonance imaging from 2008 shows localised atrophy in the left parieto-occipital region of his brain which is likely to be post-traumatic.[4] His IQ has been estimated at between 60 and 67.[5]

[2] As a youth he used alcohol, cannabis and sniffed volatile substances.[6]

[3] Prior to April 2006 Mr Pilot had collected a string of minor criminal convictions largely for nuisance offences and offences of minor dishonesty. The records document numerous unsuccessful attempts made by Court liaison officers to obtain psychiatric help for him as early as 2003 when he began interacting with the Court system.[7] As early as this he was clearly reported to be suffering from hallucinations and paranoia.

[4] On 3 April 2007 Mr Pilot was convicted on his own plea of two counts of attempted rape, one count of assault with intent to commit rape, two counts of rape (digital) and two counts of sexual assault. These charges all arose out of one incident which occurred on 17 April 2006 when Mr Pilot was aged 18. He knocked a 23 year old university student from her bike with the idea of having sex with her. The complainant was digitally penetrated and otherwise assaulted. After the assaults Mr Pilot apologised to the complainant. McLauchlan DCJ imposed a sentence of five years suspended after three years. There was no report from a psychiatrist. He had before him the report of a psychologist which described, "contradictory irrational thought patterns" experienced by Mr Pilot.

[5] Mr Pilot was in custody from the time of the offending and, from November 2006, in prison, exhibited symptoms of delusions, psychosis and thought disorder such that no-one could maintain a rational conversation with him. He was prescribed Risperidone and by 2008 had been diagnosed with schizophrenia, and alternatively, a psychotic disorder (not otherwise specified) secondary to head injury.

[6] Despite these diagnoses and treatment with Risperidone, Mr Pilot was to suffer a massive deterioration in his mental health between 2008 and 2011. It did not assist that for part of this time the psychiatrist who had his care determined that he did not suffer from any psychotic disorder and discontinued drug therapy. His history is one of being subject to numerous involuntary treatment orders and numerous

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1 Report Dr Michael Beech, 13 December 2010, p 2.
2 *ibid.*
3 Report Professor Basil James, 7 March 2011, p 9.
4 Report Professor Basil James, 7 March 2011, p 10.
5 Report Dr Michael Beech, 13 December 2010, p 2 and p 5.
6 Report Professor Basil James, 6 February 2009, p 12.
7 Report Professor Basil James, 7 March 2011, p 4.

admissions to secure psychiatric facilities. The Department of Corrective Services reports that Mr Pilot has exhibited acceptable custodial behaviour in the entire period of his incarceration.[8]

[7] On 15 November 2011 Mr Pilot was charged with rape. These charges relate to the alleged rape of a girl sometime between January and April 2002. At that stage the complainant was nine years old and Mr Pilot was 15 years old. Complaint was first made apparently in 2007. Those charges have not progressed pending review before the Mental Health Court. The material before me (hearsay contained in psychiatric reports) is to the effect that Mr Pilot denies the charge.

Court Proceedings

[8] As Mr Pilot's release date drew near, the Crown filed an originating application on 23 September 2009 seeking his indefinite detention pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, "the Act". This came on for hearing on 15 December 2009 but was adjourned to a date to be fixed, with orders made under s 9A(2)(b) of the Act, that Mr Pilot be detained in custody until the final determination of the originating application. The reason for the adjournment in December of 2009 was that Mr Pilot was incapable of giving legal representatives any sensible instructions at that stage.

[9] Thereafter the proceeding was managed as a supervised case. It was set for hearing on 15 April 2011 (order 10 December 2010). This date was vacated and a new date was set for hearing – 15 December 2011 (order 16 September 2011). At that point the matter came before me. The parties were not ready to proceed. It was adjourned until 12 March 2012, when again the parties were not ready to proceed. It finally proceeded on 5 April 2012 and, at the conclusion of that day's hearing, counsel for Mr Pilot requested another adjournment so that he could bring further evidence before the Court. The last day's hearing was 18 June 2012.

Psychiatric Opinion

[10] Three psychiatrists reported to the Court pursuant to s 11 of the Act on the application before me – Professor Basil James, Dr Michael Beech and Dr Joan Lawrence. I deal with their reports in some detail.

Professor Basil James

[11] Professor James examined Mr Pilot in 2009. At that stage he thought that an Axis 1 diagnosis of either schizophrenia or psychotic disorder (not otherwise specified) secondary to head injuries were both possible.[9] He further considered that Mr Pilot had an Axis 1 diagnosis of chronic substance abuse disorder and as well had an antisocial personality disorder. He gave "a very guarded prognosis".[10]

[12] Professor James thought that, "symptoms of poor information processing, poor capacity to make sound judgements, relatively poor impulse control, poor insight, and the history of his offending (in particular his index offences), all point to a **very**

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8 Report Queensland Corrective Services filed 5 April 2012.

