SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Wallace* [2015] QSC 354
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (applicant) **v** **LEON FREDERICK WALLACE** (respondent)
FILE NO/S:	SC No 7852 of 2015
DIVISION:	Trial Division
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	14 December 2015
DELIVERED AT:	Brisbane
HEARING DATE:	7 December 2015
JUDGE:	Ann Lyons J
ORDERS:	**1. The Court being satisfied to the requisite standard that the respondent Leon Frederik Wallace is a serious danger to the community in the absence of an order pursuant to Division 3 of the *Dangerous Prisoners (Sexual Offenders)* Act 2003 (Qld) the Court orders that pursuant to s 13(5)(b) of the Act, the respondent be subject to a Supervision Order in terms of the order in the attached Schedule until 20 December 2025.** **2. Direct that a copy of the reports of Dr Donald Grant dated 1 March 2015, Professor Barry Nurcombe dated 12 September 2015, Dr Robert Moyle dated 18 November 2015 and the letter from Dr Anthony Tie dated 3 December 2015 as well as a copy of this decision be provided to the respondent's treating psychiatrist at the PAH Mental Health Service, the District Forensic Liaison Officer, the Community Mental Health Service and the Mental Health Review Tribunal.**
	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where the applicant seeks an order pursuant to Division 3 of the *Dangerous Prisoners*

	(Sexual Offenders) Act 2003 (Qld) that the respondent be detained indefinitely for control, care or treatment, or alternatively, that the respondent be released from custody subject to a supervision order – whether the respondent should be subject to a Division 3 order
	Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld), s 3, s 11, s 13
COUNSEL:	B Mumford for the applicant J Allen QC for the respondent
SOLICITORS:	G R Cooper Crown Solicitor for the applicant Legal Aid Queensland for the respondent

This application

[1] This is an application by the Attorney-General for the State of Queensland for orders pursuant to Division 3 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (the Act). Pursuant to s 13 of the Act, the applicant seeks orders that the respondent be detained indefinitely for control, care or treatment or, in the alternative, that he be released subject to a supervision order under the Act.

Background

[2] The respondent is 42 years of age. On 18 March 1992, he pleaded guilty to nine counts on three indictments charging him with one count of wilful damage, three counts of attempted unlawful use of a motor vehicle, one count of burglary and four counts of rape.

[3] The Crown case in relation to the rape counts was that the complainant was a 16 year old school student who was sleeping at her sister's flat in Quilpie. The respondent was visiting the flat next door and he entered the flat where the complainant was sleeping. After some initial conversation, he picked up a pair of scissors and said "All I want is money. I don't want to hurt you". After that, he punched the complainant in the face, put her in a headlock and forced her into the bedroom. He threatened to kill her during the ensuing struggle and he raped her in the bedroom of the flat. He then raped her on three further occasions that night at different locations including a vacant allotment and in a caravan. At the end of the last episode, he apologised and let her go.

[4] The complainant suffered injuries to her head, forehead, jaw, throat, sternum, hands, arms and stomach. When the respondent was contacted by police, he argued that the sex with the complainant was consensual. The incident severely affected the complainant. At sentence, the Court was informed that the respondent had limited recollection of the night, as he had consumed an almost entire 40oz bottle of rum on the night.

[5] The respondent was sentenced to 13 years imprisonment on each of the rape counts and lesser concurrent terms on the other counts. The sentencing judge recommended that he be eligible for parole after serving five years.

History of offending

[6] The respondent has a number of convictions for a variety of offences. As a 15 year old, he was sentenced following conviction after trial on one count of rape. He was 14 years old at the time and was directed into the custody and control of the Director of Children's Services.

[7] Concerningly, the respondent has a number of convictions for offences which have occurred in custody. On 1 August 1994, he and a co-offender were convicted after trial of the attempted murder of a correctional officer. It would seem that there was a scuffle at the David Longland Correctional Centre between an inmate and an officer and the respondent joined in by firstly hitting the officer several times over the head with a guitar until it broke. He then returned to his cell, obtained another guitar and continued hitting the officer in the head with it. He then threw a television from shoulder height onto the officer's head and repelled other correctional officers who came to the aid of the officer. He was sentenced to 10 years imprisonment on that attempted murder charge cumulative on the sentence that he was serving with a new parole eligibility date fixed at 24 April 2002.

