SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General v Francis* [2005] QSC 381
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) v **DARREN ANTHONY FRANCIS** (respondent)
FILE NO/S:	SC No 3069 of 2004
DIVISION:	Trial Division
DELIVERED ON:	21 December 2005
DELIVERED AT:	Brisbane
HEARING DATE:	2, 3, 4 and 24 November 2005
JUDGE:	Mackenzie J
ORDER:	**It is ordered that Darren Anthony Francis continue to be subject to the continuing detention order made by Byrne J on 13 August 2004**
CATCHWORDS:	STATUTES – ACTS OF PARLIAMENT – INTERPRETATION – STATUTORY POWERS AND DUTIES – EXERCISE – GENERAL MATTERS – where respondent convicted of multiple sexual offences – where respondent "serious sexual offender" for purposes of *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) – where respondent detained after expiration of sentence pursuant to a continuing detention order – where treatment plan developed by psychiatrists to be implemented whilst respondent subject to continuing detention order – where evidence suggests that certain aspects of plan not carried out – whether Court should affirm decision that respondent is a "serious danger to the community" – whether court satisfied by acceptable, cogent evidence and to a high degree of probability that the evidence is of sufficient weight to affirm decision – whether respondent should continue to be subject to continuing detention order or should be released from custody subject to a supervision order – factors relevant to decision. *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) *Fardon v Attorney-General for Queensland* (2004) 210 ALR 50, considered

COUNSEL: M D Hinson SC with M Maloney for the applicant
M Cooke QC with M Rinaudo for the respondent

SOLICITORS: Crown Solicitor for the applicant
Aboriginal and Torres Strait Islander Legal Service for the respondent

[1] **MACKENZIE J:** This is an application by the Attorney-General under s 37(2) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) ("the Act") for review of a continuing detention order.

Nature of Review

[2] On 13 August 2004 an order was made by Byrne J that the respondent be detained in custody for an indefinite term for care, control and treatment. The order was made pursuant s 13(5)(a) of the Act. By s 14, a continuing detention order, which the order was, has effect from the later time of the time when the order is made or the end of the prisoner's period of imprisonment, and until rescinded by an order of the court. The person subject to a continuing detention order remains a prisoner (s 14(2)).

[3] Part 3 has the express purpose of ensuring regular review of continuing detention under a continuing detention order (s 26). The Attorney-General is required by s 27(2) to make the necessary application. While the prisoner continues to be subject to a continuing detention order, the court must review the order at the end of one year after the order first had effect and at intervals of not less than one year after the last review was made (s 27(1)). The present proceedings are the first review of the order made by Byrne J. The purpose of the review is for the court to decide whether to affirm a decision that the prisoner is a serious danger to the community in the absence of a division 3 order (s 30(1)). On hearing the review the court may affirm the decision 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 affirm the decision (s 30(2)).

If the court affirms the decision the court may order that the prisoner:

(a) continue to be subject to the continuing detention order; or
(b) be released from custody subject to a supervision order (s 30(3)).

[4] In deciding whether to make one of those orders the paramount consideration is the need to ensure adequate protection of the community (s 30(4)). If the court does not make an order that the prisoner be subject to the continuing detention order it must rescind the order, although a supervision order may be made (s 30(5) and 30(3)).

Making of a Continuing Detention Order

[5] According to s 3, the objects of the Act are to provide for the continued detention in custody or supervised release of a particular class of prisoner to ensure adequate protection of the community and to provide continuing control, care or treatment of that class to facilitate their rehabilitation.

[6] Part 2 of division 3 provides for the making of orders in the first instance. Section 13 (5) provides that if the court is satisfied that the prisoner is a serious danger to the community in the absence of a division 3 order, it may order that the prisoner be detained in custody for an indefinite term for control, care or treatment, or that he be released from custody subject to conditions it considers appropriate that are stated in the order. The former is a continuing detention order and the latter is a supervision order.

[7] A prerequisite set out in s 13(2) to making an order is that there is an unacceptable risk that the prisoner will commit a serious sexual offence if the prisoner is released from custody or is released without a supervision order being made. The Attorney-General has the onus pursuant to s 13(7) of satisfying the court by acceptable, cogent evidence and to a high degree of probability that the prisoner is a serious danger to the community, on evidence of sufficient weight to justify the decision (s 13(3)). Section 13(4) sets out a number of matters to which the court must have regard in deciding whether a prisoner is a serious danger to the community. Under s 30(1) the court is also required to have regard to those matters in deciding whether to affirm the decision that the prisoner is a serious danger to the community in the absence of a division 3 order.

[8] In *Fardon v Attorney-General for Queensland* (2004) 210 ALR 50 Gummow J summarised the purpose of Part 3 as follows:

> "[112] The purpose of Pt 3 'is to ensure that a prisoner's continued detention under a continuing detention order is subject to regular review': s 26. That statement of purpose guides the construction of the balance of Pt 3. That which is affirmed under s 30 is the primary decision 'that the prisoner *is* a serious danger to the community in the absence of a division 3 order' (emphasis added): s 30(1). The phrase 'is a serious danger' involves the use of the continuous present to require a decision that, by reason of the attainment of satisfaction by the means and to the degree specified in s 30(3), the prisoner presently is a serious danger to the community in the absence of a Div 3 order. Upon the reaching of that decision, the court may order further subjection to a continuing detention order or release subject to a supervision order (s 30(3)); in making a choice between those orders, the court is to have as 'the paramount consideration …. the need to ensure adequate protection of the community' (s 30(4))."

Issues considered by Byrne J

[9] A major area of contention in this hearing had its genesis in paragraphs [5] to [7] of Byrne J's reasons. Byrne J recorded that it was not, in the proceedings before him, seriously in contest that the respondent's immediate release from prison would involve an unacceptable risk that he would commit a serious sexual offence. He continued:

> "[5] ….. For reasons to be stated soon, that view is amply justified by the evidence. Importantly, in the end, the respondent was content to accept that his continuing detention for a while was warranted for a specific purpose: to permit his participation in a custodial program ("the plan") that has been designed to achieve his rehabilitation

> within the year that will elapse before any order for his detention must be reviewed: see s 27(1).
>
> [6] The plan aims to reduce, to an acceptable level, the risk of his committing a serious sexual offence upon release. It was devised by three psychiatrists, Professor Nurcombe, Dr Lawrence and Dr Moyle, all of whom have seen the respondent and provided comprehensive reports recognising the high risk of recidivism were he to be released now. It requires his detention for a year, principally to treat a propensity for polysubstance abuse and to enable the respondent's graduated release to work and into the wider community. Its successful implementation depends upon both Government and respondent: the Government to provide the necessary resources – human and material – while the respondent must commit himself to genuine participation, in the expectation that he will be released a year from now, perhaps with some supervision for a time."

[10] Paragraph [7] set out elements of the plan. It required, *inter alia*, the appointment of a coordinator in the department with authority to ensure that the plan was implemented. (The evidence suggests that this was not implemented in the way envisaged by Byrne J). The respondent was to complete the substance abuse and managing relapse program within six months. (A course of this kind was done). A therapist was to be appointed for him at the Community Forensic Mental Health Centre. (Because assistance from that body was unachievable, Dr Hogan, a psychiatrist in private practice, was engaged and visited the prison to conduct sessions with the respondent). In conjunction with the previous recommendation, it was envisaged that at four months, the respondent would be released on weekly day leave to attend the therapist. (That never occurred. Because Dr Hogan was visiting the prison leave became unnecessary; but the opportunity for the prisoner to be released for brief periods as a trial of his ability to behave while unsupervised was lost. In any event, such release would not have been approved because of the respondent's medium classification. More will be said later about this).

[11] The plan proposed that at six months, following completion of the substance abuse program and after suitable work had been found, the respondent should be transferred to a community correctional centre from which he would go to work. That never occurred either; it was later suggested that there were problems about arranging employment before the respondent had left prison and about the availability of the kind of facility enabling him to be released to work). One other recommendation was that he should not have regular daytime visits to his mother's residence for six months. The reasons for that requirement were dealt with in the psychiatrists' reports and evidence. In any event, where he would reside became academic because the respondent remained in custody. However, it became an issue in the present proceedings because of the risk of lack of an alternative.

[12] There was a provision that the respondent not form an intimate relationship until 12 months after the plan began, aimed at limiting the development of the kind of relationship that led to the detention and which was the kind of situation in which the risk of serious danger to the community was felt by the psychiatrists to be

highest. The end point of the procedures was to be review and revision of the plan. At the time Byrne J's reasons were delivered, it was "envisaged that longer term supervision of a less stringent nature will be required".

[13] Before making the order for a continuing detention order and setting out in detail the elements of the plan, Byrne J made strenuous efforts to ensure that what was being proposed was feasible and that both the applicant and the respondent were committed to its implementation. It is necessary to go into considerable detail to illustrate this point.

[14] Towards the end of the first day's proceedings, Byrne J pointed out that both the respondent and the applicant, on behalf of the community, had a common interest in the rehabilitation of the prisoner because it would serve both him and the community if it could be brought about. During cross-examination by Mr Fraser who appeared for the respondent before Byrne J, of Dr Nurcombe, Byrne J intervened, saying that it would be of assistance to him, if Mr Fraser was proposing an alternative plan, that there be a concrete proposal for Professor Nurcombe to address. He raised the issue of the need for an assurance that the respondent would undertake the plan. Then, during re-examination of Professor Nurcombe, the Professor told Byrne J that he thought it was quite likely that Dr Lawrence and Dr Moyle would agree to work with him as a group to develop a concrete plan.

[15] At the commencement of proceedings the next day, Mr Thomas, counsel in the earlier proceedings for the applicant, advised that Professor Nurcombe and Dr Lawrence were present at court and were discussing what, in their view, would be a comprehensive plan for appropriate treatment of the respondent. Dr Moyle, who was in North Queensland, was asked by telephone if he was prepared to discuss the plan with the other doctors. He agreed and arrangements were made for that discussion to occur forthwith. When proceedings resumed about 40 minutes later, Mr Thomas advised Byrne J that the psychiatrists had devised a plan they thought might be workable for helping the respondent, which Professor Nurcombe wished to reduce to writing. He said:

> "Essentially, as I understand it, it's a form of graduated release over 12 months with relapse prevention courses and therapy and then day release and then placement in a work release situation".