9 Report Professor Basil James, 6 February 2009, p 19.

10 Report Professor Basil James, 6 February 2009, p 21.

high risk of re-offending" (emphasis in the original).[11] Professor James thought that Mr Pilot was unlikely to benefit from any available sex offender treatment program.[12]

[13] Reporting again in March 2011, Professor James' view was that Mr Pilot was psychotic, although he had no doubt that the head injury contributed significantly to his "brain dysfunction".[13] Professor James saw strong evidence that Mr Pilot responded to anti-psychotic drugs.[14] He recommended trialling a range of such drugs.[15] Although, he commented that, "Realistically one has to say at this point that, even with an expanded range of treatments the prognosis is unlikely to be good."[16]

[14] Professor James said that Mr Pilot was:

> "Very vulnerable in a prison population – a circumstance likely to militate against improvement in his mental health, and that secondly, his prospects of improvement would in any case be much greater were he to be treated in a setting where the primary objective is therapeutic rather than custodial …"[17]

[15] Professor James assessed a "very high risk of re-offending, even if a supervision order were in place under [the Act]".[18]

[16] Professor James reported finally in April 2012. At this stage Mr Pilot had received consistent treatment with anti-psychotic medication for 12 months. This had led to a marked reduction in the active disorganising symptoms of his psychosis such that Professor James said, "As a result of this treatment Mr Pilot's risk of re-offending in a violent sexual way is considerably reduced."[19] However, Professor James noted that Mr Pilot was insightless and that he needed to remain under involuntary treatment orders to ensure that his drug therapy continued. Without drug therapy Professor James considered the risk of re-offending "very high".[20]

[17] Noting that other commentators had expressed the view that sex offender treatment programs were likely to reduce the risk of Mr Pilot's re-offending, Professor James said, "I am of the opinion that gains in the above area are likely to be quite modest …"[21]

[18] When giving evidence on 5 April 2012, Professor James addressed the then proposal to have Mr Pilot released into the community under some sort of 24 hour supervision. He commented that plans in relation to his mental health treatment needed to be specifically developed: what mental health service would he attend; who would treat him; what services would he be provided with, and how often – t 1-35. Professor James also raised concerns as to how Mr Pilot would occupy his

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11 Report Professor Basil James, 6 February 2009, p 22.
12 *ibid.*
13 Report Professor Basil James, 7 March 2011, p 17.
14 Report Professor Basil James, 7 March 2011, p 18.
15 Report Professor Basil James, 7 March 2011, p 19.
16 *ibid.*
17 *ibid.*
18 Report Professor Basil James, 7 March 2011, p 20.
19 Report Professor Basil James, 3 April 2012, p 6.
20 *ibid.*
21 Report Professor Basil James, 3 April 2012, pp 7-8.

time – t 1-39. He saw this as a very important matter. He also emphasised that due to his impoverished life before incarceration, his acquired brain injury, mental illness and long period of incarceration, Mr Pilot had very basic skills to acquire – t 1-35.

[19] Professor James thought it "quite essential" that Mr Pilot have 24 hour care –t 1-35. He saw this as being necessary for at least six months, but he thought that such care might be required for years – t 1-35, t 1-38. On a program where he could be provided with 24 hour care, seven days a week, Professor James thought that Mr Pilot's risk of re-offending was "moderately low" – t 1-38.

Dr Michael Beech

[20] The first report of Dr Michael Beech was made in November 2009. At that stage he diagnosed a psychotic disorder due to the general medical condition of acquired brain damage which was associated with intellectual impairment.[22] Dr Beech has remained consistent in his view of the diagnosis – re-affirming this in March 2012.[23] Dr Beech was also of the opinion that Mr Pilot had a substance abuse disorder which was in enforced remission due to his incarceration.[24] He also took the view that he had an antisocial personality disorder.[25]

[21] Importantly, however, Dr Beech noted that the form of psychosis from which Mr Pilot suffered did improve with medication, although he noted that management was hampered by poor insight and poor treatment adherence.[26]

[22] Dr Beech gave his opinion that:

> "It is my qualified opinion that Mr Pilot is at present at high risk of re-offending both generally and sexually if he were to be released into the community. That risk arises from his mental instability and impairment, his impulsivity and insightlessness, and his lack of treatment and support on a background of persistent adult criminality.
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> …
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> I cannot with any confidence say that the risk could be managed in the community with a supervision order. He has a significant history of supervision failure and in prison he has required substantial medical support that has been hindered by his poor compliance and lack of insight. There is nothing at hand that would indicate that his mental condition could be managed in the community or that family and other supports are in place to guide and assist him.
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> What is required is at least formal intensive psychiatric assessment followed by planned assertive community mental health follow-up; stable supervised accommodation; community support; and involvement in psychological counselling to address his offending. It is my opinion that much of this needs to be commenced in a secure

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22 Report Dr Michael Beech, 26 November 2009, p 15.
23 Report Dr Michael Beech, 7 March 2012, p 3.
24 Report Dr Michael Beech, 26 November 2009, p 15.
25 *ibid.*
26 Report Dr Michael Beech, 26 November 2009, p 14.

> environment either in prison or, perhaps more appropriately, a secure mental health facility."[27]

[23] Dr Beech was of a similar view in December 2010. He said, "I cannot, at the moment, envisage any form of supervision that would not amount to placement in a secure setting with intensive oversight that would suitably reduce the risk of sexualised behaviour …".[28] He continued, "It is unfortunate, but at the moment I cannot see anything in the material which points to even the beginning of a plan for appropriate management within the community …".[29]

[24] In December 2011 Dr Beech reported his opinion that Mr Pilot was a "… very high risk of re-offending sexually should he be released into the community."[30] He noted that Mental Health Services did not accept that Mr Pilot was a patient in need of in-patient services and said, "At present I cannot think of a placement in the community which would allow for appropriate management, monitoring and supervision."[31]

[25] In March 2012 Dr Beech saw Mr Pilot again. He had not examined him since 2009. He found his presentation significantly different for the better. In particular there was no evidence of psychosis.[32] Dr Beech still considered Mr Pilot's IQ consistent with mild mental retardation.[33] Speaking as at March 2012 Dr Beech said:

