QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL

CITATION:	*QN v Department of Communities, Disability Services and Seniors* [2020] QCAT 115
PARTIES:	**QN** (applicant) **v** **DEPARTMENT OF COMMUNITIES, DISABILITY SERVICES AND SENIORS** (respondent)
APPLICATION NO/S:	GAR040-19
MATTER TYPE:	General administrative review matters
DELIVERED ON:	21 April 2020
HEARING DATE:	23 January 2020
HEARD AT:	Brisbane
DECISION OF:	Member Howe
ORDERS:	**1. The decision of the Department of Communities, Disability Services and Seniors made 17 December 2018 to issue QN with a negative notice for a yellow card is confirmed.** **2. Publication of information that identifies or is likely to identify the applicant and any witnesses giving evidence in the proceeding is prohibited.**
CATCHWORDS:	ADMINISTRATIVE LAW – ADMINISTRATIVE TRIBUNALS – QUEENSLAND CIVIL AND ADMINISTRATIVE TRIBUNAL – where the applicant sought review of a decision by the respondent to issue a negative notice for a yellow card – where the applicant suffered from mental illness – where the applicant had committed serious offences including murder whilst suffering a psychotic episode but was never convicted of the offences because she was found to be of unsound mind at the time of commission – where the applicant remains subject to a Forensic Order issued by the Mental Health Court – where the applicant had recovered good mental health subject to taking antipsychotic medication – where expert psychiatric evidence was given at hearing – whether the matter constituted an exceptional case and a negative notice should be issued under the legislation *Disability Services Act* 2006 (Qld), s 41, s 52(1), s 54(3),

s 54(4), s 54(5), s 55(2), s 128, s 129
Mental Health Act 2000 (Qld), s 791(2)

Commissioner for Children and Young People and Child Guardian v FGC [2011] QCATA 291
Commissioner for Children and Young People and Child Guardian v Maher [2004] QCA 492
Harvey v Attorney-General [2011] QCA 256
MS v Department of Communities (Disability Services) [2011] QCAT 709

APPEARANCES & REPRESENTATION:

Applicant:	C R Dennis, Queensland Advocacy Incorporated
Respondent:	A Scott of Counsel instructed by Crown Law

REASONS FOR DECISION

[1] QN is a 45-year-old woman currently working as a cleaner and living in a regional town with a partner.

[2] She has been the subject of a Forensic Order under the *Mental Health Act* 2000 (Qld) ('MHA') for eight years after she was found to be of unsound mind in relation to a charge of murder of her husband, three counts of endangering children by exposure and one count of leaving a child under 12 unattended ('the index offences').

[3] The index offences occurred in 2011 when she suffered a severe psychotic episode arising from an undiagnosed psychotic illness. She has subsequently been diagnosed as suffering from either schizophrenia or schizoaffective disorder at the time of the index offences.

[4] She had no prior forensic criminal history. Nor had she any history of substance abuse or contact with mental health services prior to the index offences. Her mother suffered from mental illness however and there were other family members who had mental health problems.

[5] Prior to the index offences she had two episodes of psychosis, both episodes resolving without treatment. The first episode occurred when she was 24 years of age and lasted two weeks which involved her reading the Bible during the day and night while feeling euphoric and somewhat paranoid. The second episode occurred when she was 30 years of age and lasted for around six months and involved her experiencing delusions that were both grandiose where she believed she was a prophet, and paranoid, as well as having lots of energy, not needing sleep and spending a lot of money.

[6] QN and her husband had recently separated at the time he was killed. They had four children aged between one and seven years of age. Whilst the older children were at school her husband came to babysit the two youngest so QN could go shopping.

[7] Whilst out shopping she purchased some poison and when she got home she mixed it with Coca-Cola intending to give it to her husband. When she tasted it however

she realised it tasted awful. Instead she gave him a sandwich into which she had crushed a number of Tramadol tablets.

[8] She asked her husband to stay for a barbeque dinner. She asked him to sharpen a knife for her and after it was sharpened she massaged his shoulders and in the process took the knife and cut his throat. This was done in the presence of their two youngest children who were sitting in their chairs at the dining table at the time. He fell to the floor bleeding and although he struggled she managed to cut further into his neck and he died.

[9] After he died she had a shower then dragged his body out to a car and dumped his body on a nearby rural property in a patch of lantana. She then returned home. She went to a nearby tip where she disposed of the towels and clothing she had worn when she killed her husband.

[10] The next day she returned to the rural property with her four children and left them unattended at the edge of a dam near where she had dumped her husband's body. She knew they could not swim. She had no intention of returning to the property where she had left them.

[11] QN made full admissions to police in respect of the index offences for which she was charged.

[12] In subsequent proceedings in the Mental Health Court in 2012 she was found to be of unsound mind at the time of commission of the index offences and a Forensic Order was made under the MHA detaining her at a psychiatric hospital.

[13] The Forensic Order was later varied and she was released from the hospital into community care in May 2015.

[14] The Forensic Order remains in place and is reviewed from time to time, currently every six months.