[8] In November 1998, however, he was involved in another incident involving assault occasioning bodily harm at the Lotus Glen Correctional Centre and on 5 August 2002, he pleaded guilty in Cairns to one count of assault occasioning bodily harm. Once again, the complainant was a correctional officer and the incident occurred after a melee between another prisoner and a prison officer. The respondent was sentenced to 18 months imprisonment.

[9] There was a further serious assault of a correctional officer on 25 May 2009 to which the respondent pleaded guilty on 9 March 2011. He was sentenced to two months imprisonment cumulative on his then current sentence with a new full-time release date of 20 December 2015. At the sentencing hearing in March 2011, a report from Dr Anthony Tie dated 8 August 2009 was tendered and the Court was informed by the respondent's counsel that the respondent was the subject of an Involuntary Treatment Order (ITO). The report of Dr Tie noted that the respondent was receiving psychiatric management for paranoid schizophrenia.

[10] The respondent also has other convictions including possessing a firearm, wilful damage, possessing a dangerous drug and failing to dispose of a hypodermic syringe in 1997 whilst he was in custody. There are also convictions for unlawfully taking part in opposition to lawful authority whilst he was in custody. He also has a number of offences when he was a child including aggravated assault on a child under 14, one count of deprivation of liberty, two counts of indecent assault when he was 15 years of age, two counts of indecent assault, one count of entering a dwelling with an intention to commit an indictable offence and one count of deprivation of liberty, all of which occurred on 25 May 1995 whilst he was in custody.

[11] There have been no further convictions since March 2011 and, as previously noted, his current full-time release date is 20 December 2015.

The reports of the psychiatrists

[12] The respondent was interviewed by three psychiatrists all of whom have provided reports, namely, Dr Donald Grant whose report is dated 1 March 2015, Professor Barry Nurcombe whose report is dated 12 September 2015 and Dr Robert Moyle dated 18 November 2015.

[13] I have also had regard to the report of Dr Pamela Van de Hoef dated 8 April 2004 and the letter of Dr Anthony Tie dated 3 December 2015.

Dr Grant's report

[14] Dr Grant examined not only the respondent's custodial files, but also his psychiatric history and contact with mental health services whilst in custody. Dr Grant noted that the respondent had completed a Sex Offender Treatment Program between August 2002 and February 2003 with a largely positive exit report. He also noted that he is currently housed in the Special Needs Unit at the Wolston Correctional Centre, remains under the care of Dr Tie and is on an ITO. Dr Grant noted that the respondent supports being on an ITO, as it will provide an appropriate framework for his mental health treatment.

[15] Dr Grant noted a current diagnosis of chronic schizophrenia with paranoid and affective features which is in remission on treatment with depot antipsychotic and benzodiazepine medication. The respondent also has a diagnosis of a personality disorder with antisocial traits which meets the criteria for psychopathic personality disorder as well as a diagnosis of alcohol and substance abuse when in enforced remission in custody. Dr Grant considered that there was no evidence of sexual paraphilia and stated that, in his view, the respondent's sexual offending was a result of his immaturity, his serious antisocial personality disorder and the effects of severe intoxication with alcohol and/or drugs.

[16] In terms of the risk assessment instruments utilised by Dr Grant, he considered the following scores:

(a) On the STATIC 2002R, he scored a moderate to high risk of future sexual offending;

(b) On the HARE PCL-R, a score of 34/40, indicating psychopathic personality disorder;

(c) On the HCR 20, he is at high risk for future violence; and

(d) On the RSVP, Dr Grant noted that the fact that the respondent had been incarcerated for 23 years meant that he had not had the opportunity to commit further sexual offences against females and therefore this distorted the future predictability of behaviour.

[17] Dr Grant considered that the respondent represents a moderate to high risk of future sexual offending and a high risk of future general offending. That risk arises from the combination of his antisocial and psychopathic personality disorder, chronic schizophrenia and his history of alcohol or drug abuse. He considered that the risk would rise from moderate to high if he were to become psychiatrically unwell, use drugs or alcohol or become very socially isolated and unsupported.

