CITATION:	*R v JW (No 2)* [2017] NTSC 85
PARTIES:	THE QUEEN
	v
	JW
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	21236570
DELIVERED ON:	30 November 2017
DELIVERED AT:	DARWIN
HEARING DATES:	26 October 2017 and 30 November 2017
JUDGMENT OF:	HILEY J

CATCHWORDS:

CRIMINAL LAW – Mental impairment - Part IIA *Criminal Code* (NT) – Periodic review of supervision order - No longer satisfied on the evidence available that the safety of the supervised person or the public will be seriously at risk if the supervised person is released on a non-custodial supervision order with appropriate conditions – Custodial supervision order revoked – Non custodial supervision order with conditions made

R v JW [2013] NTSC 80, *R v KMD* [2015] NTSC 31, referred to

Criminal Code (NT) s 43ZG, s43ZH, s 43ZM, 43ZN

REPRESENTATION:

Counsel:

Crown:	S Ledek with C Dixon
Defendant:	B Wild
Department of Health:	R Brebner with E Roussos

Solicitors:

Crown:	Office of the Director of Public Prosecutions
Defendant:	Northern Australian Aboriginal Justice Agency
Department of Health:	Solicitor for the Northern Territory

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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

R v JW (No 2) [2017] NTSC 85
No. 21236570

BETWEEN:

THE QUEEN

AND:

JW

CORAM: HILEY J

REASONS FOR JUDGMENT

(Delivered 30 November 2017)

Introduction

[1] Following the periodic review commenced on 26 October 2017, I am no longer "satisfied on the evidence available that the safety of [JW] or the public will be seriously at risk if [JW] is released on a non-custodial supervision order (**NCSO**)" with appropriate conditions.

[2] Because this conclusion is contrary to the contentions made on behalf of the CEOs and the DPP, and to the position reached following the major review, it is appropriate that I provide my reasons for now being unable to reach that state of satisfaction.

Original orders made 2 December 2013

[3] On 2 December 2013 I made a Custodial Supervision Order (**CSO**) following the Court's finding that JW was not guilty of 2 offences committed on 8 September 2012, the more serious of which was causing damage to a building by using fire. I will refer to this as **the index offending**. On 19 December 2013, I provided my reasons for making that order and fixed a term of four years imprisonment for the purposes of s 43ZG.[1]

[4] JW had a history of schizophrenia dating back to 2000 when he was 18 years old. He was treated with antipsychotic medication for about two years but subsequently went undiagnosed and untreated until late 2012. In other words, at the time that he set fire to the building in September 2012, he had remained untreated for some 12 years.

[5] It seems likely that JW's untreated mental condition was also a contributing factor in his earlier offending in 2011 and January 2012. That offending involved stealing, damaging property, trespass and burglary. He had been released from prison for the January 2012 offending, only a few months before the index offending.

[6] I observed in my reasons of 19 December 2013, that forensic psychiatrist Dr Smith was particularly concerned about JW's ongoing failures to take his medication. As I said at [6] of my reasons:

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1 *R v JW* [2013] NTSC 80.

In his report of 22 August 2013 Dr Smith noted some noticeable deterioration in JW's mental state as a result of him not taking his medication. However, on the last two occasions when Dr Smith saw JW he was more settled and no longer appeared threatening and he indicated that he would continue to take his medication. Dr Smith expressed a number of concerns about JW's ongoing condition, including that "JW is a person of high intelligence who could pose a very high level of risk to the community if [he] goes untreated." He said, "Because of the difficulties experienced in medicating him recently it is only possible to recommend custodial supervision for JW at this stage." He also said:

"In my opinion Mr W shows no signs of being willing to comply with the essential conditions of a Non Custodial Supervision Order. He would be very likely to leave the NT as soon as possible, just as he was attempting to do when arrested at Darwin Airport. He would then become untreated and this would result in an unacceptably high level of risk to the community."

