SUPREME COURT OF QUEENSLAND

CITATION:	*Attorney-General for the State of Queensland v Barlow* [2018] QSC 91
PARTIES:	**ATTORNEY-GENERAL FOR THE STATE OF QUEENSLAND** (Applicant) **v** **ANDREW STEVEN BARLOW** (Respondent)
FILE NO/S:	BS No 12265 of 2017
DIVISION:	Trial
PROCEEDING:	Application
ORIGINATING COURT:	Supreme Court at Brisbane
DELIVERED ON:	11 May 2018
DELIVERED AT:	Brisbane
HEARING DATE:	30 April 2018. Further submissions received 4 May 2018.
JUDGE:	Lyons SJA
ORDER:	**The Court is satisfied that the respondent is a serious danger to the community in the absence of a Division 3 order under the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) and that he should be detained indefinitely for control, care or treatment pursuant to s 13(5)(a) of the Act.**
CATCHWORDS:	CRIMINAL LAW – SENTENCE – SENTENCING ORDERS – ORDERS AND DECLARATIONS RELATING TO SERIOUS OR VIOLENT SEXUAL OFFENDERS OR DANGEROUS SEXUAL OFFENDERS – DANGEROUS SEXUAL OFFENDER – GENERALLY – where the applicant seeks orders under Section 13 of the *Dangerous Prisoners (Sexual Offenders) Act* 2003 (Qld) – where the respondent has been convicted of multiple sexual and violent offences – where the respondent has undergone some programs in custody but not completed them – where the psychiatrists consider the respondent has little insight into his offending - whether the respondent is a serious danger to the community in the absence of a Part 2, Division 3 order – whether a continuing detention order or a supervision order should be preferred – whether the community could be adequately protected by a supervision order

Dangerous Prisoners (Sexual Offenders) Act 2003 (Qld) s 13, s 16

A-G (Qld) v Lawrence [2009] QCA 136

COUNSEL: M Maloney for the Applicant
L Reece for the Respondent

SOLICITORS: Crown Law for the Applicant
Legal Aid Queensland for the Respondent

Application

[1] This is an application by the Attorney-General for orders pursuant to s 13 of the *Dangerous Prisoners Sexual Offenders Act* 2003 (Qld) ('the Act') for the respondent's continued detention or release subject to a supervision order. The respondent is a 32 year old Indigenous man who is illiterate and unable to write. Whilst he has not been diagnosed as having an intellectual disability, his intellectual functioning is considered to be borderline. His criminal offending commenced at the age of 14 and he has served previous custodial sentences for a number of different offences. On one calculation he has had 38 court appearances on 73 charges.[1] He is currently serving a period of imprisonment for offences of a sexual nature which he committed whilst on parole.

[2] On 3 June 2011 he was convicted and sentenced in the District Court at Cairns following a trial in relation to one count of rape, one count of sexual assault and two counts of assault occasioning bodily harm in company. All of those offences were committed in February 2009. He was sentenced to eight years imprisonment for the offence of rape, four years imprisonment for each of the sexual assault counts and two years and six months for each count of assault occasioning bodily harm whilst in company. The offences of rape and sexual assault were declared to be serious violent offences which meant that the respondent has to serve 80% of his sentence prior to being eligible for parole. Taking into account the days that he has served prior to the sentence, the respondent's current date for release is 16 May 2018.

[3] The respondent's criminal history commenced in the Children's Court in 2000 when he received a caution for a charge of indecent treatment of a child under 16. In 2003 he was convicted of assault occasioning bodily harm and indecent treatment of a child under 16. The respondent was 17 and the victim was a 12 year old male. On that occasion, the respondent followed the victim who was riding a bicycle. He pulled the child off the bicycle, struck him in the face and started to pull down his shorts, telling him he was going to "root" him. The victim managed to kick him and ran off. The respondent then chased him, punched him and grabbed the victim by the neck, telling him once again he was going to "root" him. Ultimately the victim struggled free and was able to call police. On each charge the respondent was convicted and sentenced to three months detention.

[4] In 2004 he was once again convicted in the Cairns Children's Court of a number of offences which included sexual assault. On each charge he was convicted and

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[1] Report of Dr Moyle dated 14 April 2018 at [167].

sentenced to 35 days detention. In relation to those offences little information is available. It would seem however that the victim on that case was riding her bicycle on a bike track and the respondent called out to her and ultimately touched her on the breasts. Later that night, he went to the victim's home and called out to her. The respondent left when police were called.

[5] The circumstances of the offences in 2009 related to two Norwegian tourists aged 30 and 35 years old who were visiting Cairns. The two women had been out at a nightspot in Cairns and were taken by a taxi driver to the wrong caravan park. In the early hours of 20 February 2009, they were disoriented and asked for directions when they knocked on the door of the respondent's family's cabin. The respondent's teenage sister led them a short distance away and then savagely attacked them. She was joined in the attack by the respondent and his mother. Ultimately, one woman was beaten unconscious and after her clothes were ripped from her body, the respondent digitally raped her. The respondent also climbed on top of the other young woman and pulled her underwear to one side and removed her tampon. Ultimately the young women were able to regain consciousness and ran to the safety of an amenities block. The sentencing judge noted that the violence and savagery of that evening has left lasting consequences on both victims, one of whom required surgery and ongoing treatment for serious physical injuries including dental surgery and a disc prolapse. She also suffers from psychological consequences including post-traumatic stress disorder. The other young woman, while she suffered less serious physical symptoms, still has problems with her neck and back, and also has a psychological condition, namely post-traumatic stress disorder.

