CITATION:	*The Attorney-General of the Northern Territory v JD (No 3)* [2017] NTSC 48
PARTIES:	THE ATTORNEY-GENERAL OF THE NORTHERN TERRITORY v JD
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE NORTHERN TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	36 of 2015 (21518615)
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JUDGMENT OF:	BARR J

CATCHWORDS:

SERIOUS SEX OFFENDERS ACT – Review – Assessment as to whether respondent is still a 'serious danger to the community'– unacceptable risk of the respondent committing a serious sex offence unless he is in custody – Court satisfied – continuing detention order confirmed

Serious Sex Offenders Act s 6, s 9, s 63, s 65, s 70, s 71, s 79

Director of Public Prosecutions (WA) v GTR (2008) 38 WAR 307, *The Attorney-General of the Northern Territory v JD (No 2)* [2016] NTSC 12 referred to

REPRESENTATION:

Counsel:

Plaintiff:	T Anderson
Defendant:	M Thomas

Solicitors:

Plaintiff:	Solicitor for the Northern Territory
Defendant:	Not applicable

Judgment category classification:	B
Judgment ID Number:	Bar1707
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

The Attorney-General of the Northern Territory v JD (No 3)
[2017] NTSC 48
No. 36 of 2015 (21518615)

BETWEEN:

THE ATTORNEY-GENERAL OF THE NORTHERN TERRITORY
Applicant

AND:

JD
Respondent

CORAM: BARR J

REASONS FOR JUDGMENT

(Delivered 20 June 2017)

Introduction

[1] On 19 June 2017, at the conclusion of the Attorney-General's application for review, I made an order pursuant to s 71(1)(c) *Serious Sex Offenders Act* ("the Act") confirming the final continuing detention order made in December 2015, referred to in [2] below. These are my reasons.

[2] 3 December 2015, I made a final continuing detention order in relation to the respondent, pursuant to s 31 the Act. I was satisfied that the respondent was a "serious danger to the community", within the meaning of that term in s 6(1) of the Act, in that there was an unacceptable risk that he would

commit a serious sex offence unless he were in custody. In accordance with s 7(1) of the Act, I was satisfied, to a high degree of probability, that there was acceptable and cogent evidence of sufficient weight to justify my decision. After considering the matters specified in s 6(2) and s 9(2) of the Act, I was satisfied that it was very likely that the respondent would commit another serious sex offence if he were at large in the community, and that adequate protection of the community could not reasonably be provided by making a supervision order pursuant to s 14 of the Act.[1]

[3] I specified the review period for the final continuing detention order as twelve months, from 3 December 2015.

[4] On 1 December 2016, before the expiry of the review period, the applicant formally applied for a review of the final continuing detention order, pursuant to s 65(1)(a) of the Act. The application was mentioned in court on 8 December 2016 and adjourned for hearing in March 2017.[2]

[5] The Court subsequently made a medical assessment order pursuant to s 70(2) (read with s 79) of the Act, nominating Dr Danny Sullivan, Consultant Forensic Psychiatrist. Dr Sullivan subsequently interviewed the respondent at the Darwin Correctional Centre on 3 February 2017 and provided a report dated 22 February 2017.

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1 *The Attorney-General of the Northern Territory v JD (No 2)* [2016] NTSC 12 at [1], [138], [150], [153], [154], [157], [158].

2 For various reasons, not presently relevant, the evidence and submissions were not completed until 19 June 2017.

[6] The Court was also provided with a report by the Commissioner of Correctional Services, pursuant to s 69 (read with s 88) of the Act. The Act requires that the Commissioner provide an opinion as to whether, if a supervision order in relation to the respondent were to continue in force, it would be reasonably practicable for the Commissioner to ensure that the person was appropriately managed and supervised by probation and parole officers as required by s 63 of the Act. The paramount consideration referred to in s 63(2) is the need to protect, inter alia, members of the community. Rehabilitation is expressly described as a secondary consideration.[3] The legislation does not appear to acknowledge any link between the two considerations.