> "It is my opinion that Mr Pilot is currently significantly better than when I first saw him in 2009. I believe that this improvement is primarily the result of adequate treatment of his mental illness supported by the stable and secure routine of his custodial placement, and facilitated by abstinence from illicit substances. However, this stability has required an involuntary treatment order and ongoing counselling and support. I believe that were he released into the community without oversight, monitoring and supervision it is very likely that his compliance with treatment would lapse, that he would return to substances, that his mental illness would recrudesce, and ultimately that he would be lost to follow-up. Under those circumstances, I believe that his risk of return to inappropriate sexual behaviour, and ultimately sexual assault, would be very high.
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> …
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> I believe that if Mr Pilot were released into the community he would need a suitable transitional placement. Nothing in the material indicates to me that there is any substantial proposal on the table for this. I struggle myself to think of what would be suitable and available for him. It is unclear to me whether his current legal proceedings before the Mental Health Court will ultimately lead to his placement within the Forensic Disability Service. If that were the case, I would be very supportive of the placement."[34]

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27 Report Dr Michael Beech, 26 November 2009, p 16.
28 Report Dr Michael Beech, 13 December 2010, p 6.
29 *ibid.*
30 Report Dr Michael Beech, 13 December 2011, p2.
31 Report Dr Michael Beech, 13 December 2011, p 2.
32 Report Dr Michael Beech, 7 March 2012, p 6.
33 *ibid.*
34 Report Dr Michael Beech, 7 March 2012, p 9.

[26] In giving evidence on 5 April 2012, Dr Beech said that Mr Pilot would benefit more from one-to-one counselling with Mr Luke Hatzipetrou (a psychologist), than participating in sex offender treatment programs – t 1-8 – t 1-9. He thought that participation in sex offender treatment programs were "lower down the list of things" which were important to ameliorate the risk of Mr Pilot's re-offending – t 1-11 and see t 1-20-22, and t 1-22-23.

[27] Dr Beech was of the opinion that 24 hour supervision, seven days a week was required "in the first instance" if Mr Pilot was to be released from prison – t 1-14. It would be necessary for Mr Pilot to remain on an involuntary treatment order; attend regularly at a doctor or nurse for medication; attend regularly at a counsellor for sex offending counselling and counselling as to skills appropriate to living in the community, and abstaining from drugs and alcohol – t 1-18 – t 1-19.

[28] Dr Beech thought that Mr Pilot would require at least 12 months of 24 hour a day supervised care – t 1-23. He thought that he would require long-term psychiatric treatment – in the vicinity of 10 years or more – t 1-23.

[29] Dr Beech thought that if 24 hour supervision could be put in place for Mr Pilot in the community he would be a "low to moderate risk".

[30] Dr Beech discussed the dilemma of accommodating Mr Pilot's need for 24 hour supervision. He was of the view that Mr Pilot did not need acute in-patient treatment in a psychiatric ward in a hospital, because his condition is stable – t 1-23. Nor is he really suitable for the high security unit at Wolston Park, again because his psychiatric condition is stable – t 1-23. Although there is a Forensic Disability Service for people with an intellectual disability who have offended, he believed that Mr Pilot was precluded from that service by his mental illness – t 1-24. His evidence was that there are no asylums in existence – t 1-24.

Dr Joan Lawrence

[31] Like the other psychiatrists, Dr Lawrence first saw Mr Pilot at the end of 2009. She thought that he had a borderline IQ and a psychotic disorder.[35] As to this, she noted that Mr Pilot improved (insofar as active symptoms appeared less prominent) when he was on medication, but noted that he remained insightless and denying mental illness at all times. She also noted that he objected to medication and blamed it for difficulties.[36] Dr Lawrence thought that Mr Pilot was at a high risk of sexual offending in the community.[37]

[32] Presciently, in November 2009 Dr Lawrence said, "It would be my prediction that a schizophrenia type illness may well emerge in the months ahead. This could then be appropriately treated by depot medication in the longer term and efforts made thereafter to ensure compliance …".[38] Dr Lawrence was writing when Mr Pilot's first available release date was two months hence. She said, "In my opinion, the most likely effective way for this to be done would be on a Forensic Order as a patient of Special Notification to ensure as active monitoring as possible …".[39]

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35 Report Dr Joan Lawrence, 5 November 2009, p 12 and p 14.
36 Report Dr Joan Lawrence, 5 November 2009, p 12.
37 Report Dr Joan Lawrence, 5 November 2009, p 16.
38 Report Dr Joan Lawrence, 5 November 2009, p 17.
39 *ibid.*

[33] Dr Lawrence reported again in January 2011. She made three Axis 1 diagnoses: psychotic disorder due to general medical condition (acquired brain injury ABI) with hallucinations and delusions; dementia due to general medical condition (ABI) with behavioural disturbance, and alcohol and cannabis abuse/dependence, in controlled remission in prison. She made two Axis 2 diagnoses: moderate to mild mental retardation (IQ 60-69) with associated language difficulties, and antisocial personality disorder. She made two Axis 3 diagnoses: acquired brain injury – left parieto-occipital region and treated syphilis.[40]

[34] Dr Lawrence made reference to Mr Pilot's suffering a head injury as a 10 year old boy. Her opinion continued:

> "Thereafter, cognitive deficits as well as effects upon his developing personality, and seen against his social and ethnic background, led to the development of a significant personality disorder with significant antisocial behaviours involved.
>
> His behaviour is consistent with some evidence of frontal lobe disturbance as well as significant intellectual and/or cognitive impairment affecting his ability to learn, to train and to develop constructive strategies to deal with his difficulties. He is also clearly impulsive, egocentric and has little ability to control his behaviours including his sexual behaviour and aggression.
>
> There is, however, documented evidence of complaints of hallucinations, paranoid ideation and ideas of reference and delusional beliefs, which he has, in the past, been prepared to act upon … There are complaints of auditory and visual hallucinations repeatedly over several years. These have been treated, apparently with benefit, by an anti-psychotic … He appears to respond in terms of improvement of his behaviour with better control of sexual and aggressive impulses, diminished lability of mood, improved cognitive abilities, i.e. the ability to obey directions, participate in a meaningful way in his surroundings and be less distressed by the presence of both auditory and visual hallucinations."[41]