[16] Byrne J said that Mr Thomas had best check with the Department of Corrective Services whether the courses that were proposed could be delivered. Mr Thomas said that there were other technical questions of compliance with the Act in terms of a continuing detention order and, in particular, whether such an order allowed the kind of outplacements proposed. There were also funding questions. There was also discussion of elements of the plan, including the need for commitment by the respondent to cooperating, in light of evidence that, to that point, there had been a failure on the respondent's part to display commitment to rehabilitative steps. Mr Fraser asked for the chance to impress on the respondent what he thought the respondent should do with respect to the plan.

[17] Professor Nurcombe and Dr Lawrence were asked if they wished to say anything in view of the discussion that had just taken place. Professor Nurcombe said:

> "I think a critical aspect of this plan is the appointment of a coordinator who will coordinate all aspects of the plan and make sure that it progresses properly, and if it isn't, make decisions as to what

> needs to happen in that case. It is not clear to me who that person should be. Conway suggested it really should be someone within the correction system who has the authority to make certain parts of the plan operate. But I'm somewhat at a loss who I should recommend, but it does need to be a sympathetic but firm coordinator who has the authority to implement the plan. I'm not sure how that person should be appointed or selected."

Dr Lawrence agreed.

[18] Byrne J said:

> "That really suggests that the people within the Department of Corrective Services are those who should be approached in the first instance. It may be that there are officers within the prison system who could see to this coordination role as he's gradually released."

[19] When the hearing resumed about two weeks later after it had been adjourned to allow the proposal to be discussed with interested parties, Mr Thomas informed Byrne J that a graduated release plan had been submitted by Professor Nurcombe in consultation with Drs Lawrence and Moyle. Mr Fraser said that the respondent was "very positive" about it. Mr Thomas pointed out that the substance abuse education program did not exist any more but there was a Sexual Abuse Preventing Relapse Program that the respondent could attend. More fundamentally, he pointed out that since conditions could not attach to a continuing detention order the plan could only be a recommendation, unlike the case where binding conditions could be attached to a supervision order. However, he submitted that none of the psychiatrists thought a supervision order was appropriate because it required immediate release. He said, however, that the Department could take the plan forward.

[20] Mr Thomas also told Byrne J that the General Manager of the prison would have to be the coordinator because he was the only person who had a discretion to regulate day release placement. Also, the Community Forensic Mental Health Centre was administered by the Health Department. Sometimes they would and sometimes they would not make therapists available if a person did not have a psychiatric condition. That would mean that the General Manager would have to obtain other psychiatric support if negotiations with the Health Department were unsuccessful.

[21] The following passage is particularly important in understanding the efforts to which Byrne J went to ensure that what had been proposed was achieved.

> "HIS HONOUR: I must say I thought that one of the purposes of the adjournment was to enable not only the plan to be developed, and for the respondent to commit to it, but also to enable the Government to establish that it was practicable and that the resources would be available to meet it. There's little point in my making an order for his continued detention if there's no assurance that the steps that the psychiatrists think are necessary would be implemented, is there?
>
> MR THOMAS: Well, perhaps let me say that having spoken to people within the department, they certainly would take every step, but there are a series of steps that have to be taken. As I say, it is not entirely within Corrective Services control whether-----

HIS HONOUR: No, but it is within the control of the Government.

MR THOMAS: Yes.

HIS HONOUR: And if there isn't a government commitment to facilitate the plan, then it is a question whether I should order his continuing detention to give effect to it. The alternative is that he be released into the community with such supervision as is practicable. It is just that it is not a very attractive proposition that the man should be kept in continuing detention in the hope that without any real assurance that the object of keeping him in detention, mainly to implement the graduated release through this plan, would be implemented.

…….

HIS HONOUR: That would put the Court in this position of being invited to make an order which would see him detained for at least a year in circumstances where there is no assurance that the resources necessary to implement the plan will be devoted to it. That doesn't seem, at first blush, a very attractive proposition.

MR THOMAS: Well, perhaps it is the way the scheme of the Act is constructed, much like, I suppose, other areas of detention – that the Court doesn't get to specify what the prison does with a prisoner; that is, it is left to them and the resources available, but certainly all the indications that have been made to me is that every effort will be made to make things available. But, in advance, there are various options that show up if he is detained, then the first step will be to approach Community Mental Health.

HIS HONOUR: I'd be then placed in the situation of being asked to keep this man in prison for a year in circumstances where the suggested justification for it essentially is to enable a graduated release plan to be implemented, in circumstances where there is not assurance that the resources that are necessary to achieve it would be supplied. That could produce the result that he is just held in detention for another year without the implementation of a plan.

Mr Thomas, I accept that it is inevitable that there may prove to be some difficulties in the working out of the plan, but if the document that is presented to me is not shown to be one which is capable of practical application, to which as firm a commitment as might reasonably be expected is made on the part of Government, then it may be that the only alternative is to see him released into the community with such supervision in the community as practicable. To deprive him of his liberty for the purpose of implementing the plan is one thing, to deprive him of it in circumstances where there's no reason to be sure that the plan will be implemented is quite another.

…….

HIS HONOUR: Why am I being invited to deal with it if, as I gather, the Health Department hasn't even been asked yet whether it will commit to this proposal?"

[22] Then Mr Thomas made submissions about the construction of the Act and the effect of the psychiatrists' reports which led to the following discussion:

"HIS HONOUR: There's no recommendation of any psychiatrist, is there, that this man be detained on unspecified terms. There's no suggestion that that's necessary in the community interests, or even it might, by any possibility, advance it, except that he might be out on the streets.

MR THOMAS: Yes.

HIS HONOUR: Indeed, I thought the only evidence was that his continued detention has a potential for harm.

MR THOMAS: Well, potential for harm in so far as he may lose motivation, but that's not addressing the other aspects of the potential risk to the community.

HIS HONOUR: Am I not right in thinking that on such evidence as there is, his continued detention, if he is not participating in a graduated release plan, jeopardises the community interests upon his eventual release. Wasn't that the effect of the evidence of one of the psychiatrists?

MR THOMAS: If he remains completely untreated, yes.

HIS HONOUR: Yes. And there is no proposal to have him treated. So, I know that on the expert psychiatric evidence, his continued detention without appropriate treatment has the potential to put the community at risk upon his eventual release. Now, if he is not going to be treated while he is detained – and I know that the expert evidence is that his continued detention may make things worse for the community – then is not the only suitable alternative to release him under such supervision as is practicable?

MR THOMAS: No, I submit it is not that there is no intention to treat him. In fact, that's quite the opposite.

HIS HONOUR: It is just that there is no commitment to do so.

MR THOMAS: Well, there is a commitment to do so, but I was being open with the Court about the current situation with the-----

HIS HONOUR: I know, but I go back to one of the objects which the adjournment was intended to facilitate. It was not, as I

> understood at the time, designed merely to enable a psychiatrist to propose a plan that might or might not be feasible in the abstract, or that may or might not be capable of implementation by government. Wasn't a purpose of the adjournment to ascertain the extent to which there would be a commitment by Government to the implementation of the plan, and you tell me there isn't one?
>
> MR THOMAS: Perhaps one can say that it is to inform the Court how the plan may be implemented, but one cannot say with complete certainty that this plan can be implemented.
>
> HIS HONOUR: One could never say that, Mr Thomas. It would be expecting too much for an assurance of that sort to be given. There are no certainties. Apart from anything else, it might not be able to be implemented because he did not participate fully in it. It is one to thing to anticipate that it might not work, quite another not to have a commitment to attempt to implement it…."

[23] Byrne J then called on Mr Fraser who, in summary, said that, following extensive conferences with the respondent, the respondent realised that the proposal was probably the best way for him to go forward and would commit to it. Byrne J, in subsequent dialogue with counsel, reinforced the benefit of the respondent developing insight into his predicament. Byrne J enquired of Mr Thomas about what he should do if there was a commitment on one side but not on the other. Mr Thomas responded that paramountcy was to be given to adequate protection to the community. Even with the assertion that the respondent had changed his attitude, the weight of the evidence was that the respondent presented an unacceptable risk to the community. Byrne J said:

> "He presents a danger, and if the resources can be provided to him to implement this plan, the risk is significantly diminished. That appears to be the evidence, doesn't it?".

Mr Thomas agreed.

[24] Soon after, Byrne J asked Mr Fraser if his client was willing to take his chances that the program might or might not be implemented. Mr Fraser replied that, after full explanation of the plan to the respondent, he had committed to it. He went on:

> "I suppose our starting position is that we would like some sort of commitment from the Government that he just not be put away, here we are in 12 months time, arguing these same things. That's what I'm concerned about. That's what I'm concerned about. If there was a commitment to this program, all interests are served, because his rehabilitation serves the community protection, and it seems from what Dr Nurcombe says that he's not beyond redemption; he is not in the "too hard basket", and he says if he addresses, as your Honour said, some of the issues that confront him, as well as his substance abuse problems, that he will have made some substantial steps along the way to rehabilitation. So, we would like a commitment from the Government, your Honour, and I don't think that's unreasonable, with respect."

Byrne J agreed with the last proposition.

[25] After a further brief adjournment, Mr Thomas told the court the following:

> "Your Honour, I can say that the Department of Corrective Services will give a commitment to implementing the plan. I should point out that there are statutory discretions that need to be exercised in relation to certain parts of the plan; that is, a weekly, daily, even placement at a community correctional centre and they are exercised by the Director-General or the general manager or their delegates. To that extent they obviously can't fetter themselves in advance but any recommendation by Your Honour would be given decisive weight in decision, assuming the prisoner has been undertaking the plan as recommended."

[26] Mr Fraser, on being invited to say anything more he wished, said:

> "The only thing I wished to say is this, your Honour: given that the government has made a commitment, Your Honour, we're satisfied that – and your Honour quite properly said during the course of these proceedings that this strictly isn't an adversarial process, it seems to me with the greatest respect that it's in my client's interests and indeed it's in the community's interests that the way to go forward is the implementation of this program."

It is surprising that, if there were insuperable difficulties in implementing the plan, as has now been said to be the case, Byrne J was not clearly told of them when he was putting it in place. Why the Department's position was expressed as a commitment to implementing the plan, with his recommendations being given decisive weight, subject to discretions which could not be fettered having to be exercised**,** is hard to justify, when the discretion to grant leave could not be exercised in the respondent's favour because his classification meant that he could not be lawfully granted leave at all.