[7] At the review hearing, Commissioner Payne gave evidence on three separate occasions. Dr Sullivan also gave evidence. Dr Olav Nielssen, psychiatrist, provided reports and gave evidence in the respondent's case. All of the witnesses were cross-examined by opposing counsel.

Background to the review

[8] The respondent was previously assessed as having borderline intellectual functioning. I referred in my earlier decision to the respondent's low level intellect and significant deficits in executive functioning and memory, possibly as a result of organic brain damage. These deficits were such as to affect his judgment and insight. I also referred to the respondent's severe

[3] *Serious Sex Offenders Act*, s 63(2)(b).

anti-social personality disorder, which appeared to strongly persist. I also referred to the respondent's paranoid and antagonistic behaviour while a serving prisoner.

[9] Dr Sullivan referred to the respondent's personality disorder as follows:[4]

> There has long been consideration of personality disorder, reflecting pervasive aspects of character or temperament which may be maladaptive or problematic. Mr D has variously been noted to have anti-social, paranoid and narcissistic traits. He is impulsive, lacks planning or life goals, and has marked inter-personal difficulties manifest in suspiciousness, hostility and aggression, little capacity or inclination in forming relationships, externalisation of responsibility and self-referential thinking. This is consistent with a mixed personality disorder with anti-social and paranoid elements.
>
> Mr D's frequent aggression and rapid escalation of hostility is noted to be founded in misperceptions of hostile intent from others, which has raised the possibility of psychotic illness. There has been concern that his behaviour may reflect the influence of persecutory delusions or hallucinatory experiences. However, there has been no clear evidence of overt sustained delusions or significant hallucinatory experiences …. I do not think it likely that there is evidence of a psychotic illness, including one which has been partially treated through antipsychotic medication. No psychotic symptoms were elicited or apparent at my assessment.

[10] Dr Sullivan's opinion, that the respondent does not suffer psychosis, is consistent with the opinions of all three of the psychiatrists who have examined the respondent in recent times, none of whom has found evidence of a diagnosable mental illness.[5]

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4 Report dated 22 February 2017, pars [68] – [69].

5 See the references in *The Attorney-General of the Northern Territory v JD (No 2)* [2016] NTSC 12 to the opinion of Dr Michael Beech at [121] – [122], and of Dr Lester Walton at [134] – [135], which incorporates the opinion of Dr Craig Raeside at [134].

Respondent's participation in rehabilitation programs

[11] After the final continuing detention order was made in relation to the respondent in late 2015, he participated in an individual Sex Offender Treatment Program ("the Program") at the Darwin Correctional Centre in the period 14 January 2016 to 9 December 2016. He engaged in 23 sessions of between one to three hours each, a total of 30 hours of treatment. The senior clinician responsible for the Program was well aware of the matters which could have reduced the benefit of the respondent's treatment, including his borderline intellectual functioning and personality disorder, and the Program format and treatment were modified to accommodate the respondent's complex needs.

[12] The early part of treatment under the Program was intended to develop rapport and build trust between the respondent and clinicians. Concepts were broken down into less complicated 'components' so as not to overwhelm the respondent. The aim of treatment was to assist the respondent to develop insight, to develop appropriate cognitive attitudes towards women, to overcome his sense of sexual entitlement and reduce his impulsivity.

[13] The respondent initially found it difficult to focus on the content of the Program. He even refused treatment in the second session. However, he then made a clear decision to engage in treatment and committed himself to the Program. From that point, he maintained high levels of motivation and a consistent level of effort. In the early stages, he had difficulty understanding and overcoming the 'hurdle of entitlement' (male entitlement to sexual

intercourse) and the concept of consent. For example, he maintained that he was innocent and that women had tempted him to be sexual. Over time, however, he appeared to appreciate that he had done the wrong thing. He was reported to have acknowledged that his sexual offending in 2005 was his responsibility. He expressed remorse, guilt and shame for the harm caused to the victim.

