SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Doolan* [2013] QSC 115
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **GEOFFREY DOOLAN** (respondent)
FILE NO:	BS 1454 of 2013
DIVISION:	Trial Division
PROCEEDING:	Originating Application
ORIGINATING COURT:	Supreme Court of Queensland
DELIVERED ON:	3 May 2013
DELIVERED AT:	Brisbane
HEARING DATE:	29 April 2013
JUDGE:	Applegarth J
ORDER:	**The Court, being satisfied to the requisite standard that the respondent, Geoffrey Doolan, is a serious danger to the community in the absence of an order pursuant to Division 3 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, orders that the respondent, Geoffrey Doolan, be detained in custody for an indefinite term for control, care or treatment**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY– application pursuant to s 13 of the *Dangerous Prisoner (Sexual Offenders) Act* 2003 – where respondent is a persistent offender – where respondent lacks insight into his offending – whether respondent is likely to comply with a supervision order – whether respondent is a "serious danger to the community" pursuant to the *Dangerous Prisoner (Sexual Offenders) Act* 2003 – whether respondent should be subject to a continuing detention order *Dangerous Prisoners (Sexual Offenders) Act* 2003 ss 3, 11, 13

Attorney-General v Francis [2006] QCA 324; [2007] 1 Qd R 396, cited

COUNSEL: K F Philipson for the applicant
J Sharp for the respondent

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

[1] The respondent is a chronic alcoholic, aged 47. When he is not in prison, he drinks alcohol practically every day and becomes drunk. He has a lengthy criminal history, including 14 sexual offences. These mainly involved approaching young people, predominantly under 18 years of age, in public whilst intoxicated, and asking them for sex. He would grab their breasts or genitals and often try to prevent them from leaving. The absence of a more serious sexual offence, such as rape, is probably due to his extreme intoxication, giving the victims a reasonable chance of escape.

[2] On 29 April 2011, the respondent, having pleaded guilty, was sentenced to three years imprisonment on three counts of indecent treatment of children under 16. These offences were committed against two brothers, aged 12 and 13, in the toilet of a hotel. The respondent is due for release on full-time discharge on 5 May 2013. The applicant seeks orders pursuant to s 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 ("the Act").

[3] There is no dispute that, in the absence of an order under Division 3 of the Act, the respondent presents a high risk of committing further sexual assaults on young people. A likely scenario is that he will become drunk and touch, grope or threaten females or males, either children or adults. His behaviour would be sexually motivated and disinhibited by intoxication. The expert opinion is that his conduct is unlikely to escalate to serious sexual violence or life-threatening violence.

[4] The applicant acknowledges that the sexual offences that the respondent has committed in the past are not at the higher end of the spectrum of sexual offences. However, the respondent has a 20 year history of sexual offences of this nature, and the offences for which he is currently imprisoned are the most serious sexual offences he has committed. The respondent's persistence in committing sexual offences and the high possibility that he will again commit similar offences if released from custody or, if released from custody without a supervision order being made, constitutes an unacceptable risk. I am satisfied that the respondent is a serious danger to the community in the absence of a Division 3 order.

[5] The risk of re-offending would be lowered if the respondent complied with a supervision order, which required him to abstain from alcohol, illegal drugs and other intoxicating substances, required him to undertake treatment in the community and provided him with other forms of support.

[6] If supervision under a supervision order is apt to ensure protection, having regard to the risk to the community posed by a respondent, an order for supervised release should, in principle, be preferred to a continuing detention order. This is because the intrusion of the Act upon the liberty of the subject is exceptional, and the liberty

of the subject should be constrained to no greater extent than is warranted by the statute which authorises such constraint.[1]

[7] The issue then is whether a supervision order is apt to ensure that the community is adequately protected. In terms of s 13, the issue is whether adequate protection of the community can be reasonably and practically managed by a supervision order, and whether the requirements of such an order can be reasonably and practicably managed by corrective services officers.[2] In deciding whether to make a continuing detention order or a supervision order, the paramount consideration is the need to ensure adequate protection of the community.[3]

[8] For the reasons which follow I conclude that adequate protection of the community cannot be achieved by a supervision order in the present circumstances. Those circumstances include the respondent's refusal, until recently, to participate in a sexual offender treatment program, despite his high risk of sexual recidivism. If a supervision order was complied with then the risk of re-offending might be lowered to an acceptable level. However, in the present circumstances, the prospect of the respondent complying with a requirement to abstain from alcohol is very poor. The significant risk that, notwithstanding monitoring of his conduct under a supervision order, he will become intoxicated and commit an offence of a sexual nature against children, is unacceptable. The need to ensure adequate protection of the community warrants the making of a continuing detention order in the present circumstances, particularly so that the respondent can receive treatment, gain insight into his past sexual offending and develop skills to improve the prospects of abstaining from alcohol if and when he is released under a supervision order.

The statutory scheme

[9] Section 13 of the Act provides that the Court may decide it is satisfied a prisoner poses a serious danger to the community only if satisfied by acceptable, cogent evidence, and to a high degree of probability that the evidence is of sufficient weight to justify the decision.

[10] 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.

[11] A "serious sexual offence" is an offence of a sexual nature, whether committed in Queensland or outside Queensland, involving violence or committed against children.

[12] Section 13(4) contains a list of factors to which the Court must have regard when deciding whether a prisoner is a serious danger to the community. These include:

- 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;

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1 *Attorney-General v Francis* [2007] 1 Qd R 396 at 405 [39].
2 *Dangerous Prisoners (Sexual Offenders) Act* 2003, s 13(6)(b).
3 *Dangerous Prisoners (Sexual Offenders) Act* 2003, s 13(6)(a).

- 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; and
- the need to protect members of the community from that risk.