Issues Concerning Implementation of Byrne J's Recommendations

[27] Regrettably, for a variety of reasons, the kinds of problems Byrne J strove to avoid have arisen. Much of what was comprised in the plan, carefully formulated in conjunction with the psychiatrists, has not been implemented. However, the focus of the present proceedings is narrow. It is whether, in terms of s 13, the respondent is a serious danger to the community because of an unacceptable risk that he will commit serious sexual offences if released from custody at all or is released from custody without a supervision order being made. The paramount consideration is the need to ensure adequate protection of the community.

[28] If a person needs to be held under a continuing detention order, he is to be detained in custody for an indefinite term for control, care or treatment. There is no provision for conditions to be placed on the order. If he is released on a supervision order, issues of control, care and treatment may be addressed in the conditions, although the person is released into the community. There was unanimity among the psychiatrists at the time of the first proceedings that the best option was that there be a staged process of treatment of the prisoner to address the causes of his offending followed by controlled release into the community.

[29] There was to be a safeguard that someone in the corrections system would monitor whether the prisoner was fulfilling the requirements of the plan. That person was to be the person appointed under the first element of the plan whose function was expressed as follows:

> "A coordinator is to be appointed from the Department of Corrective Services with authority to ensure that the plan is implemented. That person needs to have 'the firmness and sympathy to help the respondent adhere to and make use of the plan'".

[30] While there seems to have been an expectation that the General Manager of the Correctional Centre for the time being where the respondent was confined would be the coordinator, there was no evidence before me that the function was ever performed in the way envisaged by Byrne J. Two of the problems, in so far as evidence with regard to implementation of the plan is concerned, are firstly, that it is not obvious that there was a clear grasp in the department of the importance of a single person having responsibility for overseeing the process of putting the plan into effect. The need for someone with authority to do so which was fundamental to the plan was either not understood or was disregarded in favour of collective oversight of it. Secondly, it is not obvious, either, so far as the evidence goes, that there was a clearly defined understanding within the department of what was required to be done; some of those making reports were unaware of the existence of the plan It may also be that assimilation of cases of this kind into the ordinary correctional management system, due to the absence of any regulatory framework specific to cases under the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld), compounds the problem. There is a power to make regulations (s 53) which has not been used.

[31] The case of a person detained indefinitely for the protection of the community, especially one where there is evidence that treatment and gradual return to the community may provide some hope that the person may afterwards cease to be a serious danger to the community, is one where steps to achieve that end ought to be taken promptly. The objective of the legislation is that care and control by way of imprisonment should continue for only so long as there is acceptable cogent evidence to a high degree of probability that the person is a serious danger to the community because of unacceptable risk that he will commit a serious sexual offence if released from custody. "Treatment" is one of the three reasons for retaining the prisoner in custody after his sentence is completed.

[32] Where there is, as in this case, medical evidence supporting the possibility of reintegration of the prisoner into society after treatment issues have been addressed, it is incumbent on his custodian to ensure that the suggested treatment occurs. Perhaps the issue raised by Gummow J in para [113] of *Fardon* is an allusion to this kind of case, at least where the prisoner has done all he can reasonably do to take rehabilitative steps. What Gummow J said is:

> "**[113]** Section 30(2) may permit refusal by the court of an order for further detention, by reason of failure by the appropriate authorities to implement the earlier order. An example would be an order for treatment of the prisoner to facilitate rehabilitation, an objective of the Act: s 3(b). It is unnecessary to decide that question here. ….".

[33] It cannot be lost sight of that the Act is concerned with preventative detention after the prisoner would otherwise have been released by effluxion of his finite sentence.

Undue protraction of incarceration of the person because administrative procedures either do not exist to enable him to rehabilitate sufficiently to be released, or to prove that the actual risk in his case is not unacceptable, or because the administrative procedures unduly delay such rehabilitation or proof, is hard to convincingly justify. The Act is, after all, intended by its terms to allow continued detention only for as long as the unacceptable risk to the community clearly exists. It is not intended to lock up people and throw away the key if they may have prospects of rehabilitation to an extent where they can be released, given the opportunity, but are denied that opportunity due to administrative or procedural inadequacies.

Events after the order was made

[34] The order was made on 13 August 2004. Mr Hall, a drug and alcohol counsellor, wrote an exit report in respect of the Substance Abuse: Preventing and Managing Relapse Program completed by the respondent on 9 September 2004. The conclusion he reached was that the respondent's attendance and conduct were good, as was comprehension of material. Acceptance of the concepts presented was marginal. Practice of the skills presented in the program was fair and would continue if the respondent decided to work on them. His relapse prevention plan was marginal. It was suggested he should fully accept the concepts presented in the program to enable the avoidance of relapse into drug and alcohol use. Mr Hall was not aware that a continuing detention order had been made against the respondent.

[35] On 17 September 2004, Mr Conway, a Senior Social Worker employed by the Aboriginal & Torres Strait Islander Corporation (QEA) for Legal Services (ATSILS) wrote to Ms Gregory as Principal Advisor, Custodial Directorate of the Department. He referred to the reasons of Byrne J, which he described as recording an expectation that both the respondent and the Department would keep to the "treatment plan" as proposed by psychiatrists during the hearing. He asked for advice on what steps were being undertaken by the Department in relation to Byrne J's "directions" including the identity of the person selected to undertake oversight of the plan. He said that he was concerned that the respondent had complied with directions relating to his completion of substance abuse courses but there appeared to be no details available to him or sentence management at Sir David Longland Correctional Centre ("SDL") as to how the plan was to proceed from there.

[36] On 24 September 2004 Ms Gregory, then Acting Director, Custodial Operations, replied, advising that the respondent was, at the time of writing, undertaking a Substance Abuse: Managing and Preventing Relapse Program. It had not been possible to appoint a therapist from the Community Forensic Health Centre to assist the respondent but the Department was actively seeking to engage a psychiatrist to provide intervention for him by way of weekly counselling sessions. At the time of writing five psychiatrists had been approached with no positive outcome.

[37] She said that at that time the Department was taking the approach of centrally overseeing the intervention plans of prisoners subject to continuing detention orders. Consequently, sentence management staff at SDL may not be aware of the progression of the plan. She said that a group of staff drawn from relevant areas of the department including operational support services, program services, custodial corrections and legal services were working together to ensure the timely

implementation of planned activities and that the plan unfolded taking into account the respondent's response to those activities. She continued:

> "The General Manager has been appraised of the requirements of the initial phase of the plan and those individual staff who are to assist in the oversight of components of the plan"

[38] She said that the Department was cognisant of the requirements established by the Court in the respondent's case and was engaged in activities to ensure he was provided with relevant opportunities to achieve the best outcome. Two comments may be made with regard to this response. The first is that further efforts to obtain a psychiatrist to give therapy to the respondent succeeded in securing the services of Dr Hogan, who was prepared to go to SDL to conduct sessions with the respondent. The second is that the terms of the letter do not suggest that any one person was made responsible for performing the role of coordinator as envisaged by Byrne J.

[39] Where there is an administrative task of complexity, and one which may involve more than one discipline, there is plainly an advantage in having consultative mechanisms in place to ensure a coordinated effort. However, the notion of a number of people being involved in the oversight of the plan with no one person having direct personal responsibility for ultimate decisions has the potential for inefficiency, especially if the person with discretions to exercise is not a member of the group. Firstly, personal responsibility is attenuated and secondly, it is often said of committees that, when all is said and done, more is said than done. More particularly, to the extent that there are other suggestions in the evidence that the General Manager of the Correctional Centre may have been the person responsible for the oversight of the plan, the reference to him having been "appraised of the requirements of the initial phase of the plan and those individual staff who were to assist in oversight of components of the plan" suggests that he was not a person fitting the description of coordinator or responsible for carrying out implementation of the plan in the way envisaged by Byrne J. The situation may have been compounded by an apparent change in the identity of the General Manager during the year.

[40] On 7 December 2004, Mr Conway wrote again in the knowledge that Dr Hogan had visited the respondent twice. Mr Conway's understanding that the Department had requested a treatment plan and further advice from Dr Hogan within six weeks of the referral, including advice as to recommended steps in any release plan "as directed by the Supreme Court" was referred to. He again referred to the respondent not having received any written directions in relation to its implementation of the plan apart from receiving the visits. He asked if the Department could provide a clear written outline of how it intended to proceed.

[41] On 24 December 2004 Ms Gregory confirmed that the Department had requested a treatment plan and further advice from Dr Hogan regarding the recommended progression of a release plan prior to implementation. It was said that it was anticipated that upon receipt of the advice, a working committee (once again) would monitor the implementation based on Dr Hogan's recommendations. The General Manager of the Correctional Centre had provided the respondent with a copy of the order and plan.

[42] Ms Bennett, Regional Coordinator, Sexual Offenders Treatment Program, South East Region was requested verbally in February 2005 by the then General-Manager

of SDL, Mr Kruhse, to complete a progress report with respect to the respondent. The purpose of her involvement was to assess current risk factors. She had not been asked to do any assessment prior to that. She was aware that the respondent had been undergoing "assessment" by Dr Hogan in the period prior to that. She knew that Byrne J had made a continuing detention order. She was not aware, however, of the plan in the reasons. She was aware that the respondent was supposed to be granted leave of absence, (she thought to seek employment), and that he was supposed to be released for it at six months. In her view, it was not possible to do that because the correctional centre was a maximum security facility. The plan could not have been implemented because of the kind of facility in which the respondent was held.

[43] She interviewed the respondent on 2 February 2005. He was cooperative and forthcoming, and not particularly devious or manipulative. He impressed her as wanting to present himself in a good light. However, although the interview was not a formal assessment, it was evident that he remained untreated in a number of offence-related areas. He struggled to accept responsibility for his offending, tending to blame his victims and external circumstances. He minimised his abusiveness and the levels of violence and aggression in his relationship with the victims. Although he believed that what he had done to his victims was "horrible" he was unable to offer any clear insight into why he offended or what motivated him to treat his victims as he did. He evidently believed his behaviour was out of character and related to his drug abuse. His prevention strategy, of avoidance of situations likely to lead to further offending, was considered by her inadequate because of his limited understanding of the nature and circumstances of the risk of abuse to women. There was little change in the beliefs and attitudes underlying his offending. His remedy for future risk was to avoid the kinds of relationships he had had and to avoid returning to old patterns of drug and alcohol abuse.