[14] Although the respondent made very good progress as a result of his participation in the Program, he started from a low base, and still has a long way to go. In my assessment, he is a simple and unsophisticated man who has made efforts to change his world view in relation to relationships with the opposite sex, but who may well stall in his progress and revert to previously held attitudes. The following passage illustrates the limits to his progress:[6]

> Mr D was able to reflect on his offence pathway and identify the contributing factors that underpinned his offending … a lack of intimacy "feeling lonely", poor relationship skills "not listening but telling", an entitlement "don't just touch a woman's *choonu*" (vagina) and excessive and harmful use of alcohol. Mr D has gained insight into his attitudes of sexual entitlement and developed an increased understanding of consent. He acknowledged that he would need to ask for permission before having sex with a woman and, if she said 'no', he would accept that and ask another woman: "I have to ask for *kadjuck* (language for intercourse) and if she says 'no', I'll just ask someone else or wait and ask her another day, it's alright". When discussing the way he would form a relationship, he said "I won't touch a woman's *choonu* or *munga* (language for vagina)... I'll ask her name first, go for a walk, take her dancing or fishing and walk around a bit".

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6 Senior clinician's Treatment Report, 14 February 2017, p 4, annexed to the report of the Commissioner of Correctional Services.

[15] When the respondent provided a history of his offending in March 2005 to Dr Sullivan, he said that he was with his girlfriend and they had had "too much grog". In that context, he claimed, his girlfriend became jealous that he had slept with another girl. In a jealous fight, he broke off a big stick and struck her in the head and arm. He told Dr Sullivan clearly, "This was not a rape … the police made it up".[7] He attributed his incarceration on the charges of rape and aggravated assault to poor legal representation. He did not acknowledge his pleas of guilty or his admission of the Crown facts at the time of sentencing in June 2005.[8] The account given to Dr Sullivan was more or less consistent with the account given to Dr Beech, but was inconsistent in significant respects with the previously admitted facts.

[16] Dr Sullivan recognised that the respondent maintained a version of events which was contrary to the facts. In his view, the respondent's false narrative arose from an apparently naïve desire to present himself in a positive light, which Dr Sullivan described as "impression management". He wrote: "This … involved minimising and denial of past sexual offending, limited recall of past events and an unwillingness to discuss incidents in prison". Dr Sullivan ultimately considered that this was a "somewhat unsophisticated attempt at impression management by a man of limited intellectual capacity".

[17] Dr Sullivan stated that denial and minimisation of sexual offending are not clearly associated with increased risk of recidivism. However, the

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7 Report Dr Danny Sullivan, par [23] and par [24].

8 *The Attorney-General of the Northern Territory v JD (No 2)* [2016] NTSC 12 at [49] - [50].

respondent's naïve strategy may well have masked the true situation and made it more difficult for Dr Sullivan to assess his true attitudes and understanding of risk factors for re-offending, particularly sexual re-offending.

[18] Although the respondent's behaviour in prison involved a significant number of aggressive and threatening incidents, predominantly directed at correctional staff, his patterns of behaviour changed after he started to engage in treatment. As noted by Dr Sullivan, the respondent appears to have undergone a striking transformation, manifest in his engagement in treatment, with positive reports; his commencement of employment, without incidents; a downgrading in security classification; a marked reduction in incidents, and an objectively improved attitude.

[19] In recent times, the respondent has continued to show positive improvement in behaviour and motivation. His prisoner risk classification is now "low" and he has maintained employment within the prison. He has commenced the group therapy stage of his Sex Offender Treatment Program and has engaged in 11 out of 12 sessions conducted to date, out of a program total of 48 such sessions. The evidence of one of the clinicians involved with the respondent in the ongoing program was as follows:[9]

> Mr D at times presents as an engaged member, offering meaningful answers that we would expect from participants. He has also been observed to be encouraging of others and receives encouragement from others. He has one member in the group that he speaks in

[9] Extract from the email dated 13 June 2017, exh D3.