[35] Dr Lawrence noted that over eight years there was a definite pattern that when Mr Pilot was off anti-psychotic medication his psychotic symptoms increased, including those of paranoid ideas and delusions of reference and auditory and visual hallucinations. This increase in psychotic symptoms had a poor effect on his ability to self-regulate his sexual behaviour. She noted that he remained insightless as to his condition and therefore stressed the need for depot medication and for him to remain on involuntary treatment orders indefinitely.[42]

[36] At this time Dr Lawrence's conclusion was that Mr Pilot was at, "ongoing risk of committing some serious sexual offending behaviour unless [he] is under close and strict supervision; medication is closely monitored; and his environment is carefully structured to minimise risk."[43] It is clear that in her opinion compliance with medication was not enough, and her report stresses the need for a "very structured

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40 Report Dr Joan Lawrence, 20 January 2011, p 13.
41 Report Dr Joan Lawrence, 20 January 2011, p 13.
42 Report Dr Joan Lawrence, 20 January 2011, p 14.
43 *ibid.*

and supervised environment".[44] Overall, Dr Lawrence viewed Mr Pilot as at "very high risk of re-offending sexually".[45] Further, she gave her opinion that, "the severity and harm that could result from his re-offending behaviour would, itself, be very serious …"[46] Dr Lawrence's view was that, "were he to be released in the community, in my opinion, no supervisory conditions likely to be implementable in a practical or realistic way would be sufficient to control the risk of re-offending."[47]

[37] Dr Lawrence re-examined Mr Pilot in March 2012. Like Dr Beech, she saw a significant contrast to his presentation in 2009. While still exhibiting what she considered to be mild mental retardation, she saw no evidence of significant thought disorder or psychotic thought process.[48] Nonetheless, she considered that Mr Pilot remained insightless about his mental illness.[49] She found that Mr Pilot denied he had a mental illness and found that he had no concept of any association between illness and treatment and no understanding of the need to continue medication.[50]

[38] Dr Lawrence saw Mr Pilot's complying with a continuing drug regime as essential. As well she said that he will need to be:

> "Significantly supported and supervised accommodation and supports for everyday living …
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> Lomax Pilot will need, in my opinion, virtually 24 hour support and supervision, at least initially, to ensure as risk free a transition to the community as possible. Total prohibition on the use of all substances such as alcohol and illicit drugs is essential.
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> In my opinion, in the absence of a multi-agency involvement in the ongoing provision of this detailed program to address Lomax Pilot's needs, the risk of him sexually re-offending is high and the harm that would ensue from his sexual offending is also **HIGH**.
>
> The provision of a detailed program addressing his psychiatric treatment needs on an ongoing supervised basis, his sexually offending treatment needs, his social care, and welfare and general lifestyle needs as well as provision of appropriate care and abstinence from all substances requires a multi-agency approach.
>
> If implemented and able to be maintained in the longer term, I believe that the risks of sexual re-offending will be reduced significantly to a **MODERATE to LOW level.**"[51] (emphasis in the original)

[39] Like Professor James and Dr Beech, Dr Lawrence saw no need for Mr Pilot to remain incarcerated in order to partake in sexual offenders' treatment programs – t 1-26. She also considered he would be better having individual counselling with Mr Luke Hatzipetrou – t 1-27 – than undertaking such programs.

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44 Report Dr Joan Lawrence, 20 January 2011, p 15.
45 *ibid.*
46 *ibid.*
47 *ibid.*
48 Report Dr Joan Lawrence, 29 March 2012, p 6.
49 Report Dr Joan Lawrence, 29 March 2012, p 11.
50 Report Dr Joan Lawrence, 29 March 2012, p 7.
51 Report Dr Joan Lawrence, 29 March 2012, p 13

[40] When giving evidence on 5 April 2012 Dr Lawrence said, "I think the primary need is to ensure ongoing adequate treatment of his mental health needs and that must be in the context of well-organised and closely – 24 hour supervision accommodation for this man" – t 1-26.

[41] Dr Lawrence expressed concern that because Mr Pilot needed to remain on an involuntary treatment order, his treatment would necessarily be in an Authorised Mental Health Service, and therefore by a public hospital doctor, in Toowoomba if that is where he was living – t 1-29. Her concern was that in the Authorised Mental Health Service there is little experience with forensic issues and that there would be a need to closely liaise with the community forensic team – t 1-28. She also expressed concern that treating psychiatrists in Authorised Mental Health Services change fairly frequently, perhaps at intervals of six months, and therefore if there was not sufficiently good handover and record-keeping, it may well be that, due to Mr Pilot's stability in presentation, the involuntary treatment order was discharged and, "that would be disastrous" – t 1-28-29. She emphasised the need for active case management by a supervising psychiatrist and case manager and a need to give very careful consideration to what triggers would call for a response, with the need to make sure that the response was appropriate to any breaches, for instance of his involuntary treatment order – t 1-28.

[42] Dr Lawrence thought that Mr Pilot would require 24 hour care for 10 years – "I could be wrong but I wouldn't be hopeful of that change" – t 1-30. She explained that long-term need for supervision as due to the fact that his problems stem largely from brain damage, which condition would not change – t 1-32. She explained that at present he would need supervision for just about every aspect of his life – shopping, cooking, personal hygiene and making everyday decisions such as whether or not to go to a hotel – t 1-32. She said, "It may be that over the passage of time he will acquire some sort of pro-social skills greater than he has at the moment, I mean, in terms of self-care and possibly some degree of self-regulation, but I think there are going to be – always going to be significant limits on his ability to take care of himself and certainly his interactions with the world around him."