[18] Dr Grant stated that his risk for future sexual reoffending could be moderated and reduced to low to moderate by the application of a combination of psychiatric treatment and supervision in the community. Whilst he acknowledged that there was a potential for an ITO to be revoked by the Mental Health Review Tribunal or the treating psychiatrist, he considered that such an outcome was "unlikely" given the respondent's history of lack of insight and refusal of treatment as well as the consequences to him of such refusal in the past. Dr Grant stated:[1]

> "And one of the issues that her Honour has raised is the ITO. It's not in place for 10 years. It can be indefinite. But it might be cancelled - - -
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> Yes?--- - - - at any stage, really. Strictly, legally, it can be cancelled by a treating psychiatrist. It's unlikely, hopefully, that that would happen, given that you would be hoping that there'd be a recognition that this man has a chronic illness, that it has been very problematic in the past, that the risk of relapse is high, and that ongoing treatment is essential to maintain his mental health. And so there would be plenty of grounds to continue an involuntary treatment order, in my view, long term just to maintain that health and recognising the role of treatment in keeping him well and seeing risk issues as a long term thing, and treatment – the need for treatment being a long term issue in the presence of a somewhat limited insight. So whilst theoretically an ITO could be stopped at any time, one would hope that it wouldn't be. But it can't be guaranteed that it wouldn't be."

[19] In his evidence, Dr Grant also highlighted the importance of communication, co-operation and the sharing of information between Corrective Services and Community Mental Health and considered that the conditions in the Draft Supervision Order at paragraphs 36 to 42 not only permitted but also facilitated such communication. He also noted that it was anticipated that the District Forensic Liaison Officer (DFLO) would be involved to assist in the respondent's management which he considered was a very positive step. He also stated that it was very important that the local mental health service at Inala receive copies of his report and the reports of Dr Moyle and Professor Nurcombe. Dr Grant also gave evidence that should the ITO be revoked at any stage the Draft Supervision Order included a requirement that he had to comply with any direction to see a psychiatrist and his mental state could be appropriately monitored by such an approach. He continued:[2]

> "But I think if that happened, the communication between the corrections and mental health should be occurring and so Queensland – the corrections people would be aware if something like that changed. And that would be an indication that there needs to be more communication and possibly close observation over time to make sure that he wasn't deteriorating."

[20] Dr Grant also stated that any supervision would need to be comprehensive and would need to have both individual psychological therapy and psychiatric treatment along with a comprehensive rehabilitation plan to overcome the effects of very long term

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1 T1-8 ll 5-19.
2 T1-8 ll 21-25.

incarceration. Dr Grant considered that the respondent would be very vulnerable to stress and destabilisation outside prison, particularly given his fears for his own safety. He considered that the reintegration into the community would need to be gradual and well supported. He noted that the mental health regime would in fact assist with the respondent's reintegration and that there were also community and voluntary agencies that could assist with his rehabilitation including the Richmond Fellowship who help people with chronic schizophrenia to integrate into the community.

[21] Dr Grant also referred to the significance of the report from his treating psychiatrist, Dr Anthony Tie, from the Prison Mental Health Service, to the Community Mental Health Service dated 3 December 2015, as follows:[3]

> "Are you confident that the material provided by Dr Tai (sic) to that service would be sufficient for them to understand all of the nuances of Mr Wallace's case?---Well, Dr Tai (sic) will be providing a comprehensive clinical report and an outline of treatment and recommendations and so on. But I think it would be very useful for whatever team takes him on to have these comprehensive reports that have been done for this matter because that would be unusual for them to get that detail and those risk assessment instruments and so on that were done. And the total risk assessment reports would be very useful for them."

[22] Dr Grant considered that there would be a risk that he would return to unhelpful strategies to deal with stress such as isolating himself or turning to the use of drugs and alcohol. He considered that breaches of supervision are likely to occur through general offending and drug and alcohol abuse with sexual offending being more likely if he was to further decompensate and become intoxicated with substances. He noted that such a risk could be manage by close monitoring.