(underlining added by me)

[7] Dr Smith also made the following recommendations:

9.1 A Custodial Supervision Order with custody at DCC is recommended for Mr W.

9.2 Mr W must be obliged to accept the medications recommended for treating his mental illness by FMHS. If he refuses his depot medication it is recommended that authorisation be given for his transfer by prison officers to an approved mental health facility (JRU) for his injection to be given. It is not recommended that Mr W be forced to have depot medication given at DCC, as it must be clear to him that this is a Health issue rather than a Justice issue.

9.3 Mr W must be obliged to accept regular reviews by FMHS and he must be willing to accept counselling and psycho-education as considered appropriate. Mr W must cooperate with any medical investigations required.

> Mr W must be willing to report any concerns he has about the verbal behaviour of other prisoners to FMHS, rather than act on them in an aggressive manner.
>
> 9.4 Mr W must do everything in his power to achieve a lower security rating and obtain a job in the prison."
>
> (underlining added by me)

Major Review – s 43ZG

Hearing 24 November 2016

[8] In his report of 7 November 2016 Dr Kini said that, despite JW's significant progress, he did not consider that JW was ready to be released from custody under the auspices of a non-custodial supervision order. He said, at [7.3]:

> In my view JW needs to engage in further psychological work and his risk and ability to cope with stress needs to be tested out incrementally before an application for his release on an NCSO is made. These measures are aimed at improving his insight, compliance and engagement in his care plan. In my opinion, if the CSO is revoked at the present time JW is likely to pose a serious risk of serious harm to others or himself even if he is subject to a NCSO.
>
> (underlining added by me)

[9] Dr Kini stressed that there had been significant improvement in JW's presentation over the previous 12 months, largely because the CSO was pivotal to his compliance with treatment, his care plan and his engagement with the treating team. Notwithstanding that, he expressed the opinion quoted above.

[10] He recommended a number of matters that should be undertaken over the following 12 months with a view to transitioning JW to a NCSO. These included:

(a) JW continuing to take his medication and continuing to acknowledge the importance of compliance;

(b) JW undertaking work or voluntary activity within the Darwin Correctional Centre (**DCC**) environment;

(c) JW gaining a better understanding and acknowledgement of his psychiatric condition and of the need to identify early warning signs of any return of symptoms;

(d) JW continuing to participate in the rehabilitation programs and psychological interventions including the Safe Sober Strong (**SSS**) program and a violence reduction program;

(e) Accompanied and supervised day release excursions to enable him to re-familiarise himself with general community activities;

(f) a further transition plan permitting overnight stays away from DCC, ideally in supported accommodation with 24 hours staffing supervision;

(g) immediate containment within the Complex Behavioural Unit (**CBU**) in the event of any return of positive symptoms of his illness.

[11] Dr Kini anticipated that the next transition phase, ideally scheduled to commence in 6 to 12 months' time, would occur within the confines of a CSO, with JW gradually spending increasing periods of time away from the DCC, with the Superintendent's prior permission. The day release aspect would continue for between 6 and 12 months before consideration should be given to an NCSO. He said, at [7.24]:

> This is contingent upon JW meeting all requirements of the transition, and continuing to maintaining stable mental health.

[12] He concluded his report by saying, at [7.25]:

> In terms of prognosis, in my opinion, JW is likely to have this illness (schizophrenia) in the long term. If he continues to remain compliant with treatment (including abstinence from alcohol and drugs) and engage with professionals involved in supervising and facilitating his care, his illness is likely to be stable, despite the likelihood of him having ongoing residual negative symptoms. When JW's illness is stable, in my opinion, his potential risk to himself and others is low.

[13] Consultant Psychiatrist Dr Walton examined JW and provided a report dated 21 November 2016. He recorded that JW said that he now unreservedly accepts the diagnosis of schizophrenia and that he requires ongoing treatment which is beneficial, despite it having some undesirable side effects. Dr Walton said there was no current evidence of acute psychosis. He said, at p 5:

> JW does now seem to have insight into the fact that he is suffering from a chronic mental illness and he speaks appreciatively of the treatment he is receiving with which he is willingly compliant.

