SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Van Hassell* [2015] QSC 39
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **PATRICK VAN HASSELL** (respondent)
FILE NO/S:	2468/11
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	27 February 2015
DELIVERED AT:	Brisbane
HEARING DATE:	23 February 2015
JUDGE:	A Lyons J
ORDER:	**1. The supervision order made on 28 November 2011 is rescinded and the respondent is detained in custody for indefinite control, care and treatment** **2. A copy of these reasons is to be provided to the Public Guardian**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where the applicant makes an application for relief pursuant to s 22 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) – whether the respondent has breached or is likely to breach a requirement of a supervision order – whether adequate protection of the community, despite the contravention, can be ensured *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) *Mental Health Act* 2000 (Qld)
COUNSEL:	J Rolls for the applicant K Bryson for the respondent
SOLICITORS:	Crown Solicitor for the applicant

Legal Aid Office for the respondent

ANN LYONS J:

[1] On Monday 23 February 2015, I made orders and gave reasons in relation to this application by the Attorney-General for the State of Queensland for an order pursuant to s 22 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) ("Dangerous Prisoners Act"). I was satisfied that the respondent had contravened the supervision order made on 28 November 2011 and ordered that he be detained for control, treatment and care. I indicated that I would publish more extensive reasons setting out in greater detail the reasons for the order and to outline some of the systemic issues raised by the psychiatrists Dr Anthony Tie, Dr Donald Grant and Dr Michael Beech in their evidence during the hearing in relation to the intersection of the *Mental Health Act* 2000 (Qld) ("Mental Health Act") and the Dangerous Prisoners Act when prisoners who are subject to the Dangerous Prisoner regime are mentally unwell. These are those reasons.

Background

[2] Mr Van Hassell has a lengthy criminal history which commenced in 1987. On 31 October 2006, he pleaded guilty in the District Court at Southport to offences which occurred in 2002 including two counts of rape, one count of stealing and one count of assault occasioning bodily harm. He was sentenced to eight years' imprisonment in relation to the rape charges and one year imprisonment in relation to the other charges, all terms to be served concurrently. The reason for the delay in bringing the charges related to the respondent's long-standing psychiatric illness was that he was regarded as unfit for trial for an extended period of time after his arrest.

[3] On 24 March 2011, the Attorney-General for the State of Queensland sought orders in relation to Mr Van Hassell pursuant to the Dangerous Prisoner Act. On 28 November 2011, Chief Justice de Jersey ordered that the respondent be released on a supervision order subject to a number of conditions. Those conditions included requirements that the respondent was required to:

> "(iv) comply with a curfew direction or monitoring direction;
>
> (ix) not commit an offence of a sexual nature during the period of the order;

(xv) not commit an indictable offence during the period of the order;

(xi) abstain from the consumption of alcohol and illicit drugs for the duration of the order."

[4] It was alleged that the respondent had contravened the provisions of his supervision order and orders are sought for the revocation of the supervision order pursuant to s 22 of the Dangerous Prisoners Act.

[5] Section 22 of the Dangerous Prisoners Act provides that if the Court is satisfied on the balance of probabilities that the respondent has or is likely to contravene a supervision order then unless the respondent satisfies the Court on the balance of probabilities that adequate protection of the community, despite the contravention, can be ensured, the Court must rescind the supervision order and make a continuing detention order.

[6] Despite the fact that orders were made on 28 November 2011, releasing the respondent into the community on a supervision order, he was in fact already an inpatient at the Park High Security Inpatient Service having been transferred there from prison on 31 October 2011[1] because he was psychiatrically unwell. He required lengthy inpatient psychiatric care and remained at the Park for almost a year when he was discharged to the Wacol Housing Precinct in accordance with the orders of 28 November 2011. Whilst at the Park, he was an inpatient in the high secure unit from 31 October 2011 until 10 August 2012 when he was moved to the medium secure unit until his ultimate release in October 2012.

[7] Whilst he was at the Park, he was charged with the unlawful assault of a female staff member on 28 November 2011[2] and he pleaded guilty to that assault on 20 December 2012. He was sentenced to a period of imprisonment of six months which was wholly suspended for a period of two years. That conviction of course breached the conditions of the supervision order which was imposed on 28 November 2011.

History of the respondent's offending

[8] The following table outlines the respondent's criminal history –

---

1 Transcript of Proceedings dated 28 November 2011 at page 2, l 11.
2 Applicant's Submissions dated 23 February 2015 at page 5, paragraph 19.