[43] Dr Lawrence thought that if Mr Pilot continued to comply with his medications; receive psychiatric treatment; was subject to 24 hour supervision, and abstained from drugs and alcohol, he was a moderate risk of re-offending – t 1-32.

Treating Psychiatrists

[44] Mr Pilot is currently well treated by Dr Eve Timmins. On a regime of depot anti-psychotic drugs and other psychiatric care he is currently stable. There were three reports from Dr Timmins before the Court. The first was dated 6 April 2011. She said, "I would recommend secure housing with 24 hour supports to ensure compliance with medications and other treatment plans. Any less structured environment would increase the risks to an unacceptable level. I do not think prison is the best environment however there is limited other environments at this stage that could manage Lomax's needs."

[45] On 25 August 2011 Dr Timmins gave a similar report saying, "I would recommend housing with 24 hour supports to ensure compliance with medications and other treatment plans."

[46] On 29 February 2012 she gave a longer report describing him as "reasonably settled" for the last 12 months. She detected no psychotic symptoms or pervasive mood disturbance. She noted that Mr Pilot had no understanding of why he needed depot medication and had no understanding of why he needed to be on an involuntary treatment order. She said that in her opinion he would be best managed in the community, given his stability of mental state.

[47] Because the parties were unable to proceed with this matter at the times set by the Court, Dr Timmins was not available when the matter came on for hearing on 5 April 2012, and Dr Andrew Aboud, a consultant psychiatrist in prison mental health service, familiar with Dr Timmins' treatment of Mr Pilot, gave evidence. Dr Aboud confirmed that Mr Pilot had been stable psychiatrically for over one year – t 1-41.

[48] He agreed with the concerns expressed by Dr Lawrence as to consistency of treatment over time and the lack of corporate memory in community mental health schemes – t 1-42 and t 1-45.

[49] Dr Aboud thought that Mr Pilot required 24 hour care, seven days a week – t 1-42 – if he were to be released into the community. He thought that the minimum time for this was six months, subject to review it may be longer – t 1-43. He described Mr Pilot's psychosis as, "a longstanding entity which was not going to disappear" – t 1-42.

Sex Offender Treatment Programs

[50] Because of the delay in getting this matter before the Court for a hearing, Mr Pilot had finished the Getting Started program in prison before the matter was finally heard so that the exit report from that was available to me. It confirmed the views expressed by Professor James and Drs Beech and Lawrence, noted above. Mr Pilot scored six on a scale where high risk was six and over. The exit report notes that he was poorly motivated during the course; that he was poorly comprehending, and had poor recall during the course. He was lacking in insight into his offending and as to his mental health issues. His participation was described as quiet and it was noted that he did not engage in group discussion. Overall it was felt that Mr Pilot was not suitable for further sex offender treatment programs.[52]

[51] Mr Luke Hatzipetrou has been suggested as a psychologist who could undertake individual sex offending counselling with Mr Pilot. He saw Mr Pilot on 6 March 2012 and wrote a report dated 4 April 2012, recounting this initial meeting. His initial thoughts were that Mr Pilot was co-operative, but he had doubts as to his capacities to learn and his memory, noting that he had to simplify his language when speaking to Mr Pilot and repeat information several times. He noted that at times Mr Pilot experienced significant comprehension problems with information processing and appeared to be overwhelmed by their interaction. He also noted that he presented with marked impulsivity and antisocial tendencies. He concluded, "Mr Pilot's treatment needs will be enduring and likely to be more in long term therapy. His treatment needs are complex but achievable."

[52] By the time the matter was finally heard there was a further opinion available from Mr Hatzipetrou dated 11 June 2012. This is a long report after several sessions with

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52 See the exit report dated 18 May 2012.

Mr Pilot. Much of it goes to his future treatment needs, rather than matters with which I am directly concerned. Nonetheless, Mr Hatzipetrou notes that Mr Pilot's treatment needs will remain complex and protracted.[53] He recommended individual treatment on a weekly or twice weekly basis, with the idea that eventually Mr Pilot might be reconsidered for inclusion in group programs. It seems he is thinking of this well in excess of 12 months after individual treatment begins.[54]

[53] Mr Hatzipetrou says that accommodation remains a critical issue for Mr Pilot:

> "If levels of supervision were less than 24 hours per day, Mr Pilot's care is likely to diminish and risk of sexually abusive behaviours is likely to increase. Of note, Mr Pilot believes the support workers are not required and he is capable of living independently in the community.
>
> If released into the community, Mr Pilot should live independently with support staff. However, he will require an extensive review of his funding package with Department of Communities Disability Services. Moreover, Mr Pilot does have an intellectual disability and requires more support than currently receiving at the correctional centre. Finally, Mr Pilot's transition to the community will be a complex and demanding endeavour yet he is likely to benefit from the social experiences and support in the community. His eventual adjustment to the community and less restrictive conditions may span over several years. His problems are not transient and he presented with intellectual disability and chronic mental health disorder, which are lifelong conditions.
>
> In the absence of adequate funding and intensive accommodation support models, Mr Pilot will remain a risk of recidivism and his responsivity to the psychological treatment of the offending behaviours will be significantly comprised. Given the complexities and chronicity of Mr Pilot's clinical disorders, the risk of institutionalisation is markedly elevated and opportunities to engage in holistic rehabilitation will remain limited in a custodial setting."[55]

Availability of Accommodation Outside Prison

[54] It will be seen from the foregoing that Mr Pilot's problems are medical. He has served considerably more time in prison than provided for by the judge who sentenced him. He has been in prison from age 19 to age 26. No-one who gave evidence or provided a report to the Court contends that prison is an appropriate place for Mr Pilot. To the contrary those treating him express the view that it is not in his interests to remain in prison. He should be somewhere where his therapeutic needs are the primary focus.