[13] In *Attorney General for the State of Queensland v Francis* the Court of Appeal outlined the scheme of the relevant provisions of the Act:

> "[25] The order which may be made by the court under s.13(5) of the Act, and confirmed under s.30 of the Act, is, in terms, an order for 'control, care or treatment' of a dangerous prisoner. By virtue of s.13(2) of the Act, such an order may be made only if the court is satisfied that a prisoner would constitute a serious danger to the community in the form of 'an unacceptable risk that the prisoner [would] commit a serious sexual offence'. As an alternative to a continuing detention order, under s.13(5)(a), the court may order, under s.13(5)(b), that the prisoner be released from custody subject to appropriate conditions.
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> [26] The objects of the Act are expressed in s.3 of the Act as being:
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> (a) to provide for the continued detention in custody or supervised release of a particular class of prisoner to ensure adequate protection of the community; and
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> (b) to provide continuing, control, care or treatment of a particular class of prisoner to facilitate their rehabilitation.
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> [27] Section 13(6) provides that, in deciding whether to make an order under s 13(5)(a) or (b), 'the paramount consideration is to be the need to ensure adequate protection of the community'.
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> [28] Section 13(5)(a), in speaking of a continuing detention order as an order 'for control, care or treatment', identifies the three purposes for which an order may be made: control of the dangerous prisoner, care for the dangerous prisoner, or treatment of the dangerous prisoner. These purposes are identified as alternatives. The phrase 'control, care or

> treatment' must, as a matter of ordinary language, be read disjunctively.
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> [29] The disjunctive reading suggests that there may be cases where the basis for an order may be, either
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> - the control of an incorrigible offender; or
> - the care of an offender whose propensities endanger the offender as well as others, or
> - the treatment of an offender with a view to rehabilitation.
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> It will often be the case that more than one of these conditions will inform the making or an order." [4]

[14] As for supervision orders, in *Attorney-General v Francis* it was stated that the Act:

> "... does not contemplate that arrangements to prevent such a risk must be 'watertight'; otherwise orders under s.13(5)(b) would never be made. The question is whether the protection to the community is adequately ensured. If supervision of the prisoner is apt to ensure adequate protection, having regard to the risk to the community posed by the prisoner, then an order for supervised release should, in principle, be preferred to a continuing detention order on the basis that the intrusions of the Act upon the liberty of the subject are exceptional, and the liberty of the subject should be constrained to no greater extent than is warranted by the statute which authorised such constraint." [5]

Background

[15] The respondent was born in 1965 on Gregory Downs in the Gulf Territory, the youngest of seven siblings and grew up in Doomadgee.

[16] He left school at 16 and moved to Camooweal where he worked as a station hand for one month, then went to Mt Isa. He has never had any other employment, spending most of his adult life living an itinerant lifestyle and consuming very large amounts of alcohol. The respondent has been single all his life, never dated regularly, nor been in a relationship. According to one report, he has never had sex. He does not appear to maintain any contact with his family, other than a nephew and the nephew's daughter.

[17] According to the respondent, he began drinking alcohol at the age of 17 and so far as he recalls has drunk alcohol every day of his adult life when he was not in prison. His convictions are related to his abuse of alcohol. When he was 23 he participated in a detoxification program at Mt Isa, but began drinking immediately after discharge. Dr Sundin noted that the records showed that the respondent had described regular cannabis use from his late teens to early thirties, however he has specifically denied the use of cannabis and other drugs. He was breached for amphetamine use in custody in 2003.

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4 Supra at 400-401 [25] – [29].

5 Supra at 405 [39].

[18] The respondent has an extensive criminal history dating back to 1983, with over 200 offences. These include multiple offences of break and enter, common assault, aggravated assault and one offence of stalking. He also has multiple convictions for breach of bail conditions.

[19] As to his sexual offences history:

(a) In 1991 he was convicted for aggravated assault after he approached a 15 year old female, asked her to be his girlfriend, put his arm around her shoulder and began kissing her on the cheek and side of her face. He touched her on her breasts and asked if he could touch her and lick her.

(b) In February 1996 he received a two month sentence for wilful exposure after exposing himself at a time when three female students aged approximately six to eight years appeared to be the focus of his behaviour.

(c) In November 1996 he received a six month sentence for aggravated assault of a sexual nature after grabbing a woman's breasts.

(d) In March 1988 he received a three month sentence for wilful exposure after he exposed his penis to an eight year old female who was in a park with her father.

(e) In July 1998 he was convicted of vagrancy and behaving in a disorderly manner within a primary school for having chased a seven year old across the oval and into an afterhours class, where he continued to disrupt the class, refused to leave and threatened to assault the Principal of the school.

(f) In September 2000 he received a 15 month sentence for indecent treatment of a child under 16 years and common assault. He had approached two girls, aged 12 and 11 and when they attempted to leave, he grabbed one of them on the top of the leg and moved his hand up to her vagina, and then he grabbed the other girl around the waist.

(g) In October 2001 he was convicted of indecent assault and common assault. He had approached two females, asked them for a cigarette and then grabbed one on the upper left thigh, making lurid sexual comments to her. When she attempted to leave, the respondent reached towards her chest and touched her between her legs in the genital area.

(h) In December 2002 during an arrest for wilful damage, it was noted by police that the respondent was extremely aggressive and abusive towards police and continually made threats of a sexual nature to the two female officers.

(i) In November 2005 the respondent was convicted on two charges of sexual assault and received a three month sentence. He had approached a female, put his arm around her shoulders, kissed her and when she tried to pull away, tightened his grip and told her that he wanted to perform oral sex upon her.

(j) In another sexual assault in November 2005, the respondent made an inappropriate sexual approach to a store attendant, grabbed her around the arms and made lurid suggestions to her.

(k) There were four charges in 2006 where the respondent made various approaches to females, grabbed them forcibly around the shoulders and neck, made inappropriate sexual advances and made lurid sexual comments to them. He was convicted of stalking, common assault and unlawful deprivation of liberty.

(l) In November 2006 he received a 12 month sentence for indecent treatment of a child under 16 years of age as a result of harassing a 14 year old schoolgirl at a bus stop, asking her for sex, grabbing her arm and kissing her on the cheek and lips.

(m) In May 2008 he was convicted and sentenced to 15 months imprisonment for sexual assault upon an 18 year old female whom he approached for a cigarette and grabbed from behind. He squeezed her breasts and tried to kiss her. It was noted that although the offence was at the lower end of the range for that type of offence, the respondent had a record of committing other offences of a similar nature and alcohol abuse appeared to lie behind the commission of the multiple offences.

[20] In her psychiatric report dated 13 August 2012, Dr Sundin, noted that many of the respondent's offences occurred shortly after his release from the Townsville Correctional Centre, that he was a constant nuisance within the Townsville area, particularly in the Flinders Mall, and was noted by police to be intoxicated on a daily basis.