[44] She said that he claimed he had no intention of entering into intimate relationships for at least 12 months after his release. He rated finding employment as his highest priority. She said that he also expressed a positive attitude towards treatment. He reported that Dr Hogan had mostly asked him questions about his offending. He said that he preferred the individual interaction with Dr Hogan to the group environment of SOTP where he objected to having to listen to offence accounts of child sex offenders. He said he believed he had been discharged from SOTP because the head facilitator had formed a negative and erroneous opinion of his attitude to treatment. He believed he had been engaging appropriately and was not treated fairly.

[45] On 8 February 2005 Mr Conway again wrote to Ms Gregory requesting an indication of what specific plans were in train for the respondent because the plan set out in Byrne J's reasons suggested that further action must be imminent. He said that he understood that Mr Francis had not been granted any authorised leave of absences in order to attend treatment sessions as recommended by the court and that the period of time after which the respondent was to be released to work was nearing completion. He repeated that apart from having a copy of the court order, the respondent had not received any written directions from the Department in relation to implementation of the plan, apart from receiving visits from Dr Hogan. He submitted that it would seem only reasonable that the Department provide the respondent with some guidance in relation to where and when he was next to be placed. The lack of evidence that any person described as a coordinator in the

recommendations in the judgment had established a working relationship with the respondent was also referred to. Mr Conway requested a clear written outline of how the Department intended to proceed in relation to the court plan and to convey it to Mr Francis as soon as practicable.

[46] On 26 February 2005, Dr Hogan completed the last of his eight visits to SDL, the first having been on 23 November 2004. On 21 March 2005 he wrote a psychiatric report, addressed to Ms Watt, Offender Assessment Services. On the last page of his report he said that he would, in light of his sessions with the respondent, anticipate a general program the outline of which contained elements similar to the plan proposed by Byrne J. The first was that the respondent be released on a weekly or fortnightly basis to attend treatment sessions outside the prison. Dr Hogan said he would be prepared to see him at a nominated centre, such as the City Clinic or Princess Alexandra Hospital. The second step was a graduated release from prison with a view to being released around the middle of the year, consistent with the timetable of Byrne J. The third was that the prisoner be strictly monitored for drug and alcohol intake by random urine drug screens at the Department's cost. He suggested he be given assistance in obtaining and maintaining work.

[47] He also suggested that the respondent reside with his mother with no one else residing there. However, in his oral evidence, he was asked about that recommendation by the respondent's counsel. He replied that he would be concerned about the respondent residing with his mother initially. He thought that for six to 12 months it would be better if he went into a more neutral setting in the community. He accepted that the respondent's mother had been an important part of his life and had seen him weekly at the prison. The problem was that the respondent would be going from a completely regulated regime to having no external control over him. It would be useful if he was in a house that had set rules but was community-based such as a community work release facility. After a six month period there could be a review to see whether he could perhaps live with his mother. However, as Dr Hogan observed, one of the offences happened in his mother's house and if he was exposed to the same group of people in the area where his mother's house was, he may relapse into drug taking and re-offending. He accepted that the best sort of environment was one that was forced upon him so that he had time to acclimatise to life outside prison at first in a fully structured environment, then in a semi-structured environment in the community and then, if all went well, with a lesser form of supervision.

[48] In cross-examination Dr Hogan said that in reporting as he did, he was trying to obtain some sense of where the process being engaged in was going. He said:

> "It didn't appear that anybody knew where this was going. And that was my concern about this. It was very frustrating because, again, I think the methodology was flawed. You know, we are going to slowly release this man. I mean, if you are looking at the dangerous offenders legislation, you've got to work out, first of all, whether you are going to release him or no one has actually – it all seemed to be going around and around. There didn't appear to be a good clear viewpoint on where this was heading".

[49] On 23 March 2005 Mr Conway wrote again to Ms Gregory noting the absence of a response to his letter of 8 February 2005. He posed a series of 14 questions and added several comments about the consequences of failure to follow the steps in the

recommendations in the reasons for judgment. He alleged a lack of commitment on the part of the Department to implement the plan proposed by Byrne J on advice from the psychiatrists, having regard to the basis upon which Byrne J acted in making the order. He requested a response to those questions and concerns.

[50] On 20 May 2005 he wrote to Mr Airton, Executive Director, Offender Assessment and Services with a copy to Ms Taylor, Executive Director, Offender Programs and Services, in which he recited the previous correspondence directed to Ms Gregory and his other attempts to get information. He asked for an indication of how the Department was providing assistance to the respondent, how it was intending to inform him of the plan for his rehabilitation and how it was incorporating the recommendations of Byrne J. He noted that he had received no reply to his letters of 8 February 2005 and 23 March 2005.

[51] On 31 May 2005 Mr Airton wrote a reply, the substance of which is as follows:

> "Mr Francis is being managed by staff at Sir David Longland Correctional Centre in accordance with Department of Corrective Services procedures and the *Dangerous Prisoners (Sexual Offenders) Act 2003*. The Centre has already given Mr Francis opportunities to participate in rehabilitation activities, including psychiatric counselling and an intervention program.
>
> The Department has obtained a progress report from the external psychiatrist and is in the process of assessing Mr Francis' case. Mr Francis will be provided with an opportunity to participate in this process. The Department is committed to providing Mr Francis with opportunities to engage in activities that will assist him in developing skills during his imprisonment."

[52] On 20 June 2005 Mr Conway again wrote to Mr Airton pointing out that a number of the queries had not been addressed but that he was grateful for the general information provided. He then addressed five specific questions to Mr Airton. They were the following:

> "1. What specific opportunities to participate in rehabilitation services had the Department given to Mr Francis other than psychiatric counselling you mention, since the implementation of the Continuing Detention Order and prior to your letter to me?
> 2. May we be provided with a copy of the external psychiatrist's progress report on Mr Francis?
> 3. How specifically do you intend to include Mr Francis in the process of 'assessing his case'?
> 4. What particular 'skills' is the Department considering assisting Mr Francis develop, what particular activities is it planning to offer to so assist and when?
> 5. As Mr Francis was assessed as unsuitable for participation *(sic)* the SOTP on what grounds *(sic)* this course now being offered to him (as of 15/06/05)?"

[53] On 28 June 2005 Mr Airton replied, declining to supply a copy of the psychiatrist's report on the grounds of confidentiality. He continued:

> "I can assure you that the Department of Corrective Services will continue to offer Mr Francis opportunities for rehabilitation and education whilst he is in custody. Mr Francis' case is currently being assessed and this assessment will identify future opportunities for rehabilitation and education for Mr Francis.
>
> Mr Francis is able to self refer for educational programs at any time and is encouraged to do so. Any opportunities for rehabilitation or education identified by the Department of Corrective Services, will only be implemented with Mr Francis' consent.
>
> The Department is engaged in a continuing assessment process with Mr Francis to ensure that his offending behaviour is being adequately addressed. To this end, consideration is being given to Mr Francis' suitability to undertake a Sex Offender Treatment Program. If as a result of this process Mr Francis is offered a place on an intervention program he may choose to participate in such program."

[54] On 30 June 2005 a letter jointly under the hands of a lawyer from ATSILS, appointed by the respondent to act for him, and Mr Conway again requested a copy of the report. On 12 July 2005 Mr Airton confirmed that he was unable to provide a copy of the external psychiatrist's report on the counselling conducted with the respondent. Then follows advice that a copy of the report had been sent to Crown Law. The letter then says that given that the document may be used in the respondent's pending court matter, it was appropriate that all requests in respect to material that may be used in court should be requested from Crown Law. It may be noted that if it was thought that the document was subject to legal professional privilege, that may be doubted having regard to the purpose for which it was prepared. However that is of no consequence in the resolution of the matter.

Departmental Preparation for Review

[55] While the correspondence between Mr Conway and the Department was being engaged in, there was a catalyst for the preparation of a variety of reports relating to the respondent's case. This was a memorandum dated 6 June 2005 from Mr Airton to Mr McCahon, General Manager of SDL. On its face it was a follow-up to a memorandum of 11 May 2005 requesting a progress report on the respondent's conduct and behaviour. In it, Mr Airton explained that the order of 13 August 2005 was subject to annual review and that it was "essential that the Department of Corrective Services can explain how it has been managing the prisoner and engaging him in rehabilitation activities". He also said that the Offender Assessment and Services Directorate was coordinating the Department's efforts in managing the prisoner and providing Crown Law with information to assist in the annual review process.

[56] The reference to the Department needing to be able to explain its conduct has a rather defensive tone. The question in the end is whether the criteria for affirming the decision to make a continuing detention order exist in the respondent's present situation. Whether the terms of the letter are coincidental or intended to echo the passage from para [113] of Gummow J's reasons in *Fardon*, quoted in para [32] above was not explored when Mr Airton was giving evidence. That issue is peripheral to the resolution of the matter.

[57] Mr Smith, a psychologist who at the time was Project Officer (Clinical Assessor) for the Offender Programs Unit, was requested to complete a form called "Identification of Risk, Needs, Exclusion and Responsivity Factors for Sexual Offending Program Allocation and Preparatory Intervention Decision – Version 1" in relation to the respondent. In preparation, he read the respondent's professional management files and his detention files. He reviewed the 2004 reports of Professor Nurcombe and Dr Lawrence, and Dr Hayes' report of 21 March 2005. He saw the respondent on 8 June 2005. He completed the Stable–99 part of the form from records available to him. That test is based on historical information. However, Mr Smith was unable to complete the Static-2000 part fully because the respondent would not participate in the necessary interview. Mr Smith's report fairly indicates that the respondent was apparently only not prepared to participate at that time, essentially because of concerns over the possible impact of the assessment on his chances of release which the respondent thought were significant. Mr Smith did not interpret the refusal to cooperate as other than contingent; the respondent would reconsider engaging in the assessment and intervention after the court proceedings, if necessary. This issue was not enlarged on by the respondent in his affidavit or oral evidence.

[58] Ms Kingsford, a psychologist at SDL, interviewed the respondent on 14 June 2005. To her, he appeared honest and open in his disclosure although he did not or was unable to acknowledge the severity of sexual deviation involved in the offences. He acknowledged poly-substance abuse problems, and had little insight into factors contributing to and maintaining his substance dependence. He attributed all the blame for the offences to drugs and was unable to identify any internal factors that may have contributed to the sexual deviancy involved in the offences. Ms Kingsford was unaware of the plan prepared by Byrne J.