Date	Description of Offence	Sentence
Cairns Magistrates Court 25.10.1987	• Possession Dangerous Drugs (on 03.10.87)	Fined $500
Cairns District Court 13.08.1993	• Assault with intent to steal and then used actual violence (on 13.1.88)	No conviction recorded Recognizance $200 and to be of good behaviour for 2 years, $70 compensation
Cairns Magistrates Court 10.03.1994	• Possession Dangerous Drugs (on 09.03.94)	Convicted and Fined $300 Fine option order 50 hrs community service
Cairns Magistrates Court 18.10.1994	• Breach bail undertaking (on 10.10.94) • Wilful and unlawful damaged to property (on 24.09.94) • False Pretences (bwn 12.09 & 10.10.94) • Stealing (3 charges on 10.10.94)	Convicted and not further punished, time spent in custody taken into account On each charge: Convicted and sentenced to 12 months' probation
Cairns Magistrates Court 22.02.2001	• Use threatening words (on 06.01.01)	Convicted and Fined $60
Cairns Magistrates Court 16.10.2001	• Stealing (on 31.08.01)	Convicted and Fined $150 Restitution $6
Cairns Magistrates Court 09.11.2001	• Common Assault (on 21.10.01)	Convicted and Fined $250
Brisbane Magistrates Court 11.09.2002	• Public soliciting for prostitution (on 01.09.02) • Breach bail undertaking (on 15.08.02) • Assault occasioning bodily harm (on 30.07.02)	One penalty for all matters dealt with on this date Convicted and Fined $600
Richlands Magistrates Court 14.12.2005	• Assault occasioning bodily harm (on 15.07.05)	Convicted and Sentenced to 4 months imprisonment. Declared that 17 days spent in pre-sentence custody be deemed time served under this sentence
Richlands Magistrates Court 22.12.2005	• Wilful destruction (on 20.03.05) • Assault occasioning bodily harm (on 21.04.05)	On each charge: Convicted and sentenced to 3 months imprisonment
Richlands Magistrates Court 02.03.2006	• Wilful damage/destruction (on 21.11.05)	Convicted and sentenced to 6 weeks imprisonment cumulative
Southport District Court 31.10.2006	• Rape (2 charges on 5.11.02) • Stealing (on 5.11.02) • Assault occasioning bodily	8 years imprisonment on each charge 12 months imprisonment

	harm (on 19.10.02)	On each charge: Conviction recorded All terms to be served concurrently Declared that 1,144 days spent in pre-sentence custody be deemed time served under this sentence Court ordered parole eligibility date 30.11.06

The respondent's psychiatric history

[9] A number of psychiatrists have prepared reports in relation to the respondent since the initial application in 2011. They include reports from Dr Donald Grant, Dr Michael Beech as well as Dr Anthony Tie from the Prison Mental Health Service. Dr Basil James also prepared a report dated 5 November 2010 in relation to the initial application. Given the history of the matter over the last three years, I consider it necessary to have regard to the respondent's presentation in 2011 to evaluate his treatment and progress since that date. As extensive reasons were not given at the time the supervision order was made, it is necessary to refer to the earlier reports in some detail.

[10] The respondent is currently 44 years of age and, as previously noted, until September 2011 he was serving the eight year sentence for the four offences which occurred in 2002. All of the reporting psychiatrists noted that the respondent has a history of alcohol and drug abuse in his mid-teens and that the respondent developed a major psychiatric illness around the age of 16. At that age, he developed severe symptoms and behavioural disturbances and spent about seven years in the Baillie Henderson Psychiatric Hospital in Toowoomba from 1989. He also had periods as an inpatient in the Cairns Hospital and a number of Brisbane hospitals. The respondent had not displayed any sexual violence prior to the offences which occurred in November 2002. Investigations revealed that there was no evidence of epilepsy or any structural brain disease.

[11] Dr James in his initial report considered that the respondent had a chronic underlying psychosis which is intensified by episodic changes in mood, in particular, grandiosity, hyposexuality and disinhibition or depression. He diagnosed the respondent as having a

chronic schizophrenic illness or chronic schizo-affective disorder. Dr James also considered that the respondent had an anti-social personality disorder but was uncertain as to whether it was secondary to the psychotic disorder or independent of that condition. Dr James at that point considered that the respondent had limited insight into the nature, consequences and the need for treatment of his illness.