> language with and asks for help from. At other times he can be quiet and distracted depending on what is going on with his court processes. He has not expressed any agitation or frustration in the group environment. … A theme that has been identified is Mr D's disclosures to the group that he has been imprisoned for a very long time, that he misses family and that he feels a disconnection from his family and culture due to this. He reports a strong desire to reconnect with family.

[20] These matters suggest that the respondent's prospects for rehabilitation may not be as poor as previously thought. Dr Sullivan wrote as follows:[10]

> JD appears to have been motivated by the prospect of indeterminate incarceration. I suspect maturation, aging and physical frailty may also impact upon his changed demeanour. In addition, most evidence supports that positive reinforcement and rewards for good behaviour are more effective than punishment in leading to behavioural change. It may be that JD has taken the first steps in rehabilitation, whereas he was trapped in a cycle of abuse and recrimination against the correctional system.

[21] Dr Nielssen attributed the respondent's improved behaviour in prison to his realization or understanding that "it is in his own interests to behave better".

[22] Although JD has made considerable progress, with a markedly changed attitude and significant improvement in personal interactions and psycho-social functioning, Dr Sullivan is of the view that the respondent would be at high risk of committing another serious sex offence if not detained in custody or subject to a supervision order.

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10 Prior to the respondent commencing the group therapy stage of his Sex Offender Treatment Program.

Assessment of risk

[23] Dr Sullivan assessed the respondent by the risk assessment method known as 'structured professional judgment'. This involved formal and structured assessment which combines static and dynamic prediction variables, derived from validated risk assessment instruments.[11] The risk categorisation may then be modified by clinical judgment. Notwithstanding that this is current best practice in risk assessment, Dr Sullivan acknowledged that prediction of re-offending risk is imprecise, with a significant rate of false positive and false negative results. Dr Sullivan also acknowledged that the Static-99 instrument has not been specifically validated in the Northern Territory or in relation to indigenous offenders. Nonetheless, he noted that the respondent scored in the 'high risk' category on the Static-99, which he explained as follows:

> The risk of recidivism for people in this category is higher than that expected of others convicted of sexual offences: of the reference group, 39% were re-convicted for sexual offending and 44% for violent offending at five years after release, and at fifteen years, 52% had re-offended sexually and 59% violently.

[24] Dr Sullivan also utilised RSVP (Risk for Sexual Violence Protocol), a structured professional judgment instrument which incorporates both static and dynamic risk variables associated with sexual re-offending. His overall conclusion was as follows:

> Taking into account the Static-99 and the RSVP, I consider that Mr D's overall sexual offending risk is in the *high* range. This

[11] Three instruments were used: Static-99, RSVP (Risk of Sexual Violence Protocol), and the HCR-20 V3 (a violence risk assessment tool, well-validated to assess violence risk in adults).

> reflects that although the anchoring Static-99 score is likely to overestimate future risk, due to ageing and a change in attitude, Mr D's altered behaviour is relatively recent and has not had the opportunity to be tested in a public setting.

[25] A point emphasized by Dr Sullivan in his oral evidence in cross-examination was that the prognostication of the risk of serious sexual offending has to take into account the seriousness of past sexual offending.

[26] The respondent relied on the evidence of Dr Olav Nielssen, forensic psychiatrist.[12] Dr Nielssen's general hypothesis is that psychiatrists have very limited ability to predict the future behaviour of any individual, because the science of behaviour prediction is weak. This weakness is because the base rates of serious adverse events are low, and those events are not so much due to the effect of enduring traits as they are the result of circumstances which arise and which are difficult or impossible to predict. I observe, however, that while particular circumstances may be difficult or impossible to predict, the likely response of a person to those circumstances may not be so difficult to predict.