[55] Because of the nature of his offending he is caught by the provisions of the Act. Because of his medical conditions he is an unacceptable risk if he is released without 24 hour supervision. In those circumstances, the Act requires that he not be released in circumstances where 24 hour supervision cannot be provided for him.

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53 Report Mr Hatzipetrou, 11 June 2012, p 13.

54 Report Mr Hatzipetrou, 11 June 2012, p 14.

55 Report Mr Hatzipetrou, 11 June 2012, p 16.

Yet the State makes available no facility, other than a prison, to Mr Pilot, and will not fund care individually.

[56] The Wacol Precinct is described in Court Document number 45. No party contended that it was a suitable alternative for Mr Pilot. And in any case, there were no vacancies there. At the Wacol Precinct, and at other similar precincts in Townsville and Rockhampton, the High Risk Offender Management Unit within Probation and Parole, Queensland Corrective Services do not provide, "intensive personal support programs. … All persons subject to DPSOA supervision orders are expected to manage their own activities in the community within the limits of their order requirements."[56] Mr Pilot is not capable, for medical reasons, of managing himself in the community, at all, let alone subject to the detailed requirements of a supervision order made under the Act.

[57] Queensland Corrective Services staff swear that contact has been made with 22 supported accommodation providers and none provides the level of support required by Mr Pilot.[57] Queensland Corrective Services cannot provide funding for Quality Lifestyle Support (see below) to provide 24 hour, seven day a week, supervision of Mr Pilot.[58]

[58] Queensland Corrective Services will provide treatment in relation to sex offending – in this case they will provide counselling with Mr Hatzipetrou or a similar counsellor, although even this is limited. A report from Queensland Corrective Services says:

> "Aside from treatment [i.e. counselling with Mr Hatzipetrou or equivalent], offenders are primarily responsible for their reintegration. However, they are provided with support and assistance where required."[59]

[59] It will be noted that for medical reasons Mr Pilot cannot be responsible for his own reintegration and, lest the last sentence of the extract immediately above be thought to mean that support and assistance as required by Mr Pilot will be provided, the report continues:

> "Department of Communities, Disability and Community Care Services (DCCS) has indicated that PILOT is eligible to access specialist disability services. PILOT will be allocated to a Case Manager to work with him for approximately two hours per week. Case management is initially time limited, up to three months and will then be reviewed. DCCS will not be providing a 24 hour accommodation support level of service … Dr Lawrence's supplementary report dated 29 March 2012 notes that PILOT will need 24 hour support and supervision, at least initially, to ensure a risk free transition to the community. QCS is not funded to provide this level of support and supervision."[60]

[60] An officer from Corrective Services gave evidence before me that the State's total budget for individual intervention and accommodation for every single offender in

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56 Court Document 60 [16].
57 Court Document 60 [20].
58 Court Document 60 [20].
59 Report Queensland Corrective Services, filed with leave 5 April 2012, p 4.
60 Report Queensland Corrective Services, filed with leave 5 April 2012, p 5.

the community on a dangerous prisoner order is $330,000 per annum – t 1-60. At present there are 85 such individuals in the community – t 1-61 – leaving very little money for each individual. Currently the Department is over budget – t 1-61.

[61] There was affidavit material and evidence from the Department of Disability Services before the Court. Disability Services will fund "support services". This amounts to two hours "case management" per week for three months, with a review at the end of that time – t 1-48 – and up to 15 hours a week for "community participation and skills development" – t 1-49. This level of assistance will be provided to Mr Pilot because the Department itself assesses him as having a "mild intellectual impairment". The Department, notwithstanding the psychiatric evidence in this proceeding (which it has), does not see that Mr Pilot warrants any further assistance or care. The witness who gave evidence before the Court said that the case management of up to two hours per week was not time actually spent with Mr Pilot but was time spent co-ordinating his case. The 15 hours per week was time which the Department sub-contracted to a private enterprise organisation to assist Mr Pilot. When pressed to specify anything useful that could be provided to him in this time, the representative of the Department resorted to generalities – t 1-50-51.

[62] The amount of funding for the time allocated by the Department to Mr Pilot was based on the Department's own assessment and was apparently not able to be influenced by the evidence given by the psychiatrists to this Court – t 1-52-53. Clearly the assessment by the Department is unrealistic and inadequate, as is the idea that two hours case management and 15 hours per week allocated to Mr Pilot is anywhere near adequate. I note that the Department did not put forward any professional or other justification for the assessment it made. It simply asserted its view.

[63] The only other material from the State before the Court deserving of mention is a report from the High Risk Offenders Management Unit. It said:

> "HROMU has had regard to the psychiatric reports in this matter … HROMU considers that it is, to a large extent, premature to finalise accommodation for the respondent until a well formulated, long term rehabilitation plan is established and that respondent has participated in treatment aimed at reducing his risk of sexual offending prior to his release from custody."[61]

[64] This conclusion really betrays no understanding of Mr Pilot's situation. His long-term psychosis is stable so that, so far as his mental illness is concerned, his mental state is optimal, or close to optimal. Other difficulties he suffers are organic and cannot be expected to improve. Clearly, since 2009 the psychiatrists who have been reporting on his condition have said that there is no point in his remaining in prison to complete standard module sex offender treatment programs. There can hardly have been any doubt about this, but all doubt should now have been dispelled having regard to the exit report for the Getting Started program.

