SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Spoehr* [2015] QSC 362
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **KYM SPOEHR** (respondent)
FILE NO:	SC No 8624 of 2015
DIVISION:	Trial Division
PROCEEDING:	Originating Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	18 December 2015
DELIVERED AT:	Brisbane
HEARING DATE:	30 November 2015
JUDGE:	Flanagan J
ORDER:	**The Court, being satisfied to the requisite standard that the respondent 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 (Qld), the Court orders that pursuant to s 13(5)(a) of the Act, the respondent Kym Spoehr 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 SEXUAL OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where the respondent was sentenced to 14 years imprisonment for seven counts of rape, one count of sexual assault, one count of deprivation of liberty and one count of disabling in order to commit an indictable offence – where the respondent is due to be released in January 2016 – where the applicant applied for an order pursuant to s 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) ("**the Act**") – where the respondent will not engage in a sexual offenders treatment program in custody but will do so once released – where the respondent suggests that a mental illness was responsible for his offences – whether the respondent is a serious danger to the community in the absence of a division 3 order

	under the Act – whether the respondent should be released subject to a supervision order or remain in custody pursuant to a continuing detention order under the Act
	Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld), s 13
	Attorney-General for the State of Queensland v Francis [2007] 1 Qd R 396; [2006] QCA 324, cited *Attorney-General for the State of Queensland v Lawrence* [2010] 1 Qd R 505; [2009] QCA 136, cited *Attorney-General for the State of Queensland v Sutherland* [2006] QSC 268, cited *Turnbull v Attorney-General for the State of Queensland* [2015] QCA 54, considered
COUNSEL:	K Philipson for the applicant T Ryan for the respondent
SOLICITORS:	Crown Law for the applicant Legal Aid Queensland for the respondent

Introduction

[1] On 26 May 2003, the respondent was convicted on his own plea of guilty and sentenced to 14 years imprisonment for seven counts of rape, one count of sexual assault, one count of deprivation of liberty and one count of disabling in order to commit an indictable offence. All offences were committed on 25 December 2001.

[2] The respondent is due for release on full-time discharge on 23 January 2016.

[3] The applicant, the Attorney-General for the State of Queensland, applies for an order pursuant to s 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) ("**the Act**"). The applicant's position is that the respondent should be subject to a continuing detention order. The respondent, however, seeks either no order or alternatively to be released from custody subject to the requirements of a supervision order.

Legislative provisions

[4] The objects of the Act are set out in section 3:

(a) to provide for the continued detention in custody or supervised released of a particular class of prisoner to ensure adequate protection of the community; and

(b) to provide continuing control, care or treatment of a particular class of prisoner to facilitate their rehabilitation.

[5] Section 13 falls within Part 2 division 3 of the Act which deals with final orders:

"**13 Division 3 orders**

(1) This section applies if, on the hearing of an application for a division 3 order, the court is satisfied the prisoner is a serious danger to the community in the absence of a division 3 order (a serious danger to the community).

(2) A prison is a serious danger to the community as mentioned in subsection (1) if there is an unacceptable risk that the prisoner will commit a serious sexual offence—

(a) if the prisoner is released from custody; or

(b) if the prisoner is released from custody without a supervision order being made.

(3) On hearing the application, the court may decide that it is satisfied as required under subsection (1) only if it is satisfied—

(a) by acceptable, cogent evidence; and

(b) to a high degree of probability;

that the evidence is of sufficient weight to justify the decision.

(4) In deciding whether a prisoner is a serious danger to the community as mentioned in subsection (1), the court must have regard to the following—

(aa) any report produced under section 8A;

(a) the reports prepared by the psychiatrists under section 11 and the extent to which the prisoner cooperated in the examinations by the psychiatrists;

(b) any other medical, psychiatric, psychological or other assessment relating to the prisoner;

(c) information indicating whether or not there is a propensity on the part of the prisoner to commit serious sexual offences in the future;

(d) whether or not there is any pattern of offending behaviour on the part of the prisoner;

(e) efforts by the prisoner to address the cause or causes of the prisoner's offending behaviour, including whether the prisoner participated in rehabilitation programs;

(f) whether or not the prisoner's participation in rehabilitation programs has had a positive effect on the prisoner;

(g) the prisoner's antecedents and criminal history;

(h) the risk that the prisoner will commit another serious sexual offence if released into the community;

(i) the need to protect members of the community from that risk;

(j) any other relevant matter.

(5) If the court is satisfied as required under subsection (1), the court may order—

(a) that the prisoner be detained in custody for an indefinite term for control, care or treatment (continuing detention order); or

(b) that the prisoner be released from custody subject to the requirements it considers appropriate that are stated in the order (supervision order).

(6) In deciding whether to make an order under subsection (5)(a) or (b)—

(a) the paramount consideration is to be the need to ensure adequate protection of the community; and

(b) the court must consider whether –

(i) adequate protection of the community can be reasonably and practicably managed by a supervision order; and

(ii) requirements under section 16 can be reasonably and practicably managed by corrective services officers.

(7) The Attorney-General has the onus of proving that a prisoner is a serious danger to the community as mentioned in subsection (1)."

[6] In order for s 13 to apply, the Court must be satisfied that the respondent is a serious danger to the community in the absence of a division 3 order. The Attorney-General has the onus of proving this requirement. If the Court is satisfied that the respondent is a serious danger to the community in the absence of a division 3 order, the Court may make a continuing detention order, a supervised order or no order.[1] Although the respondent's primary position was that he be released from custody subject to a supervision order, his Counsel also submitted that there should be no order. This was on the basis that the Court would not be satisfied to the requisite standard that the respondent is a "serious danger to the community in the absence of a division 3 order" within the meaning of s 13(1) of the Act. The requisite standard is that the Court must be satisfied, by acceptable and cogent evidence and to a high degree of probability, that the evidence is of sufficient weight to justify the decision that the respondent is a serious danger to the community in the absence of a division 3 order.[2]

[7] The paramount consideration in deciding whether to make an order under s 13(5)(a) or (b) is the need to ensure adequate protection of the community.

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1 *Attorney-General for the State of Queensland v Lawrence* [2010] 1 Qd R 505, [28]-[29] (Chesterman JA); *Attorney-General for the State of Queensland v Sutherland* [2006] QSC 268, [26] (McMurdo J).

2 *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) s 13(3).

[8] For the purposes of deciding whether the respondent is a serious danger to the community in the absence of a division 3 order the Court must have regard to those matters stated in s 13(4)(a) to (j) of the Act.

The Proposed Supervision Order

[9] The respondent provided to the Court a proposed supervision order which was referred to in the course of evidence of the three assessing psychiatrists. The applicant did not press paragraphs 15 and 30 of the proposed order.[3] The proposed order is Annexure A to these Reasons.

The respondent's antecedents and criminal history: section 13(4)(g)

[10] The respondent was born on 1 May 1952 and is 63 years of age.

[11] He grew up in South Australia. His father died in a motorbike accident when the respondent was four years old. The respondent struggled academically and reported a pattern of truanting behaviour. In Years 5 and 6 he attended a special school for people with learning disabilities. He left school at the age of 15 and worked on a farm and a fishing boat, in construction work, labouring and truck driving and reported always being a drifter travelling around Australia.[4]

[12] The respondent has two younger brothers but has had no contact with his mother or brothers for 30 years.[5]

[13] The respondent was married at the age of 24 in South Australia but that marriage ended when he was 26 years of age. He then had an "on and off" relationship with another woman over four years in Wagga Wagga when he was in his early to mid-30's.[6]

[14] He has a criminal history in four states, dating back to 1968 for various minor offences including some property offences, and one offence of wilful exposure in Western Australia in 1980.[7]

[15] The index offences were committed against a 29 year old Japanese woman who was in Australia on a working visa and who was unknown to the respondent. There is no suggestion that at the time of the offences the respondent was affected by either drugs or alcohol.[8]

[16] The victim was walking through the Noosa National Park on Christmas Day 2001 where she encountered the respondent and asked for directions. He told her he would walk with her to the main entrance. As they walked along a track, the respondent said he needed

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3 Transcript of proceedings, 30 November 2015, 1-43, lines 27-30; 1-45, lines 22-23.
4 Applicant's amended outline of submissions undated, [11].
5 Applicant's amended outline of submissions undated, [12].
6 Applicant's amended outline of submissions undated, [14].
7 Affidavit of Carolyn Lois Murphy sworn 11 August 2014.
8 Exhibit 3, report of Dr Andrew Aboud dated 20 November 2015, 6.

some water and when the victim's back was turned he struck her over the head four or five times with a piece of wood, causing deep lacerations.

[17] The respondent then dragged the victim off the track into the bush to a site where he was camping. He tied the victim's arms around her body and to a tree with a rope, taped her mouth with gaffer tape and cut her clothing away with a knife. He then shaved her pubic hair and performed oral sex on her. He then had vaginal sex with her on seven separate occasions throughout the night, ejaculating inside her on at least two occasions and he also masturbated himself in front of her and forced her to masturbate him with her hand.