[12] Dr Grant also considered that the respondent suffers from a combination of an anti-social personality disorder, a schizophrenic psychosis and substance abuse. Dr Grant initially considered that if the psychosis and substance abuse were controlled then the risk of violence would be significantly reduced, although some violence and anti-social behaviour would persist which was secondary to the personality disorder rather than the psychosis. At the 2011 hearing, however, Dr Grant considered that the risk of reoffending was not so severe as to constitute a need for continuing detention as any further treatment could be provided in the community. It was clear that Dr Grant considered that there needed to be open communication and co-operation between Queensland Corrective Services ("QCS") and Mental Health Services and that supervision and psychiatric treatment needed to be vigorously applied. Dr Grant noted that the relationship between a supervision order and compulsory psychiatric treatment would be potentially complex and difficult. In particular, I note his somewhat prophetic observation in his initial report:

> "It may be at times difficult to discern whether a behavioural problem should be dealt with through clinical or disciplinary means. Breach of the supervision order might relate to the personality disorder or to psychosis and it may well be difficult to determine which is the most relevant at any one time. If psychiatric illness appears to be underlying behavioural difficulties then psychiatric admission might be the preferable approach, whereas if deliberate behaviour issues are relevant it may be that breaches will lead him to return to prison. **Decisions in relation to difficulties that arise will require a great deal of consultation and good judgment on the part of those managing Mr van Hassell's psychiatric treatment and the supervision order."**

[13] Dr Beech has also prepared a number of reports and at the hearing in 2011, he considered that the respondent suffers from chronic schizophrenia and he raised the question as to whether at the time of the rapes the respondent was psychotic and not compliant with medication and management. Dr Beech noted that the respondent had been unstable during his eight year incarceration. In 2011, Dr Beech considered that the

greatest risk of reoffending arose from the respondent's unstable mental illness and that should he be released into the community, he would not comply with treatment and community management and that he would relapse into psychosis.

History since release on supervision

[14] As previously noted, on 23 October 2012 the respondent was released to the Wacol Precinct after 11 months in the Park Centre for Mental Health. He was required to submit to an electronic monitoring device, was subject to a 24 hour curfew and required an escort when on leave from the precinct. Difficulties arose in relation to his management at the Wacol Precinct, and on 30 January 2013 he contacted QCS staff, indicating that he wanted to have his monitoring device removed so he could return to prison. There were concerns about his mental state and when he was assessed he was agitated and complained of hearing voices that were saying unpleasant things. He also indicated he did not think his medication was working. The psychologist who assessed him, Mr Nicholas Smith, was concerned that his agitation would escalate to physical violence and the following day he was heard calling out in a loud aggressive voice to female surveillance officers and making sexually suggestive comments. He was also yelling abuse and making aggressive gestures.

[15] On 31 January 2013, an arrest warrant was issued for the respondent alleging he was likely to contravene a requirement of the supervision order. On 1 February 2013, he was arrested and brought before the Supreme Court where it was ordered he be subject to an interim detention order. On that date, an order was made for his examination by two psychiatrists under the Dangerous Prisoners Act. On 27 June 2013, an amended application was filed alleging the respondent was likely to contravene the supervision order and in fact had also contravened the supervision order by virtue of his conviction in the Magistrates Court on 20 December 2012 in relation to the charge of common assault.

[16] Since the filing of the application in 2013, the respondent has been housed, when well, at the Wolston Correctional Centre or when he deteriorated psychiatrically, at the Park Centre for Mental Health. The matter has been listed for hearing on four separate occasions in the last two years and at various times the proceedings have been required

to be adjourned because he has been too unwell to instruct his legal representatives. It is also apparent that he becomes acutely unwell as the time for the hearing approaches.

[17] On 24 October 2014, a guardianship order was made in QCAT appointing the Public Guardian to make decisions on the respondent's behalf in relation to accommodation, health care, provision of legal services and legal matters not relating to his finance or property. The respondent is presently awaiting transfer from the Wolston Correctional Centre to the Park Centre for Mental Health, as it would appear he currently presents with symptoms of an act of psychosis.

The reports of the psychiatrists since 2011 which have been prepared for this application

[18] At the hearing of the application on 23 February 2015, Dr Tie, Dr Grant and Dr Beech all gave oral evidence. Dr Beech and Dr Grant have also both prepared a number of reports in relation to the application and Dr Tie had provided a number of written updates.

Treating doctors' reports

[19] Dr Anthony Tie from the Prison Mental Health Service, who is the respondent's treating doctor gave an update as to the respondent's current condition and outlined his recent history. Dr Tie confirmed the diagnosis of schizophrenia (disorganised type) and that he also fulfils the criteria for anti-social personality disorder. Dr Tie stated that there was a re-emergence of psychiatric symptoms in early December 2014 when he presented as tearful and distressed with a prominent formal thought disorder and a rambling and disorganised account in relation to religious themes. He was particularly preoccupied with the godlessness of fellow inmates and was experiencing thoughts of self-harm. At that point, Dr Tie stated:

> "Given the emergence of acute psychiatric inpatient needs, Mr Van Hassell has been placed on a recommendation for assessment to the High Secure Inpatient Service (HSIS), pending the availability of a bed in this facility. I would emphasise that his psychiatric management under the *Mental Health Act* is fundamentally a separate process to the *Dangerous Prisoners (Sexual Offenders) Act* 2003."