[27] Dr Nielssen questioned the validity of actuarial tests when applied to indigenous Australians from the Northern Territory. He cited a study of sexual recidivism from Western Australia which found that neither the Static-99 nor the Static-99R were able to significantly predict sexual recidivism among indigenous sexual offenders, despite a higher base rate of re-offending in that group. Dr Nielssen also said that there had been no

studies validating the use of RSVP or HCR-20 in indigenous offenders. His conclusion was as follows:

> Hence any assessment of the likelihood of re-offending by an indigenous person would rely on a clinical assessment, with the items in the available instruments acting as an aide memoir.[13]

[28] Dr Nielssen's ultimate conclusion was that there is no reliable method of predicting whether a released offender will commit a serious sexual offence. Attempts to estimate the probability of future offending invariably include predictions of more common less serious offences, as serious offences are rare. Dr Nielssen wrote:

> With regards the criteria set down in section 6 of the *Serious Sex Offenders Act*, it is not possible to predict with any certainty whether a person who has committed previous sexual offences will go on to commit another sexual offence, let alone a serious sex offence. There is general agreement that Mr D does not have a disorder of abnormal interest, or any compulsion to commit sex offences, and that his previous sexual offending was part of a general pattern of reckless substance use and anti-social conduct that is evident in his criminal history.
>
> The prospect of indefinite detention appears to have motivated Mr D to participate in counselling and to improve his conduct in prison, which suggests some capacity to act in his own interests to avoid offending if he were to be released. Moreover, a regime of supervision that was not so onerous as to be counter-productive or impossible to adhere to, and was able to assist Mr D in his adjustment to life in the community and minimise the likelihood of a return to a pattern of substance abuse and anti-social behaviour would also reduce the likelihood of further offending.

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12 Report dated 9 April 2017; Supplementary report dated 28 April 2017.

13 Report dated 9 April 2017, p 7.9. It appears that the Doctor's reference to aide memoire was intended to be as a cross-reference or cross-check, rather than an aide to memory.

[29] In re-examination, Dr Nielssen agreed that the respondent was probably at high risk of sexual re-offending, but maintained his opinion that the likelihood of the respondent committing a serious sexual offence was low, apparently for the reason that serious sexual offences are rare, even in the case of high risk offenders who have a propensity to re-offend.

[30] Although Dr Nielssen wrote that the predictive accuracy of actuarial instruments, which are based on measurable historical factors, consistently out-perform those of clinical evaluations, he was critical of probability estimates derived from studies of groups of offenders which, he said, have limited application to an individual at the point in time in which decisions have to be made about that individual's perceived risk. Dr Nielssen wrote that the recidivism rates reported by studies using Static-99 and Static-99R "conflate the rates of minor offences … with less common serious offences." He then argued as follows. Assessments using an instrument such as Static-99 provide only an estimate of probability, without considering the seriousness of any future offence. Risk assessment instruments mostly consider historical or static risk factors, which by definition do not change. For example, an individual's score on the Static-99R can only be reduced when the person reaches the age of 60. The effect of this is that instruments relying on static risk factors do not take into account participation in rehabilitation programs, counselling which a person might receive, a person's future circumstance or the person's capacity to act in their own best interests by staying out of trouble.

[31] In my opinion, the identified shortcomings of instruments relying on static risk factors, referred to in the previous paragraph, actually justify and necessitate the use of 'structured professional judgment', the method adopted by Dr Sullivan (and Dr Beech previously). That enables the inflexibility of the static prediction instrument to be modified by clinical judgment when, for example, a person has achieved a positive outcome by participation in rehabilitation programs or engagement in counselling.

[32] Dr Nielssen acknowledged in an article co-written by him that 'structured clinical judgment' (which I assume is the same thing as 'structured professional judgment') allows the assessor "some latitude in their judgment of the weight to be placed on the score derived from actuarial instruments", but argued that, even though the method ensures that all known factors are considered along with the patient's current condition and circumstances, it is not a solution to the shortcomings of either clinical or actuarial risk assessment.[14] With respect, I disagree with that opinion. Dr Nielssen's separate criticisms of the use of actuarial instruments and of clinical judgment as means of assessing the risk of future serious sexual offending does not, in my judgment, discredit or detract from the use of a combination of the two kinds of assessment methods involved in 'structured professional judgment'. I accept the evidence of Dr Sullivan that 'structured professional judgment' is current best practice.