[23] Ultimately, Dr Grant considered that the conditions in the Draft Supervision Order were appropriate in all of the circumstances to manage the respondent in the community.

Professor Nurcombe's report

[24] Professor Nurcombe also considered that the respondent has a diagnosis of chronic schizophrenia, paranoid type, in remission on medication and antisocial personality disorder. He did not consider that there was evidence of paraphilia or a psychopathic personality disorder. In particular, Professor Nurcombe noted that the respondent is an indigenous man from a violent, culturally disadvantaged rural community. He considered that his crimes, as an adolescent, were committed when he was intoxicated and he was alcohol dependent from the age of 11 and addicted to heroin for three years whilst in prison.

[25] Professor Nurcombe noted that for the decade between 1998 and 2008, the respondent suffered from a psychotic illness and, at one stage, considered that female staff were provoking his sexual interest. He stated that the psychosis had been controlled by

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3 T1-12 ll 27-34.

medication since 2008. He also noted that the respondent has spent all of his adult life in prison and knows little of the outside world.

[26] On the formal risk assessment instruments, Professor Nurcombe noted the following:

(a) On the PCL-R, a score of 12/40 which was below the cut-off for psychopathy;

(b) On the STATIC-2002R, a score of 8/13 indicating he was at moderate to high risk of sexual reoffending;

(c) On the STABLE 2007, a score of 9/26 indicating a moderately high level of treatment need, particularly in relation to the paucity of significant social influences in the community, uncertain capacity for relationship stability, lack of concern for others, some impulsivity, poor problem-solving skills and past sexual preoccupation;

(d) On the VASOR, he had a reoffence subscale risk score of 60/125 and a violence risk subscale score of 60/125, which resulted in the respondent having a high risk of sexual reoffending;

(e) On the SVR 20, Professor Nurcombe noted the following risk factors: victim of child abuse, major mental illness in remission, substance use, past non-sexual violent offences, past non-violent offences, high density sex offences, use of weapons or threats of death in sex offences and the escalation in frequency or severity of sex offences. His risk of reoffending sexually on the SVR20 was therefore moderate to high; and

(f) On the RSVP assessment, Professor Nurcombe noted that he committed three sexual offences over four years when he was an adolescent and he has not been convicted of a sexual offence since his imprisonment 23 years ago. Whilst the sexual violence was not diverse, there was an escalation in the severity of the sexual violence and physical and psychological coercion were also involved in two episodes of rape. Professor Nurcombe noted that the respondent has never had an intimate personal relationship.

[27] Professor Nurcombe concluded that if the respondent reverted to drinking or taking drugs or became psychotic, the risk of sexual reoffending is high and would involve the rape of an adolescent or adult female. He also considered that the risk of psychological damage to the victim would also be high.

[28] Professor Nurcombe noted that there are a number of difficulties, including the fact that he is institutionalised and has not been out of prison for his whole adult life. He also noted that he had no particular work skills, although he was noted to be a hard worker. He also would need help to find accommodation and employment and in adjusting to the community environment.

[29] He considered that electronic monitoring would be required and the respondent would need to be monitored closely for drug and alcohol intake. He considered that he should be released under an ITO to ensure that the psychiatric treatment continues. He considered it is essential that the psychiatrist and supervising correctional officer be in close contact. He also considered that support from a treating psychologist was important.

[30] Professor Nurcombe recommended a supervision order of 10 years and whilst he need not be kept at a distance from children, he should be on a curfew at night and be referred to the Alcohol, Tobacco & Other Drugs Service for alcohol and drug treatment if required.

[31] Professor Nurcombe considered that the Draft Supervision Order was appropriate and if he were to be released under a supervision order pursuant to the Act, the risk of sexual recidivism could be reduced to moderate or low.

[32] Professor Nurcombe also stated that there needed to be close liaison between Community Mental Health and Corrective Services and considered that it should be "mandatory" that the psychiatrists' reports which had been prepared for this application should be sent to the treating team at Community Mental Health.