[15] On 24 April 2018, QN applied to the Department of Communities, Disability Services and Seniors ('the Department') for a prescribed notice ('yellow card') to enable her to provide services to clients with disabilities. On 17 December 2018 the Department issued her with a negative notice under the *Disability Services Act* 2006 (Qld) ('the Act') on the basis the case was an exceptional one in which it would not be in the best interests of people with a disability for her to be issued with a positive notice entitling her to a yellow card.

[16] QN has applied to the Tribunal to review the decision to issue her with a negative notice.

Statement by QN

[17] QN says she has not been unwell since the time of the index offences and that is attributable to her medication, her treating team, her supports and the insight she now has into her illness.

[18] She takes good care of herself when stressed and she has come across many stressors since being released from high security inpatient control and despite that has maintained good mental health. She has now extensively studied about schizophrenia and knows her warning signs and she is vigilant about taking her

medication which is by depot injection.[1] She has a partner who is very supportive. They have been partners for four years. Her family has also been extremely supportive and she often sees them.

[19] Her treating team are supportive. Her partner is very proactive in engaging with her treating team and her psychiatrist.

[20] At the time of the index offences she was an enrolled nurse. In April 2018, and prompting her application for a yellow card, she had gained employment as a disability support worker and worked for an individual, a man, who had quadriplegia and was dependent for many things. The work she did for him entailed showering him, dressing him, cooking, cleaning, shopping, gardening and a myriad of other jobs.

[21] Currently she sees a psychiatrist every month and her treating team every week. The current medication is an injection in the arm every 28 days. She has no side effects from this medication. She has a list of conditions in her Forensic Order and she has never breached any. Her mental health has been stable for a long time and she has never had a relapse since the index offences in 2011. She says she has no negative or positive symptoms and if she did she would seek attention from her treating team straight away. She knows all of her warning signs and so does her partner.

[22] She is a caring and gentle person by nature and loves to help people. She forms relationships easily and she is an easy-going person. She has never been in trouble with the law other than when she was unwell. Her passion is nursing. She wants to continue to help people in the future.

Her partner

[23] Her partner has provided a statement of evidence. He first met QN at school. They lost touch for some time after that but in 2015 they reconnected through mutual friends.

[24] He said soon after their relationship started she told him about the index offences and the Forensic Order.

[25] They have lived together for nearly four years, and at one stage his daughter from a previous marriage lived with them. He has never had any cause for concern about his children or his own safety with QN. He has attended mental health reviews and psychologist appointments with her and he is aware of her warning signs and is always up-to-date with her treating team.

[26] Her role as a carer for the individual suffering quadriplegia entails shift work both mornings and night and both weekdays and weekends. He found QN always willing to attend upon her disabled client and she never complained about it. He has never seen her stressed about her work has a disability support worker, in fact just the opposite.

SD

[27] SD was a client of QN. QN provided him with care for approximately six months. The care extended to many aspects of personal care including dressing and feeding

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[1] Slow release, slow acting.

and shopping and other things. She worked for him several days and nights each week.

[28] He said in a statement of evidence that she had compassion and natural caring capabilities and he thought she was well suited to the role of carer.

[29] She was honest and he depended on her for everything whilst living on his own with quadriplegia paralysing all four limbs. In his statement of evidence he said he had never known nor wanted to know what had happened in her past, however his intuition was that she was a first-class person who could be trusted and would not let him down, nor others.

The Department's evidence

[30] Ms G, a director of Accommodation Support and Respite Services of the Department, filed a statement of evidence.

[31] She explained that the role of a disability support worker covers a broad range of duties. The work requires the worker to have emotional resilience, self-control and self-discipline to manage and work with vulnerable people who at times may display challenging behaviour. The worker may be presented with unexpected challenges or crises. They may be physically harmed, pinched, slapped, kicked, bitten, hit by thrown objects or have their hair pulled. Hence a disability support worker must possess highly developed emotional regulation and anger management skills.

[32] It is unlikely that a disability support worker will not encounter stressful working conditions.

[33] People with disabilities can be more vulnerable to abuse, neglect and exploitation than other members of the community. The nature and extent of the vulnerability can depend on the nature and impact of the disability.

[34] A person with a yellow card can change their employment after they receive a positive notice and move from working for an organisation to working directly for a person with a disability. Some of the work may require night shifts where they are required to stay awake for 8 to 12 hours.

The psychiatric reports

Dr T

[35] Dr T provided a report. He is a consultant psychiatrist in public practice. He had treated QN from May 2016 through to April 2019 when she relocated to another regional community.

[36] He said in his report that QN was an exemplary patient. There had been no instances of breach, substance use, or non-compliance with 'follow-up'. She voluntarily moved from oral anti-psychotic tablets to monthly injections to reduce any chance of forgetting to take the medication or accidental non-ingestion (for example, vomiting causing a dose to be missed). She had coped with changes in address, relationship stress and loss of employment.