[6] The sentencing judge noted that whilst it was a digital rape, what occurred was "cowardly, brutal and degrading" and that it was "an episode of sustained and ferocious violence".[2]

Statutory Scheme

[7] The Act establishes a comprehensive scheme for the continued detention in custody or release under supervision in relation to prisoners who are considered to be at risk of committing serious sexual offences if released.

[8] The primary orders which can be made under the Act are called Division 3 orders, and are set out in s 13 in the following terms:

> **"13 Division 3 orders**
>
> (1) This section applies if, on the hearing of an application for a Division 3 order, the court is satisfied the prisoner is a serious danger to the community in the absence of a Division 3 order (a serious danger to the community).
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> (2) A prisoner is a serious danger to the community as mentioned in subsection (1) if there is an unacceptable risk that the prisoner will commit a serious sexual offence—
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> (a) if the prisoner is released from custody; or

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[2] Sentencing Remarks of Judge Everson at the District Court at Cairns on 3 June 2011 as quoted in the Report of Dr Arthur dated 9 March 2018 at [141].

(b) if the prisoner is released from custody without a supervision order being made.

(3) On hearing the application, the court may decide that it is satisfied as required under subsection (1) only if it is satisfied—

(a) by acceptable, cogent evidence; and

(b) to a high degree of probability;

that the evidence is of sufficient weight to justify the decision.

(4) In deciding whether a prisoner is a serious danger to the community as mentioned in subsection (1), the court must have regard to the following—

(aa) any report produced under section 8A;

(a) the reports prepared by the psychiatrists under section 11 and the extent to which the prisoner cooperated in the examinations by the psychiatrists;

(b) any other medical, psychiatric, psychological or other assessment relating to the prisoner;

(c) information indicating whether or not there is a propensity on the part of the prisoner to commit serious sexual offences in the future;

(d) whether or not there is any pattern of offending behaviour on the part of the prisoner;

(e) efforts by the prisoner to address the cause or causes of the prisoner's offending behaviour, including whether the prisoner participated in rehabilitation programs;

(f) whether or not the prisoner's participation in rehabilitation programs has had a positive effect on the prisoner;

(g) the prisoner's antecedents and criminal history;

(h) the risk that the prisoner will commit another serious sexual offence if released into the community;

(i) the need to protect members of the community from that risk;

(j) any other relevant matter.

(5) If the court is satisfied as required under subsection (1), the court may order—

(a) that the prisoner be detained in custody for an indefinite term for control, care or treatment (continuing detention order); or

(b) that the prisoner be released from custody subject to the requirements it considers appropriate that are stated in the order (supervision order).

(6) In deciding whether to make an order under subsection (5)(a) or (b)—

(a) the paramount consideration is to be the need to ensure adequate protection of the community; and

(b) the court must consider whether—

(i) adequate protection of the community can be reasonably and practicably managed by a supervision order; and

(ii) requirements under section 16 can be reasonably and practicably managed by corrective services officers.

(7) The Attorney-General has the onus of proving that a prisoner is a serious danger to the community as mentioned in subsection (1)."

[9] Accordingly, the first issue for the Court is to ascertain whether the respondent is a serious danger to the community in the absence of a Division 3 order. The question is whether there is an unacceptable risk that the prisoner will commit a serious sexual offence if released without a Division 3 order. In deciding whether to make an order under the Act, the paramount consideration is the need to ensure the adequate protection of the community and in that regard the Court must consider whether the adequate protection of the community can be reasonably and practically managed by a supervision order and whether the requirements under s 16 can be reasonably and practicably managed by Corrective Services officers.

[10] In hearing an application the Court is required to be satisfied by acceptable cogent evidence to a high degree of probability that the evidence is of sufficient weight to justify the decision. In determining whether a prisoner is a serious danger to the community, the Court needs to consider the matters set out in s 13(4) which includes reports prepared by the psychiatrists, the prisoner's antecedents and criminal history as well as a consideration of efforts the prisoner has made to address the cause or causes of his offending behaviour including whether he has participated in rehabilitation programs.

[11] The respondent has been examined by three psychiatrists as required by the Act. Dr Donald Grant prepared a report dated 17 April 2017, Dr Ken Arthur has prepared a report dated 9 March 2018 and Dr Robert Moyle has prepared a report dated 14 April 2018. All the psychiatrists gave further evidence at the hearing.

Report of Dr Grant dated 17 April 2017

[12] Dr Grant considers that the respondent suffers from significant personality disorder with anti-social traits and that his risk for sexual reoffending relates to this anti-social personality disorder and his substance abuse. He considers his history indicates strong features of immaturity, impulsivity, dishonesty, lack of trust, poor ability to relate to others, difficulties in intimate relationships with women, distortions in his attitudes

towards women and a general tendency toward suspicion and distrust in people. Dr Grant also noted the respondent's significant history of interpersonal violence as well as a history of general criminality. He considered that those issues appear to have been based on his very disturbed childhood history as well as a range of social and cultural influence from his extended family.

[13] Dr Grant, as well as relying on his clinical judgment, also applied a number of risk assessment instruments during his interview with the respondent. He noted that the risk assessment instruments had not been standardised for Australian populations and in particular have not been standardised for Indigenous populations and accordingly they would need to be interpreted with caution. However, he noted that they added some statistical weight to the risk assessment.

[14] In relation to the STATIC 99R, Dr Grant considered that the respondent scores very high, with a total score of 9, which places him in the higher risk group which is described as well above average risk. In relation to the Hare Psychopathy Checklist PCL-R 2nd Edition ('PCL-R'), which is the psychopathy checklist, the respondent scored 30 out of 40, which meant that he reached the threshold of a diagnosis for Psychopathic Personality Disorder which increases a risk of sexual reoffending, particularly in combination with any sexual paraphilia or substance abuse, noting that substance abuse was present in the respondent's case.

