SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Roles* [2015] QSC 223
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) v **JAMES RICHARD ROLES** (respondent)
FILE NO/S:	BS1552/15
DIVISION:	Trial
PROCEEDING:	Application
DELIVERED ON:	20 July 2015
DELIVERED AT:	Brisbane
HEARING DATE:	20 July 2015
JUDGE:	Bond J
ORDER:	**Delivered ex tempore on 20 July 2015:** **1. Pursuant to s 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, the respondent be detained in custody for an indefinite term for control, care or treatment; and** **2. The affidavits of Shane Ryan and Christopher Kelly filed 30 June 2015, which are subject to the sealing order of Burns J made on 13 July 2015, be resealed, placed on the Court file and not to be opened without an order of this Court.**
CATCHWORDS:	CRIMINAL LAW – JURISDICTION, PRACTICE AND PROCEDURE – JUDGMENT AND PUNISHMENT – SENTENCE – OTHER MATTERS – QUEENSLAND – where the applicant made and application under the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) for an order seeking the continued detention of the respondent – where the respondent had been convicted of multiple offences involving indecent dealings with children – where the respondent committed further offence of making child exploitation material while imprisoned – whether respondent posed an unacceptable risk to the community for the purposes of s 13 of the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld)

	Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld), s 13 *Criminal Code (Qld)*, s 22B(1)
	Attorney-General Queensland v Roles [2015] QSC 198, cited
COUNSEL:	BH Mumford for the applicant
	KT Bryson for the respondent
SOLICITORS:	Crown Solicitor for the applicant
	Legal Aid Queensland for the respondent

HIS HONOUR**:** This is the final hearing under s 13 of the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld) of an application by the Attorney-General for a Division 3 order under that Act. The respondent is a male aged 28 presently in custody for a number of sexual offenses. His fulltime release date is 5 August 2015.

The Attorney-General contends that the court would be satisfied to a high degree of probability, by acceptable cogent evidence, that the respondent is a serious danger to the community in the absence of a Division 3 order. That proposition is not disputed by counsel for the respondent.

It follows that the real question for determination by the court today is what sort of an order should be made pursuant to s 13(5) of the Act. Should I order that the respondent be detained in custody for an indefinite term for control, care or detention or should I order that he be released from custody, subject to requirements that I consider appropriate stated in a supervision order?

In order to answer that question it is necessary to identify the circumstances of previous offending by the respondent.

On 15 January 2003, when the respondent was 16, he was sentenced in the District Court of Beenleigh for one count of rape of a female child who was seven or eight years old at the time of the offence. The respondent was 14 or 15 at the time of the offence. The respondent was released on three years' probation, subject to a condition that he undergo such psychological or psychiatric treatment as was directed. He was also directed to perform community service.

On 20 December 2007, when the respondent was 20, he pleaded guilty in the District Court in Beenleigh to two counts of indecently dealing with a child under 12. The first count concerned a four year old male child who was indecently dealt with at the public toilets at a shopping centre. The second count concerned an eight year old male complainant who was indecently dealt with whilst he and the respondent were sleeping in a tent in the backyard, in the complainant's backyard. The respondent was sentenced to three months imprisonment and three years' probation in respect of count 1. He was sentenced to 15 months imprisonment, suspended after having served three months of an operational period of five years in respect of count 2.

On 16 July 2012, when the respondent was 25, he pleaded guilty to 13 offences of indecently dealing with two boys. Five counts involved a nine year old male complainant and the other complainant involved was a 14 year old boy. The respondent was sentenced to three years' imprisonment on five of the counts and on the remaining counts two years' imprisonment. The remainder of his suspended sentence was activated and that was ordered to be served cumulative upon the sentence of three years.