[18] The respondent detained the victim overnight, and in the early morning walked her to the beach and forced her to wash herself in the surf. He gave her a pair of old shorts, a shirt and a pair of sandals, walked her to the gate of the National Park and released her. He told her not to tell the police about what had happened.

[19] In passing sentence, Judge Robertson noted:[9]

> "… These crimes shocked the community, as can be expected. It is anathema to the vast majority of Queenslanders that on a day reserved for celebration and joy, a young defenceless visitor to our State from another country could be so violently attacked and violated in a public place during the day time.
>
> Your victim showed enormous fortitude and courage during what proved to be a 12 hour ordeal. One can only speculate what might have happened had she resisted you further. She had asked you to help and, under the guise of assisting her, I am satisfied that you lured her to a point on the track which was close to your illegal campsite and you there attacked her for the sole purpose of using her for your own sexual gratification.
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> The attack on her was extremely violent and it was sustained.
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> …
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> You told police that after the first acts of rape you spoke to her and you realised that what you had done was horrendous. Nevertheless, you went on to subject her to three further sexual attacks during the course of that night. She was effectively held prisoner. That you did not have to use any more violence to subdue her and have her submit is entirely irrelevant, in my view. The ferocity of your initial attack, coupled with the bizarre features of degradation and humiliation to which I have referred, had completely overcome any resistance that she might have had.
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> …
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> I am not satisfied that your plea is accompanied by genuine remorse. You have been examined by two eminent professors of psychiatry. Both agree that you suffered and suffer from no abnormality of mind and that you have a schizo typal and/or paranoid personality disorder. … I reject any notion of abnormality of mind that could have caused you to attack the complainant in the first place. I agree with Professor Yellowlees that you rationalise your

[9] Exhibit RHB-2 to the affidavit of Renee Helen Berry affirmed 25 August 2015.

> behaviour to a great extent, taking the view that you are not entirely responsible for what happened. You are reasonably intelligent and verbally articulate, yet you are still blaming these so-called seizures for your initial conduct. In my opinion, the evidence suggests that you have very little insight into the shocking nature of these crimes and the effect on your victim, and you have very little genuine concern for her.
>
> Despite your lack of history of violent offending, I am satisfied on the basis of the material before me that you still present as a real danger to the women in isolated places."

The psychiatric evidence: section 13(4)(a) and (b)

[20] The respondent accepts that the applicant has adequately and accurately summarised the contents of the reports and the conclusions made by each of the psychiatrists as set out in paragraphs 20 to 72 of the applicant's amended outline of submissions.[10] Having read the reports I accept the accuracy of the applicant's summary of the psychiatric reports. I also consider below the oral evidence given by each psychiatrist.

Risk assessment report of Dr Michael Beech psychiatrist dated 25 February 2015

[21] Dr Beech noted that it was a difficult interview with the respondent and from the outset the respondent tried to set parameters. His talk was very circumstantial and he tended to dominate the topic of discussion and where it would go. Once the respondent decided to go down one track, he was not easily redirected.

[22] Dr Beech stated that despite the circumstantiality, when it came to specific questions, the respondent was quite vague and imprecise. He made claims such as that he was suffering from bipolar disorder and he spoke inconsistently about the index offences. When pressed for details he became irritable and guarded, often said that he did not know, could not remember, or impressed that he did not want to talk about issues. Overall he was an uncooperative interviewee.

[23] Dr Beech noted that there was limited engagement by the respondent and what was an early precarious rapport quickly dissolved. The respondent cited past reports and a general dislike for going back into the past as reasons for his limited cooperation. Overall the respondent had a tendency to ramble on about extraneous details. Dr Beech thought there was some evidence of formal thought disorder.

[24] Dr Beech could not discern any evidence of delusional thinking and there was no evidence of psychotic phenomena. Whilst there was talk of electrical discharges, fits, and other perceptual abnormalities, Dr Beech was unable to clarify those with the respondent, and gave the opinion that they may represent either the strange experiences and feelings of those with a personality disorder, or dissociative phenomena, or retrospective accounts of altered mental states.

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[10] Respondent's outline of submissions dated 25 November 2015, [6].

[25] Dr Beech believed that the respondent was significantly minimising his offending. He seemed to minimise the number of times the victim was hit, the number of times she was raped and he minimised her distress. Dr Beech opined that the respondent was attempting to deflect responsibility and there was nothing in the interview that indicated empathy or remorse. Dr Beech noted that, at times, the respondent seemed to project responsibility for some of his difficulties, particularly around his psychiatric reports, and he repeatedly referred to his history of fits, psychosis and bipolar disorder. Dr Beech was unable to pin the respondent down on his symptoms. When Dr Beech pressed him about how they in fact related to his offending, the respondent became irritable. Dr Beech thought that the respondent's insight was very limited.

[26] Dr Beech noted that in a post-facto manner, the respondent described a history of quasi-psychotic symptoms, non-epileptic seizures and mood disturbance. Dr Beech noted that the material in relation to the respondent also referred to odd thoughts and some grandiose claims. Dr Beech opined that it was difficult to piece all of that together but the most likely explanation was that the respondent had a schizotypal personality disorder, with additional notable anti-social traits.

[27] Dr Beech stated that the respondent's account of his mood symptoms was unconvincing and similarly, from his account of fits, it was difficult to construe any significant seizure disorder, although he had been prescribed anti-psychotic and anti-convulsant medications over his incarceration. It was Dr Beech's impression that the respondent was seeking to use mental illness as a way to exculpate himself from his offending and to project or minimise responsibility for it.

[28] Dr Beech noted that there was also a history of alcohol use that indicated that at some time in the past the respondent had a problem with alcohol abuse that was now in remission in a prison setting.

[29] Dr Beech stated that the respondent was a reluctant and difficult interviewee which became more evident as the offences were explored and he was pressed about his thoughts about what had occurred. Dr Beech was concerned that the respondent had harboured and had continued to harbour, thoughts that condoned in part what had occurred. While the respondent was clear that he had assaulted the victim and raped her at the start of the episode, the description of what transpired over the course of the incident seemed to convey to Dr Beech the idea that the victim had, by the end of it, consented to sex which had become "normal". The respondent ended the interview abruptly at this point.

[30] Dr Beech also noted that the respondent had not undertaken any rehabilitation programs and had declined to participate in sex offending treatment programs and it was therefore difficult to assess his current attitudes towards what had occurred and his current thinking about sexual offences.

[31] Dr Beech did not think that there was any significant evidence of a paraphilia. However, Dr Beech noted that the sexual offence itself was brutal and went over a significant amount of time. Further, there were odd elements in it, such as shaving of the victim's pubic hair, which may have been ritualistic, there was a mixed pattern to the assault, and

at times, the respondent seemed solicitous to the victim's needs. In Dr Beech's opinion, it was a rather disturbed and callous assault with a significant lack of empathy.

[32] Dr Beech assessed the respondent with a number of assessment instruments, as follows:

- On the Hare Psychopathy Checklist – Revised, the respondent received a score of 17/40 which was not in the range of psychopathy, but he had scores for his itinerant restless and loner nature, for his (proposed) promiscuity, antisocial acts, irresponsibility and for his lack of acceptance of responsibility.

- On the STATIC-99R, the respondent was given a score of 3, placing him in the group considered to be moderate-low risk of further offending. Dr Beech was of the opinion that it was the respondent's age which acted to significantly reduce the risk group into which he had been placed;

- On the Risk for Sexual Violence Protocol (RSVP), the respondent met a number of relevant risk factors – physical coercion in sexual violence; extreme minimisation of sexual violence (in relation to the latter offences); attitudes that support sexual violence (possibly present); problems with substance abuse (alcohol abuse – in remission); violent ideation; problems with intimate and non-intimate relationships; problems with employment; non-sexual criminality; problems with planning; and problems with treatment.

[33] Dr Beech opined that the respondent falls within the range of low-moderate risk of further sexual violence and his risk was probably in the group below moderate and less than the nominal 'average' sexual offender. His age was a significant factor in reducing his overall risk and he did not have any significant pre-morbid history of sexual violence.

[34] Dr Beech noted, however, that the respondent had a history of criminality and had been a loner, often on the periphery of society. His thinking was odd, his self-awareness was limited, he lacked empathy and he had no real attachments. He had declined treatment and rehabilitation. There was nothing that pointed to any realistic plan for his future and he appeared to have made odd grandiose statements to the parole board. He saw himself as having a mental illness and seemed to rely upon that as a way of escaping blame for his actions.

[35] Dr Beech stated that there are a number of possible scenarios if the respondent were to be released into the community:

(a) He will simply go back into his earlier drifter lifestyle, seek to obtain the pension and, with that support, live in campsites as he pursues his itinerant vocation. He may return to drinking alcohol and get into some mischief. There may be some ongoing low level criminality, but as a result of his experience, age and lack of inclination, he would not seek any further liaisons or sexual contact. He did not now appear to be particularly sexually pre-occupied and so in the community would not seek to form any sexual relationships. He would go on, as he had for most of his life, living in a schizotypal trajectory, but without repeating further sexual violence;

(b) The more worrying, although less likely, scenario is that he will return to his itinerate lifestyle, camp out at parks or other isolated places. His odd thoughts will lead him to start to ruminate again about his past grievances. As he becomes further angered, his mind might be drawn to a passing female. Whatever compelled him last time will resurface again and he will assault the woman. It might be that once an assault has started, it will become prolonged again as he weighs up the consequences. His thinking seemed to be along the lines that once he had commenced to assault a women he might as well continue. There was a significant risk that if the respondent were to reoffend, the victim would suffer severe physical injury because the respondent lacked empathy and self-awareness.