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61 Court Document 60 [25].

Respondent's Proposal for Release to the Community

[65] On behalf of Mr Pilot, Legal Aid Queensland put material before the Court from an organisation called Quality Lifestyle Support (QLS). The material was poorly drawn and inadequate. It is not even evident what legal entity trades under the name Quality Lifestyle and Support. There is almost no information about the organisation before the Court. It is said that it has over 200 staff managing 100 "clients". QLS is said to be a disability support service. Its "clients" have a number of disabilities including, "acquired brain injuries, mental impairments, mental illness and a combination of these. Some of our clients have a criminal history, including a history of violence and sex offending."[62] Notwithstanding this, the organisation has never had the care of somebody who has been released under the *Dangerous Prisoners (Sexual Offenders) Act* – t 1-71.

[66] The deponent who gave evidence on behalf of QLS did not reveal what qualifications, if any, she had. She said that her staff had a "minimum qualification of a Certificate 3 in disability. Our staff are required to complete in-house training in Positive Behaviour Support. They are also required to undertake medication training, social role valorization and any specific training relevant to the individual needing support."[63]

[67] It was not explained what those qualifications actually meant, or how they would be appropriate to assisting Mr Pilot.

[68] At the time the deponent from QLS swore her affidavit, QLS was planning to rent a house at Withcott, near Toowoomba. By the time the matter came on for its final day's hearing, that property had in fact been rented, on a month to month tenancy – t 1-70. The property is a five bedroom house on about five acres. There are, or are planned, vegetable gardens and some sheep and hens on the property. There is a dam which it was planned to stock with fish.

[69] The property is currently inhabited by a 61 year old male with both mental illness and intellectual disability who is on a forensic order from the Mental Health Court and on 12 hours a day, five days a week supervision, together with a 25 year old male who has extreme autism, on 24 hour a day, seven day a week, supervision.

[70] Queensland Corrective Services visited the property for the purpose of assessing its suitability to Mr Pilot. They identified a single mother living with two children on the next door property – 50 metres away[64] but that did not prevent them considering the property itself suitable for Mr Pilot. They expressed no opinion on the proposed co-tenants, merely noting that QLS had assessed these as suitable co-tenants for Mr Pilot.

[71] The deponent from QLS swore that she understood Mr Pilot was on an involuntary treatment order and said that QLS would be willing to ensure that he attended at medical health services as appropriate.[65] The deponent swore that she had seen a draft supervision order, although this was not exhibited.

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62 Court Document 50 [2].

63 Court Document 50 [3].

64 Queensland Corrective Services report, dated 7 June 2012, pp 1 and 2.

65 Court Document 50 [14].

[72] It was clear that the representative of QLS who gave evidence had really not considered the ramifications of supervising someone who was subject to such an order. Her thinking was that if, for example, Mr Pilot used alcohol in contravention of the terms of a supervision order under the Act, the carer would have no power to restrict his doing that – t 1-71, t 1-72-73. And that is probably correct. Further, it became clear that really she had no idea what ought to be done if one of the conditions of the supervision order were breached – her notion was that it would be the appropriate course to ring the Adult Guardian – t 1-73.

[73] The Court of Appeal in *Attorney-General v Francis*[66] discussed the difficulties where private citizens without any coercive or legal powers are put in a position supervising someone subject to supervision orders of the type which would have to be imposed on Mr Pilot were he to be released from custody. Imposing terms upon the carer of Mr Pilot, by way of order, is an even more objectionable course. As discussed, it cannot be assumed that those caring for Mr Pilot under the proposed situation at Withcott would have the training or understanding of their complicated legal position in respect of these matters. Indeed, it could only be predicted that considerable training and experience with prisoners under a supervision order and an involuntary treatment order would be needed before such supervision could be attempted as a practical matter.

[74] At the time of the hearing on 5 April 2012 there was no evidence whatsoever that the care proposed by QLS was funded.[67] By the time of the hearing on 18 June 2012, a representative from QLS had sworn an affidavit saying that QLS was prepared to provide care at the Withcott property 24 hours a day, seven days a week, provided that Disability and Community Services provided QLS with an amount equivalent to 15 hours funding per week. It was said that QLS proposed to make up the shortfall in funding by using existing funding provided to the two other co-tenants at the property, and using funds no longer required by two former clients of QLS who had passed away.

[75] As to this latter idea, it was explained that funding is allocated quarterly in advance and two former clients of QLS had been funded so that there was 24 weeks' funding, provided in advance, which was no longer needed as those clients had died. QLS said that in circumstances such as that, money is not refunded to the State, but can be used by QLS for other clients. In this case QLS could use it for Mr Pilot.

[76] With money from these three identified sources it was said that the following situation would obtain:

> "There are currently two carers residing at the property. One resides there on a 24 hour, seven day a week basis. The other resides there 12 hours per day, for five days per week. The funding received for Mr Pilot from DCCS would enable QLS to extend this carer from five to seven days per week. The two carers would provide live in support for the three males at the property."[68]

[77] This funding scenario does not withstand analysis. The witness from QLS assumed firstly that an amount of money equivalent to 15 hours support service would be available to be paid to her organisation from the Department of Community

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66 [2007] 1 Qd R 396 [35] – [39].