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14 Large and Nielssen "Probability and loss: two sides of the risk assessment coin", The Psychiatrist (2011), 35, 413 - 418.

[33] Dr Nielssen also referred to the natural tendency for the magnitude of a feared outcome to cloud a psychiatrist's view of the probability of that outcome occurring, and hence to over-estimate the likelihood of very serious events. However, I do not consider that Dr Sullivan's assessment of risk suffered from that suggested defect. Moreover, it must be borne in mind that the task for this Court under the *Serious Sex Offenders Act* is to decide whether a person is (or continues to be) a "serious danger to the community", which means that there is an *unacceptable* risk that he will commit a serious sex offence unless in custody or subject to a supervision order. The risk does not need to be absolute. In considering whether a risk is 'unacceptable', the Court must engage in a balancing exercise, having regard to the nature of the risk (that is, the commission of a serious sexual offence and the consequences for the victim), and the likelihood of the risk being realized, as well as the consequences for an offender who may be detained or subjected to an onerous supervision regime without having committed any further offence.[15]

[34] In his report referred to in [6] above, Commissioner Payne expressed the opinion that it would not be reasonably practicable for him to ensure that the respondent was appropriately managed and supervised in accordance with s 63 of the Act if a supervision order were made at this time. He expressed the view that the respondent must make further progress with his rehabilitation. In his most recent evidence, Commissioner Payne stressed that his concern

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[15] See *The Attorney-General of the Northern Territory v JD (No 2)* [2016] NTSC 12 at [141], and the reference to *Director of Public Prosecutions (WA) v GTR* (2008) 38 WAR 307 at [27], per Steytler P and Buss JA.

was about mitigating risk to potential victims and the community: ensuring the respondent was provided with every opportunity to engage in programs which will reduce the risk he poses to the community and enable him to be effectively managed and supervised by probation and parole officers if he were released from detention and placed under a final supervision order. The Commissioner's opinions and general approach were ultimately not undermined by cross-examination of the Commissioner or by any other evidence adduced in the hearing.

Conclusion

[35] The respondent has made far greater progress than might have been anticipated eighteen months ago. There is a real possibility that he will secure his release, subject to a continuing supervision order. At this stage however, no realistic residential option has been identified. The respondent should not be released into the community unless stable accommodation is found for him, such that residential conditions could be imposed.

Dr Sullivan recommended a number of other interventions to reduce risk, including a condition that the respondent wear an alcohol monitoring bracelet, that he receive case management, initially daily, to maintain oversight of his re-integration into the community; that he be subject to a curfew; that he receive ongoing offence specific treatment support, to help

him to incorporate relapse prevention strategies into his lifestyle; and that he receive assistance with managing medication.[16]

[36] In the circumstances, I considered that it was necessary to confirm the continuing detention order pursuant to s 71(1)(c) of the Act. I was satisfied that the respondent is still a serious danger to the community. There remains an unacceptable risk that he will commit a serious sex offence unless he is in custody. I do not consider that effective and appropriate management and supervision of the respondent in the community would be reasonably practicable at the present time.

[37] I made an order to amend the continuing detention order so as to specify a review period as 12 months from 19 June 2017, in lieu of the review period previously specified.

[38] If the respondent continues to make progress, but remains a serious danger to the community, it is foreseeable that the need to protect potential victims and the general community (referred to in s 9(1)(a) and s 14(2)(a) of the Act) could be met by appropriate management and supervision in the community, under a final supervision order, rather than by a continuing detention order. The Commissioner of Correctional Services and those who assist him should continue to plan and prepare an appropriate management

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16 The report of Commissioner Payne, par 69, contains detailed conditions which could be imposed if a final supervision order were made.

and supervision regime, and in particular to seek out appropriate stable accommodation for the respondent.
