SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General (Qld) v Watkins* [2017] QSC 5
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) v **CHISTOPHER COLIN WATKINS** (respondent)
FILE NO/S:	BS No 10338 of 2016
DIVISION:	Supreme Court at Brisbane
PROCEEDING:	Originating Application
DELIVERED ON:	6 February 2017
DELIVERED AT:	Brisbane
HEARING DATE:	30 January 2017
JUDGE:	Brown J
ORDERS:	**The orders of the court are that:** 1. Pursuant to s 13(5)(a) of the Act the respondent, Christopher Colin Watkins, be detained in custody for an indefinite term for control, care or treatment. 2. The applicant provide the reports of Dr Grant, Dr Lawrence and Dr McVie and a transcript of these proceedings to the Prison Mental Health Service and Forensic Mental Health Service.
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY– where there is an application pursuant to s 5 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 for an order pursuant to Division 3 of Part 2 of that Act – whether the respondent is a serious danger to the community in the absence of a Division 3 order – where the Court may order a continuing detention order or a supervision order pursuant to s 13(5) of the Act – whether the adequate protection of the community can be reasonably and practicably managed by a supervision order – whether the requirements under s 16 of the Act can be reasonably and practicably managed by corrective services officers

COUNSEL:	BHP Mumford for the applicant K Bryson for the respondent
SOLICITORS:	Crown law for the applicant Legal Aid Queensland for the respondent

[1] **BROWN J**: The applicant, the Attorney-General for the State of Queensland, seeks a Division 3 order pursuant to s 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 ("the Act"). The applicant primarily seeks an order for the continued detention of the respondent, Christopher Colin Watkins, but in the alternative seeks an order that the respondent be released subject to a supervision order under s 13(5)(b) of the Act. The applicant relies on psychiatric assessments provided under the Act, together with affidavit evidence which includes, inter alia, a psychiatric report of Dr Grant, sentencing remarks, the respondent's criminal history and the material provided to the psychiatrists for their consideration. The respondent has not presented any evidence.

[2] Mr Watkins' full time release date is 7 February 2017.

[3] In order for s 13 of the Act to apply, the Court must be satisfied that the respondent is a serious danger to the community[1] in the absence of a Division 3 order. The Attorney-General has the onus of proving this requirement. Pursuant to s 13(3) of the Act, the Court may decide that it is satisfied as required under ss (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 determining whether a prisoner is a serious danger to the community as referred to in ss (1) of s 13, the Court must have regard to the matters set out in ss (4).

[5] 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. 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. In so considering, the Court must consider whether adequate protection of the community can be reasonably and practicably managed by a supervision order; and whether requirements under s 16 can reasonably and practicably be managed by corrective services officers.

Psychiatric opinion

[6] Three psychiatric reports were relied on by the applicant. Dr Donald Grant carried out a preliminary psychiatric assessment and provided a report dated 12 April 2016. Dr Joan Lawrence provided a report[2] and supplementary report.[3] Dr McVie provided a report dated 30 December 2016.[4] Both Dr Lawrence and Dr McVie were appointed to provide reports pursuant to s 11 of the Act.

Respondent's criminal history

[1] As defined in the Act.
[2] Exhibit 1.
[3] Exhibit 2.
[4] Exhibit 3.

[7] The respondent is a 47 year old man. Prior to 1990, the respondent had been convicted of a number of offences, which are set out in the criminal history in the affidavit of Ms Murphy[5] at ex CLN-2 and in the psychiatric reports. Those offences were mostly for matters such as break and enter and/or stealing. The respondent is recorded as having a difficult childhood and started offending from a relatively young age. He consumed alcohol and taken drugs from a young age.

[8] In 1990, the respondent pleaded guilty in the Southport District Court to a number of offences which included rape of an adult woman. The following factual summary of these offences is taken from the sentencing proceedings in the District Court Brisbane on 14 October 1998:

> *"Your Honour, dealing with those convictions on 24 September 1990 briefly relating to that, the complainant's residence was on top of a dental technician's office premises. The prisoner and two other people - males - broke and entered this office with the intention of stealing money from a safe that was believed to be there. They were unsuccessful in that and they broke into the dwelling by opening an internal door. A knife or knives was obtained from the kitchen of the dwelling and the male and female occupants of the dwelling were found in bed and they were threatened with the knife or knives.*
>
> *The prisoner at one stage threatened the female with the knife. The male was taken out of the bedroom and bound, tied up, and…the prisoner then had intercourse with the female without her consent and one of the other offenders had intercourse with her also after that. Property was taken from the two occupants and the prisoner and the other two left in a stolen car."*

[9] The respondent was sentenced to eight years imprisonment for the offence of rape with a recommendation that he be considered eligible for parole after serving two years.

[10] While on parole in respect of those offences, the respondent committed the index offences to which he also pleaded guilty in the District Court which included assault with intent to rape, child stealing, indecent treatment of a child under 12 and rape. The victim of those offences was a 10 year old girl. In sentencing the respondent, his Honour said:[6]

> '*You have pleaded guilty to 17 separate offences, by far the most serious of which are counts 5 to 8 inclusive, involving as they do various offences committed upon a 10 years old girl arising from your snatching her from the street near her school, forcing her into your car and driving her some distance, requiring her to put on a shirt to disguise her school uniform into bushland, where you demanded she remove her school uniform and lie naked face down on the rear seat of*

[5] Court Document 2.
[6] Affidavit of Rachel Berry Doc 4,RHB 2

your car. You forced fingers into her anus to a substantial extent and following upon that you sodomised her.

The terror and horror she must have suffered in order for you to gain about one minute's worth of sexual gratification is almost too terrible for any decent citizen, particularly a parent who has had the care of a 10 years old girl to contemplate.

Up until this time she was a normal young girl whose parents were doing all they could to provide a happy and secure upbringing for her and an older sibling. It is no exaggeration to say you have shattered their lives and left them with indelible memories of your disgraceful and degrading behaviour.

At the time of the commission of these offences, you were on parole, to make matters worse, in respect of sentences of eight years for rape, five years for armed robbery, three years for burglary and various other property offences, those sentences being served concurrently and you had almost completed your parole.

The previous rape was committed in serious circumstances on a female in her own home after she was awoken from her sleep. Her partner was disabled and there were threats with a knife or knives and you were in the company with two other persons, one of whom at least proved himself to be a rapist as well as yourself on this occasion.

It is in your favour that you managed to stay out of trouble for a substantial period of time after you were paroled on 26 February 1993, despite a long prior criminal history of various offences, notably offences of dishonesty commencing in December 1985.

It is almost as if the strain of staying out of trouble over the years you were on parole was too much for you to bear, because in January this year you went on a spree of predatory behaviour, stealing from people who had befriended you and shared their accommodation with you, and also stealing from strangers money, car keys, and on a number of occasions, driving off in their cars whilst they slept.