The Current Offences

[21] The offences of indecent treatment of children under 16 were committed against two brothers, aged 12 and 13, in the toilet of a hotel where the respondent approached the boys, touched one on the shoulders and on the outside of his jeans below his fly and attempted to clench his testicles. He knocked on a cubicle door and told the other child he was going to grab him and rape him when he came out of the cubicle. The respondent later pulled out his penis and testicles and exposed them to the children and rubbed his penis repeatedly in front of them. He blocked their exit from the toilet for a brief period.

[22] In sentencing the respondent, Baulch DCJ remarked that he was satisfied that the respondent had no remorse and seemed to have little understanding of the effect of his actions on others.

Compliance with orders

[23] The respondent has a poor history of compliance with any community-based orders.

[24] His detention file indicates numerous breaches and suspension of parole orders, including refusing to obey orders, using offensive language and threatening behaviour. Conditional release has been repeatedly refused. The file reveals that:

(a) the respondent completed a six day drug and alcohol awareness course in May 1994, and attempted, but did not complete other courses;

(b) in 1997 it was noted that he had not completed any courses since re-entering the prison and was not interested in anger management courses, he had not seen a counsellor and was not interested in a substance abuse course;

(c) in 2001 it was noted that he had some difficulty with literacy and reading ability but was not interested in any particular courses;

(d) in May 2001 he was breached for climbing up the side of one of the buildings in the Townsville Correctional Centre. He was to participate in the Ending Offending and ATSI Pre-release programs and was recommended to attend a ceramics program, but chose not to do so, and ultimately did not attend the ATSI pre-release program;

(e) in July 2001 it was noted that he had previously escaped from a work scheme and threatened suicide and self-harm in the past;

(f) in July 2001 he reported suicidal ideas and threatened to hang himself and was followed up by a psychologist, but appeared to settle fairly quickly;

(g) in July 2003, he fulfilled four elements of the requirements of a Certificate II in Horticulture; and

(h) in 2003 a urine sample tested positive for amphetamines.

Psychiatric and Psychological Reports

Sexual Offending Program Assessment, Belinda Boyle and Kylie Thomas, 10 December 2012

[25] This report noted that according to the STATIC 99 Assessment Guide, the respondent's long-term static risk of sexual recidivism had been identified as being in the high risk category with a score of 9.

[26] Although the respondent willingly participated in the two interviews regarding the STATIC 99 and reported that he was motivated to participate in further programs in the future, when he was offered a place on the Getting Started: Preparatory Program on 7 September 2012, he declined the offer and stated that his reasons for declining placement were that he could not remember his sexual offences. The respondent discussed having some literacy concerns, however, he demonstrated an ability to read and write during a Turning Point Program completed on 19 November 2012.

[27] It was recommended that the respondent undertake the Getting Started: Preparatory Program in order to prepare him for participation in Changing Our Stories Sexual Offending Program for Indigenous Males ("SOPIM").

Psychiatric Risk Assessment Report of Dr Josephine Sundin, dated 13 August 2012

[28] Dr Sundin interviewed the respondent for two hours on 2 August 2012, however the interview was ended prematurely by the respondent. Dr Sundin noted that

throughout the interview the respondent was highly distractible and somewhat difficult to interview in that he gave limited, non-expansive answers. The respondent was extremely reluctant to discuss his history of offences, and simply repeated that his intoxication explained all that he had done. He denied he had ever stolen as part of his intoxication or that he had ever been aggressive to victims of his offences, but he did admit to becoming involved in fights with mates and with the police whenever intoxicated.

[29] The respondent stated he first remembered having sexual fantasies of children when he was aged around 18 and that was when he first acted on those thoughts. He said he had remained sexually attracted to both boys and girls with pre-pubescent sexual characteristics, it was the lack of secondary sexual characteristics which he found attractive, he was particularly attracted to indigenous children and his thoughts or fantasies of sex with children were "nice, just nice". He reported that he used to fantasise a lot about having sex with children, but claimed that he no longer thought about that. As to his indecent dealings with children, he stated the children had simply come to him and he would touch their private parts. He denied ever threatening children or using bribes to gain access to them.

[30] The respondent said that he was aware that in indigenous culture, indecent treatment of children was taboo and would be punished by being hit with a stick. But when asked what was wrong about sexual interactions with children, he could not identify anything in particular that was wrong and when asked if such behaviour could cause children harm, he said he did not believe that children were upset or hurt.

[31] He denied remembering any of the physical assaults for which he had been convicted and he did not believe that he had ever frightened any of his victims. He said he was now too scared to touch either alcohol or children.

[32] As to the sexual assaults on adult females, the respondent said the thoughts just came into his head to have sex with them, and he agreed that in touching the women on their breasts or kissing them, that he was hoping that they would agree to have sex with him.

[33] The respondent said he did not think he will offend again because he has missed a lot in jail, but it was only on direct questioning that he acknowledged that he had missed out on contact with his family.

[34] Dr Sundin noted that the respondent was very vague in his plans for life after prison. He said he had no place to stay, but it might be an option for him to live in one of the houses outside Stuart Prison or go to a half-way house in Brisbane, so he could get away from his troubles. Despite agreeing he had never lived in a big city, he believed that he would have no difficulty in finding his way around Brisbane.

[35] The respondent reported that he last travelled on a train in 1986 and travelled on a bus in 2008 and he did not have a driver's licence and was reliant on a Disability Support Pension. In discussing where he would reside, he said he would look for rental flats in the paper but he was not aware of the issues to do with bonds, the amount and money likely to be needed, or the need for references within the private rental market. He discussed that in the past he had lived an itinerant lifestyle on the street and in parks mostly. When asked about risk factors, he indicated these were alcohol and "bad people" and he intended to stay away from both in the future. However he had no other plans for how he would reduce his risk factors.

[36] On mental state examination the respondent was highly distractible, and was somewhat disinhibited. His affect was bland and there was no evidence of any particular distress. His answers to questions were simple, non-expansive and gave the general impression of either a general poverty of content of thought or a specific reluctance to discuss the matters in hand in any detail. Any exploration of his offending history led to the same answers being reiterated, wherein he made repeated reference to his past history of chronic intoxication and demonstrated an absence of empathy and little or no comprehension of the effect of his actions on any of his victims. He did not appear to comprehend the adverse effects on many of his victims of both non-sexual and sexual offences had suffered. Generally, he gave the impression of being oddly disconnected, with little emotional expression and little emotional responsiveness to any matter discussed.