[59] Mr Burgess, Acting Assistant General Manager at SDL, compiled a progress report dated 20 June 2005 in relation to the respondent by reading the case management notes, the breach/incident history, the employment history and the urinalysis results. The report was brief although the documents attached contained detailed information. From his understanding of the documents, Mr Burgess concluded that the respondent's behaviour towards staff and other prisoners was acceptable. There had been only two breaches, one on 19 February 2005 for allowing another prisoner to tattoo him, and another on 14 April 2005 for leaving the oval and returning to the accommodation block without instruction from the oval security officer. He had been uninterested in working in the prison, preferring to paint, but had from 12 June 2005 become a cleaner.

[60] Mr Burgess interviewed the respondent on 2 August 2005 concerning his residential plans if released. The respondent's preferred option was to live with his mother. Otherwise, he had no clear plan. Mr Burgess was not aware of the graduated release plan. He said that when he began at SDL, he had been instructed to make the respondent available weekly for "interviews" with Dr Hogan. He was not sure how many times Dr Hogan had seen him.

[61] Ms Stocks (not Stokes as the transcript records), a Senior Psychologist at SDL, was requested to prepare a progress report. She had instructed Ms Kingsford to interview the respondent. Ms Stocks wrote her report on 28 July 2005 after reading the case management and psychologist files. She also requested a list of vocational and educational programs on offer to the respondent. Her report was not based on a

personal interview by her with the respondent. From the files she noted that there was no current case plan "due to end of sentence". He had completed a general safety induction (construction industry) course on 3 May 2005 and the Substance Abuse: Managing and Preventing Relapse Program on 27 May 2004. The exit report for the latter recorded good comprehension of the material but only marginal acceptance of the concepts contained therein. He was ambivalent about avoiding some drugs but agreed to abstain from others.

[62] She noted that Dr Hogan had seen him intermittently for three months "from April 2004" - (this is not correct) - but Dr Hogan's findings were not recorded and the respondent did not have a copy. A current psychological assessment report indicated that the respondent continued to blame drug use, wholly, for his offending behaviour; he was convinced that because he had avoided drug use while in gaol, he would be able to avoid drugs in the community; he had a strong feeling that he had matured; and he was willing to conform to any community program that may be ordered as part of his release conditions. She listed courses available during the relevant period but wrote next to the heading "Educational and Vocational Activities" the words "name not down on list so no offers". In cross-examination she agreed that the absence of any case notes for the period after the continuing detention order was made suggested that there was no case manager. She had no knowledge of the plan suggested by Byrne J for the respondent.

Psychiatrists' Evidence

(a) Professor Nurcombe

[63] Professor Nurcombe evaluated the respondent on 7 June 2005 and reported on 10 June 2005. During his assessment of the respondent Professor Nurcombe was told, *inter alia*, that the respondent had been told by the coordinator of the Sexual Offenders Treatment Program in 2001 that he had to discuss the sexual assault on him in prison with other prisoners participating in the course. He did not wish to do so, fearing further assaults. Nor did he want to hear child molesters talk about their crimes. He was eventually excluded because the view was formed that he was disruptive and because he had walked out of several classes.

[64] The respondent told Professor Nurcombe that Dr Hogan was easy to talk to but considered seeing him was "something that has to be done" and not what he was disposed to do. He also preferred not to discuss the offences against the two women.

[65] Professor Nurcombe's categorical diagnosis of the respondent's case was that on Axis 1, he suffered from anti social personality disorder, poly-substance abuse disorder, amphetamine withdrawal psychosis (which was in remission) and sexual sadism. On Axis 2, he suffered anti social personality disorder and on Axis 3, there was no diagnosis.

[66] Professor Nurcombe observed that after the respondent had been sexually assaulted in prison, he exhibited sexually sadistic behaviour towards the two women. In the Professor's opinion, there was likely to be a connection between unresolved conflict concerning his experience in prison, unresolved conflict concerning his abandonment as a child and his overreaction to his suspicion that the two women were unfaithful. He had limited insight and capacity for empathy or guilt. He

minimised and externalised the responsibility for his crimes. He had some capacity for remorse, but generally avoided upsetting emotions of this type. He was not prepared to "fake" guilt or remorse in order to ingratiate himself with those who interviewed him. He viewed therapeutic programs as, at best, procedures he needed to endure to get out of prison.

[67] The report then addresses the fact that the capacity of clinicians to predict violence or sexual offences is controversial. He accepted that it was doubtful that the accuracy of prediction of sexual violence will ever exceed 50% notwithstanding improved research designs correcting flaws in earlier methodology. While there had been a debate about the use of actuarial prediction on the one hand and clinical decision making as means of predicting future offending on the other, it is now generally conceded that it is as important to have knowledge of statistical base rates for particular sub-groups as it is to have a considered clinical opinion about a particular case. Professor Nurcombe said that he would adopt a combined actuarial-clinical approach in his report, but pointed out that the actuarial findings were Canadian in origin and involved mixed groups of child molesters and rapists. Therefore the validity of the findings for an Australian population and for sexual sadists was unknown.

[68] Professor Nurcombe said that, in his previous report, he had rated the respondent as having a high level of psychopathy. There was no change in his rating using the applicable check list. Clinical issues potentially addressable by the respondent in order to reduce the risk of future violence or sexual offences were lack of insight, negative attitudes towards victims, future plans (which lacked feasibility), impulsivity, personal support, and non-compliance with treatment for alcohol and drug abuse and sexual offending.

[69] Professor Nurcombe considered that the respondent had not gained insight into the nature and motivation for his offences and that he was not capable of enduring, or willing to endure, the pain of exploring such matters in therapy. In the interview, the respondent's attitude towards his first victim seemed to have softened and he expressed muted guilt about what he had done, but he expressed no remorse concerning his behaviour towards his second victim whom he thought falsely accused him. He had not behaved in an impulsive way in prison but his capacity to resist the use of alcohol and drugs had not been tested there. His future plans were more feasible than when interviewed in 2004. He was realistic about his occupational prospects. He wanted to live away from the area where his associates might draw him back into a life of drug use. He planned to avoid drug use altogether and would like to live with his mother. On the other hand he was undecided whether he would avoid the use of alcohol, and his capacity to temper that use was untested. He would accept future therapy if it was necessary to secure his release but he was not motivated to do more than to examine day to day problems. According to Professor Nurcombe, he would not be suitable for exploratory psychotherapy.

[70] In summarising his risk status, Professor Nurcombe said there had been little change since 2004. He remained at between moderate to high and high risk of violent re-offending or sexual re-offending within the next seven to ten years. He had little insight into the nature and motivation of his offences and no desire to explore them. He continued to have negative attitudes towards at least one of his victims and to minimise, rationalise and externalise the blame for his offences. He ascribed all the

blame to amphetamine addiction, not appreciating that his abuse of stimulant drugs unleashed powerful internal forces, which were likely to have stemmed from his deprived childhood and the residual affects of the sexual assaults on him in prison. His plan for release was more realistic than in 2004. However, as he was likely to drink alcohol again, his capacity to resist sliding into substance abuse remained in question.

[71] Professor Nurcombe summarised his conclusions by saying that cognitive behaviour therapy for sexual or violent offenders is at best only mildly effective overall. Other forms of treatment, except hormonal, were ineffective. Further, there have been no research studies specifically directed at the effectiveness of treatment for sex offenders involved in sadistic behaviour.

[72] In his oral evidence Professor Nurcombe confirmed that the situation in which there was most risk was where the respondent was cohabiting with a female and taking poly-substances. There were many things that he had to do before he engaged in another cohabitation. It was necessary for him to be kept away from such a situation for some time until he completes other tasks that were necessary.

[73] He also confirmed that the estimate of a 50% chance that someone may offend was the best that could be advanced and that there was a tendency for psychiatrists to overestimate the likelihood of violence. With regard to the retesting in 2005, he confirmed that he essentially found no change although he had hoped to find some but did not expect to. The list that he had given of factors that might be addressed were clinical factors which were potentially changeable.

[74] He also said that he had a problem about the respondent residing with his mother. He said that being placed on work release for about six months would be satisfactory. In re-examination Professor Nurcombe was asked about a further set of steps that had been recommended by him. He said that release from custody forthwith subject to conditions conformed to the view that from a psychiatric point of view keeping him in prison any longer was not going to make gains so far as his psychological adjustment was concerned. If the respondent was not motivated to continue with therapy, failure to complete it would leave the risk status unchanged; but successful completion would clearly reduce the risk. The things that had to be addressed were avoidance of drugs and alcohol, finding a job and stabilising sufficiently in it.

(b) Dr Moyle

[75] Dr Moyle interviewed the respondent on 11 July 2005. In his report dated 12 July 2005, exhibited to his affidavit, he describes the course of his interview at some length, particularly recording that initially on several occasions the respondent indicated considerable disquiet at discussing his violent behaviour with the two complainants and his current sexual thinking and experiences. Later he gave “the best understanding he could” of his beliefs and attitudes in relation to the offences. Dr Moyle concluded that initially the respondent was trying to say what he thought he wanted Dr Moyle to hear. In the end he attempted to clarify some of his attitudes and thinking that may have led to the complainants becoming victims, from which Dr Moyle gained a much better understanding of him, albeit not good enough to formulate the sort of quality management plan he thought was necessary. He considered that was likely to take a number of hours of steady work with a therapist

to achieve. He concluded that section of his report by saying "Progress will be recommended based on his achievements, not systemic criticism". Doctor Moyle also made a comment that I interpret as somewhat of a criticism, that Dr Hogan's treatment had not been continued notwithstanding Dr Hogan's willingness to do so.

[76] One of the other matters that comes through in the report is that the respondent was concerned about the possibility that the interviews that were taking place may jeopardise his chances of release. Dr Moyle records a remark which suggests that the respondent thought that because the Department had not followed the terms of Byrne J's recommendations, he was in an advantageous position in the present proceedings. (Page 11 ex RJM-(1)). I interpolate that that, of course, is not correct since the criteria in the Act are what have to be addressed; it is not appropriate to resolve the matter by applying a punitive approach based on perceptions of the quality of the Department's performance.