You contemplated a robbery by pretending to be armed on 23 February 1998, but elected instead to kidnap, to put it in ordinary language, this schoolgirl and committed the offences on her I have already outlined.

...

> *So far as the remorse is concerned, often times one suspects that that is simply in order to gain sympathy from the Court and it is feigned remorse, but in your case I have carefully observed you during the time that I have had you before me, and in all of the circumstances I am prepared to regard the remorse that you have demonstrated as genuine.*
>
> *You significantly cooperated with police and the authorities and this is an early plea of guilty on an ex officio indictment. Also as I previously mentioned, a matter in your favour is that you had completed most of earlier your parole in respect of the matters. But for all… of the things in your favour have outlined, the sentence for rape in my view would quite properly be fixed at the higher end of the range of 15 to 18 years submitted by the Crown.*
>
> *I should say I have taken into account also your unfortunate upbringing, your parents apparently leading what you have described as deviant lifestyles for much, if not all, of your formative years which no doubt had a significant damaging effect on you.*
>
> *I have no hesitation in with counts 5, 7 and 8, that is, assault with intent to commit rape, aggravated indecent treatment and rape, in this case to be serious violent offences under the relevant provisions of the Penalties and Sentences Act and I make any declaration that may be necessary in respect of any or all of those offences. That is not the subject of argument to the contrary by your legal representative, quite properly in the circumstances I should say."*

[11] Paragraphs 10 to 15 of the applicant's outline of submissions relevantly sets out summaries of the respondent's offending history and previous sexual offending. The respondent adopted the summary of the respondent's offending history and previous sexual offending as particularised in the applicant's outline of submissions.[7]

Dr Grant

[12] Dr Grant interviewed the respondent at Wolston Correctional Centre on 7 April 2016. He also refers to having been provided with an array of material although he did not have the opportunity to see medical records at the Park High Secure Unit nor the records from the Prison Mental Health Centre. He considered that those records should be obtained for future reference for any further psychiatric evaluations, however he considered it was possible for him to make the following diagnosis on the basis of the material received and his interview with the respondent. In that regard he opined[8]:

> *"Paranoid Schizophrenia*

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7 Respondent's submissions, para 7.

8 Report of Dr Grant (Court Doc 3), p 21.

> *1. Mr Watkins has a clear history of psychotic symptomatology since at least 1999 and probably for some period before that. Psychotic symptoms have been observed and recorded in custody. He has had two admissions to hospital and he now describes and displays prominent symptoms including delusions, hallucinations, ideas of reference and passivity phenomena, these apparently being resistant to treatment. He indicates that there may be plans to readmit him to hospital and give him a trial of Clozapine in the future.*
>
> *2. A Past History of Substance Abuse and Dependence particularly involving heroin and marijuana, currently in remission in custody.*
>
> *3. A Personality Disorder with prominent antisocial traits and possible borderline traits. The presence of a Major Psychiatric Disorder, however, makes it difficult to be sure exactly to what extent that Personality Disorder is affecting his current functioning.*
>
> *4. Paedophilia with an attraction to underage females, that being non-exclusive, in that he has had heterosexual relationships in the past. However, his sexual history is confused in that he has reported transgender issues and homosexual relationships in the past. He denies current paedophilic attractions but has reported them as being quite prominent in the past. Therefore, I believe a diagnosis of Paedophilia is appropriate."*

[13] Dr Grant found that the respondent was suffering major psychotic symptomatology and had a poor level of cooperation which made the interview incomplete and quite difficult.

[14] He gave the following account to Dr Grant of his previous sexual offences:

> "*Mr Watkins gave me some limited detail about his previous offending. In regard to the first rape offence he said, 'This was just some bikie shit'. He was involved with a gang. A number of them went into a house to rob the man that owned the house. However, that man wasn't there and they discovered renters inside. Mr Watkins felt very angry. He lay on top of a female to restrain her, then 'she smelt good, so I fucked her'. Meanwhile the other men hogtied the man. One other 'retard' lay on top of the woman but Mr Watkins said that he didn't rape her.*
>
> *Mr Watkins said that they were all 'smashed off our guts' on drugs and alcohol at the time of this offence.*
>
> *In regard to the offence against the 10-year-old girl, Mr Watkins said it was 'sheer fucking stupidity and paranoia'. He said that he was afraid of getting locked up in New South Wales because drug dealers were after him there. If he had been locked up down there the 'Lebs' would have got to him. He offended in Queensland to get into more trouble and get incarcerated there rather than in New South Wales. He thought that gave him some chance of survival because he feared otherwise that he would die.*

> *Mr Watkins said that the opportunity arose when he saw the young female. He agreed that he had had thoughts about having sex with a young female for years. He said that during the years young girls had presented themselves to him. He said, 'They would say it was okay to finger them'. He said that a 14-year-old girl approached him in Newcastle to have sex for money but he didn't do so. However, he did used to think about having sex with young girls. He attributes a rise and interest in this regard to hearing about these things during his first incarceration. He said that he had watched adult pornography and then had seen child pornography.*
>
> *Mr Watkins said that he was very remorseful for what he had done to the young girl."*[9]

[15] Dr Grant summarised the respondent's mental status on examination in the following terms[10]:

> "*During the interview Mr Watkins was at times somewhat inappropriate in his behaviour. For example he put his legs up onto the desk, until told to remove them by a prison officer who had observed him on camera. After that incident he told me that he would punch the prison officer when he saw him next. Mr Watkins was quite controlling and very difficult to interview. He initially said that he wouldn't answer any questions but eventually the interview extended for about an hour and a half in a very disordered fashion because of his controlling and psychotic behaviour.*
>
> *Mr Watkins was quite voluble and loud and at times quite aggressive in his manner. I considered that at times he was showing significant formal thought disorder, although that was not greatly prominent. Nevertheless he was demonstrating tangentially and some loose associations.*
>
> *Mr Watkins' affect appeared to me to be somewhat elevated. He was very grandiose. He described his mood as often angry. The content of Mr Watkins thought contained grandiose beliefs amounting to delusions. He described prominent auditory hallucinations, which were fairly constant. When asked whose voices he was hearing he told me the prominent one was of Samantha. The next most prominent was Ruby, his boyfriend whom he had not seen for years. He also heard the voice of his daughter Brittany and a woman called Nadine who was Brittany's mother's second youngest sister ('I used to have the hots for her')."*

[16] In reviewing whether the respondent posed any level of risk Dr Grant employed a number of risk assessment instruments. Dr Grant found the following[11] using those risk assessment instruments:

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9 Report of Dr Grant (Court Doc 3), pp 16-17.
10 Report of Dr Grant (Court Doc 3), p 19.
11 Report of Dr Grant (Court Doc 3), pp 20-22.