[15] In relation to the HCR-20, Dr Grant considered that the respondent scored in the high risk area for future violent behaviour, with his scores being particularly high in the risk management area.

[16] In relation to the Risk of Sexual Violence Protocol ('RSVP'), the respondent scored positively for chronicity of sexual violence, escalation of sexual violence and physical coercion in sexual violence. Dr Grant noted that the respondent scored positively for extreme minimisation or denial of sexual violence and other attitudes in relation to the mental disorder aspect. The respondent scored negatively for sexual deviance, positively for Psychopathic Personality Disorder, negatively for major mental illness, and positively for problems with substance abuse and violent ideation. He also scored positively for problems in relation to intimate relationships, non-intimate relationships, employment and non-sexual criminality. In terms of manageability, Dr Grant considered that the respondent had problems with planning, probable problems with treatment and problems with supervision. Using the RSVP instrument, Dr Grant considered that the risk scenario would involve violent sexual assault, especially whilst intoxicated, most likely involving adult females or possibly adolescent females. He considered that the assaults would be motivated by anger, sexual drive, interpersonal stress or feelings of rejection. He also considered that the potential for psychological harm to victims would be potentially high with physical harm potentially significant and a possibility it could escalate to serious physical harm. He considered that in terms of the imminence of any offending, such reoffending would occur quite soon after release from custody if the respondent was feeling isolated and intoxicated. He noted that if the respondent was shown to be abusing alcohol or drugs or feeling neglected or isolated or angry, they would be the warning signs of an increasing risk. He also considered that future offending would be recurrent but probably not very frequent and that the risk was long-term.

[17] In relation to the PCR overall, Dr Grant considered that the PCR instrument demonstrated a high risk of sexual violence in the future. He considered that a supervision order would be an appropriate means of attempting to manage the risk, but it would need to mandate abstinence from alcohol and drugs and the avoidance of negative social influences might involve placing a curfew on his activities at night at least initially, and that if there was a recurrence of substance abuse, relationship conflicts or emotional collapse, that would indicate increasing risk and the need for intervention.

[18] Dr Grant concluded:

> "Overall Mr Barlow's case using this instrument would indicate that his management requires quite high prioritisation, that there is at least a moderate risk of physical harm to future victims and that intervention should occur immediately after release. There would be a significant risk of general criminality as well as sexual offending risk."[3]

[19] Dr Grant noted that whilst the respondent had undergone treatment of the SOPIM program (which is the Sexual Offending Program for Indigenous Males) and the Getting SMART Program, the outcomes of those courses indicated he only had achieved limited insight and that he required a lot of further assistance. Dr Grant was also concerned that the respondent has continued to deny the sexual offences in 2009 and accordingly has not been able to take full advantage of the SOPIM Program and achieve insights into that offending. Whilst he did complete the substance abuse course, that report indicated he had a long way to go in achieving full insight. It was also noted that he failed to complete the SMART recovery program.

[20] Taking all of that into account in his Report, Dr Grant considered that the respondent has quite a long way to go in terms of coming to terms with his sexual offending and developing strategies to deal with the risk of a reoccurrence. He considered that whilst Mr Barlow could be released under a supervision order which would mandate abstinence from alcohol and drugs and further treatment in the community, he noted that the respondent was currently very suspicious about DPSOA programs and there would be some difficulties in community management. He considered it would be likely that there would be breaches, particularly in terms of substance abuse. He considered however that a diligent application of a supervision order might have the possibility of reducing risk from high down to moderate.

[21] In his Report, Dr Grant also considered that an alternative approach would be to consider the respondent as not yet fully treated and insufficiently insightful to render him safe in the community even under a supervision order. Dr Grant noted that the respondent could be kept in custody to complete a sexual offender maintenance program and also to complete the Pathways Program for substance abuse, which is a more intensive program than the Getting SMART program. He considered that such an approach would hopefully result in the respondent achieving more insights and a clearer relapse prevention plan. Overall, Dr Grant favoured the second approach to properly address risk factors in a more thorough way prior to releasing Mr Barlow into the community. If the respondent was released under a supervision order, Dr Grant considered such an order would need to be in place for 10 years and would require

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[3] Report of Dr Grant of 17 April 2017 dated at p 21.

group programs for sexual offending and substance abuse, and he would require individual therapy over quite a long term to help him deal with his personality disorder.

[22] In his evidence to the Court on the day of the hearing, Dr Grant agreed that once on a supervision order the restrictions can be quite extensive and require curfews, monitoring of a person's whereabouts, including extensive travel restrictions and restrictions on interpersonal relationships, access to the internet and monitoring for the use of substances and alcohol. He noted that they were external restrictions and if a person was determined not to stay within that structure then there were likely to be problems with remaining on the supervision order.

[23] In terms of whether there were any obstacles to Mr Barlow receiving treatment in the community on a supervision order, Dr Grant gave the following evidence:

> "The only obstacle would be if he was to do the Pathways program which I thought would be a good idea because it's a more intensive drug and alcohol program. But if he's seen as not suitable for that then you're left with the Getting Smart – or the recovery program which he dropped out of before, and he would have to complete that in the community and, also, the – the SOMP which he would have to complete as well. And he would have to have the motivation to do that or else he'd be in breach of the order.
>
> Wouldn't it be advantageous to him, though, whilst going through those two programs to have the additional support of a psychologist?---Yes. I think he should have a psychologist right from the start when he gets out of prison."[4]

[24] As to what was required into the future, Dr Grant was referred to Dr Arthur's opinion that there was little utility in continuing to detain the respondent in custody and that he could engage in appropriate treatment in the community, particularly with a trained psychologist. Dr Grant was of the view and considered that the respondent should "show that he has sufficient application and motivation to complete some programs that he hasn't completed yet and [if he] did that in custody, that would demonstrate that he has that degree of motivation. Otherwise he may well get into the community and he is still being resistant to doing those programs."[5]

[25] Dr Grant continued:

> "But I think it would be important for him to have some culturally appropriate counselling especially when he leaves custody to try to help him understand the – the implications of a supervision order and so on and to – and to assist him in understanding it from any cultural viewpoints that might be difficult for him.
>
> What does that look like in practice, Doctor, in terms of is that a psychologist trained with extensive experience in treating and working with indigenous offenders, or do you envisage something more like the involvement of an elder in his treatment program?---I think he's going to need a psychologist who's trained and experienced, and particularly with

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4 Transcript 1-44: 12 – 23.
5 Transcript 1-44: 40 – 44.