[36] Dr Beech stated that the respondent's risk could be lowered or, perhaps, more reliably assessed, if there was some understanding of the respondent's thinking and some understanding of his plans for release. That insight could come through his participation in a sexual offender program. But, for the moment, the assessment was based on past behaviours, the respondent's lifestyle and his limited disclosures.

Supplementary report of Dr Michael Beech dated 11 November 2015

[37] Dr Beech noted that there were a number of assessments through 2003 and 2004, but there was no clear evidence of a psychotic illness. Given the personality traits that were evident, a trial of anti-psychotic medication was commenced with some evidence of possible improvement. However, the respondent did not continue to take the medication and he was then trialled on an anti-convulsant and there appeared to have been some improvement in sleep, but no other significant changes. The respondent continued to describe what were considered to be bizarre symptoms that were not consistent with a primary mental illness.

[38] The respondent was seen throughout 2005 and 2006 by Dr Domonique Hannah, psychiatrist, who thought the respondent's symptoms were possibly consistent with a psychotic illness. Although, in 2007, Dr Edward Heffernan, psychiatrist, could not elicit any symptoms of ongoing psychosis. There was a similar reluctance by Dr Ken Arthur in 2008 to diagnose a mental illness.

[39] Dr Beech noted that on 24 January 2008, Dr Arthur obtained an account of the offence from the respondent. The respondent said that, at the time, a man owed him money and he had thoughts of hitting him on the head, taking his wallet and killing him. He was out walking and carrying a rope and tape in case he encountered a goanna and he wanted to trap and kill them because they had become the dominant species in the National Park. He met the victim and became confused and had a thought that if he was going to kill the person who owed him money, he may as well rape and kill the woman. He said that he had a very strong thought in his head and his arm "just raised on its own". He described a lack of control over his movements, that he struck the woman and then went completely blank. She screamed and he hit her in response, took her back to the camp and tied her up, realised what he was doing and untied her and apologised, and they "ended up having sex again". It became too dark for them to leave; he apologised and reassured her, then took her down to the beach "thinking of her comfort, and they walked out the park". The respondent suspected that seizures had something to do with his actions. However, Dr Arthur thought there was no evidence of a psychosis. The respondent later proffered that

he had suffered an automatism and reported a history of seizures. Those were considered not to represent epilepsy. The respondent appeared preoccupied with the injustice of his sentence and the failure of his appeal.

[40] It was noted that Dr Arthur continued to see the respondent throughout 2008, 2009 and 2010. At times the respondent reported that he was depressed. Dr Arthur could see no objective evidence of that. Although others had diagnosed epilepsy and psychosis, Dr Arthur could see no evidence of a primary mental illness and he considered the diagnosis on 4 November 2010 to be a personality disorder with dysthymia. There was a similar assessment by Dr Sunil Reddy throughout 2011. There were trials of anti-depressant medication to assist with the respondent's irritability.

[41] Dr Timmins took over the respondent's care in 2012. She noted his symptoms but was not convinced that the respondent has a psychosis, mood disorder or organic disorder, but rather thought that his diagnosis of a personality disorder was the most likely condition. Dr Timmins noted on 15 October 2013 that the respondent continued to seek a diagnosis of mental illness, but she thought that there was little support for a mental illness and there was no clear indication for medication at that time and closed his case.

[42] Dr Beech noted that none of this additional information altered his opinion expressed in his earlier report.

Dr Beech's oral evidence

[43] In oral evidence Dr Beech accepted that it is difficult to properly assess the risk posed by the respondent's release because:[11]

(a) the respondent does not give much information;

(b) he tends to say he cannot remember much of what happened and to displace responsibility;

(c) much is "hidden" about the respondent.

[44] Dr Beech agreed that if the respondent was to engage in a sex offender treatment program, a better understanding of his offending and thoughts would be achieved and place both the Court and the psychiatrists in a far better position for the purposes of assessing risk.[12]

[45] Dr Beech was of the opinion that even if the respondent was to be released without being subject to a supervision order, his risk of further sexual violence would probably be a "bit below" the average sex offender. This risk would reduce to low if he were subject to a supervision order because the respondent would be monitored and his movements would be limited. He would also have to engage in psychological treatment.[13]

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[11] Transcript of proceedings, 30 November 2015, 1-4, lines 19-33.
[12] Transcript of proceedings, 30 November 2015, 1-4, lines 30-33; 1-7, lines 35-45.
[13] Transcript of proceedings, 30 November 2015, 1-5, lines 1-41.

[46] Whilst Dr Beech accepted that the respondent had no known paraphilia he added this qualification:[14]

> "… I believe so, and the caveat to that are – I think it's the known unknowns.
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> …
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> I can't see anything further suggests of paraphilia but there was a ritualistic aspect to the offence. You know, this is his only sexual violence offence we can see, it's the only one that's been detected. The worry is he's been a drifting man throughout – throughout Australia, so there are worries, but, from what you see, I think that what you say is true, that a supervision order would further reduce the risk."

[47] Dr Beech further clarified this qualification:[15]

> "… [t]he concern is that what has – what has not been disclosed is that he's got a paraphilia, that, you know, he's been thinking about this over time, that he's got it in his head a fantasy about how this will go, and – so that's why there was a ritualistic aspect to it. If that's true, if he has been fantasising about it before that offence and if he's continued to fantasise about similar offences, then I think the risk is higher because he's got that form of paraphilia, that form of sexual deviance, but we've not – the difficulty is we've not seen that, and the earlier assessments by psychiatrists who saw him way back at the time of the offence didn't detect anything like that. He's not disclosed anything like that over the 14 years that he's been custody, and it doesn't come across when you assess him; however, he does minimise much of the activity, so the – the short answer is yes. It's a worry. It's a worry that – and it does elevate the risk, but even then, he's only – and he's, throughout his adult life, only acted once on that fantasy."

Psychiatric and risk assessment report by Dr Scott Hardin dated 7 November 2015

[48] Dr Harden noted that it was difficult to obtain a clear and coherent history from the respondent of his actions and motivations as he continually put forward the proposition that the index offence had occurred as a result of a psychotic or bipolar illness on his part, and he interpreted the events in that light.

[49] Dr Harden noted that, in general, the respondent described a high level of remorse and distress at the offences, but then rapidly switched into his description of how they had to be related to a mental illness on his part. In response to questions about the risk of him offending again, he said that effectively it was not an issue as "I understand what has happened, I've been upfront, I'm a responsible person". He also said that he thought he should see a psychiatrist and have medication for his putative mental illness and that if counselling was said to be indicated, he would "probably take both".

[50] The respondent said that being in custody was "absolute hell". He avoided associating with criminals, and he wished to be released and go into the bush.

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[14] Transcript of proceedings, 30 November 2015, 1-6, lines 31-39.
[15] Transcript of proceedings, 30 November 2015, 1-10, lines 7-18.

[51] Dr Harden noted that Professor Whiteford had reported on 27 March 2002, that while there was a history of educational underachievement and academic difficulties at school, as well as an itinerant lifestyle throughout his adult life, the respondent had no history of psychiatric treatment or neurological disorder. Professor Whiteford made a diagnosis of schizotypal personality disorder and believed that would explain the respondent's unusual psychological and cognitive symptoms and his long-standing difficulties with inter-personal relationships and work. There were no features depriving the defendant of any relevant capacities under the *Criminal Code* 1899 (Qld).

[52] Dr Harden noted that Professor Yellowlees, psychiatrist, in a report dated 23 April 2003, stated that diagnostically he agreed with Professor Whiteford that there was a personality disorder present, either schizotypal or paranoid in type, and there was no evidence of a major psychotic illness.

[53] Dr Harden noted that Dr Eve Timmins, psychiatrist, had provided a report from Prison Mental Health Service ("**PMHS**") dated 28 February 2012, wherein it was noted that the respondent had been seeing PMHS services since entering custody in 2002. Diagnostically on longitudinal assessment, he appeared to have a personality disorder with anti-social and some schizoid traits. Epilepsy had been ruled out on investigation 10 years previously. He had difficulties with engagement with his treating practitioners and Dr Timmins remained unconvinced that there were psychotic symptoms or a pervasive mood disorder.

[54] Dr Harden also noted that other forensic psychiatrists, including Dr Kinswell and Dr McVie during 2002 and 2003, had also made diagnoses of personality disorder with paranoid and schizoid features.