[77] In the section headed 'summary', Dr Moyle said that although the respondent seemed to acknowledge that the offences occurred, there was still an element of justification stemming from an apparent belief that annoying behaviour on the part of the victims in the period leading up to the offences merited a reaction from him. His reluctance to look in any great depth at his own contributions was noted. However, later in the discussion, the respondent started to show an understanding of some of the non-sexual factors and developmental factors relating to his violence. Dr Moyle said that it would be useful if the respondent could engage in a treatment process exploring those attitudes, which may be cognitive distortions or mistaken beliefs about the unfairness of his development compared to others (a subject which appears to surface occasionally in the earlier part of the commentary in the report). It was also stated by Dr Moyle that the respondent's attitudes towards women remain disparaging to a degree and reflect, to some degree, a low self esteem often associated with personality problems in people who have had deleterious developmental periods. He was confident that the respondent scored highly on a psychopathy checklist. He said that the respondent should not live with a woman in a situation that placed the woman at risk for a considerable period of time after leaving prison. That was the most risky situation for any woman while his attitudes remained as expressed.

[78] Dr Moyle said that currently he did not feel that the respondent had made it very far along the treatment plan in Byrne J's order. The respondent, in some ways, saw himself as destined only to have relationships with people who were vulnerable potential victims in the future. He did not seem highly motivated to change that prospect by improving his occupational situation other than in a basic way. It was also of concern that he seemed inclined to drink and take drugs in the future. He accepted that that admission was superficially honest and realistic. However, alcohol and amphetamines were the two substances he needed to avoid above all others. Both were irritants that increased his sense of anger and the degree of paranoid jealousy, not reaching psychotic proportions, that suggested itself to Dr Moyle. It was necessary for him to abstain from alcohol or amphetamines. However, given the description of the lifestyle that he preferred, Dr Moyle saw it as risky to engage in use of the substances.

[79] Dr Moyle said that the respondent remained at "moderately high risk" of re-offending on release. The negative features that remained were his motivation, which was mainly extrinsic, his limited insight into the need to deal with the causes

of his sexually sadistic behaviour, "that he has avoided assessment processes other than those by Professor Nurcombe…Dr Hogan" and himself, tried to prevent a gathering of information from New South Wales, and devalued programs in prison on the basis of his past experience. He had low responsitivity to programs.

[80] Dr Moyle said that on the positive side, the respondent seemed "reasonably honest in his account" and towards the end, he did start to address some of the issues that placed him at risk. Dr Moyle said he would have been happier if the respondent had been able to present him with a clearly evaluated and thought out management plan on how he understood the risk, and his past behaviour, and how he planned to overcome the identified factors he may be able to modify in the future. Dr Moyle referred again to his unwillingness to take part in assessment interviews because he thought it was likely to result in him remaining in prison longer.

[81] He concluded this section of the report by saying that some of the difficulties may reflect the under-education he achieved and the risk that he could only survive if his mother assisted him. However, that conflicted with the respondents desire to live independently, which he needed to learn how to do. Unfortunately, that and his apparent willingness to place himself in situations of risk in the future such as by abusing alcohol and amphetamines worried Dr Moyle. That was especially so, in the context of reported psychosis in the past, which may or may not be related to both drugs and paranoid anger, generating some of the sexually sadistic and otherwise violent behaviour and the suggested justification for that behaviour.

[82] In his section headed 'conclusion', Dr Moyle said that the respondent had made some early gains in improved inmate behaviour, but little in the way of understanding of the factors contributing to his sexual and otherwise violent offending, if those could easily be separated. He said that that was not uncommon in sexual sadism. He said that the respondent had also made gains forming a therapeutic relationship with Dr Hogan that might be useful in the future. He said that focus on the factors that contribute to the sense of rage that he then used as justification for his sadistic sexual behaviours would require him to commit to a lifestyle of abstinence from alcohol and amphetamines. He said that attendance with Dr Hogan or other treatment programs to assess the risk factors that were ongoing, and living, when released from prison away from an intimate relationship for at least six months to a year, while heading towards the lifestyle he said he wished to live, and learning to live both responsibly and independently, were all important.

[83] The program should centre on good employment initially, while living with a supportive other person, and perhaps, after a year, considering moving in the community to greater freedom. Social and living skills programs should be added to any treatment program, but not to the extent of teaching him more skills to victimise others. Dr Moyle recommended that all components of the treatment program work together in a coordinated manner. He concluded by saying the respondent's behaviour in the interview was well controlled, even when he appeared agitated and distressed. He found a way of containing his anger and overcoming it. However, Dr Moyle would not trust that happening if he was intoxicated with alcohol or amphetamines. Abstinence was essential. In his opinion the respondent should continue with the treatment program. Any release prior to the past treatment program being fully implemented would be premature.

[84] In cross-examination when giving his oral evidence, Dr Moyle said the respondent was in remission from sexual sadism and drug and alcohol abuse; otherwise he suffered no mental illness. It was accepted that his history did not suggest he was a risk to children, nor of committing an indiscriminate attack on women generally. The risk was to people who were vulnerable because he could exercise power over them. His offences had happened in the situation where he and the victim were partners and there was poly-substance abuse by them.

[85] Dr Moyle said that the plan devised when the matter was before Byrne J was intended to be a dynamic process, with the steps flowing one after another. All of the steps were based on successful negotiation of the previous steps. Since the respondent's victims were all on intimate terms with him, the intent of the plan was that he be settled in the community, in stable employment and lifestyle and not using drugs, before he started looking at developing any form of sexual relationship with anyone. Dr Moyle did not want the respondent to enter into a sexual relationship until he had been able to deal with the issue of his previous sexual violence.

[86] Asked whether the respondent had made any progress in the past twelve months, Dr Moyle said that the respondent seemed a little more receptive when he saw him in June 2005 than he had been previously. There had been some advances. However, a lot of the steps in the plan had not taken place. He said that he had also seen Dr Hogan who had made a commitment to an ongoing treating relationship, so he was further advanced in that respect but was not very much further advanced. He agreed that it would have been preferable if Dr Hogan had been able to continue to see him regularly.

[87] He said that a difficulty with the respondent was that, rather than accepting that the plan was in his best interests and seeking to cooperate with it, he may simply go along with it even though he may not agree with it. Encouraging the respondent to see there was value in the plan was a challenge for the therapist. Encouraging rapport, preferably by means of regular sessions was important.

[88] In relation to risk assessment, Dr Moyle said that the modern approach was to use a combination of checklists to assess factors relevant to the risk assessment, and clinical judgment. He said that he did a structured clinical judgment, which meant that he used the tests to form his decision as to whether the person was low, medium or high risk. As long as that was done, a person's clinical judgment was more reliable than simply relying on clinical judgment. He conceded that his experience was, in the case of a person who scored as the respondent did on the scales, that the reliability of prediction of further offending should be at least 50% risk.

[89] He agreed with Dr Nurcombe's comment that cognitive behaviour therapy for sexual or violent offenders is at best only mildly effective overall. He said that the risk of the respondent offending against children in a sexual manner was low. Dr Moyle said that, in his opinion, given the respondent's extreme behaviour, a person experienced in supervising such people and who would be actively involved in rigidly checking on compliance with any plan should be appointed. He also said that there should be a prescriptive element in any order relating to psychiatric treatment, requiring the respondent's sexuality and anger to be discussed. It was necessary for the key issues with respect to ongoing risk factors to be addressed.

[90] He said that there was a moderately high risk of the respondent re-offending if released immediately. There was at least a 50% risk of re-offending by means of a serious sexual offence in the next one to two years.

(c) Dr Hogan

[91] On 19 January 2005, Dr Hogan spoke to Ms Gregory by telephone for the purpose of seeking confirmation and clarification of the Department of Corrective Services' requirements in terms of his interaction with the respondent. On 14 March 2005 he received a letter which said in substance that, as a psychiatrist engaged by the Department, he had been advised in previous conversations of:

> "• the need for you to determine and deliver appropriate psychiatric treatment for the respondent based on the documentation provided to you by the Department, and
>
> • a request that you provide an assessment of risk to the community in progressing him to less restrictive environments as outlined in the court's plan."

It also recorded that on 19 January 2005 they had discussed the nature of the correctional environment in providing psychiatric intervention. He was advised that, should he have any difficulties with access, it was recommended he contact the General Manager of SDL directly.

[92] In his report exhibited to his affidavit, Dr Hogan noted that the respondent said he had suffered two incidents of violent sexual assault by several inmates while in prison on a previous occasion. Dr Hogan said that, initially, the respondent was reluctant to talk about them but, as rapport increased, he was able to talk to Dr Hogan about them. In Dr Hogan's opinion, the respondent had symptoms of post-traumatic stress disorder after the attacks. He believed some of the respondent's indifference to attending the Sexual Offenders Treatment Program was centred around that disorder, the risk of being further targeted by inmates, and being considered a "dog" for talking about the incidents that had happened in prison. Dr Hogan thought the disruptive behaviour at the course was an attempt to distract attention from the subject at hand. There were ongoing issues relating to the attacks on him in prison. Dr Hogan thought that the work done by him with respect to them should continue when the respondent left prison.

[93] With respect to the respondent's mental state, Dr Hogan said that the respondent was generally of a quiet nature and his affect and mood were normal throughout most interviews. There was no cognitive abnormality but insight was limited. On the basis of the rating scales used, Dr Hogan assessed him as having a moderate to high risk of re-offending over the next seven to ten years. He stressed that these scales were at best a guide and often overrated the risk of re-offending.

[94] In the summary and recommendations section of the report he noted that sexual offences committed by the respondent occurred in the setting of a romantic relationship the respondent was having with the victims and of heavy abuse of psychotropic substances particularly amphetamines and cannabis. The acts were "repetitive, violent and derogatory". His concerns about the respondent's chances of re-offending centred on several issues.

[95] One was that the respondent had anti-social personality disorder which renders the sufferer prone to impulsive behaviour, callousness and lack of empathy to others. There was no therapy that will successfully eliminate the risk of such a person re-offending. If the respondent was both seriously abusing psychotropic substances and in a romantic relationship, the stage would be set for a high chance of re-offending.

[96] In his oral evidence, Dr Hogan repeated the substance of his evidence in the report that a combination of drugs and alcohol and co-habiting with a female was the setting where there was most risk. He did not consider the respondent a risk to children. Nor did he consider the respondent predatory. It was possible that there may be some risk if he met someone in a social situation and attraction occurred on the sudden. He stressed that the use of amphetamines was likely to increase the risk since the respondent's psychopathy tended to lead to criminal behaviour.