[14] He said, at p 5:

> I am inclined to agree with Dr Kini that while the progress in recent times has been quite favourable, that outcome has only been relatively recently achieved and I believe it is a little premature to commence the process of returning JW to the community in the immediate future. However, I note that Dr Kini has the view that that particular question should be revisited in 6 months and if the progress in the interim has continued to be satisfactory, then progressive day release might then commence. That seems to be a thoroughly sensible plan of treatment and rehabilitation with which I agree.
>
> … I believe it is a little premature at this point to be considering actually accommodating JW in the community. There needs to be a programme of progressive day release prior to that.

[15] Importantly, Dr Walton did not disagree with the opinions expressed by Dr Kini in [7.3] of his report to the effect that there would be a serious risk to the safety of JW or the public if JW was released from the supervision order.

[16] Prior to the hearing on 24 November 2016, JW's counsel provided an affidavit from Philip Carroll and written submissions. Mr Carroll was employed by the Northern Australian Aboriginal Justice Agency (**NAAJA**) in a disability support worker role. He identified accommodation and health services and volunteer work that could be available to JW.

[17] Counsel contended that, notwithstanding the opinions expressed by Dr Kini and apparently agreed to by Dr Walton, the Court should not consider that the safety of JW or the public would be likely to be

seriously at risk if JW was released. Accordingly JW should be released unconditionally from supervision. She referred to s 43ZG(6) and the principle in s 43ZM that "restrictions on a supervised person's freedom and personal autonomy are to be kept to the minimum that is consistent with maintaining and protecting the safety of the community."

[18] Counsel contended, in the alternative, that if the Court considered that his unconditional release would place JW or the public at serious risk, then the Court should consider whether he should be released on a NCSO.

[19] At the hearing on 24 November 2016 I agreed with counsel for the CEOs that both specialists appeared to have similar opinions, to the effect that there was still a serious risk to safety in the event that JW was released from supervision. Counsel for JW indicated that she would have liked to have had the opportunity of asking questions of Dr Kini about his opinion concerning the risks of JW being released. I adjourned the major review to enable the parties to obtain and provide more evidence directed to whether JW could be released on a NCSO and if so under what conditions.

Hearing 13 February 2017

[20] The matter was further mentioned on 13 February 2017. By then the Court had been provided with an Individual Care Plan dated

16 December 2016, a CBU Transition Plan dated January 2017 and a further report of Dr Kini dated 10 February 2017 which updated his previous report of 7 November 2016.

[21] Dr Kini said that:

(a) JW's mental health had continued to be stable over the past three months and that he has complied with his psychiatric medication;

(b) JW had had six consultations with Mr Casey, a psychologist, during which time he did not present with overt psychotic symptoms. He expressed interest in his future including volunteering, education and employment;

(c) he had completed workshops and programs including an "Alternative to violence program", 11 anger management sessions on an individual basis, and an alcohol and other drugs course. He was on a waiting list to do the SSS program and was being assessed for eligibility to the Violent Offender Treatment Program (**VOTP**) scheduled to commence in July.

[22] Dr Kini stated that the opinion and recommendations contained in his report of 7 November 2016 essentially remained unchanged. JW was not yet at the stage where he could recommend his release from custody under the auspices of a NCSO. He recommended that he:

(a) complete the SSS program and any further psychological work found suitable;

(b) engage in work initially in the CBU eventually culminating in work placements external to DCC;

(c) continue complying with pharmacological treatment and participate in therapeutic interventions.

[23] Importantly he repeated his opinion (at [5.3]) that "if the CSO is revoked or varied to a NCSO at the present time, JW is likely to pose a serious risk of serious harm to himself or others." (underlining added by me). Dr Kini also agreed with a graded approach to JW's reintegration into the community along the lines of the CBU Transition Plan of January 2017.

[24] Counsel for JW indicated that she wished to question a number of people including the manager of the CBU and also a psychologist at the prison who was working closely with JW. Concern was also expressed about the fact that JW's medium security rating would render it difficult for JW to undertake work at DCC outside the wire and thus to satisfy that part of the proposed Transition Plan. The matter was listed for further hearing on 12 April 2017.