[37] There had been no signs of psychosis since early 2012. She had arranged her own GP appointments for medication injections. She has an acute management plan to be used if she or anyone in her circle notices a change in her mental state. She was acutely aware of the symptoms she had leading up to the index offences.

[38] In his opinion there are no current risk factors or triggers identified which could contribute to a risk of further offending. She has successfully negotiated several stressful life events without any early warning signs. She is an active participant in society, engaged in meaningful social relationships and she wants to maintain her wellness.

[39] Future risks could arise if she ceased her anti-psychotic medication, or her current relationship broke down, or there was a serious illness that precipitated a relapse, or if there was some significant stressor that she could not relieve. She has many protective factors that will reduce the risk of a future offence:

(a) She has no history of antisocial behaviour before the index offences.

(b) She had trained and worked in a helping profession (nursing) without issue. Helping others is her personality.

(c) She does not use non-prescribed mind altering substances.

(d) She is engaged in active social networks (her own family, fiancé and his family and friends) who are aware of her past and are prepared to call for help if they notice any issues.

(e) She is actively engaged in treatment; she does not need reminders or force.

(f) She had an excellent response to medication and is aware of the need to continue it lifelong. There have been no relapses or return of her past delusions and there are no residual symptoms.

(g) Her history of endangering her own children and committing murder and her memories of that with which she has had to live was a one-off episode of untreated illness.

(h) The index offences did not occur in a rapid manner. In hindsight there were weeks of early warning signs, changes in behaviour, changes in her belief systems, and new delusions. A future episode is likely to give similar warnings, and now her intimates are aware.

(i) There has only been one hospital admission and that occurred after the index offences.

(j) Her supervision and conditions have been reduced over time as she has maintained her health and mental state and engaged in treatment. No deterioration in compliance or mental state has been seen with this reduction. The most recent risk management committee recommendation is that monitoring be reduced to monthly by her case manager and every three months by her psychiatrist.

(k) Because she has only had one full episode, which episode responded to anti-psychotics, and that was eight years ago, her prognosis is excellent.

(l) She has endured a number of stressors since being released from secure custody without relapse. These have included the ending of a romantic relationship, loss of a job, work stress, study and at least three changes in address.

[40] Dr T pointed to a number of strategies QN has adopted to reduce the risk of relapse:

(a) She voluntarily takes her medication by long acting injection because this removes the uncertainty of oral medications and it provides a more consistent medication dose.

(b) She has an Acute Management Plan to be followed if any within her social networks notice any deterioration.

(c) She has a Police and Ambulance Management Plan to be followed if concerns are raised.

(d) She has engaged her family and her fiancé and his family as part of her early warning network. They have permission to call mental health or emergency services if they are concerned.

(e) She organises her own injections and her appointments; she is vigilant in ensuring that her treatment is maintained.

(f) She engages in purposeful activity, work, hobbies and relationships which maintain links to the external world and her mental and physical health.

(g) She has identified early warning signs and the strategies to be adopted if they are identified.

(h) She tries to look after her psychological and physical health through routines, seeking help when required and lifestyle (including sleep, diet and social activities).

[41] Dr T says he is confident that QN is an appropriate person to be issued a yellow card. He says the issue is not what she did in 2011 but whether there is a risk that what she did were acts that she could repeat. At the time of the index offences she was suffering a first episode of a psychotic episode which had developed over weeks and was not identified and therefore not treated. It included command hallucinations, paranoia and complex delusions in a setting of sleep loss. The consequences were severe and long lasting for all involved.

[42] He concludes his report by saying the 'greatest protective factor we have' is that QN never wants to go through a similar event. She is vigilant in ensuring she is medicated and that those supporting her know what to look for in a relapse. She has an extensive social network aware of the history and the risks including an intimate partner. Of particular significance is that there have been no early signs of relapse in many years and no signs of her wavering in her desire and intent to stay well.

[43] At hearing Dr T made clear that he thought QN did not need a Forensic Order or a stepped down Treatment Support Order. When she was held at the mental health hospital she was under an Involuntary Treatment Order. When she was released to community care a Forensic Order was made in lieu, and then after several years of him treating her he was persuaded that she represented no risk to the community subject to her receiving treatment and therefore advocated that the Forensic Order be replaced by a Community Treatment Order. In his opinion no order at all was necessary.

[44] Whilst under his care she had an excellent response to her medication with no fluctuations of mental state or return to psychosis. Accordingly in his opinion it was unlikely that she would develop treatment resistance to the anti-psychotic drug she was taking, it could be taken to keep her well for the rest of her life and she would need the drug for the rest of her life.

[45] He conceded he could not guarantee that QN would never suffer a relapse. He pointed out however that she had had a number of significant stressors such as changing address and break down in relationships, publication of a book about her and none had led to deterioration or change in her mental state. He thought it unlikely that she would suffer a relapse to psychosis.

[46] In the long term he expected a transition from the formal involvement of mental health services to placing responsibility on QN and her intimates to control her mental health condition, much as would occur in say the treatment of someone with a cardiac condition.