[97] He did not believe that extensive psychotherapy was indicated. What the respondent needed, because he was unskilled, unsophisticated and did not appreciate the difficulties of adapting to life in the community, was intensive, broadly based problem solving therapy to give him the skills to adapt.

Supervised accommodation?

[98] Mr Cooke called evidence, under subpoena, from Mr Gavin Wright, Organisational Development Manager with Aus-Care, a community support services organisation. Aus-Care ran a facility with capacity to house prisoners placed on release to work orders by Community Corrections Boards, in part of a building providing services to homeless men. The process was that a prisoner would be placed on a release to work order. The details would be provided to Aus-Care and a decision would be made by Aus-Care whether the prisoner was acceptable. If he was, he would be transferred from the correctional facility to the Aus-Care facility. Under the contractual arrangement Aus-Care had the right to decline to take a prisoner in circumstances where it was considered either that he was a threat to the health and safety of other people at the facility or, alternatively, where he might himself be at risk of harm if placed in the facility.

[99] It became apparent that it would be impracticable to make any supervision order in these proceedings on the assumption that he would be able to reside there. Firstly, Aus-Care had the ability to decline to accept a prisoner for placement. Secondly, there was no guarantee he would be accepted. Thirdly, because the departmental policy of phasing out release to work orders, it was uncertain whether Aus-Care would have its contract with the Department renewed when the current one expired next June.

[100] It was conceded by Mr Cooke that it was not possible to have the respondent placed in that facility. The matter was then adjourned to enable him to explore other options. When the hearing resumed, Walter John Ogle, General Manager of the Brisbane Boarders Association Inc ("the Association") gave evidence of facilities available under the auspices of that body.

[101] In summary it provides "social housing for people in greatest housing need and its clientele is from a homeless or at risk of homeless background". The aim is "to have tenants place a social ownership on the places where they live and to create …

a microcosm of what true community should be about and that is where people care for each other and where there is a genuine sense of sustaining a community type life". The organisation was experienced in housing people released from prison, including aboriginal prisoners, and people with drug and alcohol problems.

[102] According to Mr Ogle, the internal dynamics of the residences were influenced by the tenants themselves, in that they themselves identified and tried to resolve disruptive behaviour which threatened the social order they wished to sustain in their community. Bi-monthly meetings enabling tenants to participate in management of the property were held.

[103] Rent is charged, with the objective being to limit it to 30% of income in an individual case, although in some cases it may exceed that. There was a special relationship with a Centrelink initiative with respect to homelessness. The Association encouraged tenants to supplement their income by part-time work. However, because of the needs based nature of the premises available through the Association, there is an income limit beyond which a person would be required to move out. Subject to that, and acceptable behaviour, the tenancy could be open ended. Acceptance of a person as a tenant was subject to an interview being successfully completed, although Mr Ogle suggested that it was unlikely that there would be a problem in the respondent's case. The process was described in the following passage:

> "[The property manager] would interview Mr Francis on the basis of his ability to pay rent, on his ability to socially live in that environment, on the basis of what his needs might be and whether any support – formal support agreements need to be drawn up in order for him to be able to sustain that tenancy in terms of social and financial issues.
>
> Is a relevant consideration in that context the ability of the person being offered accommodation to fit in with the other people that are housed in the same facility?-- Yes, that – we try to ensure that there is no social disorder if I can put it like that. That people are able to live happily together and that any – any sense of disruption to that, we would tend to deal with immediately rather than let it go on. And we have had situations where it has been necessary for us to move a tenant from one tenant community to another in order for them to sustain a tenancy and they have found in the second tenant community, they've been much happier with personality difficulties, and you always find that but it is not an every day occurrence.
>
> …..
>
> We don't consult the existing tenants …."

[104] With respect to security of the buildings, the evidence is that in the properties under consideration for the purposes of this case, entry is gained by a master key or a swipe card given to the tenant. People wanting to visit tenants use bells and button systems to communicate. The properties have caretakers. However, with regard to curfews and the obligation to reside at the premises Mr Ogle gave the following evidence:

> "…. we have had a working arrangement with the – I think it's called the South Brisbane office of Corrections at Stones Corner. We do have caretakers at our property. They have no control over tenants' lives but we do expect them to let us know if there is any difficulty and that is the way in which it is – it seemed to operate in the past and there's been no trouble at all.
>
> HIS HONOUR: Yes. What would that involve? …. would they actively check to see if somebody was within the curfew hours?-- No, that would not be the case at all, no.
>
> No?-- But if it is known, for instance, the person has had a tendency to use illicit drugs and the caretaker happened to notice that person was having a lot of visitors at all hours of the day and night, then we would want to act on that because we don't want the tenant community destroyed by drug dealers.
>
> If you had somebody who was …. required to be …. at the premises at certain times, would you actively support that ….? Yes, we would support that, but it would be the means of trying to work out how we could actually do that."

[105] However, answering a question about reporting to the Department that someone required to live in the premises had absconded, Mr Ogle said that if it was a term of an order releasing the person that the Association should report it if he ceased to live at the premises without having prior permission to move to other premises, the order would be complied with. He took the view that in housing the person the Association would have to take into account the court's orders.

Issues for Consideration

[106] **(a) Should Byrne J's decision be affirmed?** Mr Cooke accepted, on the respondent's behalf, that the decision of Byrne J that the respondent was a serious danger to the community in the absence of a Division 3 order should be affirmed. The evidence summarised earlier in these reasons is acceptable, cogent evidence by which I am satisfied to a high degree of probability that he remains a serious danger to the community in the absence of such an order. I am satisfied that it is of sufficient weight to require me to affirm Byrne J's decision, which I do.

[107] **(b) Considerations in making an order.** According to s 30(3), the two options are that a continuing detention order to be made, or that he be released from custody subject to a supervision order. The paramount consideration is the need to ensure adequate protection of the community (s 30(4)).

[108] Adequate protection, not absolute protection, is what is referred to. What is adequate protection requires a judgment to be made concerning the nature of the risk, the level of risk he poses and what measures would provide protection commensurate with the risk.

[109] Where a person has a history of violence, there can be no certainty that he will not commit further violence again if circumstances arise in which he is prone to do so. Most offenders are released into the community, without any external control, either

because post prison community based release has come to an end, or they have completed the full sentence. Not all re-offend, notwithstanding that there are factors, peculiar to them, in their personality and history that suggest that there may be a significant risk that they may. The evidence of the psychiatrists confirms that risk prediction is necessarily imprecise.

[110] Where the choice is between preventive detention, which a continuing detention order is by another name, and allowing the offender to live in the community subject to a supervision order, the difficulty is to identify, as precisely as possible, circumstances in which danger to the community is likely to occur and whether there is a degree of control short of continuing detention that will provide adequate protection to the community. That formulation of the approach to be followed recognises that continuing detention beyond the expiry date of a finite sentence imposed for an offence can only be justified by the existence of a risk that is so great that anything less than a continuing detention order would not provide adequate protection to the community from it.

[111] **(c) What is the nature of the risk?** Unlike many sexual offenders, the respondent's sexual offending has been of a particular kind. The two incidents which led to imprisonment, first in New South Wales, and then in Queensland, the latter of which led to his continuing detention order, were very violent and sadistic. In each case, they occurred in circumstances where amphetamine and alcohol abuse were factors. In each case, he assaulted a woman with whom he was in a sexual relationship because he apparently believed she had been unfaithful to him. In each case, there were bizarre acts involving insertion of objects into and other forceful acts in relation to the woman's sexual organs, and otherwise. Details of the offences can be found in Appendix C to Dr Moyle's report (pp 65-72 of his affidavit).

[112] None of the psychiatrists consider he is a danger to children; he is not, in their opinion, a paedophile. None of the other previous offences suggest a propensity to commit serious sexual offences. Dr Hogan, the only psychiatrist asked about, it said that there might be some risk if he met someone in a social situation and attraction occurred on the sudden. However, that is as high as he put it. The nature of the identified risk is that, if he forms an intimate relationship with a woman, he may commit a serious sexual offence on her, especially if he were to be abusing amphetamines or alcohol during the relationship.

[113] **(d) What is the extent of the risk?** In this section the references to the paragraphs in square brackets is to the paragraphs of these reasons. The reasons for judgment summarise the comprehensive reports of the doctors which are best read in full to understand the subtleties that may be lost in the process of making summaries for the purposes of the reasons.

[114] Professor Nurcombe said that the respondent continues to have a high level of psychopathy, the rating of which had not changed from the previous report, [68]. Dr Hogan said that the respondent had an anti-social personality disorder which rendered him prone to impulsive behaviour and lack of empathy to others. There was no therapy that would successfully eliminate the risk of such a person re-offending, [95]. Intensive broadly based problem solving therapy to give the respondent skills to adapt to life in the community was needed, [97]. As to this also see Dr Moyle, [83].

[115] Professor Nurcombe, [71], and Dr Moyle, [89], referred to the limitation of cognitive behaviour therapy in treating offenders of this kind. Dr Moyle, [89], said that there should be a prescriptive element in any order relating to psychiatric treatment, requiring the respondent's sexuality and anger to be discussed. Dr Hogan said that issues relating to the prison attacks on the respondent should continue when the respondent left prison, [92].

[116] Professor Nurcombe reported a statement by the respondent suggesting that participation in the sessions with Dr Hogan was considered by him as something he had to do to facilitate release from prison, rather than something he was participating in because he thought it might be of benefit in addressing the problems that caused him to commit offences, [64]. Dr Moyle referred to the same kind of concerns, [66], [87]. Dr Hogan noted initial reluctance on the part of the respondent to talk about the attacks in prison which diminished as rapport increased between them, [92].

[117] On a related subject Dr Moyle reports a remark by the respondent concerning his belief that the interviews being conducted with him might jeopardise his chances of release which he considered to be advantaged by the failure of the Department to implement Byrne J's recommendations, [76]. This mirrors the experience of the psychologist Mr Smith referred to in [57].

[118] Professor Nurcombe also touched on the contribution of the prison assaults and referred to the respondent's limited insight and empathy and attribution of guilt [66], [69], and [70], although some progress had been made, [69]. Dr Moyle also referred to some progress in the respondent's understanding of factors relating to his violence, [77], [86], but to a limited extent, [79], [81].