[55] Dr Harden noted that Annette O'Brien, Acting Senior Program Delivery Officer, had completed a sexual offending program assessment form, dated 10 January 2012, and had completed the Static 99R, giving the respondent a score of 0. This placed him in the low risk of sexual recidivism group. The respondent chose not to participate fully in the assessment and abused the staff member and left the interview room.

[56] Dr Harden applied a number of assessment instruments in order to measure the respondent's static risk factors, as follows:

- on the STATIC 99R, the respondent scored 3, placing him in the low-moderate risk category relative to other adult male sex offenders;

- on the STABLE 2007, the respondent had a score of 15/24, placing him in the high needs group in terms of sexual offenders dynamic risk;

- on the Sex Offender Risk Appraisal Guide, the respondent scored 15, placing him in category 6. In general people in that category had a 58% rate of violent or sexually violent reoffending at 7 years and a 76% rate at 10 years;

- on the Hare Psychopathy Checklist, the respondent scored 17, which was elevated, but not compared to the custodial population; and

- on the SVR-20 the respondent scored positive for 7 out of 20 items and possibility positive for 3 items, which placed him generally in a moderate risk category on that measure of sexual violence risk.

[57] Dr Harden noted that the respondent had a long history of isolation from others, social and occupational inconsistency and geographic restlessness associated with a consistent history of relatively minor criminal behaviour throughout his life. He had an inability to sustain intimate relationships, although no apparent difficulty in initially forming them. He also had a long-standing history of reporting unusual psychological symptoms, being preoccupied with inventions and having a rather suspicious attitude towards others.

[58] Dr Harden noted that the index offence was prolonged, violent and concerning because of the abduction and repeated assaults of a stranger female after isolating and physically incapacitating her. The respondent's version was that the events occurred effectively because of some mental disorder he had, and/or confluence of angry thoughts he was having about other people at the time.

[59] Dr Harden opined that there were a number of elements to the offence which were concerning. This included the respondent carrying a bag at the time which was effectively a rape kit, using sudden overwhelming physical assault to subdue the victim, moving her to a secondary site (his campsite), cutting off her clothes and immobilising her very effectively using a range of materials including duct tape for her mouth, the removal of her pubic hair (especially when that had already been removed), and his attempts to later wash her before and after the sexual assaults.

[60] Dr Harden stated that it was possible to see those elements as either a product of the respondent's unusual lifestyle, itinerancy, isolation and particular beliefs about feral creatures in the National Park or, alternatively to see those elements as being part of a very organised sexual offence.

[61] Dr Harden noted that the respondent said effectively that he did not attempt to evade capture after the offence. However, Dr Harden expressed the opinion that going to another State seemed inconsistent with that. Dr Harden noted that whilst the respondent maintained he had some sort of mental illness that explained his crime, he had seen a number of psychiatrists, none of whom believed he had a psychotic or severe mood disorder that would provide an explanation for the assault. Dr Harden noted that the respondent had resisted assessment and any kind of treatment program on that basis.

[62] Dr Harden diagnosed the respondent with meeting the diagnostic criteria for personality disorder, not otherwise specified, for mixed type, with paranoid and schizotypal elements.

[63] Dr Harden stated that most approaches to risk assessment were limited with the respondent as he had committed one very serious sexual offence that had been detected, and there was limited other information regarding his offence pathway. The other variable that made risk assessment difficult was the respondent's unusual personality and ongoing

preoccupation with the idea that he had a mental illness that was responsible for his offence. He was also poorly socially integrated into the community, with few or no protective factors prior to the offence and that had not improved, nor was there a meaningful plan for it to improve. Dr Harden expressed the opinion that that meant that although the standard risk assessment instruments would place the respondent at a moderate risk of offence following release, the error of measurement was much greater, and his risk could be somewhere between low-moderate up to the moderate-high range. However, a supervision order would reduce the risk to low.

[64] Dr Harden also stated that more data would probably be of some assistance in quantifying the respondent's risk of recidivism and individual or group psychological therapy for sexual offender treatment might be helpful in providing that data. Dr Harden was unconvinced that alcohol played a significant part in the offence and saw no reason for restrictions in that area.

Dr Harden's oral evidence

[65] Dr Harden accepted that if the respondent was to undertake a sex offender treatment program prior to being released from custody this would enable risk to be more reliably assessed.[16]

[66] He expressed the view that as the respondent disavows the index offence there is "a great deal we don't know".[17] He remains, however, of the opinion that the imposition of a supervision order in terms of the proposed draft would reduce the risk to a low level.[18]

[67] The respondent informed Dr Harden that he was willing to participate in a sexual offender treatment program in the community.[19]

[68] Dr Harden accepted that in terms of the proposed supervision order the respondent would be required to participate in a sexual offender treatment program in the community and undertake one on one counselling. In such circumstances Dr Harden was of the opinion that it may be "possible" that over time as the supervision order is administered more may be known about the respondent's thoughts behind his sexual offending.[20]

[69] Dr Harden described the necessary effect of the proposed supervision order as follows:[21]

> "… I think it's to avoid reconstructing the circumstances of his offence because in terms of risk, we don't have lots of other information to go on."

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16 Transcript of proceedings, 30 November 2015, 1-12, lines 1-6.
17 Transcript of proceedings, 30 November 2015, 1-12, lines 8-16.
18 Transcript of proceedings, 30 November 2015, 1-12, lines 45-46; 1-13, lines 1-2.
19 Transcript of proceedings, 30 November 2015, 1-13, lines 35-36. This is to be contrasted with the respondent's refusal to participate in such a course whilst in custody. This issue is further considered below.
20 Transcript of proceedings, 30 November 2015, 1-14, lines 32-46; 1-15, lines 1-2.
21 Transcript of proceedings, 30 November 2015, 1-15, lines 36-38.

[70] Dr Harden accepted that if the respondent participated in a sexual offender treatment program whilst in custody, it may assist in assessing the risk but such further information may not necessarily affect or change the way in which the risk "is contained".[22]

[71] Dr Harden was asked to explain the risk of re-offending in circumstances where there was a lack of data:[23]

> "… you've got an offence which looks, on the face of the facts, to be planned, organised and have ritualistic elements. And then a man who you don't have much access to his internal world because of his, effectively, saying that it was all related to, you know, a mental illness which doesn't appear to be present. So you – we've got a lack of data to explain some of the elements of the crime and so we can only hypothesise about them.
>
> …
>
> So the lack of understanding means we can't then necessarily plan as well … beyond the basic keeping a really close eye on what he does in the community."

[72] Dr Harden also considered it very concerning that the respondent had admitted to Dr Aboud that in relation to the index offence the respondent had homicidal thoughts:[24]

> "Your Honour, I think it's very concerning and I think Dr Beech once again identified that although, as best we can work it out, there's, you know, X chance of such a thing happening again probably – probably not greater than the medium sort of moderate range, if it were to happen, this is a very concerning offence there's not much difference between this offence and sexual homicide, even without knowing that there has been some very angry homicidal thoughts at times."

[73] Dr Harden also addressed the respondent lessening his responsibility for the index offence in that he was suffering from a mental illness at the time and his suggestion of a consensual element in relation to his offences:[25]

> "It probably is part of a pattern of denial and disavowal which means that – and while denial of an offence doesn't increase a risk of recidivism in and of itself, it means that people don't comply as frequently with the risk reduction strategies. So it interferes with the idea that I've committed this offence, I'm responsible for the offence, I have to be responsible for making sure that I take appropriate steps to manage myself so that this kind of thing doesn't happen again. It – in my view, it increases risk because it interferes with that process."

Risk assessment report of Dr Andrew Aboud dated 20 November 2015

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[22] Transcript of proceedings, 30 November 2015, 1-16, lines 31-35.
[23] Transcript of proceedings, 30 November 2015, 1-17, lines 17-36.
[24] Transcript of proceedings, 30 November 2015, 1-17, lines 40-46.
[25] Transcript of proceedings, 30 November 2015, 1-18, lines 17-24.

[74] Dr Aboud noted that on mental status examination, the respondent's speech was rather circumstantial and he repeatedly spoke past the point and became irritated if interrupted. The respondent seemed to have a list of points he wished to make in relation to any question and was not satisfied unless he was allowed to make those points and in the order he wished to make them. While his speech was odd and mannerisms intense, he was not obviously thought disordered (as seen in psychosis). There was no evidence of mood elevation or depression from his current presentation or from his descriptions of previous times in his life. However, he did say that he had been mildly depressed throughout his adult life. Cross-sectionally, Dr Aboud found no evidence of hallucinatory experience, although the respondent made reference to hearing a voice in his head at the time of the incident and also on a previous occasion. Dr Aboud found no clear evidence of delusional thinking, although some of the respondent's statements about his plans for inventions appeared far-fetched and overvalued and he clearly retained vulnerability to various paranoid interpretations (such as his view of conspiracy by prison authorities).

[75] Dr Aboud stated that the respondent was unable to readily answer direct questions with direct answers and instead was only able to do this with prompting, clarification and supporting encouragement. He tended to become pre-occupied with minor details which allowed him to become side tracked and ultimately tangential. His disposition was angry and belligerent at times and at other times calm and cooperative. That disposition appeared to relate to whether his version of events or personal narrative was being accepted or challenged.