(a) Static 2002R: the respondent was assessed as being in the moderate to high risk group for sexual reoffending. As this relied on historical information Dr Grant considered that the assessment was reasonably accurate, given it was independent of issues to do with the respondent's current mental illness.

(b) HARE PCL-R 2nd Ed: the respondent scored a possible 33 out of 40 for psychopathy, the cut off in Australia being 30/40 placing him in the psychopathic personality disorder range. He considered that the respondent had very prominent psychopathic traits but the presence of psychosis may have distorted those scores and made the score higher than it would otherwise be.

(c) HCR-20: the respondent was assessed as being in the very high risk range for future violent offending.

(d) RSVP (The Risk for Sexual Violence Protocol) assesses static and dynamic factors to produce an estimate of group risk. Under the instrument a possible violent offence would be the rape of a female, adult or child, driven by sexual drive, sexual deviance and psychotic motivations. Warning signs would include increasing psychotic symptoms and increasing sexually deviant thoughts. The risk is likely to be long term. The risk of such possible violence is unclear. The respondent was assessed overall as having moderate to high risk of sexual reoffending and a very high risk of non-sexual violence.[12] Using this instrument, Dr Grant opined that the respondent's management would be primarily under an involuntary mental health treatment order and would require close observation and anti-psychotic treatment. Such management would need to be in close co-operation with any Supervision Order that may be made under the Act.

[17] On the basis of his review Dr Grant[13] found that the respondent was currently suffering from paranoid schizophrenia which was poorly responsive to treatment. The assessment of risk could change considerably if his mental status was much more stable. He concluded however that the respondent was of very high risk for non-sexual violent behaviour and of moderate to high risk of sexual reoffending. He considered that the respondent's mental status and level of risk rendered him unsafe to be in the community and he should either be kept in custody or preferably transferred to a high secure psychiatric institution for long term psychiatric management. Dr Grant noted the possibility that the respondent's schizophrenia may have been a factor in the offending spree of the respondent including the rape of the 10 year old girl. He noted however this may not have been the case given the patient saw Dr Fama soon after the incident and at the time did not diagnose schizophrenia. He considered that the risk for sexual offending in the future will depend on the extent of paedophilic drives being experienced by the respondent and its interaction with disturbance or behaviour from his mental illness along with some psychopathic personality traits. He considered that the combination of those factors made the risk unacceptably high in terms being returned to the community at this stage. He considered that Mr Watkins would be best managed under the *Mental Health Act* and that it was likely that the respondent would need long term secure hospital treatment. He considered that if the respondent was not transferred to a psychiatric institution he would not be able to recommend that he be released from prison into the community under a DPSOA Supervision Order. He considered it was unclear whether

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12 Report of Dr Grant (Court Doc 3), pp 21-22.

13 Report of Dr Grant (Court Doc 3), p 23. A risk of non-sexual violence does not constitute a serious danger to the community under the Act.

placing him on a supervision order would be of long term assistance in terms of risk and management. He stated that the risk of general violence and sexual violence would be unacceptably high and not really managed under a supervision order.

[18] Dr Grant in examination-in-chief was asked whether the fact that the respondent was no longer subject to an involuntary treatment order had any effect on the risk of reoffending proposed by the respondent. Dr Grant considered it greatly increased the risk. Dr Grant stated he was stunned to hear that another psychiatrist had taken over the respondent's care and had taken him off his involuntary treatment order such that the earlier plan for him to go from prison to the high secure service for extended treatment and commence taking Clozapine and the subsequent provision for his release from high secure service on a gradual basis no longer existed since he considered that plan was appropriate (T1-12 29-38). The notion of the respondent leaving prison without such an order would in his own view be alarming.

[19] Dr Grant considered that there was no way that the respondent could be managed on a supervision order since he would not be able to recognise the reality of his situation and would be subject to psychotic symptoms which would control his behaviour, and that he would be unable to comply with the supervision order. He further indicated that the respondent would see the authority of his hallucinations as being superior. He stated in his psychotic state there was no way a supervisor could form any kind of reasonable relationship with the respondent (T1-13/1-10).

[20] When asked about the steps to manage the respondent's future risk, he indicated that there were three aspects to risk: one is a serious personality disorder, one is the sexual deviation, paraphilia; and the third one is schizophrenia. As Dr Grant considered that the schizophrenia was so severe, it is presently the highest priority in terms of treatment and until that was controlled there was no point in addressing his sexual problems (T1-14/12-19). In cross-examination when asked about his future treatment Dr Grant indicated that the respondent would be best placed in a high secure system and treated until his paranoid schizophrenia was in remission or controlled and at that point other forms of treatment such as medium intensity or maintenance sexual offenders treatment would possibly be appropriate. He considered that he needs treatment as the highest priority. He said if he was then able to be released from custody after having treatment he could possibly be managed on a combination of an ongoing involuntary treatment program with very tight control over his psychiatric treatment combined with a supervision order under the Act to make sure that in other ways the risk was addressed (T1-14/33-36). He stated that the respondent's illness of paranoid schizophrenia needed to be controlled for a period of months at least before steps could be put in place before addressing the respondent's anti-social personality disorder as paraphilia (T1-14/37-44). Dr Grant was asked how long he would like to see the respondent's illness in remission before contemplating release under an involuntary treatment order coupled with a supervision order (T1-15/4-6). He indicated what would normally happen was he would go to the high secure mental health institution for an extended period of time of months probably to get well and then when well enough, he would be transferred back to custody and continued on the treatment and then consideration could be given to him being released on a combined program between the two services (T1-15/12-16).

Dr Lawrence

[21] Dr Lawrence interviewed the respondent on 3 November 2016 and provided a report dated 15 November 2016.[14] She also reviewed various records that were provided to her. Dr Lawrence was subsequently provided with further documents and provided a supplementary report dated 6 January 2017.[15]

[22] Dr Lawrence noted that the respondent had engaged in the High Intensity Sexual Offending Program, amongst other programs, and noted that his completion of the program and the exit report that was generated implied a reasonably constructive participation in the program and coherent plans emerging in response to the various modules. Dr Lawrence however, indicated that differed dramatically from the presentation of the respondent to her at the interview on 3 November 2016.[16]

[23] At paras 8.12 to 8.14 Dr Lawrence made note of her observations while interviewing the respondent. In the course of that the respondent revealed the presence of the significant auditory hallucinations, supposedly of a female officer. The voice, "Sam" provides feedback, information, watches over him, provides advices and guidance to him on various matters of his behaviours. He sees her as all powerful and appears to obey her command. Dr Lawrence indicated that he revealed extensive paranoid delusional beliefs, though some of his beliefs may have had a reality basis, with other clearly paranoid delusions and that he had his own delusional system of belief about himself as a devil and the female voice known as "Sam" appeared to have almost all encompassing divine quality, fortunately of positivity. She noted that while he acknowledges he has a psychiatric illness and takes medication for it, he displayed little evidence of insight during the interview into the psychotic nature of much of the material that he is verbalising.