[20] Dr Tie stated he saw him again on 28 January 2015 when he presented with prominent formal thought disorder associated with poorly systematised self-referential and religious ideas and was reporting persistent auditory hallucinations. Dr Tie noted that Mr Van Hassell denied any aggressive ideation towards himself or others. He noted that Mr Van Hassell had been passively compliant with depot anti-psychotic injections in the custodial setting but had been poorly compliant with oral anti-psychotic augmentation of the depot medication.

[21] Dr Tie confirmed that whilst Mr Van Hassell is currently on an involuntary treatment order to the Park High Secure Inpatient Service, he had not been able to be moved given a shortage of beds. He stated that Mr Van Hassell remained a priority because he required an extensive period of psychiatric care but there is a waiting list of mentally unwell prisoners awaiting inpatient admission into the psychiatric facility as there is usually only one bed available. Dr Tie indicated that he could not estimate when he would be admitted as there were "a couple of individuals who are ahead of him in terms of clinical priority"[3] and therefore he could not give "a definitive answer as to when exactly he will be admitted."[4]

[22] He also stated that amending the involuntary treatment order, so that it was changed from a community setting to a secure inpatient classification would not change the respondent's position in the clinical priority waiting list, nor he said would it change the fact that there were a limited number of psychiatric beds available in this facility.

[23] In terms of his current treatment in the prison, he indicated that Mr Van Hassell is currently on a maximum dose of Flupentixol depot medication and that in the custodial setting, given the limited mental health and medical facilities available, the addition of a second depot medication might result in side effects that would be difficult to manage. He also stated that in terms of any additional depot medication which might be added, it usually takes some time to be clinically effective, and in terms of balancing the risks versus benefits a review of the psychotropic medication regime should be undertaken in an inpatient setting, given the monitoring facilities available. He also stated that Mr Van Hassell would have to agree to accept any new medications and to date he has shown a

---

3 Transcript of Proceedings dated 23 February 2015 at page 7 ll 13-14.
4 Transcript of Proceedings dated 23 February 2015 at page 7 l 15.

limited inclination to trial alternative psychotropic medications. Dr Tie indicated that involuntary treatment cannot be enforced in a custodial setting and has to be enforced in an authorised mental health service, such as the High Secure Inpatient Service not the prison. He confirmed that there is really nothing that could be done to advance Mr Van Hassell's mental health status until he is transferred to The Park.

[24] Dr Tie also gave evidence that since the respondent's return to custody, attempts have been made to organise a comprehensive treatment plan to facilitate his release into the community and that he had been instrumental in attempting to get that treatment plan together and to get the relevant agencies working towards the compilation of that plan. He stated that he has had extensive communication with the Community Forensic Outreach Service ("CFOS") and it had been hoped that a treatment plan would have been compiled by the end of this month, however, that was contingent upon the respondent being well enough to participate in the process. The respondent needs to be well to ensure that the CFOS assessment was reliable in terms of case formulation, risk assessment and risk management planning.

[25] Dr Tie stated that in formulating the plan in the future and in finding accommodation for the respondent if he was to be released, the CFOS would look towards QCS to finalise suitable accommodation in the community to commensurate with the requirement for QCS monitoring and risk management. However, once suitable accommodation was located, it was conceivable that the High Secure Inpatient Service and the CFOS could collaboratively put in place appropriate mental health support within the graduated transition plan into the community.

[26] Dr Tie stated that although a definitive formulation risk assessment and management plan has yet to be finalised and although there might be mixed views regarding the exact nature and degree of relapses involving Mr Van Hassell, there is no disagreement that Mr Van Hassell suffers from an underlying psychotic illness. He stated that the clear view was that Mr Van Hassell is not progressing under the auspices of a plan that only attends to deteriorations reactively. He indicated that in evaluating his broader mental health vulnerabilities more proactively, there is now consideration being given to the need for longer term psychiatric rehabilitation in a secure facility, which would most likely be the High Secure Inpatient Service, which would then eventually facilitate his

transition into the community setting. That would obviously take place when the respondent's mental health was stable.

[27] Dr Tie also confirmed that the respondent's psychiatric rehabilitation would be a joint responsibility involving all branches of the Forensic Health Service which would involve himself and Dr Aboud as clinical director, as well as Dr Neillie from the CFOS and Dr Mann as the clinical director of that psychiatric facility and his appointed treating psychiatrist in that particular inpatient facility. Dr Tie also indicated that the Princess Alexandra Mental Health Service, who had followed him up when he was released to the Wacol precinct, had made it clear that their view was that Mr Van Hassell would be optimally managed in a secure facility.