> his personality problems then someone does need to be experienced and – and have the skills to deal with someone with those psychopathic traits and so on. He certainly needs that. You're not going to find probably that there's someone who's indigenous who has all the training and experienced at the moment, unfortunately. So he will have a Caucasian or whatever psychologist who's probably very used to dealing with indigenous offenders, but you also need someone from indigenous communities that he trusts at a different level; an elder from his community, or some other person from indigenous culture that can give him just guidance from a – from that viewpoint like, you know, the – the fatherly advice or the – the indigenous elder advice that can be very helpful."[6]

The report of Dr Ken Arthur dated 9 March 2018

[26] Dr Arthur noted that the index offences were a violent and callous attack on two victims with the sexual component described as an act of denigration and contempt. He also considered the respondent used sex as a coping mechanism and that he displayed a tendency to inappropriately sexualise relationships during the SOPIM program. He also considered the respondent fulfilled the criteria for anti-social personality disorder and that he displayed a number of prominent psychopathic personality features. He also has a history of substance abuse which would fulfil the DSM-V criteria of Substance Misuse Disorder, predominately alcohol and cannabis.

[27] Dr Arthur considers that while the respondent had coped reasonably well in the prison environment, he continued to display aggression in order to manipulate his environment and there is a history of interpersonal violence. He considered that during his assessment that the respondent displayed cognitive rigidity, a predisposition towards angry rumination and avoidant coping strategies. He also considered the respondent attempted to control the interview by angry withdrawal, accusing the examiner of being culturally insensitive/ignorant and employing a not-so-subtle hostility and interpersonal aggression.

[28] Dr Arthur also set out the results of his application of the risk assessment tools. On the Static-99R the respondent scored 10 which Dr Arthur considered was an extremely high score. On the PCL-R he had a score of 30 which is consistent with a diagnosis of Psychopathic Personality. On the RSVP Dr Arthur identified a number of significant factors including physical coercion, extreme minimisation and denial, problems with self-awareness, problems with substance abuse, and problems with supervision.

[29] Dr Arthur considered that the respondent displays poor problem solving skills which minimises his sexual pre-occupation. Overall, Dr Arthur considered that the respondent's risk of sexual recidivism was moderate to high and noted that he continued to employ avoidance and denial in relation to his offences, with a low level of self-awareness, denial of risk and inadequate coping strategies. Whilst he noted that the respondent claims to be motivated to maintain abstinence towards alcohol use, he considered it was an ambivalent attitude.

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6 Transcript 1-45: 26 – 45.

[30] Dr Arthur also noted that whilst the respondent identified a number of community supports available to him, including Indigenous based services and various family members, he considered the respondent's pervasive sense of mistrust made it less likely he would access those supports independently. Dr Arthur considered the respondent's main protector factors to be the relationship with his grandfather and the presence of uncles who would assist him on release. Dr Arthur also noted that whilst the respondent also claimed that his partner was committed to a relationship, he considered that the respondent was ambivalent.

[31] Ultimately, whilst he considered that a supervision order may reduce the risk of recidivism, Dr Arthur noted that the respondent's underlying personality disorder would make psychotherapy challenging but that he may benefit from involvement with a skilled therapist. He considered that the respondent should remain abstinent from all drugs, particularly alcohol, and there should be restrictions on his access to licensed premises, and there should be regular urine analysis and breathalyser monitoring. He considered that there should be a monitoring of his intimate and non-intimate relationships, particularly in regard to his association with anti-social peers and his intimate relationships should be closely monitored for any signs of domestic violence. He also considered that the completion of a sex offender maintenance program in the community may assist him in reinforcing aspects of the SOPIM course.

[32] In his evidence at the hearing Dr Arthur gave the following evidence:

> "He was assessed as not requiring the Pathways course, that more intense drug and alcohol course in custody, and instead assessed as eligible for the more – or the less intense course. Would you agree with that assessment?---I – I saw that that was stated, but I didn't actually see the assessment or the basis for that assessment.
>
> No?---So it's hard for me to agree or disagree with it.
>
> It does only appear, as I understand it - - -?---Yes.
>
> - - - in a recent affidavit. But you certainly – your baseline would be that he requires ongoing treatment in relation to drug and alcohol dependency?---I think that Mr Barlow should have ongoing, I suppose, education. It should be reinforced to him how important it is, and I think that the treatment program should be based around that, and also based around alternatives to drug use, which is a core aspect of any substance abuse program. That's going to be an ongoing – ongoing thing, and I imagine that that will be a part of his one-to-one therapy.
>
> Dr Arthur, Mr Barlow nominates his grandfather as being really the most important person in his life. Do you see his grandfather as being a prosocial influence in his life?---I would assume that he is. I don't know. I haven't seen anything in the documentation about his grandfather, his character, his interactions with Mr Barlow. But certainly, from the descriptions I've seen, his grandparents were probably the most supportive people of him. So I would assume so, yes.
>
> And you'd agree, wouldn't you, that isolation, loneliness will be significant risk factors for him in the community?---Yes