[24] At paras 15.1 and 15.7 Dr Lawrence refers to the respondent's retelling of his account of his armed robbery/rape which had occurred in 1990. When asked how he felt about the rape the respondent responded, *"Great! It was very exciting and satisfying."* In terms of the rape of the 10 year old girl he indicated to Dr Lawrence that it was a demon inside him who apparently influenced him to rape the 10 year old girl and also indicated that the first time he had ever heard of having sex with a child was at HISOP group.

[25] The respondent indicated to Dr Lawrence that he now saw himself as a protector of women and children and that he will do anything he is told to do by a woman. This appeared to Dr Lawrence to be in part due to the belief system he appeared to embrace currently partly under the influence of his regular voice Samantha.

[26] Dr Lawrence noted that the respondent had completed sexual offender treatment programs and the HISOP. She indicated however his attitude to the programs did not engender confidence that they had been understood and accepted as useful and liable to have been of any benefit to him in the future. In this regard she indicated the presence of his current degree of psychosis was likely to invalidate any experience during his previous sexual offender treatment programs.

[27] The respondent acknowledged that he suffers from paranoid schizophrenia. Samantha's voice, which he described as hearing day and night gives orders and advice to him. From her discussions with the respondent, in particular his current philosophical approach to his life and to new futures planned, combined with his presentation of thoughts and his

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14 Exhibit 1.
15 Exhibit 2.
16 Report of Dr Lawrence, ex 1 [6.19] p 12.

account of his behaviour and subsequent approach to the interview, Dr Lawrence formed the opinion he was displaying a significant disorder of thought process leading to a disorder of thought content influenced by his extensive paranoid delusional beliefs. Without having psychiatric records available to assist in the assessment, her independent assessment was that he was likely to be suffering from a chronic psychosis characterised by thought disorder affecting judgment, paranoid and grandiose delusions and hallucinations and currently under partial control by an antipsychotic[17] (emphasis added).

[28] Dr Lawrence noted that while the respondent readily acknowledged his guilt in committing the sexual offences against both an adult young woman and the 10 year old girl, and in relation to particularly the child sexual offence, he expressed disgust with himself and said that his plans in the future reflect his desire to ensure there is no recurrence of such a crime, a significant part of his discourse appeared possibly influenced by psychotic features to finally absolve himself of moral responsibility for the crime. In this regard she pointed to the example that according to the respondent, the demons which had been within him all his life had incited him to commit the crime or, in one sense, given him the approval to do the crime (see 19.1-19.2, ex 1, p 23).

[29] Dr Lawrence has used a number of different risk assessment tools which are set out at paras 20.1-20.5 of her report. In short summary she made the following findings:

(a) PCL-R Scale (for psychopathy): the respondent achieved a score of 29 which indicates a diagnosis of psychopathy with its implications for recidivism. Reservations were expressed on the basis of active psychosis, however Dr Lawrence considered the scores indicative of a significant psychopathic trait as well as his obvious and observed grandiosity and paranoia;

(b) HCR-20 (Risk management assessment scale): the respondent scored highly on Historical factors, clinical items and risk management factors;

(c) VRAG (Violence Risk Appraisal Guide): the respondent was found to be category 7 which indicates he is in a group where there is a 55% probability of re-offending with 7 years and 64% of re-offending within 10 years;

(d) SORAG (Sex Offender Risk Appraisal Guide): the respondent is placed in a group, category 8, where there is a 75% probability of re-offending sexually with 7 years and 89% probability that he will re-offend sexually within 10 years;

(e) SVR 20 (Sexual Violence Risk-20): this identifies factors which need particular treatment of attempts and goals. He scored highly with 9 positive features of psychosocial adjustment and 2 possible features, namely the presence of actual sexual deviation and whether he was really a victim of childhood abuse. His scores as to sexual offences varied and his scores for future plans and other considerations indicated his plans were unrealistic and he did not display evidence of positive regard for intervention from SOPTP and HISOP or others undergone. The presence of his mental illness was a significant factor taken into consideration;

(f) Static 99R: the respondent scored a total of 5 putting him in the moderate to high risk category. The score of sexual recidivism in this

[17] Report of Dr Lawrence ex 1 at 18.11

> group were 33% probability at 5 years, 38% probability at 10 years a 40% probability at 15 years of sexual recidivism and a 42% probability at 5 years, 48% probability at 10 years and 52% probability at 15 years of violent recidivism.

[30] Dr Lawrence in oral evidence clarified that the actuarial risk assessments were largely based on historical information which would be unaffected by the respondent's active psychosis, but that to the extent they include some indication of clinical factors which might need attention to predict the future they would be influenced by the respondent's active psychosis.[18]

[31] Dr Lawrence in her opinion[19] found that:

> *"Significantly, Christopher Watkins currently suffers from a serious mental illness, Paranoid Schizophrenia, which appears to have been present for 8 to 9 years, though I cannot clearly identify the time of initial diagnosis and commencement of treatment. He has a past history of a significant number of periods of suicidal ideation and possible attempts leading to safety measures being implemented in the prison situation and he has had 2 periods of treatment in the High Security Unit at The Park during his period of incarceration. There are reports of his absconding on at least one of those occasions but I am unclear as to the details because of the absence of medical records.*
>
> *Currently, though treated with antipsychotic medication, he continues to display significant delusions, auditory hallucinations, and probable visual hallucinations, thought disorder and inevitably poor judgment, all attributable to his Psychotic Illness.*
>
> *Christopher Watkins' sexuality is complex and confused but I cannot be satisfied that he has significant paedophilic drives, though there is clearly, from his account and the Court account of the crime against the girl, a paedophilic attraction. There is some suggestion, also, from his account and his consciousness of such an attraction to a paedophilic nature in earlier adult life, not acted upon.*
>
> *…*
>
> *Christopher Watkins' history and record are consistent with an Antisocial Personality Disorder and/or a Narcissistic and Antisocial Personality Disorder including some psychotic traits, evident from early adolescence. The diagnosis is undoubtedly clouded by several factors.*
>
> *In diagnostic terms, it is unwise to diagnose Psychopathy when Psychosis is present. Indeed, it is unwise to diagnose any Personality Disorder in the presence of significant Psychotic Illness. In the case of Christopher Watkins, however, his antisocial behaviour, commencing at puberty and early adolescence and*

[18] T1-5/20-32

[19] Report of Dr Lawrence (Ex 1) at 21.10-21.24

almost continuous at least until the time of his incarceration on this last occasion, are consistent with the diagnosis, at least, of an Antisocial Personality Disorder….

His mental illness is a significant feature of his current presentation and has to be taken into consideration when consideration is given to management of his future behaviour.

Proper management ensuring compliance and adherence with advice and ongoing supervision of his Psychotic Illness would be essential, both for his protection and that of society if he were to be released.