[47] As to her family intimates identifying changes in her behaviour, he suggested that before any incident of violence there would be a change in her thought patterns and observable change in her interests, such as interest in religion, or interest in a new world order, or not sleeping (all of which were instances of behavioural change that took place prior to the index offences in 2011). If that occurred and she was no longer linked with a formal mental health network 'say 5 years in the future',[2] one of her support network would simply need to telephone a 1300 number and an alert against her name would come up on their mental health database with a note that an urgent assessment may be required.

[48] Her partner was trained about noting these changes and trained about what to do.

[49] If she had a relapse he thought it was highly likely she would maintain insight, at least initially, and act herself.

Dr L

[50] Dr L, a consultant psychiatrist, had provided a report in November 2018 in support of an application by QN to step down the Forensic Order to a Treatment Support Order. The report was provided by her at the request of Dr T.

[51] QN had been working for SD at the time of that report and her partner's daughter was living with her father and QN.

[52] Dr L reported that QN demonstrated a good degree of insight into the nature of her illness, its likely precipitant and her early warning signs. She considered QN was happy with her treatment and intended to continue with it long term and continue to engage with her treating team.

[53] Dr L noted she had a number of external supports who were aware of her illness and who were involved with her.

[54] Dr L said that based on QN's insight and engagement in treatment in conjunction with multiple supports she supported the change from Forensic Order to Treatment Support Order.

[55] Dr L did not provide further evidence at the hearing.

Dr Z

[56] Dr Z is a forensic psychiatrist and has worked in that field for almost 20 years. He interviewed QN (for three hours) on 11 October 2019, had had access to her medico-

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[2] Audio transcript 10.14.25.

legal records and provided the Department with a report about her for the purpose of assisting in determining her application for a yellow card.

[57] He noted she had symptoms of bulimia in her twenties as well as two episodes of psychosis which both resolved without treatment. Both episodes occurred after she had recently changed churches. The first episode occurred in 1998 lasted two weeks and involved her reading her Bible during the day and night whilst feeling euphoric and somewhat paranoid. The second occurred in 2005, lasted around six months and involved her experiencing delusions that were both grandiose, where she believed she was a prophet, and paranoid, as well as having lots of energy, not needing sleep and spending a lot of money.

[58] Dr Z noted in his report that following her recovery in 2011 she had remained completely free from psychotic symptoms.

[59] When Dr Z spoke to her she had left the regional centre where she had been treated by Dr T and moved to another regional centre with her partner. She continued to have her anti-psychotic medication by injection every 28 days.

[60] Dr Z said in his report there was nothing abnormal or unusual in QN's behaviour when he interviewed her. There was no evidence of thought disorder. There was no evidence of cognitive deficits. She demonstrated good insight as regards her history of mental health problems and accepted she suffered from a psychotic illness and that she considered it to be a lifelong condition requiring lifelong management. Whilst it is clear that she had a family vulnerability for mental illness, to which she had succumbed, it was also clear that she responded well to treatment in every way.

[61] He had assessed her using various test regimes. Generally he concluded from the tests that her current overall risk of violent reoffending was low. Should she reoffend violently the only plausible pathway would be in association with a relapse into psychosis. She had suffered three psychotic episodes in her lifetime the last of which resulted in the index offences. At that time she had been untreated and her underlying psychotic disorder undiagnosed.

[62] Now she had an established diagnosis of a psychotic disorder with a known pattern of symptoms (with early warning signs) should she become unwell. She was protected from becoming unwell by the prescription of medication given by monthly injection which guaranteed compliance. She had developed insight into her illness. Her partner, family and friends were aware of her illness and knew to alert authorities of any concerns. She has now maintained mental health stability for eight and a half years and during that time transitioned from hospital to the community and twice moved house and forged a therapeutic relationship with new treating teams. Throughout this her mental health had remained robust and she had maintained engagement, compliance, ability and remission.

[63] In his report Dr Z answered a number of specific questions put to him by the Department. In his opinion he said QN has full insight into her offending behaviour and its impact on society, the victims and any people with a disability that might be associated with her. He could not identify any current active risk factors or triggers which might contribute to risk of further offending.

[64] However she would always harbour the underlying (latent) risk factor of having a mental illness, which when actively unstable, could ultimately lead to thought patterns and behaviour that could lead to violence. He concluded his report:

> Her mental health stability and associated low violence risk status is maintained by her adherence to recommended anti-psychotic medication, and by her close engagement with the responsible mental health services. Her adherence to medication is guaranteed by the fact that it is administered by depot. Her close engagement with the treating mental health services guaranteed through the conditions of the Forensic Order. Should her medication no longer be administered by depot, or her close engagement with the treating mental health services weaken, perhaps through the revocation of the Forensic Order, then I would not necessarily hold such a confident opinion that she would be safe to care for disabled and vulnerable persons, and hence hold a yellow card. I say this in the belief that although the probability of reoffending is ultimately chronically low, any reoffending carries the possibility of being of a serious nature. Thus, should she be granted a yellow card, I would recommend that there be regular (perhaps annual) reviews of her yellow card status, in respect of her the robust circumstances of her mental health management, and in the event of any relapse into mental instability, there be a mechanism for prompt suspension of the yellow card.[3]

[65] At hearing it was made clear to Dr Z that neither the review or suspension mechanism he advocated for was available under the Act. He said in his opinion that became a factor to be considered.