> And ideally, if there were suitable family members to live either near or with, ultimately, that would provide a more stable option for Mr Barlow than the precinct or living independently?---I think, in the long term, I would agree with that statement. I think that Mr Barlow's going to need some time transitioning.
>
> Yes?---And certainly, he's going to need some time developing an understanding of the boundaries of the order, and also putting in place strategies that, hopefully, he will learn to manage his risk factors before that would be achievable.
>
> So, Doctor, would you agree that, if he were released on supervision, that the initial stages of that supervision would be essentially a progression towards more independence and being able to return to his family if certain goals were achieved along the way?---I think that's the general terms. It's very hard to comment on that, since that's not something that, as an assessing psychiatrist, I have any say in, or even if I was treating him I would have any say in that. So it really depends on the High Risk Offender Management Unit and how they manage him, yes.
>
> Certainly. I take it, though, you wouldn't support him returning to a family member in the short term?---No.
>
> And that's really because of that need to establish therapeutic relationships? ---I think it's more about boundaries. And as Dr Moyle pointed out, whilst Mr Barlow holds his grandparents and his – some of his uncles in high esteem, that wasn't sufficient for him to – to follow a more prosocial lifestyle. So I think that that relationship isn't strong enough to modify his behaviour at this point.
>
> Those observations though, Dr Arthur, you'd agree are of a man who really – this is now 10 years in the past for him, that behaviour, and that reaction to interpersonal relationships; do you agree with that?---Yes, it was 10 years ago. I suppose there's arguments to be made about maturation in jail and whether true maturation occurs, or whether we are just deferring development. Jail is not the real world, and so the relationships in jail are quite different. So we don't know. You don't know how Mr Barlow will cope emotionally when he's released, and I think we need to be very cautious about that."[7]

The report of Dr Robert Moyle dated 14 April 2018

[33] Dr Moyle also considered that the respondent has an anti-social personality disorder with psychopathic traits, and a substance misuse disorder. He noted that the respondent was an Indigenous man with a low intellect and poor educational achievement. Dr Moyle considered that clinically the respondent posed a high risk of returning to a drug and solvent abusing lifestyle when he chose to do so, taking what he wants when he feels he needs it "including sexual acts, without pausing to resist when free in the

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[7] Transcript 1-34 – 35: 30 – 45; 1 – 44.

community, if he does not accept the advice and counselling of Officers. He is at high risk of re-offending."[8]

[34] Whilst also noting the limits of the actuarial risk assessments in Indigenous populations, Dr Moyle applied the risk assessments to the respondent and stated that on the PCL-R he scored 31, which placed him in the range of psychopathy. On the STATIC 99-R, he rated at 10, which was well above the risk of sexual reoffending. On the VRAG, he scored 8, which showed 3 to 4 out of 5 in relation to risk of sexual reoffending. In relation to the Sex Offender Risk Appraisal Guide (SORAG), he rated at a high risk. In relation to the HCR-20, he was a high risk of violent reoffending and on the SVR-20, he was a high risk of sexual reoffending.

[35] In terms of the violence risk scale, Dr Moyle stated that the respondent rates highly on violent lifestyle, criminal personality and attitudes, criminal peers, interpersonal aggression, emotional control, violence during incarceration, substance use, instability of relationships, release to high-risk situations, violent cycle, impulsivity, cognitive distortions and non-compliance with supervision. On the other items he rated variably, leading to a conclusion that combined with high-static risk factors, he was at a high risk of reoffending violently.

[36] In relation to the STABLE risk assessment, Dr Moyle's view was that whilst the respondent rated somewhat on the relative paucity of significant social influences, he rated significantly on intimacy, deficits to sexual self-regulation, cooperation with supervision and general self-regulation. He considered therefore that those factors placed him at high risk of reoffending if those issues were not dealt with in the therapeutic program. He did consider however that he had gained somewhat in his ability to walk away from stressful situations which was to be commended.

[37] In relation to the RSVP, Dr Moyle noted that, like the SVR-20, the respondent rated on a number of the factors in relation to this protocol, particularly sexual violence, diversity of sexual violence, escalation of sexual violence, physical coercion and sexual violence, as well as minimisation and denial of sexual violence and attitude supporting or condoning sexual violence. He also referred to the problems the respondent had in coping with stress as well as his psychopathic traits, substance use, problems in relationships, problems with employment, problems with planning treatment, and supervision. He concluded:

> "The likely scenario if released back to the same environment and the same circumstances, free to do as he wishes, would be that he would follow his peers rather than the wise counsel of his grandfather, supervisors or therapists, as he wishes to belong and fit in and, when the opportunity arises, will ignore restrictions on his use of alcohol and drugs and solvents and, when intoxicated, if aroused, he is likely to approach people who are alone or vulnerable – e.g. victims of others' violence – and engage in sexual violence if the opportunity arose or if he felt aroused."[9]

[38] Accordingly, Dr Moyle considered the risk on release would increase and the respondent would need close supervision and monitoring. His view was that reoffending

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8 Report of Dr Moyle dated 14 April 2018 at [122].
9 Report of Dr Moyle dated 14 April 2018 at [140].

is considered to be the most likely scenario unless the respondent can actively engage in programs to learn, not only that he has vulnerabilities, but how to manage them and show that he can retain information when the situation calls for it. Dr Moyle also considered that if released the respondent would need close monitoring with urine tests and blood tests, monitoring of his associations with criminal peers or children and that he should be subject to a curfew and required to attend programs including a sex offender maintenance program, Alcoholics Anonymous, and other alcohol and drug services, and in the community, substance abuse maintenance programs are available where he would be counselled by experienced forensic psychologists.