Dr Moyle's report

[33] Dr Moyle also considered that the respondent was suffering from paranoid schizophrenia, drug and alcohol abuse in remission and an antisocial personality disorder. Dr Moyle considered that whilst the respondent was functional in social interaction at present and was free of psychotic symptoms, his history of impulsivity, violence and sexual violence as well as his drug and alcohol abuse indicates that he could readily revert to violent and sexual abusive behaviours.

[34] Dr Moyle stated that if he was not subject to an ITO, the respondent's release needed to be managed on an Involuntary Treatment Plan and a mental health team, including forensic mental health psychiatrists, drug and alcohol counsellors and psychologists. He also considered that he needed a slow, graded rehabilitation plan with supported accommodation and gradual increasing freedoms. He needed regular medication, psychological therapy and a clear rehabilitation plan which he considered at the moment seems underdeveloped. Dr Moyle considered it likely that the respondent would find it difficult to live in society, as he has never lived a pro-social life outside a highly supervised prison setting.

[35] Dr Moyle considered that there is a moderately high risk that he would regress to using drugs and alcohol when under stress and then revert to sex as a coping mechanism to feel better and he considered the risk would be lowered if he remained abstinent from drugs and alcohol and was adherent to a treatment plan. He also considered that the respondent needed a psychiatrist to monitor his state of mind and his ongoing use of depot medication.

[36] In terms of the risk assessment instruments:

(a) On the PCL-R, a score of 30/38 indicated that he had reached the cut-off for psychopathy;

(b) On the STATIC 99, a score of 6 indicated a high risk;

(c) On the VRAG, it was indicated that the respondent was at high risk of violent recidivism. Dr Moyle noted that on the SORAG, he would be almost certain to commit other sexual offences based on his past behaviour;

(d) On the HCR 20, his clinical high risk of violent reoffending has been modified downwards by his responsiveness to treatment;

(e) On the SVR 20, he is at high risk of reoffending sexually;

(f) On the RSVP, the risk remains moderately high to high that he will reoffend if ongoing treatment and supervision is not accompanied by supervision; and

(g) On the SAPROF, the score demonstrated that there were many areas in which he required ongoing support and assistance.

[37] Dr Moyle concluded that the respondent would normally be rated at high risk of sexual and violent reoffending, but the risk has been modified by his treatment for mental illness, his substance abuse treatment and maintenance of a substance free lifestyle in custody. He noted, however, that he lacked meaningful activities to occupy his mind and that he would be vulnerable to stress on release given his limited experience.

[38] Dr Moyle considered that the respondent's progress into the community would need to be slow and graded and mediated through Dr Tie, his forensic mental health psychologist and the community mental health teams, including Community Forensic Mental Health. He considered that this should be commenced before his transition starts, as he has never been socialised and survives on the good care and advice of others. He also considered that he should receive close supervision of contacts whilst outside and encouraged the development of a social network of people who are aware of his past offending.

[39] Dr Moyle was initially hesitant to recommend release until a clear, internalised idea of a well-reasoned and achievable management plan has been put in place and in his evidence to the Court he stated that the role of the DFLO was significant in this case and he was satisfied that the proposals went as far as they could practically go in addressing the risk.

Dr Van de Hoef's report

[40] I also note the report of Dr Pamela Van de Hoef dated 8 April 2004 who indicated that the respondent first came to the attention of psychiatrists in custody in 1998 when he was using amphetamine, heroin and cannabis and was starting to get paranoid. He then had a manic episode with psychotic features which was considered to be part of bipolar affective disorder. In 2001, he was diagnosed by Dr Kar with paranoid schizophrenia. There would also seem to be another diagnosis of bipolar affective disorder with psychotic features and then a diagnosis by Dr Kingswell in 2004 of a schizoaffective disorder in remission. Dr Van de Hoef considered that he has been followed up well whilst in custody and his mental state has been in remission. She considered that the schizoaffective disorder had been in remission for at least 12 months.

[41] Dr Van de Hoef considered the respondent's antisocial personality disorder heightened the risk that he will not comply with treatment or conditions prohibiting drug use. Dr Van de Hoef considered that effective treatment would only be achieved if he was subject to an ITO or if psychiatric follow-up were a condition of his parole. She considered that he needed to be on depot medication.