As well as ensuring proper compliance with the management of psychiatric illness, he will need careful and close supervision for his sexual offending behaviour. Though the features suggesting paedophilia are central or vital components of his sexuality, when combined with his Antisocial Personality and his Psychosis, the possibility of further sexual offences against female children cannot be eliminated.

Therefore, in my opinion, it would be necessary to recommend the types of conditions that would be imposed such as not being accommodated or attending near or at schools and probably the restrictions pertaining to shopping centres, pre- and after school and weekends in particular.

…

However, the severity of this man's Psychosis, the extent and severity of his active and acute psychotic symptoms currently, even when considered stabilised and 'controlled' on antipsychotic medication, lead me to the conclusion that continuing detention long term in a mental hospital may well be warranted.

The risk arising from the presence and nature of his mental illness, in and of itself, currently in this man when in 'controlled remission' of symptoms leads me to have grave reservations about the wisdom of his release even under a carefully constructed Supervision Order."

[32] Dr Lawrence concludes that in the totality of the assessment her opinion, based on the structured professional judgment allied with findings on actuary scales, leads her to the opinion that the risk of reoffending both sexually and violently by the respondent in the future is of a moderately high level. She notes that he suffers from the following diagnoses under the DSM-4TR criteria:

"Axis 1 -Paranoid Schizophrenia – in partial remission with current medication
Substance Abuse Disorder
-in controlled remission currently.

Axis 2 -Antisocial Personality Disorder
1. *Probable Psychopathy*
2. *Grandiose and paranoid traits*
   Possible Paedophilic attraction

Axis 3 -Complaints of back pain with expressions of desire for opiate medication relief

Axis 4 -Virtually no family or close personal supports
-Average intellect but limited transferrable employment skills
Likely continuing interpersonal relationship strains
Limited experience in prosocial life in the community
Poor judgment and limited insight to his problems."

[33] Dr Lawrence indicates that she feels there is a level of risk and a multiplicity of contributing factors to that risk which need to be taken into account for the Court to determine whether the respondent could be considered as an acceptable risk if he were to be released in the community, even with a very closely supervised instruction order.

[34] Dr Lawrence provided a supplementary report dated 6 January 2017 following a review of the respondent's medical records for the period November 2011 until 1 November 2016.

[35] In reviewing those records, Dr Lawrence noted that the respondent had been treated by Dr Nellie an experienced psychiatrist who had noted that the respondent appeared to have an ongoing delusional belief system and that he also appeared to have incorporated other delusional material relating to a former female prison psychologist Samantha.[20]

[36] She further noted that he had been transferred to a High Secure Inpatient Service for an assessment and had been the subject of an Involuntary Treatment Order due to the respondent's refusal to comply with medication and his delusional beliefs which impaired his judgment and the treating team's inability to otherwise manage the significant risks to others posed by Mr Watkins.[21]

[37] Dr Lawrence noted that the ITO had been revoked on 27 September 2016 by Dr Stewart, who had taken over his care, which had been said to be on the basis that the respondent was complying with his medication and that removal of the ITO might facilitate the process of discharge and return to society.[22] That is a view unsupported by Dr Lawrence, Dr Grant or Dr McVie who consider the removal of the ITO increases the risk of the respondent's reoffending.

[38] Dr Lawrence concluded her review by opining that:[23]

> *With the level of risk I would reinforce my opinion that with a multiplicity of contributory factors to that risk, the risk has been heightened by the revocation of the Involuntary Treatment Order. The risk has been heightened because Christopher Watkins continues to suffer from a serious mental illness of Chronic*

[20] Supplementary Report of Dr Lawrence (Ex 2) at 4.5.
[21] Supplementary Report of Dr Lawrence (Ex 2) at 4.6.
[22] Supplementary Report of Dr Lawrence (Ex 2) at 4.11.
[23] Supplementary Report of Dr Lawrence (Ex 2) at 5.2-5.3.

Paranoid Schizophrenia manifest by longstanding persistent persecutory thoughts, erotomanic thoughts, command hallucinations and ongoing delusional beliefs which absolve him from personal and moral responsibility for his actions. He has demonstrated over many years reluctance to comply for prolonged periods with oral medications even when those have been of documented benefit to his welfare. I agree with the opinions stated by a number of psychiatrists during that period of time that the risks to society associated with this man's psychotic ongoing Chronic Psychotic Phenomena in his mental state and his limited insight make him an unacceptable risk in the community. His mental illness is such that in my opinion he needs close supervision of his mental illness necessitating therefore an Involuntary Treatment Order in order to reduce the level of risk that he poses to the community by virtue of his mental illness alone. Combined with his aberrant sexual drives which appear to amount to Paraphilia in part and his delusional and hallucinatory phenomena which involve and appear to influence his sexuality, I believe the risk to be unduly high.

Were he to be continuing on an Involuntary Treatment Order close follow up arrangements for continuing supervision and treatment consistent with his level of risk could be organised through community Mental Health Services. In the absence of an ITO it is my opinion that one could not rely on Christopher Watkins to undertake the psychiatric supervision and treatment which is required in an ongoing and voluntary manner. It is my current opinion that even a very closely supervised and structured Supervision Order in the absence of an Involuntary Treatment Order may not be sufficient to manage the level of risk that Christopher Watkins could pose to the community were he to be released without an Involuntary Treatment Order."

[39] In oral evidence Dr Lawrence further stated that while she considered the risk of the respondent was high it was difficult to predict the nature of offence he might commit because of the nature of his psychosis. She considered that the voice of Samantha, whose directions the respondent was accepting and acting upon, while presently generally positive could change in an instant and become of a negative type. This, allied with the respondent's past performance, could be sexually motivated against adult females and also children (T 1-6/4-10).

[40] She considers that the respondent suffers from paranoid schizophrenia and that his risk is higher as he is not under an involuntary treatment order and there is no ability to ensure he takes antipsychotic medication, which does not appear to be fully effective given he continues to display significant delusions, auditory hallucinations, probable visual hallucinations, thought disorder and inevitably poor judgment which are all attributed to his psychotic illness[24]. The presence of those features increase the unpredictability of the respondent's thoughts which in Dr Lawrence's opinion affects the respondent's ability to control his behaviour which historically had been inclined to be significantly antisocial and at times, sexually oriented (T1-6/35-41).

[41] In cross-examination Dr Lawrence said that at the time the respondent presented to her, he had active psychosis, contrary to the apparent observation made by Dr Stewart at an earlier time that the respondent did not have active psychosis (T1-9/5-16). She indicated that to manage or mitigate any future risk the respondent needed to be placed in a secure mental health facility where he could be observed on a day to day basis by psychiatrists and other mental health professionals who could determine the most appropriate

[24] Report of Dr Lawrence (Ex 1) at 21.11

treatment methods for him. That could not be done effectively in a prison situation where the respondent was not being observed on a regular basis. (T1-9/20-30). In determining treatment, consideration needed to be taken of the respondent's future and the likely effects that might occur if the respondent was released in determining treatment (T1-9/34-36). If the respondent's mental state was the same as when Dr Lawrence saw him that needed to be done immediately (T1-9/41-45).