Hearing 12 April 2017

[25] The only additional material obtained prior to this hearing was a report of 11 April 2014 from Ms Michell, Residential Manager, at CBU. That report indicated a number of things including that JW:

(a) was engaging well in his usual CBU activities, was attending a number of programs and participating in various health and recreation activities;

(b) had been downgraded to a low security classification on 9 March and there had been no incidents since that downgrading;

(c) successfully completed the 15 Module SSS program;

(d) was currently in the process of being assessed for suitability for admission to the VOTP, which would be a six-month program due to start 18 July 2017;

(e) was attempting to improve his education levels and was keen to enrol in a university course;

(f) was employed as the CBU librarian;

(g) was at stage IV of the Transition Plan which involved him participating in work outside of the DCC fence - both suitable options were still being explored;

(h) contact with Top End Mental Health Service (**TEMHS**) clinicians was continuing in accordance with the Individual Care Claim.

[26] At the hearing on 12 April 2017 counsel for JW indicated that she had decided not to cross-examine Ms Michell or Dr Kini in the major review proceeding.

[27] Counsel acknowledged that the violent offender treatment program was yet to occur and that JW's risk profile may be altered as a result of proceeding through that program. However counsel submitted that that program is more directed at recidivist violent offenders and was of little relevance to JW's risk profile. She pointed out that Dr Kini's concerns were more based on JW's apparent non-acceptance of his mental illness, and the risk of him not engaging in treatment and medication for his illness. Counsel also pointed out that JW is not a recidivist violent offender. Rather he is a man who had a psychotic illness and committed a single violent offence some five years ago.

[28] Counsel suggested that the Court set the matter down for a periodic review in about six months' time during which time the CEOs should give greater consideration to transitional housing, thus placing the Court in a better position to assess the kind of conditions that might attach to a NCSO.

[29] Counsel for the CEOs pointed out that the practical or clinical issue in this matter is essentially one of engagement and insight. Counsel acknowledged that JW's insight has developed very well with the

assistance of the TEMHS, but contended that there is still some way to go.

[30] I confirmed the CSO and set the matter down for periodic review on 23 October 2017.

Periodic Review

[31] Subsequent to the April hearing:

(a) Dr Kini saw JW on 1 June 2017. Dr Kini noted that JW's mental state was stable without any aggression or violence, and there was no evidence of psychotic symptoms, although he had some other unspecified negative symptoms.

(b) Dr Das took over JW's care from Dr Kini. He provided a detailed report dated 5 October 2017. Dr Das first saw JW on 19 June. JW presented as pleasant and cooperative, and spoke about his desires to gain employment, study, and travel to visit family in WA. Dr Das and JW discussed JW's Transition Plan and stepdown options. They also discussed changes that could be made to his medication to reduce some side-effects that JW was experiencing.

(c) Dr Das saw him again on 12 July. Apart from getting angry when his then case manager, Simon Peters, raised some of the conditions of his CSO, JW appeared to have related well to

Dr Das. Dr Das could not elicit any psychotic symptoms.

However:

> His insight and understanding into his difficulties remained limited. Whilst he accepted that he has a history of offending and a mental illness, he minimised this to a large extent and rationalised for his problems.[2]

Dr Das said JW was happy with the medication plan. They discussed the process of JW moving to an NCSO and the need for JW to continue to engage in rehabilitation work. JW said that "[he knew] everything" and "what to do".

(d) The last time Dr Das saw JW was on 27 September 2017. This was with his new case manager and an aboriginal mental health worker. Dr Das said:

> He was cooperative during the interview and we did not note any oddities in behaviour, and he had normal activity levels. He presented as euthymic in mood and reported feeling fine. I could not elicit any psychotic symptoms, or depressive ideas or ideas of self-harm.[3]

They discussed his current activity programs and his plans for the future. JW maintained that he no longer poses a risk to others, and that he has benefitted from discussions about his risk behaviours and difficulties that led to the CSO with his case managers over the years.

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[2] [5.10].
[3] [5.16].

They discussed numerous other issues including a gradual stepdown program for progression to Non-Custodial conditions, preceded by a work program such as working in the laundry outside the wire and day release programs.

Dr Das also explained to JW that if he was released on a NCSO he would be subject to strict conditions. He said JW was agreeable to this.