[39] Dr Moyle also considered his risk would be lowered if he could form attachments to religious elders of the Aboriginal and Torres Strait Islander community who might help him understand his chosen moral code and how he can live by that code without relapsing by using violence to express himself when frustrated or irritated.

[40] In relation to the Structured Assessment of Protective Factors for Violence (SAPROV) Dr Moyle noted that the respondent only rated 2 out of 8 on this factor which is a low score. He considered that overall, if anything, the risk would be worse rather than better based on protective factors. Dr Moyle considered that in custody over 8 years, the respondent has learnt to walk away from confronting situations. He also noted that whilst the respondent has re-acquainted with an older female acquaintance, he is not committed to a relationship with her. Dr Moyle noted that the respondent presents as powerfully self-interested with little thought of others' rights. He continued:

> "Sadly, he wishes to do his time and get out without restrictions on his freedom, does not see the need to complete the programs in custody on sexual offending and substance use, and has actively avoided doing so and, when he did attend preliminary programs, he had limited engagement, and conflict with others resulting [sic] in poor emotional control and impulsive behaviours. Irrespective of the rules, even in custody, he breaches minor rules in a minor way apart from offender-on-offender violent acts. These include tattooing when he is not allowed, putting up barriers to officers seeing in his cell when he is not allowed, getting frustrated with the instructions of assistants in the workplace resulting in loss of jobs, and general difficulties some of the time in meeting the requirements of the prison system and the prison officers."[10]

[41] Ultimately, Dr Moyle considered the risk of reoffending is high if the respondent is released from custody prior to completing the sex offender maintenance program and the next level of substance abuse programs, and fully engaging in trying to learn how to modify his behaviours to give him a greater chance of surviving in the world outside of prison. Dr Moyle considered that the respondent's level of risk of sexual recidivism on release is high.

[42] Dr Moyle noted that on the respondent's Parole Application dated 20 August 2017 there was a reference to the fact that the respondent has had three episodes of jail. The first was in 2004 where probation was revoked and in 2005 when parole was revoked. He was released on 14 November 2008 but returned to custody on 20 February 2009 in relation to the index offences. Dr Moyle considered that the respondent's current plans

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[10] Report of Dr Moyle dated 14 April 2018 at [150].

for release are "little different from the plans for release from prior imprisonments."[11] That application also referred to the fact that the respondent had not done the Transition program and had poor involvement in the Sex Offender and Alcohol Programs.

[43] Dr Moyle gave further evidence at the hearing in this regard as follows:

> "Okay. And you were talking there about programs you see that he still needs to complete, so there's – and from your report. You talk about the sex offender maintenance program?---Yes.
>
> And should he do that in custody? Why would that need to be done in custody?---I think he – he – he needs to have a very clear acceptance of his risk of sexual offending and a – a clear strategy on how to manage that risk, more than just simply saying he's not going to do it any more, or he's going to tell friends to go away. He needs to be able to show that he can control his behaviour. He need to develop a – release plan that specifically mentions his intention to adhere to the orders. He needs to develop a release plan that targets his emotional difficulties, that – that identifies key [indistinct] in his environment [indistinct] he can plan and develop strategies around who will intervene on his behalf when his risk factors look like they're going to increase and will guide him and advise him. All of that can come out of the program. And he needs to have strategies on [indistinct] that will allow him to reliably prevent himself from becoming emotionally distressed, feeling emasculated and manage – manage those sorts of feelings that he gets whenever people challenge him, which is [indistinct] which are high risk factors. And all of that will be tackled in the program and in his abstaining from drugs and alcohol and know how he's going to do that and know which support he's going to call on when he leaves.
>
> And from what you've just said, that supports your statement in the – your report that he also needs to undergo an alcohol and substance abuse program?
> ---Yes.
>
> Does he require to enter into a form of individual treatment as well?---Yes.
>
> And should that be commenced before he is released from custody?---I believe so. I think it'd be more likely to be successful if he is already introduced to the person who's going to see him on the outside prior to his release [indistinct] develop prior to his release a – a good transition plan or release plan together that involves regular attendance at [indistinct] any emotions that he feels are – are distressing him at the time can be discussed with a – a suitable mental health professional who is experienced with male, especially aggressive male, offenders."[12]

Other material

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[11] Report of Dr Moyle dated 14 April 2018 at [152].
[12] Transcript 1-9: 10 – 42.

[44] The respondent is currently incarcerated in the Lotus Glen Correctional facility and his Prison History records that he has had multiple breaches for behaviour including fighting with other prisoners, using offensive language to prison officers and getting tattoos. His employment has been terminated on a number of occasions due to poor behaviour.

[45] The affidavit of Claire Foster dated 9 November 2017[13] referred to the respondent's involvement in the SOPIM Program which noted that his engagement and motivation fluctuated significantly and involved periods of abstinence from the program. It was noted that his version of the index offences "differed significantly"[14] from the sentencing transcript. I also note in this regard that Dr Arthur considered that whilst the respondent had an intellectual understanding of problematic behaviour which indicated a high sex drive, he did not have an ability "to assess his own risk of sexual preoccupation or strategies to mitigate this risk should it present again on release into the community."[15]

[46] The affidavit of Katherine McKinnon sworn 24 April 2018[16] stated that the Staying on Track Sexual Offending Maintenance Program (SOMP) was a 13 week program which was available to offenders who had previously completed an intensive sexual offending program with the next course due to commence between July and December 2018. The SOMP was also offered in the community but the next course in Townsville would not commence until January 2019 and would run until June 2019. Her evidence was that the Pathways High Intensity Substance Abuse Program is only offered in custody and that the respondent has not been identified as someone who currently met the criteria. The Low Intensity Program was however offered and was available across the state.