On 7 April 2015 correctional officers found a writing pad in the respondent's cell. It contained a list of boy's names, a floor plan of a house and a series of stories handwritten by the respondent which depicted the respondent and those boys engaged in sexual activity. It is fair to say that the notes depicted graphic and detailed sexual encounters with children. As a result of the discovery of this material

the respondent was charged with making child exploitation material, pursuant to s 22B(1) of the *Criminal Code*. On 17 July 2015 the respondent appeared before the Magistrates Court at Richlands in relation to the offence and was committed for sentence to the District Court at Brisbane on a date to be advised and he was remanded in custody.

The last mentioned offending conduct was significant for a number of reasons. Obviously, it was the most recent offending conduct by the respondent, but importantly it was committed very shortly after his having undergone a treatment program whilst he was in custody. In this regard, the respondent had completed the Inclusion Behavioural Sexual Offending program between 10 February 2014 and 10 June 2014. He had previously undertaken the Medium Intensity Sexual Offender program.

Against that background it is appropriate to advert to the opinion evidence adduced by the applicant from three psychiatrists who had examined the respondent.

I'll mention first the opinion of Dr Beech, whose report dated 26 June 2015 was elaborated upon during oral evidence before me. His opinion was as follows:

> *It is my opinion that the risk of reoffending sexually in the community is high. It derives from his sexual deviance, his ongoing fantasies and in my opinion his self control and insight is poor. This is despite several intensive courses. He has in the past failed to benefit from treatment and caution, probation, incarceration, and a suspended sentence have failed to curb his behaviours. Soon after the recent ISOP he has been found to be indulging in his fantasies.*
>
> *The most likely scenario is that on release he will continue to fantasise about children and this will be increased by his day-to-day exposure to them, aided perhaps by pornography. He may act initially to avoid risk situations, but eventually he will succumb to his urges. It may be an opportunistic attempt at touching a child in a toilet or it may involve a child he has met through friends. He may even groom a child or family. It will most likely involve indecent touching but it may involve oral sex. I believe there is at least a moderate risk that it will involve penetrative sex. The victim is likely to at least suffer psychological harm.*
>
> *I do not think in this case that counselling and programs have been enough to reduce the risk. The material found in his cell indicates to me that treatment has had a very limited impact.*
>
> *In my opinion, his ongoing sexual preoccupation together with the nature of his fantasies, and the nature of some of his opportunistic offending indicate that a Supervision Order will have only a limited capacity to reduce the risk of further offending.*
>
> *In order to substantially reduce the risk I believe that he requires a specific treatment for his sexual fantasies. This may involve either medication, or an intensive individual therapy.*

Dr Beech was asked questions during his oral evidence about the extent to which such conditions as might be imposed on a supervision order could operate to reduce the risk of offending conduct, such as he had described. His evidence was that the problem with conditions on a supervision order is that they could address some but not all aspects of what the doctor thought was the potential offending conduct by the respondent.

Dr Beech thought that such conditions could address the risk that the respondent might pose to children with whom he came in contact socially or the risk that he might deliberately groom other children for a sexual relationship.
However, he thought that such conditions could not adequately address the risk that the respondent posed for offending against children who were strangers to him, or the risk that he might pose by way of impulsive offending against such children. Dr Beech thought that aspects of the respondent's previous offending demonstrated that this risk was real and concerning. He adverted to:

a) the 2007 offending against a four year old male child in a public toilet block;

b) the 2003 rape offending against a seven year old female child who although known to the respondent, should probably be regarded, so the doctor thought, as an impulsive incident; and

c) the matters that were canvassed by the respondent in the writing pad discovered by Correctional Officers in April 2015 which at a number of places revealed that the respondent fantasises about sexual offending with children in circumstances that might be described as circumstances of impulsive offending.

I found Dr Beech's evidence to be persuasive and I accept the views that he expressed.

I also heard evidence from Dr Sundin. The evidence that she provided was contained in: –

a) her report of 4 August 2014;

b) her report of 17 July 2015, written after she had been provided with evidence describing the circumstances of the offending in April 2015; and

c) her oral evidence.