[28] Dr Tie also considered that should Mr Van Hassell be released on a supervision order in the future then one of the conditions should be in place under the Dangers Prisoners Act which would encourage Mr Van Hassell to attend mental health support and review which would assist the Mental Health Act in ensuring that he is compliant with psychiatric management. Similarly, he stated that although accommodation would, in all likelihood, need to be sourced by QCS, given that there are likely to be monitoring and risk management procedures in place, mental health services do have a role in ensuring that he is appropriately supported, given his fragile mental state, particularly in a less-structured community setting.

[29] Dr Tie agreed that much of the future planning depended on the goodwill of mental health services once he was released but that he was optimistic given that there are increasing opinions that are coming forth, not only from the Prison Mental Health Service, but also the CFOS and the district mental health services, which are pushing for an extended period of psychiatric rehabilitation in a secure facility as a precursor to graduated transition into the community setting.

Dr Beech's Report

[30] Dr Michael Beech has prepared a number of further reports in relation to the respondent dated 16 June 2013, 22 October 2013, 21 November 2013, 8 May 2014 and 13 February 2015. In the most recent report, Dr Beech notes the working diagnosis of schizophrenia

with the co-morbid diagnosis of anti-social personality disorder with a history of poly-substance dependence currently in remission. Dr Beech notes that the respondent is currently subject to an involuntary treatment order under the Mental Health Act, as he has suffered a significant deterioration in his mental health which has apparently been triggered by the stress of the current Dangerous Prisoners Act legal proceedings.

[31] Dr Beech notes that on 21 January 2015, the respondent presented with formal thought disorder and poorly systematised self-referential and religious ideas as well as persistent auditory hallucinations. He was compliant with his anti-psychotic medication but poorly compliant with oral medication. Dr Beech noted that there had been a plan for CFOS to undertake an assessment with the view of making plans for Mr Van Hassell's release into the community. However, given he is currently a psychotic that has not been able to be undertaken.

[32] Dr Beech concluded that the opinion he expressed in his earlier report continues and that he considers the respondent would be a high risk of further sexual violence if he were to be released into the community without a supervision order. He considers that given the more recent information, it is unlikely that the respondent would be able to comply with a supervision order and that the letter of Dr Tie indicates that there are significant psychotic processes present. Dr Beech notes that whilst the current proceedings are a stress, a further factor is the lack of compliance with oral medication. He notes:

> "It is difficult for me to imagine how Mr Van Hassell could be accommodated within the community with outpatient services if his medical state cannot be adequately managed within the structure of a prison setting. Mr Van Hassell has a severe mental illness which has seem to me to be quite unstable. I would think that in the short term he may achieve remission within an inpatient setting. There does though seem to be a pattern of significant deterioration under the stresses of assessment, pending release, and release. In my opinion it is very important that CFOS do assess him when he is well and from there a co-ordinated and comprehensive plan for his community management could be established. Without that I think that he would deteriorate in the community, contravene a supervision order and be returned to prison. I think that in a psychotic state the risk of further violence would rapidly escalate. It is my opinion that it was likely that psychosis form part of the index offences"

[33] I also note Dr Beech's earlier report dated 8 May 2014, where he considered that not only were there stresses of the court proceedings but also the stress of being faced with the prospect of being released into the community. He considers that whilst the respondent is in a secure custodial setting with regular psychiatric oversight and regular medication, his schizophrenia is reasonably controlled although he suffers from some breakout symptoms at times. He can be aggressive and combative but it seems to be fairly well-managed within prison. Dr Beech noted that during his placement at the Wacol precinct and whilst he was in receipt of support from QCS employees, Mental Health Service employees and emergency departments, his mental state deteriorated.

[34] Dr Beech considers that the respondent's presentation does not auger well for his release into the community with support akin to those that he received on earlier supervision orders. He considers that if he were to be released he would be under destabilising influences and he would experience heightened stress and quickly return to the state similar to the one he experienced in early 2013. He considers that QCS staff would have only a limited capacity to manage this within contingency accommodation and community health services would also have limited capacity to respond to his needs. He considers that once again he would be taken to an emergency department for further assessment and they would have a limited ability to manage him within the usual public sector setting.