[76] Dr Aboud noted that in the respondent's various explanations of his behaviour in relation to the index offences, he had consistently claimed that he was mentally unwell at the time and that his initial violent assault and rape behaviour was beyond his control. He disclosed that he was feeling very angry at the time of the offence and that his anger was toward a man who owed him money and he wished to seriously injure that man. Worryingly, he also described his anger, which may have therefore been displaced, as homicidal in intensity. However, he conceded that following his initial attack, his subsequent decision to hold the victim overnight and commit further sexual attacks upon her was done without any impact of mental health instability.

[77] Dr Aboud stated that the respondent was examined by two psychiatrists prior to attending court in 2003 and they concluded that he was not suffering from a mental illness that fulfilled criteria for a defence based on mental health. In fact they diagnosed schizotypal and paranoid personality disorder and concluded that the respondent was responsible for his actions at the material time. The respondent had subsequently resorted to, and continued to, displace responsibility for his actions on to his perception that he was suffering from a serious mental illness at the time. He was of the view that he required the prescription of anti-psychotic medication and would be able to live without risk of recurrence. He had been attended to by PMHS and been discharged by that service on the basis that he did not suffer from a major mental illness and did not require psychotropic medication. He presented as angry with the correctional and mental health services for not accepting his self-diagnosis and treatment needs. He had declined to participate in rehabilitation courses, including recommended sexual offender group therapy, stating that in his opinion it was not necessary.

[78] Dr Aboud noted that the respondent had led a somewhat unconventional and itinerant life and travelled widely within Australia. While he did not have an extensive prior history of sexual offending, he did have a previous conviction for indecent exposure when he was 28 years old, with the apparent precipitant being his feeling of anger towards the stranger victim(s).

[79] Clinically, it was Dr Aboud's opinion that the respondent likely suffers from a cluster A personality disorder, with both schizotypal and paranoid traits. Dr Aboud did not find any robust evidence to support a diagnosis of a major mental illness such as a psychotic or mood disorder. It appeared that there was a time in the past where the respondent regularly consumed alcohol and possibly cannabis and it was thus possible that he also met criteria for substance abuse disorders in respect of alcohol, and maybe cannabis. His personality structure accounted for his unusual presentation and for his various overvalued ideas, his persecutory positioning, his rather eccentric manner and communication style. His personality structure also explained his experience of quasi-psychotic symptoms and thus provided some understanding as to why he subjectively suffered from a major mental illness.

[80] Dr Aboud used six instruments to underpin the assessment of reoffending risk:

- on the Static 99R, the respondent scored 2, placing him in the group regarded as low-moderate risk of reoffending;

- on the Risk Matrix 2000/S, the respondent scored 2 for Step 2, with 2 "aggravated factors" for Step 2, which placed him in the group regarded as high risk of reoffending;

- on the Risk Matrix 2000/V, the respondent scored 1, which placed him in the group regarded as low risk of offending;

- on the Psychopathy Checklist (PCL-R), the respondent scored 20/40, which was a moderately significant score, but below the cut off point for a diagnosis for psychopathy;

- on the HCR-20, the respondent scored 14/20 for historical items, 6/10 for clinical items and 8/10 for risk management items giving an overall score of 28/40. Dr Aboud deemed the respondent's overall risk to be moderate to high, with a loading across static, current dynamic and future dynamic risk factors. Of particular concern was his relatively high score in the risk management items which suggested that his future risk for instability post-release required careful attention and that significant pre-release planning and engagement was indicated; aqnd

- on the Risk for Sexual Violence Protocol (RSVP), the respondent had positive scores for physical coercion and sexual violence, extreme minimisation or denial of sexual violence, problems with self-awareness, major mental illness (personality disorder) and problems with intimate and non-intimate relationships, employment, planning, treatment and supervision.

Dr Aboud considered the respondent had partial or possible scores for psychological coercion in sexual violence, attitudes that supported or condoned sexual violence, problems with stress or coping, sexual deviance (possible exhibitionism), psychopathic personality disorder (score of 20 on PCL-R), problems with substance use (past history of alcohol abuse), violent or suicidal ideation (issued threats) and non-sexual criminality.

[81] Dr Aboud opined that should the respondent reoffend sexually, it would take the form of opportunistic sexual behaviour with the preferred victim being an adult female. The victim may be a stranger. He may engage in behaviours so as to befriend the victim and take her to a remote place. Physical and psychological coercion were probable and use of serious violence (including incapacitation using a weapon) likely. He would attempt to engage his victim in masturbatory behaviour, oral sexual practice, digital rape and vaginal rape. He may try to control the victim by tying her up. Offending may take place in the background of psychosocial stressors, latent anger towards others and alcohol or substance use, but ultimately might need no precipitant beyond victim access and opportunity. He will likely employ significant cognitive distortions, including a belief that the victim was actively or passively willing to engage in such sexual activity and it was unlikely that he would regard the victim as seriously damaged by his behaviours and would seek to externalise and minimise responsibility.

[82] Dr Aboud stated that the respondent is afflicted with rather unusual personality vulnerabilities which impact on the way in which he thinks, his emotional interpretation and his behaviour. He had demonstrated little, if any, remorse. He likely had underlying deficits in his capacity to experience empathy. His self-view is flawed and he believes that to manage future risk his only need was to take a psychotropic medication that psychiatrists did not believe was indicated. Dr Aboud was concerned that in such an unusual case, standard risk assessment may be less reliable and it was hard not to be concerned about the respondent's capacity to displace anger. Even more worrying was the disclosure he made on interview with Dr Aboud that his anger was of homicidal severity, "I was thinking that if I'm going to kill Frank, I may as well rape her and kill her".

[83] Taking into consideration the various actuarial and dynamic assessments for future violence and sexual violence risk that had been applied, it was Dr Aboud's view that the respondent's overall risk was above moderate in respect of sexual re-offending. In coming to that conclusion Dr Aboud took into account the more worrying aspects of the respondent's risk profile, including the nature of the index behaviour, his lack of understanding of his vulnerabilities (and his flawed self-diagnosed psychiatric formulation), his distorted thinking, his problems with self-awareness, his lack of supports, his failure to participate in recommended group therapy and his lack of realistic post-release plan. However, Dr Aboud did recognise that the respondent had matured during his incarceration and that he did not have a history of prior sexual offending of that severity.

[84] In Dr Aboud's opinion, if the respondent was to successfully complete the recommended group sexual offender treatment program in custody, then his risk would be reduced to below moderate and would likely be considered manageable in the community in context of the supervision order, coupled with successful engagement in comprehensive future planning. If the respondent declined to participate in the recommended group sexual

offender treatment program, Dr Aboud believed that it was necessary to engage him in motivational work in order to help him understand the importance of such participation. Without participation in such a program, his risk would remain less well understood. In the respondent's case, this would not be an acceptable situation, given the potential severity of offence behaviour should recurrence occur.

[85] Dr Aboud expressed the opinion that if and when the respondent is released to the community, important considerations for future management were: access to stable accommodation, provision of ongoing professional support from a psychologist in the community (to assist with possible sexual deviance, emotional and sexual regulation, problem solving skills, intimacy deficits, alcohol and substance vulnerabilities) and efforts to improve support networks.

Dr Aboud's oral evidence

[86] Dr Aboud was present in Court when Dr Beech and Dr Harden gave evidence.

[87] Unlike Doctors Beech and Harden, he was of the opinion that the respondent should undertake a sex offender treatment program prior to being released from custody.[26] In order for the respondent to participate in such a program Dr Aboud stated that the respondent may first need to participate in intensive individual psychological treatment to ready him to do the program.[27]

[88] Dr Aboud's concerns about the respondent being released into the community and then undertaking psychological treatment is that the respondent is not sufficiently understood so as to appreciate his risk profile.[28]

[89] Whilst Dr Aboud accepted that the conditions in the proposed supervision order would reduce the risk, he is not persuaded that it would reduce it to a low level if the respondent had not already engaged in the sexual offender treatment program.[29]

[90] Dr Aboud opined that in the absence of the respondent undertaking the program, one could only hope that the restrictions of the supervision order would be enough:[30]

> "… it would be actually speculatively hopeful in his unusual case of a man who has been really quite migratory and never contained. We do not know if such containment is going to frustrate him, and it would appear that while we don't have many examples, there was certainly one key example when he was frustrated and angry, and it led to a very serious course of action on his part."

Efforts by the respondent to address the causes of his offending behaviour: section 13(4)(e)

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[26] Transcript of proceedings, 30 November 2015, 1-20, lines 15-16.
[27] Transcript of proceedings, 30 November 2015, 1-26, lines 38-41.
[28] Transcript of proceedings, 30 November 2015, 1-27, lines 26-28.
[29] Transcript of proceedings, 30 November 2015, 1-30, lines 15-23; 1-31, lines 1-3.
[30] Transcript of proceedings, 30 November 2015, 1-32, lines 3-7.