[47] The respondent's current plans are to live with his grandfather on his release but a suitability assessment has not yet been completed. The affidavit of Jolene Monson sworn 24 April 2018[17] states that in the event that no suitable accommodation is proposed the respondent will be housed in QCS contingency accommodation on a temporary basis. Such accommodation however does not provide intensive personal support and does not include escorted leave.[18]

Is the respondent a serious danger to the community in the absence of a Division 3 Order?

[48] Having considered the extensive evidence before me and taking into account the required matters in s 13 of the Act, I am satisfied to a high degree of probability that there is acceptable, cogent evidence that the respondent is a serious danger to the community in the absence of a Division 3 order. There is no doubt that the evidence before me indicates that the respondent is a serious danger to the community in the absence of a Division 3 order. I am satisfied that there is an unacceptable risk that the respondent will commit a serious sexual offence if released without a Division 3 order.

Should the respondent be released subject to a supervision order?

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13 Court Document 9.
14 Affidavit of Claire Foster dated 9 November 2017 (Court Document 9) at p 2 of "CF-1".
15 Report of Dr Arthur dated 9 March 2018 at [179].
16 Court Document 22.
17 Court Document 23.
18 Court Document 23 at [11] – [15].

[49] The real issue in this case is whether the Division 3 order should be a supervision order or whether the respondent is required to be subject to a continuing detention order for treatment, care or control. The paramount consideration is of course the adequate protection of the community.

[50] I accept the submissions of Counsel that there is, under the Act, a preference for a supervision order over a continuing detention order and I endorse the view of Chesterman JA in *A-G (Qld) v Lawrence*[19] that in cases where the Attorney-General contends that the community will not be adequately protected by a prisoner's release on supervision, the burden of proving that contention is on the Attorney. The exceptional restriction on the prisoner's liberty, after having served the whole of whatever imprisonment was imposed for the crimes they committed, and for the protection of the public only, should not be imposed unless the inadequacy of a supervision order is demonstrated. There is no doubt that the liberty of the subject and the wider public interest are best protected by insisting that the Attorney-General as applicant discharges the burden of proving that only a continuing detention order will provide adequate protection to the community.

[51] In this case however Counsel for the applicant argues that the applicant has discharged this burden and submits that the court would not be satisfied that the adequate protection of the community could not be ensured without, or that the adequate protection of the community can be reasonably and practicably protected by, a supervision order. Counsel in particular argued, in the further written submissions filed on 4 May 2018, that all of the psychiatrists were of the same view that the respondent has poor insight into his offending and that he is only just beginning to come to terms with understanding what will assist him to remain offence free in the community. Counsel referred to the respondent's level of psychopathy and argued that the evidence also indicates that the respondent does not have the right mindset as yet to "cope with a supervision order or to benefit from it… [and has] limited knowledge gained from undertaking programs to date".[20]

[52] Counsel for the respondent however argues that the recent assessment by Queensland Corrective Services is that the respondent "has not been identified as having a high level of needs in the area of substance abuse"[21] and as such, did not currently meet the criteria to be waitlisted for the Pathways Program. Counsel also argued that whilst the rationale for that assessment was not provided, none of the psychiatrists seriously challenged it, or maintained that the only appropriate course was the Pathways Program. Accordingly the Low Intensity Substance Intervention program could be completed by the respondent in the community as it is in fact offered in the community and does not have a formal waitlist.

[53] Counsel for the respondent also referred to the fact that that all the psychiatrists nominated the respondent's denial of the index offending as a problematic aspect of his presentation as it presented difficulties in organising effective treatment for him. Counsel noted however that in relation to the denial of the index offending, the evidence before the court was that denial of offending is not targeted by treatment programs offered in custody. Dr Moyle agreed in cross-examination that the respondent's denial

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19 [2009] QCA 136.
20 Applicant's Further Written Submissions dated 4 May 2018 at [12].
21 Respondent's Further Written Submissions dated 4 May 2018 at [8].

of offending would be best addressed in a one-one-one setting in a culturally appropriate therapeutic relationship. Dr Grant also agreed that denial of offending was not targeted in programs run in a correctional setting. While he was less convinced of the benefits of individual therapy, he did agree that culturally appropriate counselling should be part of the respondent's treatment. Dr Arthur was also of the view that individual counselling should be a part of the respondent's treatment. In this regard Counsel for the respondent relied in particular on Dr Arthur's evidence that the respondent's future progress could be curtailed if he were to be detained further because of feelings of frustration and that his engagement would therefore be poor.

[54] Counsel also argued that the reliability of the risk assessment tools was questionable and submitted that the court should approach with some caution the findings of the testing carried out using instruments which are as yet untested on Indigenous Australians. Whilst Counsel acknowledged that all psychiatrists were able to point to other aspects of their assessment process from which they felt they could appropriately predict the risk posed by the respondent, it was submitted the court should adopt a cautious approach in relation to the weight to be given to the tools.

[55] Ultimately, Counsel for the respondent submitted:

> "The respondent does not submit that the lack of culturally appropriate risk assessment tools completely negates the reliability of psychiatric evidence in this case. Rather the respondent points to the weight which can properly be given to the results derived by those risk assessment tools, and the inevitable impact they have on the assessment process and outcomes. The formal risk assessment tools, including the psychopathy checklist, are an integral part of the evidence presented to the court in order to justify the ongoing detention of an individual who has served his entire sentence and would otherwise be entitled to his freedom.
>
> It is respectfully submitted that the court could not be satisfied to the standard required that the respondent posed such a high risk to the community that he should be detained indefinitely. The extraordinary restrictions placed on an individual's liberty by a supervision order of the type proposed in this case provide the very highest level of supervision and control outside of a custodial environment, and can even mimic a custodial environment in instances where a 24 hour curfew is imposed. It is submitted that after his limited progress in custody, release on supervision would provide the respondent with the ability to engage in more meaningful and effective treatment which will ultimately benefit both him and the community."[22]

[56] I accept that the evidence indicates that the respondent is still a relatively young offender who is currently serving his first period of actual imprisonment, as opposed to youth detention, for sexual offences. The offending however clearly involved unprovoked attacks at night by the respondent and his family members upon two women who were total strangers to him. There is no doubt that one of the victims was subject to sustained violence. Furthermore, the respondent continues to deny that he sexually assaulted the victims.