[35] Ultimately, he considered that the comments of Dr Mantizoris, who had managed him at the Princess Alexandra Hospital when he deteriorated in 2013 were apt. Dr Mantizoris considered that Mr Van Hassell must never be admitted to a public inpatient facility again and that secure forensic rehabilitation facilities would be more appropriate. Dr Beech noted that Mr Van Hassell essentially agreed with that view when he discussed it with him. Ultimately, Dr Beech considers that there are difficulties in managing Mr Van Hassell in the community. I also note his opinion in these terms:

> "On the other hand, I do not see what could be easily achieved by simply returning Mr Van Hassell to a secure hospital setting if the scope of his treatment was simply to return his mental state to one which would allow him to be managed within a prison setting. Under other circumstances, and under different Acts, Mr Van Hassell would be held in a secure forensic hospital setting subject to an involuntary treatment order with the Mental Health Review Tribunal oversight. I would think his admission would be

> longer because, in the absence of a custodial setting, he would be required to progress through high secure and then medium secure settings before probably release to a general inpatient unit and from there to supported assertive community management.
>
> In my opinion, some of the problems relate to the fact that Mr Van Hassell falls between two Acts, the *Dangerous Prisoners (Sexual Offenders) Act* and the *Mental Health Act*."

[36] Dr Beech outlined his concern that there were potentially four bodies involved in his treatment and care namely the Prison Mental Health Service, the Inpatient Service, the CFOS, and the Princess Alexandra Mental Health Service. His concern was that there might be differences of opinion between the various agencies about how he might be managed and whilst it was heartening to hear Dr Tie indicate that there is progress towards seeing that Mr Van Hassell have long-term placement and rehabilitation, it still seemed that there was robust negotiation around that.

[37] Dr Beech also expressed his concern that the respondent had deteriorated to the extent that he had over the last 2 years to the extent that he stated:

> "I was wondering whether, in fact, the matter should go to the Adult Guardian, who could then refer it to the health ombudsman. This is something I would have thought maybe two years ago would go to the Health Quality Complaints Commission about why someone's mental health is allowed to deteriorate in prison while they're waiting for a placement in a hospital bed. I think this issue goes above the level of the people involved in his management. ……I think an approach needs to be made to someone above all those levels. Perhaps it's a director level, to sit down with someone at a similar level from Queensland Corrective Services to come up with a plan. This is - this is one of those complex cases of, you know, criminality, drug use, and mental illness which does not fit into the usual realms of either Acts, and I think just requires some inter-governmental position about how to manage this person in particular."[5]

[38] Dr Beech considered that there needed to be an inter-departmental agreement for him because when he is stable mental health services will transfer his care to the community mental health services which clearly struggled to manage him. Dr Beech continued:

> "And it's clear that community mental health services, in the - what, three months that they had him, struggled. They struggled - his actual treating team struggled and were frightened of him, but, I mean, there were a

[5] Transcript of Proceedings dated 23 February 2015 at page 24 ll 27-33, 34-40.

> number of presentations to the Princess Alexandra Hospital where the treatment seemed to be to assess him and say, well, it's a personality disturbance or a self-harm, he's settled now, and to send him back. And, I think, as I read through the material, the assumption seems to be, from mental health services in the community, in the prison, and, I think, in the hospital, that Wacol contingency accommodation is supported accommodation. The nurses at Princess Alexandra Hospital say that, you know, he's living in supported accommodation. Now, Wacol precinct is monitored accommodation. It's supervised accommodation, but I don't see it as being supported in any way that you would normally have - put someone like Mr Van Hassell into clinically-supported accommodation. And that's why, I think, a long-term rehabilitation plan needs to take into account that when he goes from hospital, there's no point sending him back to prison, because a prison can only place him then in the Wacol precinct. He needs to go through a rehabilitation process which, at the end of it, provides him with release into supported accommodation."[6]

Dr Grant's opinion

[39] Dr Grant has prepared a number of reports in relation to the respondent, in particular, those reports are dated 8 May 2013, 17 October 2013, 21 November 2013, 9 May 2014 and 13 February 2015. I note Dr Grant's most recent report and assessment that Mr Van Hassell is currently suffering from acute psychotic symptoms and that as a result he has once again been placed under recommendation under the Mental Health Act to enable his transfer to the High Secure Inpatient Service at the Park for further assessment and treatment. Dr Grant noted that a patient under such a recommendation is regarded as too ill to be adequately treated in custody and psychiatric treatment takes precedence over custodial care.

[40] Dr Grant noted that the CFOS assessment in relation to his future transition into the community has been recommended but agrees that assessment will be difficult to carry out whilst Mr Van Hassell remains unwell and such assessment would not appear to be relevant for some time. Dr Grant notes that Mr Van Hassell has been receiving depot anti-psychotic medication since a brief admission to the high secure unit at the Park but it has been inefficient to adequately treat his schizophrenia and he is demonstrating severe symptoms once again.