(e) Dr Das subsequently had discussions with JW's case manager. The case manager formulated a step-down plan in preparation for a recommendation for a NCSO in 6 to 12 months' time. JW has been accepted for work in the prison laundry, which is in a less secure area of the prison. He commenced work there on 9 October.

(f) The next stage of his transition towards an NCSO is supervised day trips out of prison. The first day trip was to occur on 27 October, followed by further day trips on 8 and 23 November. If uneventful and successful they would be increased to occur once a week. A major purpose of these activities would be to gradually expose JW to outside life, including stressors that might arise, and enable the mental health team to better assess his progress.

(g) JW has also been assessed for suitability to live in housing under TEAM Health supervision.

[32] Dr Das expressed a number of opinions and recommendations in his report of 5 October 2017. At [6.1]:

> JW has a history of a psychotic illness diagnosed as schizophrenia. He has presented with significant positive psychotic symptoms in the past as a result of this. However, his illness has been controlled with ongoing medication and in the last year, he has not manifested any positive psychotic symptoms such as delusions. It is likely he presents with some negative symptoms such as lack of motivation and restriction is his affect. He had also presented with depressive symptoms in the context of his schizophrenia in the past, however in the last year this has improved and he no longer presents with depressive symptoms. He has been compliant on his medication. In the last 3 months, he has undergone a significant change of medication to a different depot antipsychotic and oral antidepressant with a view to mitigation side effects of his medication. His mental state has not destabilised during this change of medication.

[33] He may also have some significant antisocial traits in his personality - including a tendency to rationalise for his difficulties and minimise his risk behaviours.[4]

[34] At [6.3]:

> Taking into consideration the circumstances in which JW's index violence occurred, in my view, the following factors would significantly increase the risk of his mental health deteriorating and elevate his risk of harming others or himself:
>
> - non-compliance with treatment (pharmacological and/or psycho-social interventions);

[4] [6.2].

- disengagement with professionals involved in his care;
- poor coping with stressful situations (for e.g. social anxiety in group situations, conflict in the context of intimate relationships, including due to ambivalence regarding his sexual orientation and his anxiety regarding his sexual 'performance') and;
- reverting to using alcohol or illegal drugs.

[35] At [6.4]:

> In terms of prognosis, in my opinion, JW is likely to have this illness (Schizophrenia) in the long term. If he continues to remain compliant with treatment (including abstinence from alcohol and drugs) and engage with professional involved in supervision and facilitating his care, his illness is likely to be stable, in my opinion, his potential risk to himself and others is low."[5]

[36] At [6.5]

> The framework of the CSO has offered JW adequate structure and safeguards and offered him the opportunity to receive care and treatment that has managed his risk behaviours well within the custodial setting. Over the last 18 months, he has shown a steady improvement in his mental state and a commensurate reduction in his risk profile.

[37] Dr Das proceeded to refer to FMHT's proposals for JW's transition towards an NCSO, hopefully within the next 12 months. This would include day trips into the community, continued work near the DCC precinct, and other activities that can only be effectively organised and managed if he was still the subject of a CSO. This would also facilitate the continued involvement of carers and provision of

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5 [6.4].

professional help, and the ability to assess his progress and ability to cope in the outside world.[6]

[38] And at [6.8]:

> Whilst this transitional plan in preparation for a NCSO is in progress, I recommend JW remain on a CSO for a further 6 months to allow him to participate in the work program and continue to develop insight into his illness and tools for coping with day-to-day life post release.

[39] A further Individual Care Plan dated 29 September 2017 (**the ICP**) was provided to the Court on 5 October 2017. That document recorded a number of very positive things about JW's progress including that:

(a) Since his transfer to the CBU (in September 2015, when it opened) JW has managed himself appropriately with no recorded incidents during that time.

(b) He has many friendships within the CBU and also remains close to his family.

(c) JW has completed a number of programs including the alcohol and drug program (in April 2016), the SSS program (in March 2017), and a 12 session anger management program (in January 2017). In August 2017 he was advised he would not be eligible for the Violent Offender Treatment Program.

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6 [6.6] – [6.10].

(d) He was engaged in prison work as a librarian since March 2017, but declined to work in the laundry due to physical disabilities.