[91] The respondent was assessed for a sexual offenders program in 2012.[31] He chose not to participate in the assessment and instead abused a staff member and left the interview room. He declined to participate in the Getting Started: Preparatory Program ("**GS:PP**") on 12 January 2012, 16 March 2012 and 6 May 2014, despite being recommended to participate in the program.[32]

[92] The GS:PP is a mandatory preparatory program designed to motivate offenders to participate and address their offending in a more intensive treatment program, reduce anxiety to being in a group environment, identify any possible barriers to offenders participating on a more intensive sexual offending program and increase offenders' belief in the ability to change and maintain any such change.[33]

[93] The respondent told Dr Harden that the idea of him being involved in any kind of sexual offending treatment or programs was abhorrent and that there were legal implications. The respondent stated that because of his alleged bipolar illness and because he was not on medication he would not be able to hold it together and that if he was to undertake any offender courses it would have to be on "the outside".[34]

Propensity or pattern of offending behaviour: section 13(4)(c) and (d)

[94] From a consideration of the respondent's criminal history and the psychiatric evidence, the index offences appear to be a one-off occurrence committed close to 14 years ago. It cannot be said in terms of s 13(4)(d) that the material reveals any "pattern of offending behaviour".

[95] As to s 13(4)(c) the ordinary meaning of the word "propensity" is "natural or habitual inclination or tendency".[35] It is difficult to determine as a matter of fact whether there is any propensity on the part of the respondent to commit serious sexual offences in the future. Dr Beech did not think that there was any significant evidence of a paraphilia but he noted certain elements of the index offending which may have been ritualistic. I also note Dr Beech's caveat as to the possibility of an underlying paraphilia outlined in paragraph [47] above. The difficulty is that so little is known in relation to the triggers that led to the index offending.

Is the respondent a serious danger to the community in the absence of a division 3 order?

[96] The respondent will be a serious danger if there is an unacceptable risk that he will commit a serious sexual offence if released from custody or released from custody without a supervision order being made.[36] In deciding whether the respondent is a serious danger to the community one of the matters the Court must have regard to is the risk that

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31 Exhibit MJB-2 to the affidavit of Michael Joseph Beech sworn 10 August 2015, 11, line 585.
32 Affidavit of Jolene Monson affirmed 26 November 2015, [5].
33 Affidavit of Jolene Monson affirmed 26 November 2015, [6].
34 Exhibit 2, report of Dr Scott Harden dated 7 November 2015, 6, lines 19-23.
35 Macquarie Concise Dictionary, 5th ed.
36 *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) s 13(2).

the respondent will commit another serious sexual offence if released into the community and the need to protect members of the community from that risk.[37]

[97] The respondent submits that the Court would not be satisfied to the requisite standard that he is a serious danger to the community in the absence of a division 3 order. He only has one conviction for a serious episode of sexual offending committed when he was 49 years of age. He is now 63. His age, it is submitted, is a significant factor in reducing risk. I note, however, Dr Aboud's evidence that even though the respondent is now 63 years of age he is physically fit and well. Dr Aboud was less sure that the effects of the respondent's age on the risk of re-offending would be the same as for other typical sexual offenders. This is because personalities such as the respondent "with his mix of schizotypal and paranoid traits is less common".[38]

[98] The respondent also referred to the concession made by Dr Beech in his report dated 25 February 2015 which I have set out above at paragraph 35(a).[39] The concession was that there is a possible scenario that if the respondent were to be released into the community without a supervision order he would simply go back into his earlier drifter lifestyle, seek to get the pension and with that support live in campsites as he pursues his itinerant vocation but without repeating further sexual violence. This was however, only one possible scenario suggested by Dr Beech. The more worrying scenario identified by Dr Beech is outlined in paragraph 35(b) above. According to that second scenario there may be a significant risk that if the respondent were to re-offend, the victim would suffer severe physical injury because the respondent lacked empathy and self-awareness. Further, I note that both Dr Harden and Dr Aboud qualified the effectiveness of any usual risk assessment in respect of the respondent.[40]

[99] By reference to the considerations in s 13(4), I am satisfied to the requisite standard that the respondent is a serious danger to the community in the absence of a division 3 order. The circumstances of the index offences outlined in paragraphs 15 to 18 above are in themselves extremely concerning. What adds to the concerning nature of the index offences is the lack of insight of the respondent into his own conduct. As identified by Dr Harden, the respondent has an ongoing preoccupation with the idea that he had a mental illness that was responsible for his offences.[41] The respondent's lack of insight into his offending is also evidenced by his suggestion that the victim, at least in part, consented to sex.[42] As identified by Dr Beech, the respondent was a reluctant and difficult interviewee which became more evident as the index offences were explored.

[100] Whilst Dr Beech opined that the respondent falls within the range of low to moderate risk of further sexual violence, he accepted that it is difficult to properly assess the risk posed by the respondent's release. As stated by Dr Beech much is "hidden" about the respondent.[43]

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37 *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) s 13(4)(h), (i).
38 Transcript of proceedings, 30 November 2015, 1-22, lines 40-47; 1-23, lines 1-11.
39 See also Dr Harden's concession at transcript of proceedings, 30 November 2015, 1-16, lines 26-29.
40 See [63] and [82] above and transcript of proceedings, 30 November 2015, 1-30, lines 15-45.
41 See [65] above.
42 See [29] above.
43 See [44] above.

[101] Dr Harden acknowledged that most approaches to risk assessment were limited with the respondent as he had committed one very serious sexual offence that had been detected and there was limited other information regarding his offence pathway. Although according to Dr Harden the standard risk assessment instruments would place the respondent at a moderate risk of offence following his release, the error of measurement was much greater and the respondent's risk could be somewhere between low to moderate up to moderate to high range.

[102] Dr Harden described the index offences as planned, organised and having ritualistic elements.[44] He considered it very concerning that there is not much difference between the index offences and sexual homicide.[45]

[103] Dr Aboud assessed the respondent's overall risk of sexual re-offending at above moderate. He identified what he described as worrying aspects of the respondent's risk profile including the nature of the index behaviour, his lack of understanding of his vulnerabilities, his distorted thinking, his problems with self-awareness, his lack of supports, his failure to participate in recommended group therapy and his lack of realistic post-release plan.[46] Dr Aboud identified the possible circumstances under which the respondent may re-offend sexually. As to what would precipitate such sexual re-offending, Dr Aboud opined that ultimately the respondent might need no precipitant beyond victim access and opportunity.[47]

[104] Having been satisfied to the requisite standard in terms of s 13(1), the real issue is what order should be made pursuant to s 13(5). The Attorney-General seeks a continuing detention order, whereas the respondent seeks to be released on the proposed supervision order.

The appropriate order

[105] In oral submissions Counsel for the respondent stated that he sought to "persuade [the Court] that a supervision order should be made".[48] As it is the Attorney-General that seeks a continuing detention order, the onus rests with the Attorney-General to establish that that is the appropriate order. As observed by Chesterman JA in *Attorney-General for the State of Queensland v Lawrence*:[49]

> "If an application is brought under the Act and the Attorney discharges the onus of proving that the prisoner in question is a serious danger to the community, the pre-condition for making an order under s 13(5) will have been satisfied. Invariably, or almost invariably, satisfaction of the pre-condition will satisfy the Court that it should make a continuing detention order or a supervision order. If the Attorney-General contends that the 'starting position' should be displaced and a continuing detention order be made then, in my opinion, there is an onus on him to prove that that is the

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44 See [74] above.
45 See [75] above.
46 See [86] above.
47 See [84] above.
48 Transcript of proceedings, 30 November 2015, 1-39, lines 1-3.
49 [2010] 1 Qd R 505, 512 [31] (Chesterman JA).

> appropriate order. This necessarily involves proving that the community will not be adequately protected by a supervision order."

[106] The "starting position" referred to by Chesterman JA is a reference to the decision of the Court of Appeal in *Attorney-General for the State of Queensland v Francis*[50] where the Court referred to a supervision order as being the preferred order to a continuing detention order on the basis that the intrusions of the Act upon the liberty of a subject are exceptional:

> "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 of 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."

[107] To similar effect is the statement of McMurdo J (as his Honour then was) in *Attorney-General for the State of Queensland v Sutherland*:[51]

> "What must be proved is that the community cannot be adequately protected by a supervision order. Adequate protection is a relative concept. It involves the same notion which is within the expression 'unacceptable risk' within s 13(2). In each way the statute recognises that some risk can be acceptable consistently with the adequate protection of the community."

[108] As recently observed by Morrison JA (with whom Philippides JA and Douglas J agreed) in *Turnbull v Attorney-General for the State of Queensland*:[52]

> "Once the learned primary Judge reached the conclusion that Mr Turnbull came within the provisions of s 13(1) of the Act, he was required to consider whether either a continuing detention order or a supervision order should be made: s 13(5) of the Act. In considering whether to make such an order, s 13(6) required consideration of the two factors: first, that the paramount consideration was the need to ensure adequate protection of the community; and secondly, consideration of whether adequate protection of the community can be reasonably and practicably managed by a supervision order.
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> The consideration required under s 13(6)(b)(i) is whether adequate protection of the community can be reasonably and practicably managed by a supervision order. The risk which leads to the need to protect the community is because, under s 13(1) and (2), there is an unacceptable risk that Mr Turnbull will commit a serious sexual offence if released without such an order. The means of providing the protection, and avoiding that risk, is a supervision order. When a court is assessing whether a supervision order can

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50 [2007] 1 Qd R 396, 405 [39] (Keane and Holmes JJA and Dutney J).
51 [2006] QSC 268, [29].
52 [2015] QCA 54, [35]-[36] (Morrison JA).