[66] I note Dr Z's suggestions about an annual review and power to suspend the yellow card were put to Dr T at hearing for comment. Dr T thought the annual review was unnecessary but he did agree that in the event of any relapse her yellow card should be suspended. When put to him that after grant of a yellow card there was no power to suspend it Dr T said he still believed that she should be issued with a yellow card because the risk of relapse was so very low.

[67] Dr Z said he thought the likelihood of QN reoffending was low but there were factors that might escalate the risk such as her becoming unwell, which he considered was the main risk factor. He thought it significant that any reoffending by QN, if it occurred, was likely to be 'catastrophic'.

[68] In his opinion there was no guarantee of mental stability simply because QN was being administered psychiatric medicine by way of depot injection. At best that only enhanced stability.

[69] Further, QN had suffered three past episodes of psychotic illness, not one which was how Dr T viewed her history. The first in 1998 lasting approximately two weeks and the second seven years later in 2005 which lasted months. Both episodes were unidentified and untreated, with QN seeking a form of religious solution to her problems when they were in fact mental health problems. She had noticed she was acting a little or quite differently at these times but she was able to assure her family that her problems were with religion and her belief system rather than mental ill health.

[70] Then her third episode, which encompassed the index events, occurred in 2011. He said the reports of the psychiatrists provided to the Mental Health Court suggested there may have been a period of lead up to the events during which she was unwell.

[71] The significance of this, he suggested, was that she has had a number of occurrences of psychotic episodes and they have been years apart. QN has not relapsed since she

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[3] Report 11 November 2019, 16.

became better in the high security hospital but she did have family members around her before during each previous incident. It is a positive factor that these same family members have now been educated about her mental health, but it should not be ignored that her strange behaviour associated with the previous psychotic episodes were all able to be explained away at the time by her in a somewhat plausible manner, at least prior to 2011. Dr Z described QN as presenting, when well, an endearing, highly likeable, engaging, assured, somewhat confident personality.

[72] He said her partner will be the key individual who will notice changes in her mental state, but there is no guarantee he will remain part of her life. Dr Z questioned how much faith you can place on factors that may change in the future.

[73] As to insight, she has good insight into her condition when well. However when one becomes unwell, one can lose insight quickly.

[74] Concerning the recommendation in his report about regular reviews of a yellow card if one was issued to her and in the event of relapse there be in place a mechanism for prompt suspension, he elaborated on those suggestions at hearing with an explanation about internal and external risk control in the context of access to vulnerable persons,.

[75] He said internal risk control measures occur through mental health stability effected by medication giving insight. That had occurred in the high security hospital environment and continued.

[76] External risk control measures are changes the individual has no control over but which support risk management, such as the Forensic Order with conditions that require regular contact with mental health services who would be able to observe her as either well or unwell.

[77] Another external risk control was arguably the depot injection regime. She could change her mind about that, but that would become apparent. But Dr Z said depot injections were no guarantee of mental health but a guarantee as to administration of the drug only, and a guarantee that there is medication in her system. There was no guarantee that the drug would keep her well, because an individual who suffered three psychotic episodes could suffer a fourth. In the presence of medication that was unlikely, but it was still possible given sufficient stressors. QN had withstood significant stressors after the index offences and not relapsed which was favourable in showing her resilience, but it was no guarantee.

[78] He considered suspension of her yellow card would be an appropriate additional external control. If her mental health treating team learned that she was mentally unwell they could immediately contact the Department and her yellow card could be suspended. In that way there would be no voluntary choices exercised.

[79] In his opinion if she became unwell she should have no contact with disabled people under the umbrella of the yellow card.

[80] As to his suggestion about an annual review of her yellow card, he explained that mental health care leans towards least restrictive practice, which had been mentioned by Dr T. That might take months, it might take years, it might take two decades for the Forensic Order to be stepped down to a Treatment Support Order, which would potentially still have conditions attached. But the Treatment Support Order could itself then be revoked. At that point one would be wholly reliant on the

internal risk control measures only. In those circumstances an annual review of the yellow card would be appropriate and with psychiatric evidence provided.

[81] Dr Z said he works primarily in the prison system in his public sector work and doing forensic medico-legal work for the private sector. In his experience and opinion, general mental health service psychiatrists (such as Dr T) do not see quite the same detailed picture that he sees as a result of his long experience as a forensic psychiatrist.

[82] He noted that when QN moved house transferring away from Dr T's mental health services care to another district and another team and another psychiatrist, the required frequency of her contact with the new mental health team has been increased as a matter of caution.

[83] He summed up that the likelihood of her re-offending is low, the nature and severity (of consequences) if she does is high, and she is being managed differently to that of the standard mental health patient.