Dr Tie's letter

[42] Dr Tie provided a letter to the Court dated 3 December 2015. He is the respondent's current treating psychiatrist from the Prison Mental Health Service. He stated that the respondent has a diagnosis of schizophrenia (paranoid type), superimposed upon a borderline and antisocial personality disorder with a history of polysubstance abuse in remission. He noted that the respondent is currently under an ITO managed by the High Secure Inpatient Service at the Park Centre for Mental Health. Dr Tie has been the respondent's treating psychiatrist for the last seven years. He stated that within the custodial setting the respondent's psychiatric treatment needs have been addressed through the Prison Mental Health Service. He stated that the respondent has been compliant with prescribed psychotropic medications, namely Risperdal Consta and Diazepam. He indicated that the respondent had attended regular psychiatric reviews with him and has participated and attended the biannual reviews of his ITO by the Mental Health Review Tribunal. He has sustained stability in his mental health since late 2010.

[43] Dr Tie stated that if the respondent is released, the ITO could operate to ensure his treatment needs continue to be met upon his release. Dr Tie stated that if the respondent was released to reside at the Wacol Precinct, he would be followed up by the Princess Alexandra Hospital (PAH) Mental Health Service through the closest community mental health clinic located in Inala.

[44] He stated that the ITO would facilitate assertive psychiatric monitoring, support and treatment through regular clinical appointments with an authorised psychiatrist and case management from a designated DFLO whose name was Mr Phan. Mr Phan has requested contact from the supervising correctional officer on the day, should the respondent be released from custody under a Supervision Order.

[45] Dr Tie further noted that:

> "It would be essential for the supervising correctional officer and his treating psychiatric team to sustain ongoing communication. If there were concerns about his mental wellbeing, the treating psychiatric team could consider various options ranging from:
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> - increasing the support and regularity of reviews provided to Mr Wallace at the Wacol precinct;
> - assessment and treatment at the PAH inpatient setting under the ITO, should Mr Wallace become noncompliant with psychiatric management and/or presents with a significantly deteriorated mental state."

[46] Dr Tie also stated that the Community Forensic Outreach Service has a role in assisting the District Mental Health Service with specialised clinical evaluations geared towards the risk assessment and review of the management plan. Dr Tie considered that the reports of Dr Grant, Dr Moyle and Professor Nurcombe should be sent to the treating team in the community setting. Dr Tie also considered that the respondent would be assisted by a cultural mentor who could identify additional services and referred to Dr Hayman, the General Practitioner, at the Inala Indigenous Health Service with whom the respondent had engaged well during his incarceration. Dr Tie also noted that an external psychologist was also required.

Should a Division 3 order be made?

[47] It is clear that the objects of the Act are to provide for the continued detention or supervised release of a particular class of prisoner to ensure adequate protection of the community and to provide the continuing control, care or treatment of a particular class of prisoner to facilitate their rehabilitation.[4]

[48] Section 13(4) of the Act lists the matters the Court must consider in deciding whether a prisoner is a serious danger to the community. Pursuant to s 13(4)(a), I have considered the reports prepared by the psychiatrists under s 11 of the Act. I have also considered the other assessments that have been provided pursuant to s 13(4)(b), including the report of Dr Van de Hoef and the letter of Dr Tie.

[49] In terms of s 13(4)(c), it is clear that all the psychiatrists considered that the risk of sexual reoffending, that is an offence of a sexual nature involving violence, is high or moderate to high and that the risk of the respondent committing a serious sexual offence is likely to arise in the context of intoxication or if he becomes psychotic. I note that a pattern of offending referred to in s 13(4)(d) is that the index offending was committed whilst he was intoxicated.

[50] It is clear that the risk that the respondent will commit another serious sexual offence if released into the community is the predominant consideration and the reports have all gone into this in great detail. As I have indicated, the risk of violent sexual reoffending is at least moderate to high. That risk can be managed if he remains abstinent from intoxicants and is regularly tested. It is also essential that he maintains his current medication regime, is maintained on an ITO and has other supports in place given his history of lack of insight and subsequent refusal of medication with disastrous results.