[37] Dr Sundin judged his IQ to be in the low average range, and his insight and judgment with regard to his behaviour outside of the prison appeared to have been severely reduced.

[38] Dr Sundin considered that the respondent met the DSM-IV-TR criteria for:

(a) Alcohol Abuse/Dependence, in sustained remission whilst in prison;

(b) Cannabis Abuse, in remission, diagnosis based on records;

(c) Mixed Personality Disorder with antisocial and avoidant traits;

(d) possible cognitive impairment secondary to past heavy alcohol abuse; and

(e) Paedophilia, non-exclusive type, attracted to males and females.

[39] Dr Sundin noted that the respondent described a 30 year history of persistent sexually arousing fantasies and consequent behaviours involving sexual activity with pre-pubescent children, both male and females. He had acted on those sexual urges as shown in his offence history and his sexual assaults upon adult women suggested that it was of the non-exclusive type.

[40] Dr Sundin assessed the respondent using a number of risk assessment instruments, however had insufficient information to fully rate him on the Hare Psychopathy Rating Scale (PCL-R). But in assessing him, she noted his lack of concern about his future, his failure to see himself as having any major problems and the blame he placed on external factors such as intoxication, suggesting that he scores fairly high on the grandiose sense of self-worth. He exhibited a lack of remorse or guilt and a lack of empathy for his victim. He had a history of poor behavioural controls with a pattern of being easily angered, short-tempered and irritable. Dr Sundin noted however, that she had no real information as to the respondent's need for stimulation and proneness to boredom or any evidence of pathological lying or manipulative behaviour or whether or not the respondent had any early behavioural problems. A lack of such information meant that Dr Sundin could not accurately judge whether the respondent met the criteria for Psychopath.

[41] On the HCR-20, a guide for the assessment of risk of violence across historical, clinical and risk guidance scales, Dr Sundin noted previous violence, that the respondent was at a young age at his first violent incident, he had employment

problems, substance use problems, partial psychopathy, personality disorder and prior supervision failure as well as lack of insight, negative attitudes, unresponsiveness to treatment, his plans lacked feasibility, there was potential exposure to destabilisers, a lack of personal support, noncompliance from mediation attempts and vulnerability to stress. On that guide, Dr Sundin considered that the respondent's risk of future recidivism for general antisocial and violent behaviours was high.

[42] On the Sexual Violence Risk Scale–20, Dr Sundin noted sexual deviation, partial psychopathy, substance use problems, suicidal ideation, failure to establish or maintain stable intimate relationships, employment problems, past non-sexual violent offences, past non-violent offences, past supervision failures, high density sexual offences, multiple type sexual offences, use of threats in sexual offences, escalation in severity of sex offences, extreme minimisation/denial of sex offences, lack of realistic plans and negative attitudes towards intervention. On that guideline, Dr Sundin considered that the respondent represented a high risk of future sexually violent recidivism.

[43] On the STATIC 99, Dr Sundin gave the respondent a total score of 9 which placed him amongst a group of offenders who are considered to be at high risk of future sexual recidivism.

[44] Dr Sundin noted that none of the respondent's sexual offences had been in the severe spectrum, however his history reflected persistent paedophilic cognitions present for the past 30 years. There was a lack of empathy for his victims, denial of responsibility of the seriousness of his actions, variety in the type of sexual offences that he had committed and in the index offence, and an apparent escalation in the severity of his sexual offences, including the use of threats of death. His 20 year history of convictions for sexual offences spoke to the recalcitrant nature of his attitudes and the recidivistic nature of his actions, despite multiple stays in prison over that period of time.

[45] Taking all of those factors together, Dr Sundin considered that the respondent represented a moderate to high risk to the community for future sexual recidivism and a high risk for future violent recidivism and he represented a high risk for general criminality. His recent ill-health could potentially reduce his global risk of recidivism to moderate, and his risk would be further lowered if he could maintain absolute sobriety upon release from prison.

[46] Dr Sundin expressed the opinion that future victims were likely to be male or female strangers and could range in age from pre-adolescent to adult. Any person who took umbrage at his actions was at risk of physical assault. His offences were impulsive and associated with alcohol abuse.

[47] According to Dr Sundin, the respondent represented a significant risk to the community based on the persistent nature of his violent and sexual offending, combined with his very lengthy and extensive history of alcohol abuse. Without supervision in the community, the risk that he would rapidly relapse into past offending patterns and alcohol abuse was high, and if released into the community, very high levels of supervision would be warranted to ensure that he did not offend again.

[48] Dr Sundin considered that the respondent's abrogation of responsibility and general lack of awareness of the negative impact of his behaviour needed to be addressed, and she recommended that consideration be given to his participation in the Indigenous Sexual Offender's Program ("ISOP"). She considered that he needed to be challenged by peers as to the taboo nature of his actions and to have his denial of responsibility or adverse impact challenged by his peers. She thought there was the potential for a positive beneficial impact in modifying the respondent's behaviour through his participation in such a program and she did not think that the same could be achieved on a one-to-one counselling basis. Dr Sundin found no evidence that the respondent needed any form of direct psychiatric care. Instead, she recommended that he be engaged in a more detailed alcohol and drug education program to develop a more realistic relapse prevention plan.

Psychiatric Risk Assessment Report of Dr Donald Grant, Psychiatrist, dated 31 March 2013

[49] Dr Grant found that the respondent was very vague about his offending behaviour and said it was all from alcohol. He effectively claimed amnesia for virtually all of his offending behaviour. When asked about the effects on his victims, he could not address any of the issues in regard to harm to his victims. He also had no recall of violent incidents and was unable to estimate the total number of years of all his periods of imprisonment.

[50] Dr Grant reported that the respondent was a vague and inconsistent historian and his history therefore needed to be treated with some caution in terms of accuracy. The respondent initially denied ever having had any sexual relationships, but later said that when he had been a teenager he had two or three girlfriends with whom he had had sex. He indicated that his current sex drive was fairly low. He initially denied having any sexual attraction to children, but when questioned more closely and reminded that he had told Dr Sundin something different, he admitted that in the past he had experienced attraction to children, "girls mainly" aged about 11 or 12, but denied attraction to boys.