> reasonably and practically manage the adequate protection of the community, it is necessarily assessing the protection the order can provide against that risk. Before making the order the Court has to reach a positive conclusion that the supervision order will provide the adequate protection." (footnotes omitted)

[109] The Attorney-General submits that a continuing detention order should be made because the respondent is an untreated sex offender who committed a callous and violent tranche of offences against his victim; he has shown little apparent empathy and has continued to attribute his behaviour to mental illness, despite the fact that numerous psychiatrists have failed to find any mental disorder other than a personality disorder schizotypal, antisocial and paranoid traits. His real level of risk of committing a further sexual offence would be better able to be understood and assessed with a greater level of accuracy if he participated in a sexual offender treatment program and that should occur prior to his release on a supervision order.[53]

[110] The respondent submits, however, that the proposed supervision order has the effect of imposing stringent conditions on the respondent, significantly constraining his liberty for a period of five years.[54] Counsel for the respondent identifies the relevant risk if the respondent was to be released back into the community as being that he may reside in an isolated place where his psychological state was unmonitored; that he may have a chance encounter with a female in an isolated location and may react in a sexually violent way.[55] Counsel submits that the supervision order would prevent the respondent going unsupervised to an isolated place.[56] Further, that although the respondent has not participated in any treatment program, he has been assessed by various psychiatrists over the years and a good deal of information is known about him.[57]

[111] The real difficulty with this case however, is that so much is unknown. As noted by Dr Beech much is "hidden" about the respondent.[58] Morrison JA in *Turnbull v Attorney-General for the State of Queensland* observed:[59]

> "In my view that exercise involves the court's consideration of what is known, as well as what is unknown, about the risk, as both of those matters impact upon the ability of the supervision order to provide adequate protection. Given that the risk will almost always be assessed by psychiatric experts, any unknown element is likely to be the product of the extent of the assessment of the risk posed by the offender, such as where further assessment of the offender is required before a more definite conclusion can be made as to the risk. For example, the experts may say, as they do here: on the one hand, if the triggers for the risk are use of alcohol and illicit substances, that can be reasonably and practically managed under a supervision order; however, on the other hand, if the triggers are some form of psychopathy, sexual sadism, or even the product of a well spring of anger

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53 Applicant's amended outline of submissions undated, [92].
54 Transcript of proceedings, 30 November 2015, 1-39, lines 39-45.
55 Transcript of proceedings, 30 November 2015, 1-40, lines 24-31.
56 Transcript of proceedings, 30 November 2015, 1-40, lines 45-47; 1-41, line 1.
57 Transcript of proceedings, 30 November 2015, 1-43, lines 1-8.
58 Transcript of proceedings, 30 November 2015, 1-4, lines 19-33.
59 [2015] QCA 54, [37].

> directed at women, then the risk cannot be reasonably and practically managed; we do not know enough to say that psychopathy, sexual sadism, or the wellspring of anger, are not the relevant triggers, so we cannot say that the order will provide adequate protection."

[112] I note in *Turnbull's* case that the reason the prisoner had not undertaken the high intensity sexual offender program was not because of his unwillingness but rather as a result of the success of his appeal where his sentence was reduced. I further note in relation to *Turnbull's* case that the psychiatric evidence was unanimous that Turnbull should undertake the relevant program prior to release so as to permit a proper assessment following completion of the course. The reasoning of the Judge at first instance referred to by the Court of Appeal was that the triggers for the escalating sexual violence had to be identified before any consideration could be made as to whether any conditions could be formulated which would make the risk of sexual re-offending no longer unacceptable.[60]

[113] In the present case there is a divergence of psychiatric opinion. Dr Aboud believes that the respondent should undertake the relevant course whilst in custody, while Drs Beech and Harden accept that such a course could be undertaken in the community as part of the respondent's supervision order. Before I consider the evidence in this respect in more detail there are two preliminary observations to make. First, the evidence discloses that the GS-PP course is available to the respondent both in custody and in the community. The High Intensity Sexual Offending Program (HISOP) is only available in custody. The program consists of 116 sessions of three hours duration and runs for approximately nine months. The earliest commencement date for this program is September 2016 at the Wolston Correctional Centre. [61]

[114] The Medium Intensity Sexual Offending Program (MISOP) is available both in custody and in the community. If the respondent were to be detained in custody, the High Risk Offender Management Unit would be able to arrange for a referral to a suitably qualified psychologist to attend upon the respondent in custody to assist him with developing a preparedness to engage in a group-based program. Such an arrangement for one on one counselling is perhaps easier to arrange if the respondent was released into the community.[62] If there was any difficulty in terms of access to a psychologist for one on one counselling if the respondent was detained in custody, Dr Aboud suggested that the respondent could be moved from the Maryborough Correctional Centre to possibly Wolston Correctional Centre in order to have available to him a wider range of suitable psychologists.[63]

[115] The second preliminary matter is that counsel for the respondent submitted that I should prefer the evidence of Dr Beech and Dr Harden over that of Dr Aboud because of their experience in giving evidence in these types of proceedings on "countless occasions".[64] In cross-examination Dr Aboud stated that he had given evidence in dangerous prisoner

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[60] *Turnbull v Attorney-General for the State of Queensland* [2015] QCA 54, [17] (Morrison JA).
[61] Affidavit of Jolene Monson, affirmed 26 November 2015, [11], [14]-[16], [19]-[22].
[62] Transcript of proceedings, 30 November 2015, 1-14, lines 27-42; 1-29, lines 20-27, 37-47.
[63] Transcript of proceedings, 30 November 2015, 1-29, lines 45-47; 1-30, lines 1-2.
[64] Transcript of proceedings, 30 November 2015, 1-41, lines 40-43.

applications on approximately 10 to 12 occasions.[65] The mere fact that Drs Beech and Harden have given evidence in dangerous prisoner applications more often than Dr Aboud does not, in my view, detract from the force of Dr Aboud's opinion. He is the Director of Prison Mental Health and in that position has had regular contact with mentally disordered offenders in custody who have committed a wide range of offences, including sexual offences.[66] He trained in London in the early 2000s and his particular area of specialist interest was the assessment and management of sexual offenders. He was trained some 10 years ago in use of the risk assessment instruments which he used to assess the respondent. He has also been the facilitator of group therapy in London in relation to treating sexual offenders in the community.[67]

[116] It was suggested to Dr Aboud in cross-examination that the opinions he expressed were out of step with those of Dr Beech and Dr Harden. He acknowledged the differences in opinion as follows:[68]

> "I think there's overlap between what I'm saying and what Dr Harden and Beech have been saying, but I would agree that they have reported more, shall we say, flexibility in their understanding of the need for the sex offender treatment and, in particular, its timing as to where it might occur."

[117] Doctors Beech and Harden both accepted that the risk of the respondent re-offending would be low if he was to be released on a supervision order. This is because the respondent is now 63 years of age and there has been a process of maturation whilst in custody. A supervision order would monitor and restrict the respondent's movements and he would have to engage in psychological treatment.

[118] There are, however, significant caveats to both Dr Beech's and Dr Harden's risk assessments. These caveats refer to what is unknown about the respondent's index offending and whether there is an underlying paraphilia.

[119] Dr Beech did not know whether there would be a difference in the engagement of the applicant in a treatment course if it was undertaken in custody rather than in the community:[69]

> "I don't know what would happen if you put it to him that you are staying in custody until you complete a supervision order – sorry – until you complete a course. I don't know if that's been put to him."

Dr Beech stated that the respondent would find it hard to engage in group processes.[70]

[120] It was unclear to Dr Harden as to why the respondent had refused to participate in a sex offender's course in custody. There was a degree of non-compliance with being asked to do such a program. Dr Harden could not understand why the respondent would have any

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65 Transcript of proceedings, 30 November 2015, 1-32, lines 17-20.
66 Transcript of proceedings, 30 November 2015, 1-33, lines 15-19.
67 Transcript of proceedings, 30 November 2015, 1-33, lines 19-37.
68 Transcript of proceedings, 30 November 2015, 1-32, lines 9-15.
69 Transcript of proceedings, 30 November 2015, 1-7, lines 30-33.
70 Transcript of proceedings, 30 November 2015, 1-7, line 25.

concerns as to the legal implications such as self-incrimination in participating in such a program given that the respondent has been convicted.[71] Dr Harden accepted that the lack of understanding of the internal world of the respondent means that in terms of a supervision order, it is difficult to plan "beyond the basic keeping a really close eye on what he does in the community".[72] Where so little is known about the respondent's thought process behind the index offending and where he minimises responsibility for his actions, I do not accept that adequate protection of the community is ensured by hoping to keep a "really close eye" on what the respondent does upon his release on a supervision order. Nor should one hope to properly assess the respondent's risks of re-offending through treatment after he has been released into the community on a supervision order. This should be done prior to his release.