[51] I also consider that the respondent should have more intensive advice and help from a psychologist and that such support is anticipated in the Draft Supervision Order. In the present case, it is clear that the respondent has been in custody for 23 years and has been treated for paranoid schizophrenia under an ITO. There is no doubt that he presents with a moderate to high risk of future sexual offending. That risk arises from a combination of an antisocial and psychopathic personality disorder together with chronic schizophrenia under a reversion to alcohol or drug abuse. The risk would rise to high if he was to become unwell, revert to alcohol or drug use or become isolated and unsupported in the community. He therefore requires treatment and monitoring to ensure that he does not revert to the use of drugs or alcohol.

[52] I am satisfied that the need to protect members of the community from the risk of the respondent committing another serious sexual offence can be managed if the conditions attached to this decision are put in place. In particular, it is vital that he be assertively managed by a correctional officer who understands his treatment needs and that there is liaison between the correctional officer, the psychiatrist and the Community Mental Health team who is managing him pursuant to the ITO. There also needs to be assertive monitoring of his possible drug or alcohol use. Whilst I note that some of the psychiatrists did not consider that the respondent needed to be subject to a condition that required that

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4 *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld), s 3.

he not have contact with children given the age of the complainant in the rape in 1992 I consider that such a condition should remain.

[53] I am satisfied that the respondent should be released on a Supervision Order as per the conditions set out in the attached Order.

[54] I also direct that a copy of the reports of Dr Grant, Professor Nurcombe, Dr Moyle and the letter of Dr Tie dated 3 December 2015 as well as a copy of this decision be provided to the respondent's treating psychiatrist at the PAH Mental Health Service, the District Forensic Liaison Officer, the Community Mental Health Service and the Mental Health Review Tribunal.

Orders

[55] The orders of the Court are as follows:

1. The Court being satisfied to the requisite standard that the respondent, Leon Frederick Wallace, is a serious danger to the community in the absence of an order pursuant to Division 3 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003, ("the Act") orders that pursuant to s 13(5)(b) of the Act, the respondent be subject to a Supervision Order in terms of the order in the attached Schedule until 20 December 2025.

2. Direct that a copy of the reports of Dr Donald Grant dated 1 March 2015, Professor Barry Nurcombe dated 12 September 2015, Dr Robert Moyle dated 18 November 2015 and the letter of Dr Tie dated 3 December 2015, as well as a copy of this decision be provided to the respondent's treating psychiatrist at the PAH Mental Health Service, the District Forensic Liaison Officer, the Community Mental Health Service and the Mental Health Review Tribunal.

The orders of the Court are that:

A. The Court is satisfied to the requisite standard that the respondent, Leon Frederick Wallace, is a serious danger to the community in the absence of an order pursuant to Division 3 of the *Dangerous Prisoners (Sexual Offenders) Act 2003*.

B. The respondent be subject to the following conditions until 20 December 2025.

The respondent must:

1. report to a corrective services officer at the Queensland Corrective Services Probation and Parole Office closest to his place of residence between 9 am and 4 pm on the day of release from custody and at the time advise the officer of the respondent's current name and address;
2. report to, and receive visits from, a corrective services officer at such times and at such frequency as determined by Queensland Corrective Services;
3. notify a corrective services officer of every change of his name, place of residence or employment at least two business days before the change happens;
4. be under the supervision of a corrective services officer;
5. comply with a curfew direction or monitoring direction;
6. comply with any reasonable direction under section 16B of the Act given to him;
7. comply with every reasonable direction of a corrective services officer that is not directly inconsistent with a requirement of the order;
8. not leave or stay out of Queensland without the permission of a corrective services officer;
9. not commit an offence of a sexual nature during the period of the order;
10. seek permission and obtain approval from a corrective services officer prior to entering into an employment agreement or engaging in volunteer work or paid or unpaid employment;
11. notify a corrective services officer of the nature of his employment, or offers of employment, the hours of work each day, the name of his employer and the address of the premises where he is or will be employed at least two (2) days prior to commencement or any change;
12. reside at a place within the State of Queensland as approved by a corrective services officer by way of a suitability assessment and obtain written approval prior to any change of residence;
13. comply with any regulations or rules in place at the accommodation and demonstrate reasonable efforts to secure alternative, viable long term accommodation to be assessed for suitability by Queensland Corrective Services, if such accommodation is of a temporary or contingency nature;
14. not reside at a place by way of short term accommodation including overnight stays without the permission of a corrective services officer;
15. not commit an indictable offence during the period of the order;