[119] All the psychiatrists accepted that predicting future violence by an individual was necessarily imprecise. There was a tendency to overestimate it. Professor Nurcombe said that there was a moderate to high to high risk of violent re-offending or sexual re-offending within the next 7 to 10 years, [70]. Dr Moyle said that there was a moderately high risk of the respondent re-offending if released immediately. There was at least a 50% risk of re-offending by means of a serious sexual offence in the next 1 to 2 years, [90]. Dr Hogan said that there was a moderate to high risk of re-offending over the next 7 to 10 years, [93]. He said that if the respondent was both seriously abusing psychotropic substances and in a romantic relationship, the stage would be set for a high chance of re-offending, [95].

[120] On the basis of the evidence, I am satisfied that the risk of re-offending, if he was in an intimate relationship and especially if drug and alcohol abuse was a co-existing factor, is moderate to high to high. The risk of danger to that element of the community in the vulnerable category, ie, women who may form a relationship with him, would exist over a period of years.

[121] **(e) Can the risk be managed by a supervision order?** This raises several issues. One is that, at the time the matter was before Byrne J, the psychiatrists proposed and Byrne J accepted that a graduated release into the community was the optimum approach. The plan was in the form, essentially, of a brief period of unescorted day leave to attend external psychiatric therapy, with immediate return to custody upon its conclusion, followed by release to work with a view to release into the community at the end of the 12 month period of the continuing detention order if

the respondent's compliance and performance proved successful. The plan as conceived by the psychiatrists was never given a chance. However that is not decisive; the statutory test is that referred to in paragraphs [3], [4] and [29] above.

[122] The difficulty that arises in this case is that there are several issues of concern arising from the psychiatrists' evidence. A convenient starting point is Dr Nurcombe's oral evidence, in re-examination, referred to in [74]. I do not take that to be an endorsement of the view that release without substantial supervision would be appropriate. The rehabilitation plan contained in the report is similar in many respect to the plan submitted to Byrne J, which refers to staged release, is inconsistent with any other view. The evidence of the three psychiatrists is that there is a moderate to high to high risk of committing similar offences if conditions likely to trigger such offending reoccur.

[123] While the evidence suggests some slight improvement in regard to the respondent addressing the causes of his offending and gaining insight into his inappropriate attitudes to women with whom he forms intimate relationships, there is still incomplete acceptance of them and of his responsibility for what he has done. There is also the underlying attitude that participation in psychiatric procedures is something that has to be undergone as a matter of form rather than substance.

[124] There is also the related notion that, because of the Department's non-implementation of the plan recommended in the previous proceedings, he is advantaged by that circumstance and justified in not cooperating in other processes including psychological tests that may disadvantage him.

[125] There are also concerns raised in the reports that while the respondent is confident he will not use amphetamines, there is no commitment to abstaining from alcohol. It would, as a matter of prudence, have to be a condition of a supervision order that he abstain from use of alcohol because of its potential to contribute to offending behaviour like that for which he is presently confined.

[126] The drafts of possible supervision orders in the event that such an order were to be made include prohibitions on the use of drugs and alcohol, a curfew and a prohibition on forming intimate relationships for a period. There are requirements that the respondent subject himself to testing for the use of prohibited substances at the direction of an officer of the Department. The effectiveness of them in achieving adequate protection for the community has to be weighed against the risk of serious consequences if they prove not to be effective.

[127] This is a rather difficult issue, since breaches of the four conditions are those which may create the climate for similar reoffending. At one end of the spectrum, where the respondent adheres to all of them, the risk is small. If he breaks any of them, the breach may be of varying degrees of seriousness. At the top end of the scale, if the respondent were to abscond and relapse into drug and alcohol abuse, there would be serious grounds for concern, especially if he were to remain at large for a substantial period.

[128] A breach of the condition relating to curfew could be detected by observation if a Departmental officer happened to visit the premises where the offender was supposed to be, but he was not there. A breach relating to substance abuse could be detected by testing, provided the person could be found in a timely way. One other

possible scenario is that if, for any reason, the respondent failed to find employment, he may have the opportunity to surreptitiously begin a relationship without breaking curfew or the substance abuse conditions of his release. These examples show how important intensive checking of the respondent would have to be under a supervision order, given his current state of rehabilitation.

[129] The ambivalence towards abstinence from alcohol provides the simplest example of how there would be a risk of absconding or breach of curfew. The risk of being found in breach of the abstinence condition of the order may well lead to consequential breaches of conditions. If there was no reasonable excuse for a breach, the concern that he might abscond is a real one. If there were a breach without excuse, the fear that there would be a significant chance he would be returned to prison because the breach showed he could not be trusted (ss 21, 22, *Dangerous Prisoners (Sexual Offenders) Act* 2003) would be an obvious possible catalyst. In the absence of evidence that the person has shown that he could be trusted to conform to strict release conditions, and there is no watertight regime to monitor the respondent's compliance if released into the community, it is something that must be factored in as a matter of commonsense.

[130] With respect to the proposed accommodation arrangements, it is assumed that the respondent would be acceptable as a tenant of the Association. If not, the question of accommodation is left unresolved. The answers by Mr Ogle in [104]-[105] about advising the Department about possible breaches of the conditions of release suggest, as is not surprising, that the Association does not see its role as closely monitoring the activities of its tenants, except to the extent that their conduct may be disruptive or otherwise inappropriate in the context of living in the kind of establishment the Association runs. If there was a court order requiring a report to the Department that a particular tenant had ceased to live in the accommodation provided by the association it would abide by the order. But it may, in my view, be inferred from the evidence of Mr Ogle that actively checking on a person's presence in the building at particular times or checking on whether a person appeared to have consumed alcohol or drugs is not something that would be ordinarily done in a proactive way.

[131] In my view, it is difficult, in any event, to justify imposing that kind of obligation on a private organisation or person. At the practical level, there is an issue of enforcing accountability. Monitoring the matters referred to above would be the responsibility of the caretaker from time to time, in the first instance. I have reservations that such an obligation, especially without the consent of those likely to be bound by it, at the front line level, ought to be imposed. Further, from the aspect of enforceability, it could only reasonably be taken to be an infringement if the person knew that the tenant was in breach of the terms of the supervision order. Imposing any more onerous burden than that on a private individual would be unjustifiable. To impose it only when there was knowledge of a suspected breach would be of doubtful utility. An arrangement to live in what is essentially private accommodation, would only work, from an enforcement point of view, if there was sufficiently intensive commitment of resources by the Department to monitoring compliance.

[132] The point to which the discussion leads is that I am not persuaded that adequate protection to the community can be achieved by a supervision order. The respondent has made relatively minor progress in addressing the causes of and

unacceptability of his offending. If he were to abscond and remain at large for a period long enough to form another relationship, the risk that he will commit violence on a member of the segment of the community that might be persuaded to enter into a relationship with him is inadequately protected against. I am not persuaded that his progress has been sufficient to allow his release on a supervision order of the kind proposed. I will therefore order the respondent continue to be subject to the continuing detention order made by Byrne J on 13 August 2004.

Epilogue – The Department's Performance

[133] Byrne J was told, after an adjournment specifically for the purpose of allowing firm instructions to be taken from the Department of Corrective Services, that the Department would give a commitment to implementing the plan and, subject to the exercise of statutory discretions that could not be fettered in advance, would give "decisive weight" in those decisions to Byrne J's recommendations, "assuming the prisoner has been undertaking the plan as recommended". At the risk of resorting to clichés, that reservation had overtones of Catch-22, since the Department did not allow the leave that was integral to implementing the plan for reasons that must have been known but not expressed at the time that the commitment was given. Attempts by Mr Conway ([35] to [41], [45], and [49] to [54]) to find out what the Department was doing to advance the plan were unsuccessful. Concerns over privacy considerations cannot have been the reason, since, firstly, that was never raised in the correspondence, except perhaps in the letter of 28 June 2005, at the end of the series of correspondence. Secondly, some of the correspondence was not answered; when correspondence was answered, some information was given. Towards the end when specific questions were being asked, Mr Conway's requests were responded to in terms of which Sir Humphrey Appleby would have approved.

[134] It is true that a psychiatrist was engaged. Instead of the respondent being allowed to attend him externally, as the plan agreed to by the Department envisaged, the psychiatrist had to come to SDL. There were only eight visits over three months. In the period of almost 6 months before the statutory review was due, no psychiatric help was given. Paragraphs [46] and [48] above show the psychiatrist's frustration with the apparent directionlessness of those in charge of the case. It must not be lost sight of that, according to s 13(5), "treatment" is one of the reasons for detaining a prisoner on a continuing detention order.

[135] The reason for raising the issues just discussed is not to make gratuitous criticism of the Department. It is to raise an important issue, that unless procedures exist for this special class of prisoner, the difficult question of drawing the boundary between making a continuing detention order which involves further imprisonment, or a supervision order, which does not, will have to be addressed more acutely than is necessary in this case. Of all kinds of prisoners, this category, if ready to be integrated back into the community by staged release, will need intensive supervision at least in the early stages to ensure that the conditions of release are strictly observed. Whether increasingly sophisticated use of technology may be an answer was not explored in these proceedings, but may have to be administratively. If curfews and restrictions on lifestyle are part of the early stages of the process, it does not seem appropriate to make an order casting primary responsibility on a non-departmental agency or person to notify of potential contraventions of the terms of release.

[136] Lack of some kind of scheme under which prisoners of this category can be supervised intensively in the initial period of the stage of release is a serious deficiency. In particular, the lack of a facility in which the prisoner can reside where someone has authority to deal with and responsibility for dealing with observance of the terms of release seems to me to be a minimum requirement in the interests of the protection of the community. If that cuts across existing or proposed Departmental policy, the policy may have to be reconsidered in relation to this category of prisoner. If it requires significant commitment of resources, even though the Department may wish to deploy them in other ways, hard decisions will have to be made.

[137] If the Department provides no means of effectively staging release of this category of prisoner back into the community, it may be that decisions about whether to further deprive a person of liberty, beyond the term of imprisonment imposed when the person is originally sentenced, will have to take that into account. It will have to be put into the balance, along with the fact that preventive detention is an extraordinary sanction, the consequences that flow from it by reason that it allows potentially open-ended deprivation of liberty and the inherent element of uncertainty in predicting further offending. That approach is not inconsistent with the concept raised by Gummow J in paragraph [113] of his reasons in *Fardon* quoted above in [32] of these reasons.

Order

[138] It is ordered that Darren Anthony Francis continue to be subject to the continuing detention order made by Byrne J on 13 August 2004.