[51] Dr Grant noted that the respondent was superficially co-operative with the interview but at times was distracted. When giving information he frequently denied knowledge of things, but when given collateral information, would agree about the information being true or not true. His affect was fairly bland and he laughed quite inappropriately when given details about his offending behaviour, demonstrating a fairly profound lack of insight and understanding in regard to his behaviour and its impact on others. There was a poverty of thought with very little spontaneous history given. His insight and judgment appeared quite severely impaired, but he seemed to have some understanding that he had a significant alcohol problem and needed to do something about it and cease drinking if he was to stay offence free in the future.

[52] According to Dr Grant, the respondent demonstrated some significant difficulties with cognitive function and seemed to be of low average intelligence.

[53] The respondent had no visitors in custody, and had no telephone contact with any relatives or supporters. He said he had done a course called "Turning Points" during his incarceration which he said was helpful in telling him what to do when he got out, but he had not done a sex offender's course, and understood he could do

one if he was transferred to Lotus Glen Correctional Centre. When asked about his plans upon release, the respondent said "get a job" and that he could do station work with cattle. However, he had not done any such work since 1984. When asked where he would be living, after a long pause, the respondent said he would go to the house at the farm where sex offenders live. He thought he would like to do courses at TAFE on airbrush painting or a mechanic's course. He said he had no family in Townsville, but had a number of friends in town. He said he would not be drinking and was confident about his ability to refuse offers of alcohol from friends. He thought some courses might help to keep him sober and he could "go to rehab". But he had never attended Alcoholics Anonymous[6] and was not aware of any indigenous alcohol support groups.

[54] Dr Grant observed that the respondent's offending history included numerous offences that had sexual motivation dating back to 1996, and the index offences represented an escalation in sexually motivated offending. The respondent had not completed any programs while subject to community-based orders and his alcohol abuse and homelessness had meant that he had not been able to be assisted though community-based orders in the past. He had not participated in any program addressing his specific offending behaviour.

[55] Dr Grant diagnosed the respondent with Chronic Alcohol Abuse and Dependency currently in remission, Cannabis Abuse currently in remission (such diagnosis being based on collateral information, not on the information given by the respondent directly), a possible Antisocial Personality Disorder, but it was difficult to be too precise about personality disorder in the presence of such a history of chronic alcohol abuse, and possible Paedophilia, non-exclusive type, based on the information that the respondent gave to Dr Sundin and on his offending history. However, the information the respondent gave Dr Grant at interview would not be sufficient to confirm that diagnosis, although the collateral history was fairly compelling.

[56] Using risk assessment instruments, Dr Grant assessed the respondent as follows:

(a) On the Static-2002R the respondent scored 11 out of 13, placing him in the high risk group of sexually re-offending, a recidivism rate for sex offenders with a score the same as the respondent would be expected to be approximately 6.9 times higher than the recidivism rate of the typical sex offender (defined as having a median score of 3);

(b) On the HARE PCL-R 2nd Ed, the respondent scored 23 out of 40, placing him below the cut-off point for Psychopathic Personality Disorder;

(c) On the HCR-20, the respondent scored 11 out of 20 on historical items, 7 out of 10 on clinical items, and 10 out of 10 on risk management items, placing him in the high risk group for future violent offending (including non-sexual and sexual violence); and

(d) On the Risk for Sexual Violence Protocol (RSVP), the respondent scored positively for chronicity of sexual violence, diversity of sexual violence, escalation of sexual violence, physical coercion in sexual violence,

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6 Cf he told Dr Harden that he had previously gone to AA.

> psychological coercion in sexual violence, minimisation or denial of sexual violence, violent or suicidal ideation, attitudes that supported or condoned sexual violence, and problems with self-awareness, stress or coping, sexual deviance, substance abuse, intimate relationships, non-intimate relationships, employment, non-sexual criminality, planning, treatment and supervision.

[57] Dr Grant's opinion is that the respondent is at high risk of re-offending sexually and non-sexually. The scenario would be that the respondent might touch, grope or threaten females or males, either children or adults. His behaviour would be sexually motivated and disinhibited by alcohol intoxication and the psychological harm to victims would be moderately severe. But physical harm was likely to be minimal and it was unlikely that sexual violence might escalate to serious or life threatening violence. Such a scenario could develop quite soon after he left prison and would be more likely if he became intoxicated with alcohol. Such offending might be quite frequent and the risk would be long-term.

[58] Dr Grant noted that manageability would centre around banning all alcohol consumption, undertaking alcohol rehabilitation and a sexual offender program and assisting with social stability and general social rehabilitation. Such a treatment approach could be managed under the auspices of a supervision order, with abstinence from alcohol being a major feature of that order.

[59] Taking all of the information into account, Dr Grant expressed the opinion that the respondent was at high risk of sexual re-offending after his release, and that risk would be heightened in the presence of alcohol intoxication, but if he were not intoxicated the risk would be reduced to moderate or low in regard to sexual offending. Given the respondent's apparent lack of insight into his sexual offending and the likely presence of Paedophilia, and the assessment for sexual offending program suitability conducted in custody, Dr Grant believed the respondent should undergo a suitable sexual offender treatment program, most suitably the SOPIM at the Lotus Glen Correctional Centre. In order to undergo that program he would need to remain in custody for an extended period of time beyond his release date. This was the program recommended by the assessment conducted in custody. However, it was possible that a Medium Intensity Sexual Offender Program ("MISOP") could be considered and that program might be available in the community as well as in custody.

[60] In Dr Grant's opinion, completion of a sexual offender program would hopefully increase the respondent's insight into his sexual offending and his motivations and help him to understand how to prevent future re-offending. At present his insight and knowledge of the risk was extremely limited. The program also might assist him in developing some deeper insights and empathy in regard to the effects of his behaviour on his victims. The other benefit would be that factors relating to the re-offending would be more clearly understood by his supervisors and that would enable a more rational development of a supervision program if he were released from custody.

[61] Overall, Dr Grant considered that it was best for the respondent to remain in custody until he had completed the SOPIM, but if released into the community without having done so, Dr Grant recommended that the respondent be on a supervision order and as part of that order be required to undergo a Sexual Offender Treatment Program in the community. A supervision order could significantly

reduce the risk of future sexual violence from high to moderate or low. The key features of a supervision order would revolve around insisting on a complete abstinence from alcohol and drugs with appropriate treatment and support to maintain abstinence. Regular monitoring to ensure that alcohol and drug abuse was not occurring would be required. The program would also need to address the homelessness, street dwelling and social chaos that had marked the respondent's life. If he could achieve a more stable social setting with appropriate supports, that, along with sobriety, would go a fair way to reducing the risk.