[84] Dr Z said this in answer to a question in cross-examination:

> We in forensic psychiatry place weight on the risk management and we adhere to the least restrictive practice that safely manages the patient and we don't push the patient towards autonomy in a way that fosters risk. For most mental health patients there are not significant risks of violence to others. …but my point is that [QN's] likelihood of reoffending is low, the nature and severity is high, she is being managed differently to that of the standard mental health patient…. But [QN] is not a typical patient, her past history speaks to that and therefore I place a lot of weight on what happened when she was unwell and therefore the approach is more cautious, much slower, decisions are made in a far more ponderous manner and one is always thinking about the worst-case scenario, as negative as that may sound.[4]

The legislation

[85] By s 52(1) of the Act a person engaged by a funded non-government service provider and NDIS non-government service provider may apply to the Department for a prescribed notice.

[86] Section 54(3) provides that, subject to s 54(4), the chief executive must issue a positive notice if the chief executive is not aware of a conviction for an offence but is aware, amongst other things, that there has been a charge for a disqualifying offence that has been dealt with other than by conviction.

[87] By s 54(4) the chief executive must issue a positive notice unless satisfied it is an exceptional case in which it would not be in the best interests of people with a disability to issue a positive notice. If so, by s 54(5) the chief executive must issue a negative notice.

[88] Section 55(2) states that in determining whether there is an exceptional case for a person convicted or charged with an offence the following matters must be considered:

> (a) in relation to the commission, or alleged commission, of an offence by the person—

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[4] Audio record 11:14:30 – 11:17:02.

(i) whether it is a conviction or a charge; and

(ii) whether the offence is a serious offence and, if it is, whether it is a disqualifying offence; and

(iii) when the offence was committed or is alleged to have been committed; and

(iv) the nature of the offence and its relevance to engagement that involves people with a disability; and

…

(d) any information about the person given to the chief executive under s 128 or 129;

(e) anything else relating to the commission, or alleged commission, of the offence that the chief executive reasonably considers to be relevant to the assessment of the engaged person.

[89] By s 41 the paramount consideration in making a decision about a yellow card application is the safety of people with a disability. In particular the right of people with a disability to live lives free from abuse, neglect or exploitation.

[90] Sections 128 and 129 provide for the chief executive to ask the Mental Health Court or the Mental Health Review Tribunal for information in certain circumstances.

[91] A serious offence includes murder (Criminal Code s 300 qualified by s 302) and endangering the life of children by exposure (Criminal Code s 326).[5]

[92] Acting on ss 54(4) and (5) the chief executive issued QN with a negative notice.

Discussion

[93] It is not disputed that the index offences occurred whilst QN was experiencing a psychotic episode in the context of a then-undiagnosed and untreated mental illness, and that those index offences are QN's only offending behaviour.

[94] The psychiatrists agree that the mental illness is in remission. There have been no signs of psychosis since the index offences. QN has had an excellent response to treatment.

[95] She has experienced a number of stressors since the index offences but despite that has maintained stable mental health.

[96] She is subject to six-monthly reviews by the Mental Health Review Tribunal whilst subject to the current Forensic Order.

[97] I accept there are many protective factors in place that reduce the risk of a relapse and consequent future offences occurring, such as monthly injections of her anti-psychotic medication and a strong support network both at home and with her mental health treatment team.

[98] However Dr Z points out that she has a lifelong mental illness and there is no guarantee of mental stability simply because she is being administered psychiatric medicine through depot injection. Depot injections are no guarantee of mental health but simply an observable guarantee that the drug has been taken and once taken that

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5 The Act, s 47 and Schedule 2.

the drug is in the patient's system. According to Dr Z, and I accept his evidence on this, QN will always harbour the underlying risk factor of having a mental illness; that there is no guarantee that her anti-psychotic drug would keep her well; and someone who suffered three psychotic episodes could well suffer a fourth, which was unlikely but still possible given sufficient stressors.

[99] Dr T referred to her having experienced only one psychotic episode: that when she committed the index offences. In fact however I conclude there have been three psychotic episodes and Dr T's description of the first two as brief episodes of psychosis spontaneously resolved is inadequate.

[100] In all three episodes she had managed to explain away her strange behaviour. It must be granted that at the time of these episodes her mental illness had not been diagnosed, and granted her family, and now her partner, were educated about her mental illness and warned about changes in her demeanour and attitudes. However as Dr Z pointed out when one becomes mentally unwell one can lose insight quickly. Should there be a relapse will QN lose insight quickly and again attempt to explain away strange behaviour as something other than mental illness – and that explanation might give pause to those in her social network from acting quickly.

[101] Dr T's comment on possible relapse was that he thought it was highly likely she would maintain insight, at least initially. He did not clarify how long that insight might persist. This is significant given Dr T opined QN's greatest protective factor was that she does not want to go through a similar event to that which occurred in 2011 ever again. That best protective factor, insight, may have no long lifespan however should relapse occur.