Dr Sundin's view, at least before she was apprised of the 2015 offending, was essentially as follows:

a) Mr Roles posed an unacceptably high, unmodified risk of further sexual offences;

b) his future victims would likely be young males, pre-pubertal in appearance who might be strangers or acquaintances;

c) provided he received a satisfactory exit report from the ISOP program, she considered he was a person who could be managed in the community on a supervision order; and

d) that such an order would need to include conditions identifying monitoring provisions, curfews and exclusion areas.

However her 17 July 2015 report reveals that after Dr Sundin was apprised of the circumstances of the 2015 offending she reconsidered the recommendations she had previously made regarding the respondent.

In her oral evidence she described how that new material changed her view about the risk that the respondent posed and led her to regard the risk as higher than she had previously thought. She was concerned that:

a) he had previously substantially minimised the extent of his paraphilic cognition;

b) the circumstances of the 2015 offending revealed that he had underestimated the extent of his evasions;

c) his ability to manage himself was much less than she had previously thought.

Ultimately Dr Sundan concluded (in her 17 July 2015 report) that:

> *The material raises concerns as to the extent of Mr Roles' paraphilic cognitions and his ongoing engagement with vivid sexual fantasies regarding young males. In the light of this material I suggest that Mr Roles should be detained for a trial of an anti-androgen drug or an anti-depressant/anti-anxiety medication such as paroxetine that is known to have anti-libidinal effects.*
>
> *It would be easiest to commence and monitor the efficacy of these medications if Mr Roles remained in prison for an additional short time, possibly of several months duration.*
>
> *If the court decides it would be in the interest of the community for Mr Roles to remain in prison to receive this additional treatment, then I would also suggest that arrangements be made for Mr Roles to commence sessions with the clinical psychologist who will ultimately be treating him, before he leaves the prison. This would assist development of a therapeutic alliance assisting the assessment of the efficacy of the medications and assist Mr Roles with the ultimate transition from prison into the community.*

In her oral evidence Dr Sundin elaborated on that conclusion. She thought that there were two aspects of the appropriate treatment for Mr Roles. First, he needed one-on-one therapy to address his paraphilic cognitions. She regarded this as the primary

requirement. This requirement was something that might extend into years of treatment, but it certainly needed to be intensive. Second, she thought he needed medication, but in view of Mr Roles' comparative young age, the anti-androgen therapy would not be the first course of treatment. Initially she would recommend treatment with anti-depressant, anti-anxiety medications which she referred to as SSRI's.

She was firmly of the view that it would be appropriate that both the one-on-one therapy and the medication aspects of the treatment she recommended be commenced whilst Mr Roles was in custody. She thought it was appropriate that that occur so that his compliance with, and the efficacy and impact of both aspects of this treatment would be capable of being determined. She thought that for a person of Mr Roles' relative young age, the anti-androgen therapy would not be commenced unless the SSRI treatment was having no effect. She emphasised that such treatment could not be commenced without consent because of the significant side effects of such treatment.

I also heard evidence from Dr Grant. I received his report of 25 May 2015 which - as was the case with that of Dr Beech - had been written when he was already apprised of the circumstances of the April 2015 offending by the respondent.

Dr Grant diagnosed the respondent as having the following conditions:

a) Homosexual paedophilia non-exclusive;

b) Childhood attention deficit hyperactivity disorder;

c) Asperger's Syndrome which is part of Autistic Spectrum Disorder; and

d) Some evidence of anti-social traits, not rising to the level of Antisocial Personality Disorder or Psychopathic Disorder.

Like Dr Sundin, and also Dr Beech, Dr Grant thought the respondent would benefit from individual counselling from an appropriate trained and experienced therapist which would need to continue quite long term. And Dr Grant also thought the respondent represented a treatment candidate for drug therapy. Again, like Dr Sundin, Dr Grant thought the respondent might benefit from the use of SSRI treatment and if that was not successful he might benefit from anti-androgen therapy.