[40] The ICP indicated positive progress including his attendance at appointments, taking his antipsychotic medication and cooperation with his treatment plan.

[41] On 7 October 2017, Dr Olav Nielssen, an independent psychiatrist based in Sydney, provided a report.

(a) He found no obvious signs of neurological disorder, and considered that JW did not appear pervasively depressed, but he was mildly irritable when confronted with evidence of his mental illness. His speech was superficially rational but became increasingly disorganised. He seemed to be deliberately avoiding responding to questions about past symptoms. Dr Nielssen had the overall impression that JW has a disabling form of communication disorder arising from chronic schizophrenia.

(b) Dr Nielssen identified two psychiatric diagnoses: chronic schizophrenia; and "substance use disorder, in remission".

(c) Dr Nielssen believes JW has been chronically mentally ill since 2000 and that he was able to conceal his symptoms until they were properly appreciated by Dr Smith and others in 2012 while in remand in relation to the index offending.

(d) He said, at p 7:

> [JW's] insight regarding the nature of his condition is at best superficial, and his commitment to continuing treatment with antipsychotic medication is unreliable. Given the history of two very alarming offences apparently prompted by symptoms of mental illness, I believe JW requires indefinite treatment with an adequate dose of antipsychotic medication securely administered by long acting injection.

(e) He said, at p 7:

> I concur with the opinions of Dr Kini and Dr Walton that substance use would be a risk factor for JW after his release to the community, and any Non-Custodial order would require a regime of monitoring for the relapse of substance use. I also concur with Dr Kini's opinion about the deleterious effects of disengagement from contact with his treating team, and the potential to avoid taking medication.
>
> (underlining added by me)

(f) He said, at p 7:

> With regards to the requirements under s 43ZG of the Criminal Code, I do not believe the safety of JW or any member of the community would be seriously at risk if JW's CSO were varied to that of a non-custodial supervision order, provided the conditions of the order were adhered to.
>
> (underlining added by me)

(g) Dr Nielssen acknowledged, at p 8, that

> Ideally JW would have had greater experience of community access and employment outside the prison prior to his release. However, he is now at level 4 of the CBU program, and could continue his rehabilitation in the community if suitable accommodation could be found.

(h) At p 8 he identified a number of conditions that should be imposed if JW was released, namely:

1. Reliable attendance at regular and initially frequent appointments with his case manager and treating psychiatrist;

2. Reliable adherence to an adequate dose of antipsychotic medication administered by long acting injection;

3. Residing in accommodation approved by his case manager;

4. Complying with all reasonable requests for participation in further employment, education and other rehabilitation programs;

5. Abstinence from alcohol, illegal drugs and non-prescribed medication;

6. To be available for random urine drug screens and random alcohol breath tests;

7. To attend as required for assays of carbohydrate deficient transferrin (**CDT**), a marker for recent hazardous alcohol intake.

[42] An Updated Transition Plan dated 25 October 2007 was provided to the Court. It indicates that:

(a) JW participates in the CBU daily routine, and in various programs;

(b) JW did decline to do certain kinds of work but has been working as a librarian since February 2017;

(c) JW has worked in the laundry, outside the wire, since 9 October, with minimal supervision and works there in a self-motivated manner;

(d) JW would begin day visits into the community with the aim of enabling him to seek employment and to access service providers or study without direct supervision;

(e) JW could be offered another Alternatives to Violence Program, and a place in the Step Forward Program (a reintegration program);

(f) JW "was not assessed and enrolled in [the Violent Offenders Treatment Program] as it was felt it would be destabilising for JW."

(g) JW obtained a Certificate II in Indigenous Environmental Health in November 2015. He also commenced starting at university in July but withdrew in October 2017;

(h) JW continues to be managed by the forensic mental health team. His "mental health is currently stable and he is compliant with medication. He is in regular contact with his case manager."

[43] Dr Das was asked to attend the hearing on 26 October. He was asked a number of questions by counsel and by me.

(a) A major focus of those questions were the 4 factors identified in [6.3] of his report, namely the factors which Dr Das said would significantly increase the risk of JW's mental health deteriorating and would elevate his risk of harming others or himself.