[102] The key individual playing a role in noticing changes in her mental state is her partner, but there is no guarantee that he will always be there for her.

[103] It seems clear Dr T supports QN transitioning from a formal involvement with mental health services to shouldering responsibility for her own mental health with assistance from her intimates. Dr T believed no order at all was necessary, even though he conceded he could not guarantee that QN would never suffer a relapse.

[104] In Dr Z's opinion if QN became unwell she should have no contact with disabled people. He said if she had a relapse the outcome could be catastrophic.

[105] I accept Dr Z's assessment that QN is not a typical mental health patient and her past history speaks to that.

[106] Overall Dr Z was an impressive witness. He is a consultant forensic psychiatrist. He has an impressive CV. He has undergone specialist training in psychiatry, namely Forensic Psychiatry. He has worked continuously in the area of forensic mental health since 2002.

[107] He struck me as an entirely independent witness giving independent evidence and making appropriate concessions where the evidence and his examination required.

[108] By contrast Dr T struck me as seeing his role as supportive of QN in her quest for a yellow card, which is not the role of an expert witness in Tribunal proceedings.[6]

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[6] QCAT Practice Direction 4 of 2009 – '4. An expert owes a duty to assist the tribunal which overrides any obligation to any party to the proceeding … The expert's role is to assist and advise the tribunal on issues in dispute within the expert's area of expertise.'

[109] In so far as their views and assessments of QN conflict, I prefer and accept the opinion of Dr Z. His is a specialty within a specialty. Forensic psychiatry concerns the diagnosis and treatment of mental disorders in the context of the criminal justice system which is entirely relevant to the matter at hand.

[110] Having said that, it is for the Tribunal to reach a decision in this matter. The Tribunal accepts guidance in matters where expertise in particular fields is necessary to sufficiently comprehend complex issues and permit informed decision making about issues in contention.

[111] There are a number of factors required to be considered under s 55(2) of the Act, including in relation to the commission of an offence, namely whether it is a conviction or a charge, whether the offence is a serious or disqualifying offence, when it was committed and the nature of the offence and its relevance to engagement with people with a disability.

[112] Whilst there was no conviction in respect of the index offences, QN has never denied responsibility for murdering her husband or abandoning her children at the dam. In her statement of evidence she says she went to the Mental Health Court and was acquitted of all charges. That is not correct. She was charged with the index offences but the charges were withdrawn because she was found to be of unsound mind at the time of their commission.

[113] Had she been competent to stand trial she would have been charged with murder and with endangering the life of her children, serious offences under schedule 2 of the Act obliging the chief executive to issue a negative notice upon conviction.[7]

[114] As explained by Ms G, disabled people are more vulnerable to abuse, neglect and exploitation than other members of the community. The nature and extent of the vulnerability can depend on the nature and impact of the disability. If QN suffers a relapse, the consequence for a disabled person under her care may not be just serious, but as Dr Z described it, catastrophic.

[115] The index offences occurred nine years ago, and since then there have been no instances of reoffending. However the two episodes prior to the index offences also occurred years apart, respectively seven and six years.

[116] QN submits that her case is not an exceptional case for the purpose of s 54(4). Whether QN represents a real and appreciable risk rather than a mere possibility of risk is the question. *MS v Department of Communities (Disability Services)*[8] is relied on for that proposition. There the Tribunal said:

> Risk factors may vary from the perspective of the assessor, but more particularly will vary according to the known facts. On one view of it, the existence of previous convictions means there will always remain the possibility of a risk to the safety of the community. Risk in the context of the tribunal is not concerned with what may be mere possibilities, but rather will require some foundation in fact. The tribunal is looking at whether, in all circumstances, there is real and appreciable risk. It does this as part of its consideration of whether an exceptional case exists.[9]

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7 The Act, s 54(10) – subject to it being an exceptional case in which it would not harm the interests of people with a disability (s 54(11)).

8 [2011] QCAT 709.

9 Ibid, [14].

[117] QN says the index offences occurred in the context of an undiagnosed and untreated mental illness which is not the case now. The mental illness is in remission and has been for a considerable period. It is well managed by her medication. The risk of relapse is a mere possibility only and arguably a highly unlikely one given the protective factors listed by Dr T. QN does not represent a real and appreciable risk to people with a disability under her care.

[118] I do not accept that proposition. First, *MS* must be understood in the context of its facts. There the applicant for a yellow card had an extensive criminal history, with convictions for drug offences in particular. On one occasion she had been convicted and sentenced to three months imprisonment but that sentence wholly suspended for two years for the offence of supplying dangerous drugs. Her offences were not serious offences as defined in the Act.

[119] Second, *MS* also endorsed the following statement in *Commissioner for Children and Young People and Child Guardian v Maher*:

> … the Tribunal was required to be satisfied on a balance of probabilities, bearing in mind the gravity of the consequences involved, that there was an exceptional case, in which it would not harm the best interests of children for a positive notice to be issued.[10]

[120] In the matter at hand the gravity of the consequences involved for a disabled person under the care of QN must be borne in mind.