67 Court Document 50 [7].

68 Court Document 63 [7].

Services each week that QLS cared for Mr Pilot. First, the Department has not approved that sum of money to be paid to QLS to provide supervised accommodation for Mr Pilot. The Department takes the view, contrary to all the medical evidence, that he does not need this type of care and it proposes to make funding available for 15 hours "community participation". So the first assumption that an amount of funding equivalent to 15 hours support services a week will be available to QLS for accommodation and supervision is not based on any sound factual foundation. Secondly, QLS has not applied for this funding to be given to it – t 1-9 (18/6/2012) – so again there is no certainty that that funding is available. Third, the witness from QLS was not at all sure how much money would be available to QLS if funding for the equivalent of 15 hours support services were to be made available to QLS – she first thought it would equate to $2,000 a week but then thought it was probably less than $1,000 a week – t 1-9 (18/6/2012). Lastly, the witness from QLS thought that there was no time limit on the funding for 15 hours a week community participation – t 1-10 (18/6/2012). In fact there was, it was three months funding, subject to review.

[78] Next, the witness from QLS assumed that she was able to use the funds from the two deceased clients mentioned above towards the expense of keeping Mr Pilot in the Withcott house – t 1-6 and t 1-13 (18/6/2012). But the evidence as to whether or not she could use those funds was very unclear. She did not know whether she had to ask permission for the funds, or simply let the Department know that funds which had been allocated to the deceased clients would be applied to Mr Pilot – t 1-6, t 1-12 and t 1-14-15 (18/6/2012).

[79] In any case, there was only 24 weeks funding available. When that ran out there could be no continuation to QLS supporting Mr Pilot in the Withcott house – t 1-10-11 (18/6/2012). The witness from QLS thought that during that six months she could work with the Adult Guardian to persuade the Department of Community Services to give Mr Pilot the funding he actually requires to live in the Withcott house – t 1-10-11 (18/6/2012). She disagreed with the Department of Community Services' idea that only 15 hours a week support was necessary for Mr Pilot, having regard to the psychiatric evidence before this Court – t 1-10 (18/6/2012). If one thing was clear from the evidence called on behalf of the Department of Community Services, it was that the Department is impervious to the idea that Mr Pilot needs more than 15 hours support in the community. It was quite content to rely upon its own estimations as to this, notwithstanding the great weight of psychiatric and other evidence before this Court. There seems no safe basis to think that QLS and/or the Adult Guardian could persuade the Department differently, notwithstanding the fact that the Department's view is, on the evidence before me plainly incorrect.

[80] The third source of funding which QLS assumes would be available to it, should it take Mr Pilot on at the Withcott premises, is funding from the existing two tenants in the Withcott house. The witness from QLS explained that QLS use funding allocated to co-tenants in a house as a sort of pool available to meet the needs of all the people in the house. This may be a practical solution to unwieldy and bureaucratic procedures, but it really does give rise to difficult considerations as to the use of money which has not been allocated to Mr Pilot, and could not conceivably be thought to belong to him, or belong to QLS to use on his behalf. Further questions as to the stability of the arrangement arise as the financial capacity of QLS to keep all three gentlemen in the household depends on all three continuing to receive funding and continuing to require, and be suitable for, accommodation at

Withcott in the household. Absolutely nothing is known as to the two co-tenants to enable me to assess whether or not the situation is likely to remain permanent.

[81] I do not consider the proposal put forward on behalf of Mr Pilot that he live at the Withcott house supported by QLS to be a viable proposal because: (a) there is no evidence that it is in fact funded or could be properly funded; (b) it is temporary, at the most it could last six months, and if one thing is clear it is that Mr Pilot's needs are very long term; (c) it is not necessarily stable having regard to the contingencies affecting the two co-tenants and the month to month nature of the lease; (d) there is no evidence which convinces me that the staff made available by QLS to supervise Mr Pilot would have sufficient training or capability to deal with the potentially very complex legal situations which may result if he were to engage in behaviour which was in breach of the supervision conditions on an order made pursuant to the Act, his involuntary treatment order, or the general law.

Disposition

[82] In *Attorney-General (Qld) v Sybenga*[69] Holmes JA said:

> "It is unfortunate that an individual who poses such a risk of re-offending as to require 24 hour supervision must be held in a custodial setting designed for the serving of sentences. Given the numbers now subject to orders of a kind once thought extraordinary, one might question whether there ought to be an alternative secure form of accommodation which does not impose the rigours of gaol on persons detained for protective, not punitive, purposes."

[83] Keane JA at [3] and Fryberg J at [31] agreed with these comments. Fryberg J went further at paragraphs [32] – [33] to express the view that the Government has a positive obligation to implement the preventative aspects of the Act.[70]

[84] The Court of Appeal in *Raymond Yeo v Attorney-General (Qld)*[71] made reference to the same issue – see the judgment of the President at [58] and White JA at [82].

[85] It is accepted that Mr Pilot poses a serious danger to the community within the meaning of s 13(1) of the Act. The only evidence before me is that Mr Pilot requires 24 hour per day supervision and support if he were to be released from jail. This would reduce his risk of re-offending to moderate. The solution proposed on behalf of Mr Pilot is not suitable to persuade me that he can be released on a supervision order. Thus, while the State requires by the Act that Mr Pilot not be released, it provides no alternative other than prison in circumstances where there is absolutely no doubt that his problems are medical and that he requires treatment, support and asylum, rather than incarceration in a prison system. I have no option but to make a continuing detention order for his detention under s 13(5)(a) of the Act, and I do so.

[86] The tragedy of Mr Pilot's situation is that his medical conditions are such that very little change for the better can ever be expected. On direct questioning the Crown

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69 [2009] QCA 382 [30].

70 See also the comments of Fryberg J in *Attorney-General for Queensland v Lawrence* [2008] QSC 230, [69] – [71] and in *Attorney-General (Qld) v Saunders* [2011] QSC 228.

71 [2011] QCA 170.

conceded it could make no meaningful answer as to whether or not Mr Pilot would remain incarcerated in prison for the rest of his life – t 1-21 (18/6/2012).