In his report Dr Grant stated:

> *Mr Roles will need quite stringent supervision if he is released into the community. In my opinion the application of a Supervision Order under DPSOA would be appropriate. That order would need to contain a number of relevant clauses focusing particularly on trying to ensure that he has no unsupervised contact with children. His offending history reveals that he can be predatory and will be at risk in a range of public situations involving contact with children. He should therefore be required to avoid parks, shopping centres, schools and other areas where children might be expected to*

congregate. Supervision may be assisted in his case by GPS monitoring to ensure that he stays away from risk areas.

He went on to observe:

In my opinion, if a supervision order was to be applied then the risk of re-offending could be reduced from high, down to a moderate level. The risk will be long term. Mr Roles is still quite young and his sexual deviance is not likely to disappear. Hopefully he will however achieve increasing insight and controls over time. In my opinion, a supervision order should be in place for ten years.

I observe that so far as the latter proposition was concerned, all of the psychiatrists thought that a 10 year timeframe was appropriate if the supervision order was to be made.

During Dr Grant's oral evidence, it transpired that Dr Grant was not positively of the opinion that a supervision order would be appropriate. Rather, his view was that if the respondent was released under a supervision order a supervision order with particular conditions would be appropriate. He was not positively advocating for the release of the respondent under a supervision order. Dr Grant thought that if Mr Roles was to be released, supervision was essential and it offered the possibility that risk might be reduced to "medium". However "medium" did not represent his assessment of the present state of risk posed by the respondent. In other words he was not positively advocating for the release of the respondent under a supervision order.

The medical evidence may be summarised in this way:

a) The respondent would benefit by an immediate intensive course of one-on-one therapy with an appropriately qualified practitioner and that such therapy was something that ought to be viewed as long term.

b) The respondent would benefit from at least a course of SSRI drug treatment.

c) There was no guarantee as how the respondent would react to those twin limbs of appropriate treatment.

d) If the respondent was released subject to a supervision order, it would be necessary that conditions apply for his close monitoring and supervision.

It is appropriate then to move to the evidence that addressed how such requirements could be practically managed by Corrective Services officers. In this regard I was provided with evidence from the Acting Manager of the High Risk Offender Management Unit within the Queensland Corrective Services ("HROMU"). She addressed the extent to which QCS could reasonably and practicably administer a supervision regime for the respondent in order to afford adequate protection of the community. She deposed to the following:

QCS does not have the capacity to reliably and safely escort the respondent at all times in the community, in order to ensure he does not come into contact with any children. The extent to which QCS could escort the respondent would be for QCS surveillance officers to escort the respondent for a limited timeframe (one to two hours) and on a very infrequent basis where deemed necessary (for instance, on the day of release to Centrelink and during the first visit to a treatment provider). The respondent will be required to manage any ongoing transport arrangements (usually through public transport systems) and attend his general living requirements (including shopping) without QCS supervision.

Dr Grant notes that "GPS monitoring would, in his case, be relevant and it would be important that he have no contact with children in any supervised capacity".

[I observe parenthetically that I think the deponent meant "unsupervised" rather than "supervised".]

Constant 'eye-ball' supervision of the respondent to ensure he does not come into contact with children, through physical surveillance, cannot be practicably achieved in the community.

GPS tracking could be applied to the respondent and this would (at best) provide an overview of his movements generally. GPS tracking would not provide QCS with knowledge of whom the respondent has interacted with, whether he has followed or approached a child in the community, or why he is frequenting certain places. For example, it could not detect whether the offender followed a child into a public toilet or sat next to a child on a train.

I observe that the evidence of the Acting Manager of the HROMU pointed out the practicable limitations on supervision and monitoring in a way that was consistent, although perhaps more detailed than the limitations which were accepted by some of the psychiatric evidence.

In determining this application I am required to have regard to a number of matters, as listed in s 13(4) of the Act. Those matters were the subject of submission by counsel for the applicant and for the respondent. It seems to me it is necessary only to refer to a few, given the strength of the psychiatric evidence in this case.