(b) Dr Das expressed concern that his early release on an NCSO could result in "tremendous risk" and may be "setting him up to fail"[7]

(c) Dr Das expressed concerns about JW's lack of insight concerning his disorder and his ability to recognise his symptoms, and his tendency to minimise the risk to others. In particular there is a risk of him not adhering to his medication regime and the risk associated with him using drugs and or alcohol.

(d) Further, if he is released prior to the completion of the proposed stepdown regime, he will not have been sufficiently exposed to potentially stressful situations, and professionals involved in his care will not be able to assess his progress and detect problems as well as they could if he was still in custody.

Further material

[44] Subsequent to the hearing on 26 October 2017 the Court received an Updated Court Report dated 29 November 2017 from the Commissioner of Northern Territory Correctional Service and a report from TEMHS

[7] Transcript, 26 October 2017 at 8.

dated 28 November signed by Mr James Gazzard who has been JW's case worker since September 2017.

[45] The Updated Court Report refers to three successful community day visits on 7, 14 and 21 November, and to JW's employment at the DCC laundry where he has been a good worker. The report states that JW "continues to behave appropriately throughout his visits to the community and his employment in the laundry."

[46] In the TEMHS report Mr Gazzard refers to the day visits and notes that JW engaged well with staff and members of the public during those visits. JW showed an active interest in his graded transition and in visiting places for potential employment, shopping and the like. Mr Gazzard did not observe any positive features of JW's schizophrenia whilst in the community. However during the last visit JW said he does not believe he has schizophrenia and does not consider that the treatment he has been getting has helped him, but he will continue to take his medication whilst he is ordered to do so. This does indicate a continuing lack of insight, a feature not uncommon with people with this kind of condition.

[47] The FMHT continues to support JW transitioning onto a NCSO over the next six months and "from a clinical and risk management perspective" continues to recommend that the transition should happen over that period. That would allow JW time to successfully transition

into the community in a supported manner. However if JW is released into the community on a NCSO earlier than that "arrangements have been made to respond to JW's needs to the best of our capacity."

[48] Arrangements have been made for JW to be accommodated in Darwin, for the first eight weeks at a house run by TEAM Health in Nightcliff and then in supported accommodation in Ludmilla. He would continue to be supervised and reviewed on a regular basis.

[49] The authors of the report recommend a number of conditions that should attach to the NCSO if one is made.

Consideration and conclusions

[50] JW's main medication is the long acting antipsychotic medication which is injected monthly. That is the medication that controls the manifestation of psychotic symptoms arising from his schizophrenia. His other medication is for his depression. That is administered in tablet form on a daily basis. The major risk of JW endangering himself or others would flow from his failure to take his monthly antipsychotic medication.

[51] It will be recalled that his failure to take antipsychotic medication for ten years or so prior to 2012 is likely to have been a significant factor in him committing the index offending and his reluctance to resume taking such medication was the main reason for Dr Smith's

recommendation that he be placed under a CSO. Despite Dr Das' concerns that he may still be reluctant to take his medication, the fact is that he has been doing so for the last five years, albeit because he felt he had no choice but to do so.

[52] If released on a NCSO, JW would still remain under the control of TEMHS and TEMHS would continue to provide professional care to him.

[53] Overall there appears to have been considerable improvement in JW's rehabilitation since he has been at CBU, particularly over the last six months or so. He has completed various programs, engaged in meaningful work, initially in the library and now in the laundry outside the wire, and he has been responding well to his medication and other treatment.

[54] There can be little doubt that it is in the better interests of JW, and the community, that his transition back into the community be by way of the stepdown procedures recommended by the experts and contemplated by his Individual Care Plan and his Transition Plan. It will be more difficult to effect such a transition once he is released from his CSO. The risks to the safety of JW and the community are likely to be higher if he is released now than they will be if he is not released for another six or twelve months, or ever. I accept that from a

medical point of view JW should remain in custody for at least another six months, perhaps longer.

[55] However that is not the question which Part IIA of the *Criminal Code* requires me to determine. The Court must decide whether it is "satisfied on the evidence available that the safety of the supervised person or the public will be seriously at risk if the person is released on a non-custodial supervision order."[8]

[56] In determining whether to make a NCSO the Court must apply the principle in s 43ZM that restrictions on a supervised person's freedom and personal autonomy are to be kept to the minimum that is consistent with maintaining and protecting the safety of the community.