Dr McVie

[42] The respondent refused to meet with Dr McVie for an interview. As such her report is based on the material that was provided in the medico-legal brief. Her report reviews the offence committed by the respondent, his past criminal history, his personal history, past psychiatric history, psychosexual history, progress in custody, previous breaches while on parole and in jail and his mental state examination by reference to Dr Grant's report.

[43] Amongst other things, Dr McVie noted that in 1998 the respondent had tried to strangle himself due to remorse and despair according to a report by Dr Fama dated 8 May 1998. Dr Fama at that time found no signs of mental illness and the respondent had denied a special sexual attraction towards children. Dr Fama made an ICD-10 diagnosis of dissocial personality disorder.[25]

[44] He appeared to have been first diagnosed with psychosis in 2004 when he was involved in an erotomanic attachment to a female psychologist Samantha who had been involved in his management in prison.[26]

[45] In 2008, the respondent was admitted to a high secure in-patient service for a month and his discharge diagnosis was severe personality disorder, anti-social and borderline; paedophilia, predatory type; and a speculated vulnerability to psychotic disturbances in stressful situations. His symptoms included the voice of Samantha, delusions involving sexual fantasies, delusions about Satan and a belief that Samantha is controlling his thoughts and other people. He was described as having "a well organised belief system that involves erotomanic thoughts, involves females and persecutory beliefs."[27]

[44] The respondent had been placed on a voluntary treatment order made in September 2008 while in hospital to ensure he received treatment for his psychotic illness, noting that he had a history of refusing or diverting medication. It was noted when he was unwell he was liable to self-harm or harm others and if not on treatment he would quickly become non-compliant and deteriorate in his mental state.[28] That ITO was revoked by Dr Stewart who appears to have taken over from Dr Nellie. Dr Stewart recorded on 27 September 2016 that everything was good. According to the entry of Dr Stewart, the respondent's medication was sorted and they discussed the need to continue treatment to prevent relapse. He presented as someone with partial insight into his illness and is keen to continue the current psychiatric treatment in prison.[29] The respondent's medication had only been changed in September 2016.[30] Dr Stewart did not provide evidence and as such the basis of his views and comments could not be explored and were of little weight.

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[25] Report of Dr McVie (Ex 3) at p 5.
[26] Report of Dr McVie (Ex 3) at p 5, 10.
[27] Report of Dr McVie (Ex 3) at p 5.
[28] Report of Dr McVie (Ex 3) at p 6.
[29] Report of Dr McVie (Ex 3) at p 6.
[30] Report of Dr McVie (Ex 3) at p 6.

[45] Dr McVie notes that further entries indicate that the respondent refused to attend Dr Stewart on 1 November 2016 and was "not available" on 25 October 2016.[31]

[46] In reviewing the respondent's psychosexual history, Dr McVie noted that the HISOP report noted his distorted thinking on sexual objectification of women and female children was considered to be an area that required further professional intervention. Another consistent theme was his attribution of the development of his sexual interest in young girls to his participation in a sexual offenders program in custody following the 1990 rape offence and that in the lead-up to the 1998 offences he described extensive sexual preoccupation with watching adult and child pornography using adult female prostitutes and masturbating to fantasies about a female child.[32]

[47] Dr McVie also carried out a risk assessment based on her review, using the PCL-R, Static 99, RSVP and Stable 2007 (see Ex 3 at p 9).

[48] Dr McVie carried out an assessment without the benefit of an individual assessment of the respondent based on the material reviewed. In that regard using the risk assessment tools Dr McVie drew the following conclusions:[33]

i. PCL-R: Hare Psychopathy Checklist – Revised; Dr McVie placed the respondent at 35 which was well above the cut-off score for psychopathy usually considered to be 30. In this regard she noted while others considered his score may be inflated by active psychotic symptoms she was unable to assess the psychosis;

ii. Static 99: she scored the respondent at 5 which placed him in a moderate high range for sexual violence recidivism compared with other sexual offenders;

iii. RSVP: Risk for Sexual Violence Protocol 2003 – based on the historical material she considered that the respondent presented with almost every risk factor listed in the RSVP manual. His sexual violence history has elements suggesting chronicity and diversity with definite evidence of both physical and psychological coercion. She stated that the respondent's history indicated problems with his attitudes to sexual violence, problems with self-awareness and coping and problems relating to his history of being physically and sexually abused as a child. She noted he had been diagnosed with paedophilia, schizophrenia and meets the cross-criteria for psychopathy. She also noted that he had a history of significant substance abuse and previous suicidal and self-harming behaviour. In terms of social adjustment risk factors he had a history of problems in both intimate and non-intimate relationships, poor employment history and an extensive history of non-sexual criminality. She found on the basis of the material he also presented with high risk in terms of manageability with a history of problems with planning, treatment and supervision;

iv. Stable 2007: Dr McVie omitted some of the items as she was unable to interview the respondent but on the basis of the remaining factors, considered that he

[31] Report of Dr McVie (Ex 3) at p 6.
[32] Report of Dr McVie (Ex 3) at p 7.
[33] Report of Dr McVie (Ex 3) at p 9.

presented with a significant number of areas of treatment needs or challenges, listing relationship issues, his general attitude towards others, deviant sexual interests, sexual preoccupation and problems with supervision are prominent areas of concern.

[49] McVie's opinion[34] based on the information provided is that the respondent meets the criteria for a diagnosis of anti-social personality disorder. She considers he has significant psychopathic traits and would also qualify for a diagnosis of paedophilia, heterosexual, non-exclusive. She notes his presentation is complicated by his psychotic symptoms.

[50] She further comments:[35]

> "*Though he has completed the High Intensity Sexual Offenders' Treatment Program, he continues to present with high treatment needs….*
>
> *Though he currently attributes his offending to 'voices', there is no evidence to support this at the time of the offences.*
>
> *Risk assessment indicates he is at moderate to high risk of re-offending, this risk is increased by his high score on the Hare PCL-R psychopathy scale. The structured clinical judgment instruments also identify considerable areas which require further treatment including problems with relationships and employment, attitudes to women, deviant sexual interests, impulsivity, problems with coping and problems in cooperation with supervision.*
>
> *Substance abuse, gambling and pornography were also associated strongly with his offending behaviour.*
>
> *Having not interviewed Mr Watkins, I find his mental illness diagnosis less clear. He does appear to gain some benefit from his psychotic symptoms, being somewhat ego syntonic and justifying his behaviour to himself. His symptoms of auditory hallucination, grandiose, religious and persecutory delusions with some formal thought disorder do, however, meet criteria for a diagnosis of schizophrenia.*"

[51] Ultimately Dr McVie concludes her report in the following terms:[36]

> *"Mr Watkins would be extremely difficult to manage in the community. Ideally, he should have a gradual transition to the community, based initially in High Secure Mental Health Services. He would be best managed on a combination of oral Clozapine and a depot antipsychotic medication.*

[34] Report of McVie (Ex 3) at p 10.
[35] Report of McVie (Ex 3) at p 10.
[36] Report of Dr McVie (Ex 3) at p 11.