[62] Dr Grant observed that in the past the respondent had repeatedly failed to co-operate with community programs, supervision or treatments, and Dr Grant was not confident that the respondent's motivation to mend his ways was particularly strong. Breaches of supervision were probably quite likely, particularly in regard to curfew or alcohol abuse. A supervision order would also need to address the respondent's unsupervised access to children, and he should be forbidden from going to places where children congregated in an unsupervised way, as he had demonstrated a predatory approach to children, including sexual offending against them. Whilst the respondent appeared to have adequate intelligence to undertake a treatment program, it remained to be seen whether he demonstrated the motivation and perseverance to complete such a program, and he will require a lot of support and encouragement to do so.

Psychiatric Risk Assessment Report of Dr Scott Harden, dated 15 April 2013

[63] Dr Harden reported that the respondent said he did not remember the index offences because he was drunk, and he was unable to give any further history despite being prompted from the accounts in the material. He did not express any remorse, or display any emotional reaction when the topic that children might be upset by him touching them inappropriately/sexually was being discussed. As to Sexual Offender Programs, the respondent said he did not want to do further programs, but then changed his mind and said he would and if asked to do it, he would do the SOPIM at Lotus Glen Correctional Centre.

[64] The respondent said he was interested in women sexually and had had sexual relations with more than 20 women on a casual basis. When he was in prison he had no interest in sexual matters, and when sober in the community, he had interest in sexual matters with adult women. But when he was drunk on alcohol (which was on a daily basis), he had thoughts of having sexual relations with children, mainly about girls, who were predominantly 12 to 13 years of age. He said he just liked "to have sex with them*"* but said he had never had sexual intercourse with a child at that age, but had touched them on a number of occasions. He saw no need for treatment to assist him with his sexual thoughts.

[65] The respondent reported that he might have been able to abstain from alcohol for a maximum period of three to four months at some period when not incarcerated, although he was not very specific about it and it may have been in 2004. But Dr Harden noted that that was at odds with his stated history of not having been out of prison for that length of time. He said he did not feel like drinking when in jail and he said he had previously gone to Alcoholics Anonymous at some point.[7] The respondent was confident he could give up alcohol, despite his complete lack of

[7] Cf he told Dr Grant he had never been to Alcoholics Anonymous.

success in doing so in the past and he attributed that confidence to the desire not to return to jail. He denied using marijuana or other drugs.

[66] The respondent said he had no visitors whilst in detention, received no phone calls and had no contact with his family. He reported the longest time he had spent in the community in recent years was approximately one month between periods of incarceration. He had been placed on a Disability Support Pension in 2008 after a motor vehicle accident which resulted in a fractured leg. In the community he normally lived with friends and paid some kind of rent, but was unclear about where he had been living. The respondent claimed that he would be able to give up drinking and would "just say no" and would look for a job. But he agreed with Dr Harden that it might be difficult to stop drinking and get a job. Dr Harden considered that the respondent's plans were limited and unrealistic with regard to his future offending.

[67] Dr Harden recorded that during the interview the respondent was an extremely poor historian, was disinterested in the interview process, paid attention in a patchy fashion and became irritable when pressed for details or questioned about his offences and their effects on others. Otherwise he had no emotional reaction to any of the topics under discussion, and his emotional responses seemed quite muted. The respondent appeared of below average intelligence and had received relatively poor levels of education when younger. His insight and judgments appeared to be adequate to appropriately manage day to day interactions, but he appeared to have limited insight into his own psychological functioning in general terms and with regard to his offending.

[68] Using the formal assessment instruments, Dr Harden assessed the respondent as follows:

(a) On the STATIC 99 the respondent scored 10, a very high score, placing him in the high risk of recidivism relative to other adult male sex offenders and based on a review of other risk factors, Dr Harden believed that score accurately represented the respondent's risk at this time;

(b) On the Stable 2007, he scored 16 out of 26, placing him in the high needs group in terms of sexual offender's dynamic risk, scoring highly, and which could be a focus for future intervention, in the areas of capacity for significant social influences, relationship stability, lack of concern for others, impulsivity, poor problem solving skills, deviant sexual preference and co-operation with supervision;

(c) On the Sex Offender Risk Appraisal Guide, the respondent scored 25, which was elevated placing him in Category 8 at seven years and Category 7 at ten years. Generally people in that category had a 75% rate of violent re-offending at seven years and an 80% rate of violent re-offending at ten years;

(d) On the HARE Psychopathy Check List, the respondent scored 26 which was elevated compared to offender populations, particularly with regard to lifestyle and affective (emotional) sub-facets, but did not reach the cut-off score for Psychopathic Personality, but suggested a high degree of emotional disconnectedness from others and an antisocial lifestyle; and

(e) On the SVR-20, Dr Harden assessed the respondent as being positive for 12 out of 20 items, and possibly positive for two items which placed him in the high risk category on that measure of sexual violence risk.

[69] Dr Harden noted that the respondent had a history of 14 different sexual offences, predominantly involving approaching young people, predominantly under 18 years of age, and predominantly female, in public whilst intoxicated, and asking them for sex, grabbing their breasts or genitals and often trying to prevent them from leaving. The fact that there was not a record of a more serious sexual assault or rape was most likely due to his modus operandi of being extremely intoxicated, thereby giving the victims a reasonable chance of escape. He also has a very long history of violent offences against persons of a non-sexual nature when intoxicated and a substantial criminal history covering a range of other criminal offences. The respondent's life has been characterised by a lack of emotional and relationship connection to other people, severe and consistent alcohol abuse from the age of 17, and a complete disregard for the rights of others. He saw no difficulty in being threatening or more difficult if that suited his purpose and he had not been able to abstain from alcohol use in the community, or from criminal behaviour for any substantial period of time during his life.

[70] Dr Harden expressed the opinion that the respondent met the criteria for Antiocial Personality Disorder and Alcohol Abuse (in remission because of the incarceration, but it was not clear whether he had ever met the criteria for alcohol dependence due to his poor historical information). The alcohol and abuse was significant because of the disinhibiting effect of intoxication which had been intimately involved in facilitating his committing offences. The respondent described sexual interests consistent with Paedophilia, non-exclusive, predominately oriented towards females around 13 years of age, although clearly opportunistic.