[121] Third, the test under the Act is not whether there is a real and appreciable risk, but whether an exceptional case exists in which it would not be in the best interests of people with a disability for a positive notice to be issued.

[122] What constitutes an exceptional case in s 54(4) is not defined but the meaning of the word 'exceptional' has been considered by the Court of Appeal more recently in the context of declared dangerous prisoner legislation. In *Harvey v Attorney-General*[11] the appellant was a declared dangerous prisoner subject to a supervision order which contained a condition that he not commit an indictable offence during the period of the order. He was charged with an indictable offences during the period. The respondent applied to rescind the supervision order on the basis of contravention of the order but the prosecution for the indictable offences were subsequently discontinued. The appellant applied to be released from custody pending the determination of the application to rescind the supervision order. On appeal from the primary judge's refusal to do that the Court of Appeal said:

> Once contravention proceedings had been instituted, the appellant was required to be detained in custody unless he satisfied the Court on the balance of probabilities that his detention in custody pending the final decision is not justified "because exceptional circumstances exist". The word "exceptional" is an ordinary, familiar English adjective. It "describes a circumstance which is such as to form an exception, which is out of the ordinary course, or unusual, or special or uncommon". It need not be "unique, or unprecedented, or very rare", but it cannot be a circumstance that is "regularly, or routinely, or normally encountered".[12]

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10 [2004] QCA 492, [30].

11 [2011] QCA 256.

12 Ibid, [42], citing *Attorney-General (Qld) and Anor v Francis* [2008] QCA 243, [41], approving the statement made in *R v Kelly (Edward)* [2000] QB 198, 208.

[123] The Tribunal also considered the expression 'exceptional case' in blue card proceedings in *Commissioner for Children and Young People and Child Guardian v FGC*[13] and said there that the phrase 'exceptional case' should be considered in the context of the legislation which contains it, the intent and purpose of that legislation, and the interests of the persons whom it is designed to protect.[14] The Tribunal also noted:

> …in the Queensland Supreme Court, Philippides J has said that: '… *it would be most unwise to lay down any general rule with regard to what is an exceptional case … All these matters are matters of discretion*'.[15]

[124] The comment by Philippides J was made in *Maher.* I note her Honour also observed there that the Children's Services Tribunal had taken the view that there were exceptional circumstances which rendered the case concerned an exceptional case and she saw no error in that approach.[16] The exceptional circumstances identified by the Children's Services Tribunal took the case outside the normal rule to make it an exceptional case.[17]

[125] In *Maher* McPherson JA remarked that the statutory paramount consideration in making a decision in the matter 'to which all others yield' was the right of people with a disability to live lives free from abuse, neglect or exploitation, which paramount consideration is set out in s 41 of the Act.

Conclusion

[126] I accept QN has in her favour many protective factors that reduce the risk of a future offence.

[127] I accept the likelihood of her reoffending is small because the likelihood of a relapse to psychosis is small.

[128] However I bear in mind the gravity of the consequences involved to a person with a disability in her care should she relapse.

[129] Once granted a yellow card, there is no provision for the Department to suspend it if QN suffers a relapse.

[130] Once granted a yellow card, QN may change her employment as she deems fit.

[131] QN has a lifelong mental illness and there is no guarantee of mental stability simply because she is being administered psychiatric medicine through depot injection.

[132] If relapse occurs the loss of insight into her mental illness may be quick and the experts agree mental health care leans towards least restrictive practice. In the years ahead whilst she holds a yellow card her current Forensic Order may be stepped down to a Treatment Support Order and potentially that then revoked too leaving responsibility of monitoring QN's lifelong mental illness with her and her family support network.

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13 [2011] QCATA 291.
14 Ibid, [31].
15 Ibid, [32], Philippides J endorsing the approach of Fullagher J in *Re Imperial Chemical Industries Ltd's Patent Extension Petitions* [1983] VR 1.
16 [2004] QCA 492, [28].
17 Ibid, [29].

[133] Her primary family support is her partner, and hopefully he will remain vigilant and by her side, but there is no guarantee about that.

[134] I note the statement by Dr Z who said should she lose her close engagement with the treating mental health services, perhaps through the revocation of the Forensic Order, then he would not necessarily hold a confident opinion that she would be safe to care for disabled and vulnerable persons.

[135] QN is not a typical mental health patient. Her life long illness and the small though ever present possibility of relapse, with the catastrophic possibilities that might flow from that for a person with a disability under her care, makes her case unusual and exceptional. In the words of the Court of Appeal in *Harvey*, her case is 'out of the ordinary course, or unusual, or special or uncommon'.

[136] I conclude that hers is an exceptional case in which it would not be in the best interests of people with a disability to issue QN with a positive notice entitling her to a yellow card. The decision of the Department is confirmed.

[137] Given QN has been a party to proceedings in the Mental Health Court, there is a requirement that information not be published that identifies or is likely to identify her.[18] Accordingly it is appropriate that publication of the names of the applicant and witnesses be prohibited.

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[18] MHA, s 791(2).