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[22] Respondent's Further Written Submissions dated 4 May 2018 at [11] – [12].

[57] Whilst the respondent has undergone the SOPIM and Getting Smart programs the outcomes of those programs indicate he has only gained limited insight into his offending and that he requires further assistance and intervention. I also note that he left the SOPIM program after only six sessions. In this regard I note Dr Grant's reference in his oral evidence at the hearing that "some of the research says that if people opt-out and don't complete a course or program, a sexual offender program in particular then, in fact, their risk for reoffending is higher than if they hadn't even started that course."[23] He concluded that the fact that the respondent had dropped out of the Getting Smart Recovery Program and the SOPIM was not a "good prognostic sign in terms of future cooperation or even future reoffending."[24]

[58] I also consider it to be significant that all three psychiatrists are of the view that the respondent has gained little insight or that the benefits have been equivocal from the programs he has already undertaken and that he requires further treatment. All the psychiatrists recommend that the respondent undertake group programs and individual therapy to address the level of risk of sexual reoffending. The recommendations are that the respondent undertake the SOMP and a substance abuse program as stated in each of the risk assessment reports.

[59] Dr Moyle gave evidence that not only should the SOMP, a substance abuse program and individual therapy be undertaken by the respondent but that the SOMP should be completed in custody. Dr Grant also confirmed his view that it would be preferable that the programs should be undertaken prior to release and that the completion of such programs in custody would demonstrate motivation to address the respondent's outstanding issues. Whilst Dr Arthur also recommends that the respondent undertake the SOMP and a substance abuse program, he considers the programs could be undertaken in the community.

[60] All the psychiatrists gave evidence that the respondent could benefit from individual therapy. Dr Moyle stated that the respondent would benefit from individual treatment, which ideally would be commenced in custody. He considered that individual therapy could also assist the respondent with his participation in the group programs. Dr Arthur stated that one on one therapy is "absolutely necessary"[25] and that it would be of benefit if it were to commence in custody. Dr Grant also considered that individual therapy would be of assistance to the respondent and that individual counselling had been beneficial for the respondent in the past to assist with programs and further acknowledged that individual treatment is able to be provided while in custody. Dr Grant maintained his view however that he did not believe the respondent needed such therapy while still in custody when other options such as programs was available. Whilst it would be optimal for the same counsellor to be involved in treatment prior to release into the community and in the community that was unlikely to occur.

[61] All the psychiatrists concur that the respondent has an anti-social personality disorder with prominent psychopathic personality traits. Dr Grant is of the view it reaches a diagnosis of psychopathic personality disorder and substance misuse disorder, both of which are significant risk factors for the respondent's risk of sexually reoffending.

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[23] Transcript 1-45: 13-15.
[24] Transcript 1-45: 17-18.
[25] Transcript 1-28: 8.

[62] I have considered Counsel for the respondent's arguments in relation to the fact that the risk assessment instruments are not normed against an Australian Aboriginal population and I accept that some caution has to be applied to the use of such instruments. I note however that the reports of all three psychiatrists specifically acknowledge that limitation and the evidence of all the psychiatrists was that their clinical judgment was based on a number of factors including a structured risk assessments but that a very significant factor was their clinical assessment. In this regard Dr Grant and Dr Moyle assess the respondent's level of sexual reoffending as high if no order is made. Dr Moyle is of the view that the risk is high if he is released without undertaking further treatment programs in custody for both sexual offending and substance abuse. Dr Arthur considers the level of risk as moderate to high.

[63] In my view given the level of risk which has been identified in the reports, the lack of appropriate engagement by the respondent in the programs and the limited insight he currently has into his offending behaviour, the most likely scenario on release is that he would breach the order. I also note that Dr Moyle's concerns is that the respondent would reoffend early on his release as he has done in the past. The index offences occurred shortly after his release on parole and even in custody he has been unable to conform, breaches rules and has engaged in violent confrontations. He has generally been unable to cope with the prison rules and restrictions. The evidence indicates that the respondent's view is that he should be able to be released from custody without any restrictions and return to his family. The evidence also indicates that he has poor emotional control and gets into conflict with others. In the present circumstances, given the respondent's current risk assessments and the evidence of his lack of insight and inability to cope with rules and restrictions, I cannot be satisfied that the adequate protection of the community can be ensured by the making of a supervision order in the terms proposed, even though they would include curfews, restrictions on his movements and testing for substances.

[64] I note that the programs which are proposed can be undertaken between now and the first annual review and in this regard the recommendations by the psychiatrists that he receive individual counselling to assist him to successfully engage in and complete those programs should be considered. I also note in particular the recommendation that the psychologist who is engaged should be a professional who is trained and experienced in dealing with someone who has the respondent's personality problems and his psychopathic traits. Dr Grant also considered that that it would be beneficial for him to have advice and guidance from an Indigenous elder. There can be no doubt that the respondent's successful engagement in the programs would show a significant change in his motivation not to reoffend.

Orders

[65] I am satisfied that the respondent is a serious danger to the community in the absence of a Division 3 order under the Act and that he should be detained indefinitely for control, care or treatment pursuant to s 13(5)(a) of the Act.