I have adverted to the fact it was common ground before me that the respondent posed a serious danger to the community in the sense mentioned in s 13. I've adverted to the psychiatric assessments expressed by three witnesses.

Two of the matters mentioned in s 13(4) are whether or not there is a propensity on the part of the respondent to commit serious sexual offences in the future and whether or not there is a pattern of offending behaviour. The history of the respondent's offending behaviour provides strong evidence that there is such a

propensity and that there is a very concerning pattern of behaviour. Indeed, that was the subject of commentary by the expert opinion.

I'm also required to consider efforts by the respondent to address the causes of his behaviour, his participation in rehabilitation programs and whether or not that had a positive effect on him. The evidence here was that he had undergone such treatment. But each of the psychiatrists were concerned that the fact of the April 2015 offending revealed that such participation as had yet occurred, had not adequately addressed the risks that the respondent posed.

It seems to me that the evidence is very clear that the present position is the respondent poses a very serious risk of the risk of serious sexual offending against children. Section 13(6) requires me, when I am deciding what sort of order to make under s 13(5):

> *...the paramount consideration is to be the need to ensure adequate protection of the community…*

I have also to consider whether adequate protection of the community can be reasonably and practicably managed by the supervision order and whether the requirements of any conditional release under supervision could be reasonably and practicably managed by Corrective Services officers.

It seems to me that the evidence was all one way. The respondent poses a serious risk to the community. And it is a risk which cannot be adequately managed by a supervision order at the current state. The risk is the risk described by Dr Beech, to which I have earlier referred.

The evidence from the Acting Manager of the HROMU reveals that supervision and monitoring is not able adequately to address the risk of impulsive offending. The nature of the risk is such that I am satisfied that the applicant has demonstrated that the appropriate order is that the respondent be detained in custody for an indefinite term for control, care or treatment within the meaning of s 13(5)(a).

I pause to refer to the submission that was made on the respondent's behalf that I could bring about an intermediate position whereby I could adjourn the further hearing of this application to enable the respondent to undergo the one-on-one therapy with an appropriately qualified practitioner and drug therapy, with a view to his being released under a supervision order once that had occurred.

There was evidence by the psychiatrists that the risk presently posed by the respondent might, and I emphasise might, be substantially ameliorated by such treatment. There was evidence that stabilisation of the respondent under a drug regime might be capable of being reached after between six and eight weeks to three months and that it was possible that a successful intensive therapeutic relationship could be built between the respondent and a therapist over a period of the order of two months, even though that therapy needed to be ongoing.

However, it seemed to me inevitable, when one consider that aspect, that I could not formulate a condition today which I would be assured would, if fulfilled, give rise to circumstances which made it appropriate to release the respondent under a supervision order.

It seemed to me that upon analysis the submission advanced on behalf of the respondent was effectively asking me to exercise my power under s 9A to adjourn in the hope that conditions might change such that after a course of therapy had been embarked upon and the respondent stabilised, an assessment done at that stage might reveal that a conditional supervision order was appropriate.

I do not think a proper analysis of s 9A is that it is to be used for that purpose and I find support in that respect by the analysis of Burns J in *Attorney-General Queensland v Roles* [2015] QSC 198 at [6]-[8]. Further, I have doubt whether the jurisdiction to make a supervision order conferred on me by s 13(5) extends to formulating a condition in the way posited. However, even if it did, I would not be minded to do so because I think the medical evidence was such that I could not be satisfied today that after a condition was satisfied the risk to the community would necessarily be ameliorated.

For the reasons I have articulated I make a continuing detention order as requested by the applicant. I order that the affidavits of Shane Ryan, sworn 19 June 2015 and Christopher Kelly, sworn 23 June 2015 which have previously been made subject of a sealing order by Justice Burns, which I varied at the outset of this hearing to enable the evidence to be relied on, be resealed, placed in an envelope on the court file, which envelope is not to be opened without an order of this court.

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