[121] Dr Harden accepted that it was "possible" that if the respondent engages in counselling if released upon a supervision order, more may be discovered about his thinking in relation to sexual offending generally.[73] What Dr Harden saw as particularly important was to avoid any reconstruction of the circumstances of the respondent's index offending because, in terms of his risk, the psychiatrists did not have much information to go on.[74]

[122] The respondent told Dr Aboud that he did not wish to spend any more time in prison. Dr Aboud did not view that as a good enough reason not to engage in a sex offender program whilst in custody which would assist in the better understanding of the respondent's motivation to offend, his risk profile and the interventions that may be necessary to prevent a repeat offence.[75] Dr Aboud in oral evidence explained in detail his concerns arising from the fact that the respondent refuses to undertake any course whilst in custody:[76]

> "Mr Spoehr is a man who has not provided any rich, detailed, meaningful information that reflects that he is self-aware or that he has any real insight into his behaviour at the time. He has, what I believe, is a flawed self view that he suffers from a major mental illness and that that major mental illness in itself explains why he committed the acts at the time. With that, he believes that the prescription of an antipsychotic medication will totally reduce all risk of recidivism. However, he has been assessed by more than one psychiatrist, including myself, who have – are of the view that he does not suffer from that major mental illness and, therefore, the prescription of an antipsychotic medication is not going to reduce his risk at all. It is on the basis of his flawed self view that he does not believe that he requires to engage in a sexual offender program and, in fact, he also had told me that he doesn't want to do any more time in prison. So it strikes me that he fails to understand himself, his underlying motivation for his offending, that he fails to understand what the appropriate treatment might be, and I believe it would be the right thing to give him the opportunity to embrace the necessary recommended treatment rather than another treatment that is not recommended or, indeed, necessary, medication."

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71 Transcript of proceedings, 30 November 2015, 1-13, lines 41-45.
72 See [71] above.
73 Transcript of proceedings, 30 November 2015, 1-14, lines 44-46; 1-15, lines 1-2.
74 Transcript of proceedings, 30 November 2015, 1-15, lines 35-38.
75 Transcript of proceedings, 30 November 2015, 1-20, lines 36-43.
76 Transcript of proceedings, 30 November 2015, 1-20, lines 18-34.

[123] The respondent did not give evidence. I do not have the benefit of any detailed explanation from him as to why he has consistently refused to undertake sexual offender treatment programs in custody. The Court must rely on his own self reporting to the assessing psychiatrists as to why he refuses to undertake such a course. Further, as he has not undertaken any treatment whilst in custody there is a great deal of reliance on his own self-reporting. As Dr Aboud observed:[77]

> "The only information that we have on Mr Spoehr relates to the – to his own self report in – across a number of assessments and also information that has been provided perhaps in the witness statement by his victim. I don't think that we truly understand what he was thinking at the time of the offending. We are making assumptions about, for example, the importance of isolated places and national parks. We have one offence upon which we're basing all this information and we're also getting a self report from a man who is lacking insight, is not self-aware, is in part in a process of denial and not wanting to take responsibility for his actions. … what this means to me is that he requires quite a lot of psychological support and intensive work in order for him to take the next reasonable steps to developing a better understanding of himself and that the system should – should develop a better understanding of his risk profile. We are basing a lot on very little."

[124] I accept this evidence and find it compelling. In light of the significant qualifications and caveats made to the opinions of Doctors Beech and Harden, I am of the view that the Court is simply not in a position to properly identify the risk of re-offending when so little is known in relation to the triggers for the respondent's index offending. I accept therefore that the Attorney-General has satisfied the Court that adequate protection of the community cannot be reasonably and practicably managed by the proposed supervision order. The respondent's real risk of committing a further sexual offence would be better understood and assessed if he was to first undertake one on one psychological counselling and participate in an appropriate sexual offenders program prior to his release on a supervision order.

Disposition

[125] The Court, being satisfied to the requisite standard that the respondent 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 (Qld), the Court orders that pursuant to s 13(5)(a) of the Act, the respondent Kym Spoehr be detained in custody for an indefinite term for control, care or treatment.

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[77] Transcript of proceedings, 30 November 2015, 1-21, lines 17-30.

Annexure "A"
Attorney-General for the State of Queensland v Kym Spoehr

1. Upon his release from custody on 23 January 2016, the respondent be subject to the following conditions until 23 January 2021:

The respondent must:

Statutory requirements

1. report to a Corrective Services officer at the Queensland Corrective Services Probation and Parole Office closest to his place of residence between 9:00am and 5:00pm on the day of release from custody, and at that time advise the officer of his current name and address;
2. report to, and receive visits from, a Corrective Services officer at such times and at such frequency as directed by Queensland Corrective Services;
3. notify a Corrective Services officer of every change of his name, place of residence or employment at least two business days before the change happens;
4. be under the supervision of a Corrective Services officer;
5. comply with a curfew direction or monitoring direction;
6. comply with any reasonable direction under section 16B of the Act given to him;
7. comply with every reasonable direction of a Corrective Services officer that is not directly inconsistent with a requirement of this order;
8. not leave or stay out of Queensland without the permission of a Corrective Services officer;
9. not commit an offence of a sexual nature during the period of this order;

Employment

10. seek permission and obtain approval from a Corrective Services officer prior to entering into an employment agreement or engaging in volunteer work or paid or unpaid employment;
11. notify a Corrective Services officer of the nature of his employment, or offers of employment, the hours of work each day, the name of his employer and the address of the premises where he is or will be employed at least two (2) days prior to commencement or any change;

Accommodation

12. reside at a place within the State of Queensland as approved by a Corrective Services officer by way of a suitability assessment and obtain written approval prior to any change of residence;
13. if this accommodation is of a temporary or contingency nature, comply with any regulations or rules in place at this accommodation and demonstrate reasonable efforts to secure alternative, viable long term accommodation to be assessed for suitability by Queensland Corrective Services;
14. not reside at a place by way of short term accommodation including overnight stays without the permission of a Corrective Services officer;

Indictable Offences

15. not commit an indictable offence during the period of the order;

Contact with victims

16. not have any direct or indirect contact with a victim of his sexual offences;

Motor Vehicles

17. notify a Corrective Services officer of the make, model, colour and registration number of any vehicle owned by or generally driven by him, whether hired or otherwise obtained for his use;

Activities and Associates

18. respond truthfully to enquiries by a Corrective Services officer about his activities, whereabouts and movements generally;
19. disclose to a Corrective Services officer upon request the name of each person with whom he associates and respond truthfully to requests for information from a Corrective Services officer about the nature of the association, address of the associate if known, the activities undertaken and whether the associate has knowledge of his prior offending behaviour;
20. submit to and discuss with a Corrective Services officer a schedule of his planned and proposed activities on a weekly basis or as otherwise directed;
21. if directed by a Corrective Services officer, make complete disclosure of the terms of this supervision order and the nature of his past offences to any person as nominated by a Corrective Services officer who may contact such persons to verify that full disclosure has occurred;

Alcohol and Drugs

22. abstain from the consumption of alcohol and illicit drugs for the duration of this order;
23. submit to any form of drug and alcohol testing including both random urinalysis and breath testing as directed by a Corrective Services officer;
24. disclose to a Corrective Services officer all prescription and over the counter medication that he obtains;
25. not visit premises licensed to supply or serve alcohol, without the prior written permission of a Corrective Services officer;

Medical

26. attend upon and submit to assessment, treatment, and/or medical testing by a psychiatrist, psychologist, social worker, counsellor or other mental health professional as directed by a Corrective Services officer at a frequency and duration which shall be recommended by the treating intervention specialist;
27. permit any medical, psychiatrist, psychologist, social worker, counsellor or other mental health professional to disclose details of treatment, intervention and opinions relating to level of risk of re-offending and compliance with this order to Queensland Corrective Services if such a request is made for the purposes of updating or amending the supervision order and/or ensuring compliance with this order;
28. attend any program, course, psychologist, social worker or counsellor, in a group or individual capacity, as directed by a Corrective Services officer in consultation with treating medical, psychiatric, psychological or other mental health practitioners where appropriate;

Risk Management Plan

29. develop a risk management plan in consultation with a treating psychologist or psychiatrist and discuss it as directed with a Corrective Services officer;

National and Regional Parks and State Forests

30. not visit national parks, regional parks or state forests without the prior written approval of a Corrective Services officer;

Telephones and Devices

31. allow any device including a telephone to be randomly examined. If applicable, account details and/or phone bills are to be provided upon request of a Corrective Services officer;
32. advice a Corrective Services officer of the make, model and telephone number of any mobile telephone owned, possessed or regularly utilised by him within 24 hours of connection or commencement of use, and this includes reporting any changes to mobile telephone details.