16. respond truthfully to enquiries by a corrective services officer about his activities, whereabouts and movements generally;

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

18. disclose to a corrective services officer upon request the name of each person with whom he associates and respond truthfully to requests for information from a corrective services officer about the nature of the association, address of the associate if known, the activities undertaken and whether the associate has knowledge of his prior offending behaviour;

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

20. submit to and discuss with a corrective services officer a schedule of his planned and proposed activities on a weekly basis or as otherwise directed;

21. make, if directed by a corrective services officer, complete disclosure of the terms of this supervision order and the nature of his past offences to any person as nominated by the corrective services officer who may contact such persons to verify that full disclosure has occurred;

22. abstain from the consumption of alcohol and illicit drugs for the duration of this order;

23. submit to any form of drug and alcohol testing including both random urinalysis and breath testing as directed by a corrective services officer;

24. disclose to a corrective services officer all prescription and over the counter medication that he obtains;

25. not visit premises licensed to supply or serve alcohol, without the prior written permission of a corrective services officer;

26. attend upon and submit to assessment, treatment, and/or medical testing by a psychiatrist, psychologist, social worker, counsellor or other mental health professional as directed by a corrective services officer at a frequency and duration which shall be recommended by the treating intervention specialist;

27. permit any medical, psychiatrist, psychologist, social worker, counsellor or other mental health professional to disclose details of treatment, intervention and opinions relating to level of risk of re-offending and compliance with this order to Queensland Corrective Services if such a request is made for the purposes of updating or amending the supervision order and/or ensuring compliance with this order;

28. attend any program, course, psychologist, social worker or counsellor, in a group or individual capacity, as directed by a corrective services officer in consultation with treating medical, psychiatric, psychological or other mental health practitioners where appropriate;

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

30. not establish or maintain any supervised or unsupervised contact including undertaking any care of children under 16 years of age except with prior written approval of a corrective services officer. The respondent is required to fully disclose the terms of the order and nature of offences to the guardians and caregivers of the children before any such contact can take place, and Queensland Corrective Services may disclose

information pertaining to the respondent to guardians or caregivers and external agencies in the interests of ensuring the safety of the children;

31. allow any device including a telephone to be randomly examined. If applicable, account details and/or phone bills are to be provided upon request of a corrective services officer;

32. advise a corrective services officer of the make, model and phone number of any mobile phone owned, possessed or regularly utilised by him within 24 hours of connection or commencement of use and includes reporting any changes to mobile phone details;

33. take prescribed drugs as directed by a medical practitioner and disclose details of all prescribed medication as requested to a corrective services officer;

34. notify a corrective services officer of any computer or other device connected to the internet that he regularly uses or has used;

35. supply to a corrective services officer any password or other access code known to him to permit access to such computer or other device or content accessible through such computer or other device and allow any device where the internet is accessible to be randomly examined using a data exploitation tool to extract digital information or any other recognised forensic examination process;

Mental Health Services

36. comply with any requirements of any order made under the Mental Health Act 2000 that are not directly inconsistent with the requirements of this supervision order;

37. attend any appointments with a community mental health service, as directed by a corrective services officer;

38. attend any appointments with a community mental health services provider, as directed by a corrective services officer;

39. participate in case management with a community mental health services provider, follow the recommendations made by a community mental health services provider, and discuss his case management with a corrective services officer;

40. permit a community mental health services provider to disclose to a corrective services officer details of the respondent's treatment pursuant to case management;

41. permit a corrective services officer to disclose to the respondent's treating psychologist, psychiatrist or other treating medical professional or allied health professional details of the respondent's treatment pursuant to case management; and

42. take medication as prescribed by a medical practitioner, in the manner, at the dosage and at the frequency as directed by that medical practitioner.