Considering his refusal to attend appointments and his continued high treatment needs, consideration should be given to whether he would benefit from a further Sexual Offending Program in custody.

If released on a Supervision Order he would require continued participation in treatment to address his sexual offending. He would require weekly review by a psychologist.

Further assessment of his current sexual preoccupation and use of pornography is indicated.

Further assessment of his reported problem gambling is indicated.

He requires strict conditions to block any access to children.

He needs to remain abstinent from alcohol and all illicit substances.

He would also need weekly review by a psychiatrist with expertise in managing sexual offenders."

[52] In evidence when asked to clarify whether the fact that the respondent had not attended for review since September 2016 with Dr Stewart and was refusing to meet with Dr McVie indicated anything in terms of the future treatment that the respondent may require, Dr McVie stated that it indicated having regard to the evidence of Dr Lawrence and Dr Grant, as well as their reports, that he was floridly psychotic (T1-17/17/25-26). She noted that if he is psychotic and he is refusing treatment he will be impossible to manage in the community on a supervision order (T1-17/26-27). In terms of the medical treatment she considered he required now, she stated she recommended the three psychiatrists' reports that had been done be given to the Prison Mental Health Service and High Secure Inpatient Service with a recommendation that they review the respondent's care and hopefully they would transfer him to the High Secure Inpatient Service for a period of assessment and treatment which would be for several months. In that regard she agreed with Dr Grant that once he had been stable for several months then there could be consideration to his capacity to be managed on a supervision order in the community (T1-17/30-40).

Requirements under the Act

[46] The objects of the Act are stated in s 3 as follows:

> "(a) To provide by the continued detention in custody or supervised release of a particular class of prisoner to ensure adequate protection to the community; and
> (b) To provide continuing control, care or treatment of a particular class of prisoner to facilitate their rehabilitation."

[47] For the purpose of this application a prisoner includes a person who is detained in custody, serving a period of imprisonment for a serious sexual offence. The respondent falls within that definition.

[48] While appreciating that what is at stake is a prisoner's fundamental legal right to unfettered personal liberty on the expiration of the term of imprisonment,[37] there is acceptable and cogent evidence on the basis of the psychiatric evidence and the supporting affidavit evidence that there is an unacceptable risk that the respondent will commit another serious sexual offence if released from custody or released without a supervision order being made. The evidence does reach the high degree of probability that is required.

[49] I have had regard to the matters in s 13(4) of the Act in determining whether the respondent is a serious danger to the community in the absence of a Division 3 Order.

[50] The psychiatric evidence has been canvassed above. It is relevant to s 13(a) and (b), although the reports also address some other matters relevant to s 13(4). Dr Grant found that the respondent was not completely cooperative in the examination by him and the respondent refused to be examined by Dr McVie. Dr Grant considered that the lack of cooperation may well have been due to the respondent's psychosis. None of the psychiatric evidence was subject to any real challenge by the respondent.

[51] In terms of s 13(4)(c) the actuarial assessments administered by the psychiatrists consider the risk of reoffending. Relevantly the risk of reoffending considered is the risk of sexual reoffending either against children or against an adult female involving violence. The actuarial assessments administered by the various psychiatrists suggest the reoffending is at least moderate to high. Their assessment of the dynamic factors also tends to the conclusion that the risk is at least moderate to high. As noted above, the opinion of Dr McVie did not have the benefit of an interview with the respondent but she has noted the limitations in that regard in reaching the opinions expressed. The psychiatric evidence indicates that the risk of reoffending without a Division 3 order under the Act is heightened by the fact that the respondent is presently "floridly psychotic" and is not subject to an involuntary treatment order. It was noted by Dr Grant, Dr Lawrence and Dr McVie that the respondent's psychotic state might elevate some of the assessments made but not so as to negate their overall findings.

[52] In terms of s 13(4)(d), the respondent has committed two sexually-related offences which have been referred to above. The first in 1990 against an adult woman in the course of a violent home invasion/robbery and the second involving anally raping a 10 year old girl. It appears that it occurred in somewhat opportunistic circumstances. Dr Grant raised the possibility that the respondent may have been disintegrating and the beginnings of schizophrenic illness might have been developing when the offence against the 10 year old girl occurred although it did not become evident until a year after he was in custody. In this regard, he noted that the respondent was assessed in hospital immediately after the 1998 offence by Dr Fama who found there was no evidence of schizophrenia.

[53] In terms of s 13(4)(e) and (f), the respondent has made efforts to address the cause or causes of his offending behaviour by participating in sexual offenders programs. Although it was noted at the time of the HISOP that the respondent had positively participated in that program, Dr Lawrence raised in her evidence whether in the respondent's present state the program could be seen to have had any positive effect. In that regard, the exit report of HISOP had raised that the respondent would benefit from a maintenance program. Dr McVie considered notwithstanding the respondent's

[37] *Attorney-General v Van Dessel* [2006] QSC 16 at [17].

participation in HISOP he still continued to present with high treatment needs and considered he would benefit from a further sexual offending program in custody. However all of the psychiatrists called were of the view that presently the priority for the respondent is that his mental illness be addressed and stabilised before the question of any participation of the respondent in a further sexual offender's program and its benefit could be properly considered.

[54] Section 13(4)(g): the question of the respondent's antecedents and criminal history has been set out relevantly in the affidavit material (particularly the affidavits of Ms Berry and Ms Murphy) and the psychiatric reports.

[55] Section 13(4)(h) requires the Court to address the question of whether the risk that the prisoner will commit another serious sexual offence if released into the community. That has been addressed in the context of the psychiatric evidence. As set out above, the risk of reoffending sexually either with violence or against children is at least moderate to high if released into the community.

[56] In terms of the need to protect members of the community from that risk, which is referred to in s 13(4)(i), there is presently a clear need based on the material for members of the community to be protected from the risk of the respondent committing another serious sexual offence.

[57] No evidence was presented as to whether the respondent could or would be transferred to a secure mental health institution.

[58] Counsel for the respondent conceded that there is evidence upon which the Court may rely to conclude that the respondent is an unacceptable risk of committing a serious sexual offence if he is released from custody or released without the imposition of a supervision order.[38] That concession on the evidence is, in my view, properly made. As such the respondent identifies that the issue for determination is whether the respondent can be adequately managed in the community by the imposition of a supervision order.