---

[6] Transcript of Proceedings dated 23 February 2015 at page 25 ll 9-25.

[41] Dr Grant considers that Mr Van Hassell has probably been psychotic on a more or less continuing basis since he last reported on him in November 2013. Dr Grant stated that in regard to priorities, Mr Van Hassell's urgent need for secure inpatient treatment is the highest priority and that need for treatment would render any placement in the community at this stage inappropriate and potentially a high risk for both Mr Van Hassell and for potential victims of violent or sexual offending. I noted his view:

> "Risk management in this case over the long term must be a shared responsibility between Mental Health Services and Corrections. Supervisors of a person under a DPSOA supervision order cannot be expected to be able to adequately supervise a person who is actively psychotic. That task requires mental health training and expertise. Supervision under the DPSOA is in my opinion appropriate only when any psychotic process is treated and resolved to the point where the person would be considered able to live in the community under intermittent outpatient monitoring and treatment.
>
> In Mr Van Hassell's case, risk of violent or sexual offending arises both from his anti-social personality disorder and his schizophrenia. Whilst his personality disorder is not readily amenable to treatment his schizophrenia is treatable and that treatment is currently inadequate as evidenced by his active psychotic symptoms. Efforts will be necessary to reach a point in treatment where his symptoms are more effectively controlled on a continuous and long term basis.
>
> In my opinion he needs a prolonged admission to a secure mental health facility to receive effective treatment. Consideration of his DPSOA status at this stage should conclude in my opinion that he is not suitable for release under a supervision order until his mental status is sufficiently stable to enable safe community management."

[42] Dr Grant noted the slow progress in relation to Mr Van Hassell's transfer to the Park and the frustration of his treating doctor, however, he considered it was reassuring that the clinical opinion at both the High Secure Inpatient Service and the Prison Mental Health Service is that he should have a prolonged stay of many months in a high secure unit to achieve more mental stability. Dr Grant considered that the respondent's clinical needs required the following:

> "…firstly, the prolonged admission to the inpatient unit at high secure, and then a step-down sort of process where he either goes to a medium secure unit for a period of time, or maybe to the step-down more open forensic beds at the high secure unit for an extended period of time, months or longer, and maybe a long-term placement in a suitable community care unit in the - in the facility, in the - in the community. I think Mr Van Hassell does need long-term rehabilitative care, and I think it's all complicated by

> him being under the Dangerous Prisoner Act, actually. I think it makes it difficult. There are divisions of responsibility which are hard to overlap and so on, and so I think it's causing more problems than its solving."[7]

[43] In terms of future treatment, Dr Grant indicated that psychotherapeutic or educational approaches cannot be utilised when a person is psychotic, delusional and insightless and that those approaches cannot be utilised until he achieves a level of mental improvement and stability which are really the primary aims at the moment. He stated:

> "So in the long-term rehabilitation process they're talking about, they would be aiming to get his mental status and his psychotic symptoms under control and then be dealing with the other issues that might be relevant, such as any organic factors that there were some questions about early on, sexual offending sort of treatment to understand that, and get some more insight as to his control of sexual issues."[8]

[44] Dr Grant emphasised that a comprehensive treatment plan needs to be put in place prior to any consideration of Mr Van Hassell's release into the community. He considered that the difficulty is that the respondent is under two different Acts and responsibilities can be blurred. In his view, there should be a very clear plan made with meetings between Corrections and Mental Health and CFOS as well as the local mental health service which might be involved in his care in the community. He stated that it was necessary to make it clear who had responsibility for managing his mental health, and also to make it clear where the responsibilities under the Dangerous Prisoners Act fall.

[45] He also indicated that given the history of this matter and the fact that the respondent seems to decompensate when court proceedings are imminent in order for him to be actively involved in the formulation of a treatment plan, it should be formulated when he is stable well in advance of the next hearing. He also considered that a transfer from high secure to precinct housing in the future would be inappropriate as he needed step-down mental health facilities and needed "to go from high secure to a less secure mental health facility before he goes into a community facility, which is what precinct housing is."[9]

---

7 Transcript of Proceedings dated 23 February 2015 at page 13 ll 27-36.
8 Transcript of Proceedings dated 23 February 2015 at page 15 ll 15-20.
9 Transcript of Proceedings dated 23 February 2015 at page 16 ll 29-30.