[71] Based on the actuarial instruments and his clinical judgment Dr Harden suggested that the respondent's future risk of sexual re-offence was high. The respondent has an extremely high risk of sexual assault if returned to the community with no modifying factors in play. He had not undertaken effective intervention for either his substance abuse or sexual behaviour.

[72] The critical issue was alcohol abuse in that if he was not intoxicated his risk would drop from high to moderate in terms of risk of sexual recidivism but if nothing was done to modify his behaviour in the community, it was very likely the respondent would immediately return to alcohol use on release and at some point quite soon after, would approach young people, most likely in a public place, and attempt to touch them sexually. That pattern had occurred so many times that it was very unlikely it would change without substantial external modifiers.

[73] Dr Harden recommended that the respondent have sex offender group treatment, preferably whilst incarcerated, and that the program, if successfully undertaken, be carefully reviewed prior to considering his release from prison. If released he should be monitored in the community by means of a supervision order. His difficulties are long-standing in nature and unlikely to improve.

[74] Dr Harden recommended that the respondent be required to be abstinent from alcohol and drug use and undergo an appropriate random testing regime if he is

released on a supervision order and that he participate in an ongoing individual therapy program for sex offender and substance abuse treatment. If he were to breach a supervision order in the community by using alcohol, it would be hard to think of a regime in the community which would adequately produce any significant reduction in his risk of sexual harm to others. In Dr Harden's view, the respondent's long-term prognosis was extremely poor.

Oral evidence of the psychiatrists

[75] I had the advantage of the oral evidence of each psychiatrist, which I will summarise. It highlighted issues that had been raised in their respective reports, and provided additional insights.

[76] Dr Harden observed that the respondent's alcohol intoxication is such a strong risk factor that it may "bury everything else in terms of their relevance as risk factors." A treatment program in custody might develop a more comprehensive way of managing the respondent's risk in the community. Such an intense program over a prolonged period was more likely than a shorter less intense program to produce some change in insight by the respondent and a different attitude towards supervision and co-operation with authorities. This might reduce risk. However, neither Dr Harden, Dr Grant nor Dr Sundin were confident that it would do so.

[77] Dr Harden expressed the opinion that there was "no chance" that the respondent would comply with an abstinence provision of a supervision order at the current time. He explained that if a person does not have insight into the fact that he or she has an alcohol problem or a problem with sexual preference then he or she is not going to take steps to address those problems.

[78] Dr Harden accepted that if the respondent was subject to strict supervision under a supervision order and also received "the supports that also come with that order" he would have the advantage of supports that he had not had in the past under parole and other community-based orders. Still, Dr Harden was not confident that this would necessarily improve the respondent's chances of complying with an abstinence order. He observed that the respondent had never been dissuaded from his behaviour by incarceration previously, so monitoring and the consequences of not complying with an abstinence order would not figure greatly in the respondent's mind.

[79] Being placed in accommodation near the Townsville Prison, which is a long way from the centre of the city, would be a practical impediment to the respondent obtaining alcohol, but Dr Harden was not sure whether this would necessarily make much difference. Dr Harden strongly supported the respondent undertaking treatment programs whilst in custody. Although not optimistic about their outcome, Dr Harden thought that such programs might enable the respondent to gain additional understanding of his problems with alcohol, sexual interest in young girls and general antisocial behaviour. It might offer him more insight into the pathways that lead him to drinking, and treating staff could identify with him matters that might act as barriers to the respondent using alcohol. A further period, possibly 18 months, without alcohol in his brain may also be of some benefit to the respondent in his reasoning and in his ability to resist alcohol.

[80] Importantly, Dr Harden observed that the respondent could not describe "how he goes from sober to drunk, and what happens precisely." The respondent could talk

in very general terms, but he did not think he had a problem, and so he sees no need to address it.

[81] Dr Grant gave evidence to similar effect. He thought that the respondent was unlikely to complete a medium-intensity program in the community and that, in any case, such a program was not at the intensity that the respondent needs.

[82] Importantly, Dr Grant observed that the respondent's sexual deviance was "masked and overwhelmed by his alcohol problem". There was a need to address both alcohol issues and the problem of sexual deviance. According to Dr Grant, "we don't really know much about his paedophilia; he has not been very forthcoming at all." An intensive group program would challenge the respondent and produce a much better degree of disclosure than other forms of treatment.

[83] Dr Grant provided the important insight that presently we do not know whether the respondent would present a serious risk of sexual offending if he was not drunk. Such a risk may still be significant, but not enough is known about it. Both the respondent and those who would supervise and treat him would need to know more about his paedophilia if they were going to manage it.

[84] Dr Grant confirmed that if the respondent was, in fact, abstinent, the risk of his committing a further sexual offence would be reduced from high to moderate-low, based upon what is known about the respondent at the moment. Such a reduction assumed that the respondent would be abstinent whereas, according to Dr Grant, whilst the respondent has some level of understanding that alcohol is a big issue for him and that he has to stop it if he is going to stop re-offending, he has not shown any ability to do that, so far. Although the respondent had not received the kind of supervision that he would under a supervision order, Dr Grant expressed the view that the respondent "needs the treatment before the supervision order has a chance of realistic success."

[85] Finally, Dr Grant confirmed that in addition to requiring the respondent to remain sober, undertake alcohol rehabilitation and undertake a sexual offender program, the respondent required assistance with social stability and a network of supports which he has never had if any supervision order was to be effective. Dr Grant was "very pessimistic" that the respondent could achieve such a support network quickly without the benefit of treatment.

[86] Dr Sundin, who was the third expert witness to give oral evidence, agreed with the reports and oral evidence of Dr Harden and Dr Grant. Dr Sundin acknowledged that if there was some way to help the respondent to remain abstinent, then that would go some way to mitigating risk, and reduce it from high to moderate. However, Dr Sundin identified the problem as being the low prospect of the respondent's compliance with a supervision order at the moment. This was because "he just so repeatedly re-offends so rapidly after release."

Propensity and pattern of offending

[87] I have previously summarised the respondent's pattern of offending. It involves his becoming intoxicated and approaching people, predominantly young people, in public and asking them for sex then grabbing their breasts or genitals.