[59] I am satisfied on the basis of the material before me that the applicant has discharged the onus to the required standard of satisfying the Court that the respondent is a serious danger to the community in the absence of a Division 3 order as required under s 13(1) read in conjunction with s 13(2).

What, if any, Order should be made?

[60] In deciding to make an order under s 13(5), s 13(6) requires consideration of two factors: first, the paramount consideration is the need to ensure adequate protection of the community; and secondly, consideration of whether adequate protection of the community can reasonably and practicably be managed by a supervision order. According to Morrison JA in *Turnbull v Attorney-General for the State of Queensland*, 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 the respondent 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 reasonably and practicably manage the adequate protection of the community, it is necessarily assessing the protection the order can provide against that risk. Before

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38 Outline of Submissions on behalf of the Respondent, para [5].

making the order the Court has to reach a positive conclusion that the supervision order will provide the adequate protection.[39]

[61] In terms of whether an order should be made under s 13(5) and what the appropriate order is, if the Attorney-General contends that the starting position of a supervised order should be displaced and a continuing detention order be made, the onus is on her to prove that it is an appropriate order: see Chesterman JA in *Attorney-General for the State of Qld v Lawrence*.[40] That necessarily involves proving that the community will not be adequately protected by a supervision order.

[62] No proposed supervision order was presented to the Court by either party.

[63] The Attorney-General submits that a continuing detention order should be made on the basis that the respondent's greatest risk factors are his paranoid schizophrenia, his paraphilic interest in pre-pubertal girls, his personality disorder with prominent antisocial traits and his previous substance abuse disorder. It contended the Court could not be satisfied any supervised order could be made which could satisfy the considerations in s 13(6)(b) of the Act. On the basis of the evidence, the Attorney-General has, in my view, discharged its onus.

[64] The psychiatric evidence presented indicated that there presently could not be a properly constructed supervision order which could be reasonably and practicably managed to ensure the adequate protection of the community from the risks posed by the respondent, nor that could be reasonably and practicably managed by Corrective Services officers.

[65] While Dr Mc Vie did canvass in her report conditions she thought should be imposed if a supervision order was made, however her oral evidence made clear that she did not think that the respondent could presently be managed under a supervision order. None of the psychiatrists called considered that even if an order providing for close and constant supervision of the respondent was made the respondent was capable of complying with such an order.

[66] Dr Lawrence was of the view that the respondent would have to be supervised 24 hours a day or in a highly secure institution if released and did not consider that the respondent could be managed on a supervision order nor could one be constructed with enough safeguards (T1-10/45-47, T1-11/1-3). She also made comment that because of the respondent's condition he could be complying with the order but at any point in time he could suddenly, if almost impulsively, as a result for instance of a command hallucination, do something that was very antisocial and could easily be sexually directed (T1-7/3-7). Dr Grant also indicated that with his psychotic symptoms the respondent would not be able to comply with a supervision order as he would see the authority of his hallucinations as being superior (T1-13/5-7). Notwithstanding the apparent view expressed by Dr Stewart in September 2016 (who the respondent did not see in October 2016 and refused to see November 2016) it would seem that if the respondent's psychotic symptoms had abated to any extent after Dr Grant saw him, they were active again when he presented to Dr Lawrence in November 2016 and were not being properly controlled by antipsychotic medication.

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39 *Turnbull v Attorney-General for the State of Qld* [2015] QCA 54 per Morrison JA at [35]-[36], with whom Philippides JA and Douglas J agreed.

40 [2010] 1 Qd R 505 at 512, [31].

[67] According to Dr Lawrence, because of the unpredictability of the respondent's condition due to his psychosis, there is no way that one can be assured, so to speak, that he would comply with the requirements of any supervision order. At any point in time he could suddenly, if almost impulsively, as a result of, for instance, a command hallucination telling him to do something which could be very anti-social and could easily be sexually directed to reoffend. Dr Lawrence, in her supplementary report, considered the respondent posed an unacceptable risk to the community. All psychiatrists were also of the opinion that the fact that the respondent is no longer subject to an involuntary treatment order increases the risk of reoffending posed by the respondent, given that the respondent is regarded by the psychiatrists as being a very unwell man presently and compliance with any treatment regime could not be enforced in the absence of such an order. Dr Lawrence in particular noted that the respondent had a history of not complying with treatment. Without such an involuntary treatment order she doubted that even a very closely and supervised supervision order could manage the level of risk the respondent poses to the community.

[68] The psychiatric evidence strongly supports the fact that the respondent needs to have his mental illness addressed and properly treated as a priority before consideration can be given to the respondent being released into the community under a supervision order with or without an involuntary treatment order. Dr Grant expressed the view, that the respondent needs to be placed in a high secure psychiatric institution for long-term psychiatric management and only when his mental illness is stabilised for a number of months could the question of a gradual transition to the community be considered under a supervision order. This view was supported by Dr Lawrence and Dr McVie. Dr Grant considered that such a gradual transition would need to be done through a combination of an involuntary treatment order in conjunction with a supervised order under the Act. That view seems to have some support from the views of Dr Lawrence.

[69] I raised with counsel for the Attorney-General whether the Court could make any direction in relation to the views expressed that the respondent was in need of treatment in a secure mental health institution. I was informed by the applicant's counsel that the Court may direct, and in the circumstances of this case the Court perhaps ought to direct, that the Attorney-General provide copies of the reports and also the transcript of these proceedings to the relevant Mental Health professionals, in this case, the Prison Mental Health Service and the Forensic Medical Service. This was supported by counsel for the respondent. It is possible that if the respondent's mental illness can be stabilised, a supervision order may be formulated in the future, which could address the considerations required under the Act. However, it is evident that would have to address other risks posed by the respondent as identified by Dr Grant. That presently cannot be done.

[70] While counsel for the respondent fairly canvassed the evidence of the psychiatrists, and the divergence of opinion between the experts and respondent's treating psychiatrists about whether the respondent should be subject to an involuntary treatment order, the fact is that the respondent is presently not subject to such an order and it appears further treatment may be required while in custody. His mental illness however needs to be addressed in the context of mental health services, as stated above. The evidence overwhelmingly supports the fact that no supervision order could be made by this Court which could satisfy the considerations in s 13(6) of the Act.

[71] A continuing detention order is required to control the respondent. The risk posed by the respondent in terms of the relevant provisions of the Act cannot be reasonably and

practically managed through a supervision order in order to provide adequate protection to the community.

Disposition

[72] 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 Act, orders that pursuant to s 13(5)(a) of the Act the respondent, Christopher Colin Watkins, be detained in custody for an indefinite term for control, care or treatment.

[73] I further direct that the applicant provide the reports of Dr Grant, Dr Lawrence and Dr McVie and a transcript of these proceedings to the Prison Mental Health Service and Forensic Mental Health Service.