[46] In terms of the respondent's current treatment needs, Dr Grant indicated that he needs to be in a hospital where there would be other treatment options including possible ECT as well as being in a more therapeutic environment where there are trained people who understand mental illness and his symptoms. He could also participate in some sort of therapeutic activities around the ward and if necessary, he can be placed in a seclusion situation if he's acutely suicidal, where he would be observed very closely by mental health professionals. Dr Grant indicated that "In prison, he's not under the ongoing care of anyone who knows anything about mental illness".[10]

[47] Dr Grant also stated that an involuntary treatment order is not effective in a prison setting, as it is not possible to enforce the Involuntary Treatment Order ("ITO") in custody because the prison is not an authorised mental health service and noted the potential for disasters in ordering compulsory mental health treatment when there are no trained mental health staff with an ongoing monitoring role. Furthermore, he stated that the respondent does not have to accept depot medication in prison however if he is in hospital, then the Mental Health Act says he has to have the medication.

Should an order be made pursuant to s 22(2)

[48] Section 22(2) provides that upon the Court being satisfied on the balance of probabilities that the respondent has breached or is likely to breach a requirement of a supervision order then unless the respondent satisfied the Court on the balance of probabilities that adequate protection of the community can, despite the contravention, be ensured the Court must if there is an existing supervision order rescind it.

[49] It is clear that the respondent pleaded guilty to assault on 20 December 2012 and was sentenced in the Richlands Magistrates Court to a period of six months imprisonment wholly suspended for a period of two years. Counsel for the respondent accepts that he has breached his supervision order. I am accordingly satisfied on the balance of probabilities that he has breached the requirements of his supervision order of 28 November 2011.

---

[10] Transcript of Proceedings dated 23 February 2015 at page 17 ll 20-21.

[50] Has the respondent satisfied the onus on him to establish that, despite the contravention of the supervision order, the adequate protection of the community can be ensured? I am satisfied that the respondent is currently acutely unwell and is awaiting transfer to the High Secure Inpatient Service at the Park Centre for Mental Health so that he can undergo prolonged treatment and rehabilitation. The evidence currently indicates that the respondent would be a high risk of further sexual violence if he were to be released into the community without a supervision order. The overwhelming evidence is that the respondent is too acutely unwell to be released on a supervision order, as the current evidence indicates that he is currently has psychotic processes present and it is unlikely that the respondent would be able to comply with a supervision order in those circumstances.

[51] I am satisfied therefore that the supervision order made on 28 November 2011 should be rescinded and that the respondent be detained in custody for indefinite control, care and treatment.

Other Comments

[52] The facts of this case indicate that the respondent was due for release on a supervision order over three years ago. Because of the unstable nature of his mental illness, he has in fact only been in the community for a period of three months in those three years. He spent ten months in the High Secure unit at the Park in an effort to stabilise his mental condition before he was moved to a medium secure unit for a few months prior to his release to the Wacol Precinct. As the psychiatrists have made manifestly clear the move to the Wacol Precinct was inappropriate given the level of support the respondent required in the community from mental health services at that point in time. QCS officers clearly cannot provide that type of support and the Wacol precinct is not supported accommodation but rather monitored accommodation. Given that inappropriate accommodation, the respondent deteriorated within a short space of time and was returned to custody in January 2013 when he became acutely unwell and breached his supervision order.

[53] Since his return to custody, the respondent has, according to the psychiatrists, been more or less frankly psychotic during that entire period. It is also clear that during that

period the respondent has not been able to receive optimal involuntary mental health treatment under an ITO, as he cannot receive involuntary treatment in a custodial setting. He is now acutely unwell and self- harming. A recommendation was made for his transfer to an authorised mental health service by his treating psychiatrist from the Prison Mental Health Service on 2 December 2014 which is now almost three months ago. That recommendation has not been able to be actioned due to a chronic bed shortage.

[54] I share the concerns of the psychiatrists who gave evidence in this case that the respondent is acutely unwell and his treatment needs are not being met. I also note the effect these proceedings have on his mental condition.

[55] I commend the careful and thorough assessments of the respondent's treating psychiatrist Dr Tie at the Prison Mental Health Service and the reporting psychiatrists Dr Beech and Dr Grant and would endorse the recommendations they have made as to how this matter can be better managed into the future, particularly in relation to his long term rehabilitation and proposed treatment in a community setting. In particular, I note the recommendation of the need for an interdepartmental committee to progress those issues in advance of the next scheduled annual review.

[56] I also order that a copy of these reasons be forwarded to the Public Guardian who is the respondent's guardian for health matters as well as accommodation and legal matters not involving finance or property so that they can consider what representations can be made on his behalf in relation to his health care and future proposals for his rehabilitation. I note Dr Beech's suggestion that consideration should be given a Reference to the Health Ombudsman.

ORDERS

[57] The supervision order made on 28 November 2011 is rescinded and the respondent is detained in custody for indefinite control, care and treatment.

[58] A copy of these reasons is to be provided to the Public Guardian.