Efforts to address causes of offending behaviour and participation in programs

[88] The respondent lacks insight into his offending behaviour, its causes and its consequences for his victims. As noted, in 2012 the respondent was offered a placement on the Getting Started Preparatory Program, but refused this offer. This group-based program is designed to prepare offenders for participation in further intensive intervention programs. It is conducted at either Townsville or the Lotus Glen Correctional Facility. Whilst the 2013/14 program is currently being finalised, it is likely to run at one of these correctional centres prior to September 2013. A place will be reserved for the respondent on such a program.

[89] The ISOP is designed to treat indigenous sexual offenders who are identified as high risk of sexual re-offending. The goal of the ISOP is to use culturally appropriate methods to facilitate cognitive and behavioural change specifically targeting psychological, social and lifestyle factors associated with sexual offending. The ISOP is facilitated in a custodial environment only. Lotus Glen Correctional Centre facilitates the ISOP. This program usually runs for five to twelve months on a rolling format.

[90] If the respondent is detained in custody on a continuing detention order after his full time release date and participates in the Getting Started Preparatory Program prior to September 2013, then he would be offered a place on an ISOP scheduled to commence at the Lotus Glen Correctional Centre in late September or early October 2013.

[91] The psychiatric evidence is that the ISOP is likely to be more effective for the respondent's rehabilitation than a Medium Intensity Sexual Offender Program ("MISOP") undertaken in the community. Dr Grant explained in his oral evidence that a MISOP would be less helpful. The respondent would have a better chance of completing ISOP than MISOP. The ISOP program would be of greater intensity. It would have better prospects than MISOP of providing the respondent with insights into his condition and assisting him with planning and preparation for life in the community. Dr Grant also thought that the completion of such a program would assist those who would be required to supervise the respondent under any supervision order. Individual counselling of the respondent may not be enough. Whereas ISOP required a few hours a day, three or four days a week over a period of about nine months, the MISOP program was far less intensive. It involved a three hour session once a week for 12 weeks.

[92] Dr Harden, in his oral evidence, also favoured the applicant undertaking a high intensity program, whilst in custody. Such a high intensity program had the best chance of providing the respondent with an insight into his condition. Dr Sundin agreed with this approach. The respondent would also benefit from undertaking a substance abuse program.

Respondent's antecedents and criminal history

[93] I have previously addressed the respondent's antecedents and criminal history. He has an extensive criminal history and a 20 year history of sexual offences.

The risk that the respondent will commit another serious sexual offence if released into the community

[94] The evidence, particularly the evidence of the psychiatrists, convincingly establishes that the respondent is an unacceptable risk of committing a "serious sexual offence," particularly an offence of a sexual nature against children, if released into the community. Although, as the applicant's submissions observe, the sexual offences committed by him are not at the higher end of the spectrum of such offences, there is a need to protect members of the community from such offences.

Submissions

[95] The applicant submits that the respondent's history and the psychiatric risk assessments support the conclusion that the respondent is a serious danger to the community in the absence of a Division 3 order, and that he should be detained in custody for an indefinite term for treatment. Accordingly, a continuing detention order is sought.

[96] The respondent's submissions acknowledge that the greatest concern is the respondent's persistent offending over many years. The respondent's counsel acknowledges that the evidence of the psychiatrists is that the respondent lacks insight into his offending. A supervision order, if complied with, would lower the risk of harm and the kind of harm is less serious than in many other cases of serious sexual offences. The respondent's submissions point to the psychiatric evidence that a supervision order which required, among other things, abstinence from alcohol, treatment and support would reduce the risk of future sexual offences from high to moderate-low, provided the supervision order was complied with.

[97] The critical issue, then, is whether a supervision order is likely to be complied with and, if it is not, whether there is an unacceptable risk of the respondent re-offending before his contravention is detected.

[98] Counsel for the respondent submits that it is likely to become evident very quickly whether or not the respondent is serious about abstaining from alcohol and living a crime-free life in the community if he is released subject to a supervision order. The respondent will be closely supervised on release and subject to regular drug and alcohol screening. If he contravenes the supervision order, then an application can be made under the Act and he will be returned to custody. In the circumstances, the respondent submits that, particularly taking into account the principle discussed in *Attorney-General v Francis* and the low level of past sexual offending, the respondent should be given an opportunity to be released subject to a supervision order with strict conditions (including of course that he be abstinent from alcohol).

Conclusion

[99] In the present circumstances the respondent, if released into the community subject to a supervision order, is likely to abuse alcohol. It might be hoped that such consumption and a contravention of a supervision order would be quickly detected before the respondent committed a sexual offence of the kind for which he is presently in custody. However, the respondent's chronic alcoholism, his lack of insight into the causes of his offending and its consequences for his victims and his

past persistent offending creates a significant risk that he will become intoxicated and re-offend before his contravention can be detected.

[100] The expert evidence, which I accept, is that the resumption of alcohol would create an imminent risk to the public.

[101] Temporary accommodation under close monitoring at a residential precinct, like that one close to the Townsville Correctional Centre, might isolate the respondent from alcohol. However, such accommodation is of a temporary nature. The controls that would need to be placed upon the respondent's movements and his conduct at such a temporary place of accommodation would not be very different from being held in custody in terms of restriction on the respondent's liberty. But the opportunity for him to abscond from such a facility, consume alcohol and re-offend is greater than the opportunity to escape from custody. Monitoring, including electronic monitoring, might reduce this risk. But the respondent's disregard of authority means that he is likely to disregard directions to remain at such a precinct, and once he is in the community he is likely to obtain alcohol and become disinhibited. Once disinhibited, he is likely to commit offences, including sexual offences of the kind he has committed in the past.

[102] If permitted to leave one of the precincts in which persons subject to supervision orders are accommodated on a temporary basis, the respondent would be unlikely to abstain from alcohol, despite a requirement to submit to testing. Once intoxicated, sexual offending would be likely to occur soon afterwards. There is a significant and unacceptable risk that such offending would occur before the respondent's contravention was detected and he was taken into custody.

[103] Because of the high probability that a supervision order requiring the respondent to abstain from alcohol will not be complied with, and the unacceptable risk that the respondent will re-offend soon after becoming intoxicated, the respondent should not be released subject to a supervision order.

[104] In the present circumstances, a supervision order is not apt to ensure adequate protection of the community.

[105] Those circumstances may change if the respondent completes appropriate programs, gains insights into his behaviour, develops realistic plans to prevent a relapse into alcohol abuse and sexual offending and has the support to successfully implement those plans.

[106] A continuing detention order should be made, principally for the respondent to receive treatment with a view to his rehabilitation.