[57] The Court must also have regard to the matters in s 43ZN(1).

[58] As to the matters referred to in s 43ZN(1)(a), (b) and (c):

(a) I consider that the main risk of any danger to JW or the public will only be likely to arise if JW does not continue to take his (long acting) monthly antipsychotic medication. The likelihood of such a risk occurring is minimal. If he fails to attend for his monthly antipsychotic medication and thereby breaches a condition of his NCSO, he can immediately be taken into custody and encouraged to take his medication before any danger arises.

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[8] *Criminal Code* (NT) s 43ZH(2)(a).

(b) Risk of such danger might also occur if he disengages with professionals involved in his care particularly if he encounters a stressful situation, or if he reverts to using alcohol or illegal drugs. These risks can also be minimised by including conditions requiring him to fully cooperate with and obey directions of professionals involved in his care, and to submit to testing for drugs and alcohol.

[59] As to the matters in s 43ZN(1)(d), I consider that there was a direct relationship between JW's untreated schizophrenia and the index offending. Now that his condition has been and is being treated, and his condition is stable, the likelihood of him engaging in similar offending or other offending that might cause serious injury or damage, is minimal.

[60] As to s 43ZN(1)(f), I do consider that he is likely to continue to comply with conditions of a supervision order.

[61] The remaining express provision in s 43ZN(1) is s 43ZN(1)(e) which requires me to consider whether there are adequate resources available for the treatment and support of JW in the community. The main treatment and support that JW will need will be the administration of his medication, and measures necessary to ensure his continued engagement with professionals involved in his care including monitoring for possible use of illegal drugs or alcohol. If released on a

NCSO JW would still need to attend a hospital or other prescribed venue each month for the administration of his antipsychotic medication. The daily administration of his medication for depression, and his cooperation with others involved in his care and supervision, can occur outside the prison, preferably in accommodation provided and staffed by one or more relevant government agencies.

[62] Following the report of 28 November 2017 from TEMHS it does appear that suitable accommodation is now available. The Court has been provided with a certificate under s 43ZA certifying that the facilities and services necessary to provide the care and treatment recommended in that report from TEMHS are available.

[63] Although the Court is required to have regard to each of the matters in s 43ZN(1), including the adequacy of resources available for the treatment and support of JW in the community, the primary direction which the Court must follow is that contained in s 43ZH(2)(a), guided by the principle identified in s 43ZM.

[64] For the purposes of provisions such as s 43ZH(2)(a) the assessment of risk involves a number of considerations. Per Riley CJ in *KMD*:[9]

> The risk assessment must reflect both the likelihood of conduct of concern occurring and the magnitude of the harm that may result from any such conduct. The legislation calls for an assessment of the degree of likelihood of the occurrence of the risk along with the nature of the risk and its consequences.

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9 *The Queen v KMD* [2015] NTSC 31 at [39].

> Some level of risk will, almost always, be present. The extent of the risk must be weighed in the balance in determining the nature of the supervision order to be imposed.

[65] In the case of JW, I consider that the likelihood of JW engaging in conduct that will place him or the public seriously at risk if he is placed on an NCSO is remote for so long as appropriate conditions are applied and enforced if necessary. Further, in the unlikely event that he does engage in such conduct, it is unlikely that it would be conduct which directly injures himself or a member of the public. Although the index offending was serious, neither it, nor his prior offending, involved any direct attack upon the person.

[66] Accordingly, I am not "satisfied on the evidence available that the safety of [JW] or the public will be seriously at risk if [JW] is released on a non-custodial supervision order" with conditions designed to avoid the circumstances identified by Dr Kini in his report of 7 November 2016,[10] and Dr Das in his report of 5 October 2017,[11] namely: non-compliance with treatment; disengagement with professionals involved in his care; poor coping with stressful situation; and reverting to using alcohol or illegal drugs.

[67] I propose to vary the CSO to a NCSO with conditions.

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10 [7.18].
11 [6.3].