Statement of Reasons

This is an edited version of the statement of reasons issued pursuant to section 756 of the *Mental Health Act 2016*. The patient and persons attending the hearing have been de-identified and, in some cases, may be allocated pseudonyms for privacy reasons. Other details that may lead to the identification of the patient may have also been modified or omitted. The modification or omission of these details does not affect its decision or its reasons for the decision.

Matter	Forensic Order Review
Attendees	
Patient:	Attended
Patient's Legal Representative:	Attended
Psychiatrist:	Attended
Case Manager:	Attended
Attorney-General's Representative:	Attended
Public Guardian:	Attended
Support Worker:	Attended
Decision	
Date of decision:	2021
Decision:	The Forensic Order is CONFIRMED The Category is COMMUNITY

The patient was placed on a forensic order by the Mental Health Court. The Mental Health Court found the patient permanently unfit for trial in relation to a charge of dangerous driving causing death.

A previous Tribunal issued an order for an examination report under Section 721 of the *Mental Health Act 2016* which was completed by the examining doctor and included in the dossier **(the examination report)**.

Statutory Framework

Appendix A to these reasons is a summary of the provisions of the *Mental Health Act 2016* (**Act**) that are relevant when the Tribunal reviews of a person's forensic order.

Clinical Report

The patient received the clinical report within the statutory time frame.

Matters to which the Tribunal must have regard

The Tribunal had regard to the factors in section 432 of the Act as follows.

The relevant circumstances of the person subject to the order

In reaching a decision, the Tribunal had regard to the patient's relevant circumstances.

Mental state and psychiatric history and any intellectual disability

The written material outlines the patient's history of treatment and care for an acquired brain injury which has led to an organic personality disorder, as well as frontal lobe deficits. The acquired brain injury is a result of poorly controlled epilepsy and iatrogenic neuro surgical interventions on a background of possible head injuries. Prior to the index offence, the patient was prescribed antidepressant and anti-anxiety medications.

Since the imposition of the forensic order the patient has continued to experience seizures, the treatment for which is largely managed by his general practitioner (GP). Recently, the patient was hospitalised for stiches after a fall related to a seizure. The patient denies he had a seizure and though prescribed medication levels were under the therapeutic range at the time the patient said he was compliant. The patient previously presented with hallucinations which were temporarily treated with anti-psychotic medication.

The patient consistently drinks two standard drinks every day and smokes twenty cigarettes a day. He does not have a history of using illicit substances. Alcohol consumption is monitored by the team and the patient abides by the doctor's orders, reporting a bloated feeling after more than two drinks. The clinical report said that there is some ongoing risk of verbal aggression and the patient's history of sexually inappropriate behaviour is managed by ensuring male staff and support workers.

The examination report recorded that the patient was verbally challenging and hostile with a prickly and disinhibited manner (frontal lobe dysfunction). A mini mental state examination indicated a moderate level of dementia or moderate profound intellectual impairment. Reports from support workers were that the patient can be frequently verbally abusive but with no episodes of physical violence. The patient was assessed as having basic daily living skills but complex domestic tasks such as paying bills and managing a bank account were beyond him. The report opined that there

had been a slow decline in cognitive function over the years consistent with poorly controlled epilepsy.

At the hearing, the patient's treating psychiatrist said that the patient continues to experience symptoms of frontal lobe syndrome which can be associated with disinhibition and verbal irritability with no physical aggression involved. The doctor confirmed no female support workers attend his home. The treating psychiatrist said that he had not noted any cognitive decline and considered that the patient's functioning was better than documented. Neurological testing is managed by others and is not shared willingly with the treating team.

The patient's case manager said that alcohol consumption is self-monitored. The team indicated that the amount of alcohol reported in the examination report (two drinks a day) was more than the patient reported to the team. The team noted that the patient's most recent admissions were in the context of seizures and sub-optimal medication compliance but hallucinations have not been an issue for 20 months or so.

The patient spoke for himself at the hearing and explained his view about the underlying cause of the index offence and that he had been '…set up for years'. He said he kept busy and was well and saw no need for the treating team. He said he has at least two drinks of rum and coke every day.

Response to treatment and care and the person's willingness to receive appropriate treatment and care and if relevant, the person's response to previous treatment in the community.

The written material outlined that the patient continues to deny his seizure history and does not report seizures to the treating team. There is a history of non-compliance with anti-convulsant medication and the patient previously refused to engage with a GP when he was experiencing seizures.

The treating psychiatrist explained that, despite this history, the patient is sufficiently engaged with community treatment at present. The patient's anti-convulsant medication is dispensed by his GP and the treating team have deliberately reduced contact with the patient over the last six months to test this engagement. Ongoing compliance concerns are managed by webster packing medication and supervision by National Disability Insurance Scheme (NDIS) support staff and the GP with little input from the treating team. The examination report records that the patient said that he did not want to take his tablets, felt pressured by his doctor to do so and would prefer not to see the treating team.

The patient said that he takes his medication three times a day and nobody checks to see if he takes them. On the patient's account he does not know who suggested the webster pack, but he prefers to take them from the packet. He said he rarely sees his GP which was disputed by the treating team who described regular contact, confirmed in discussions with the GP quarterly. The patient said if he did not have to attend the mental health services clinic he would not, but it is okay when he does.

Social circumstances, including, for example, family and social support

The written material outlined that the patient lives alone in his own home. He last worked twenty years ago and receives the disability support pension. He is currently single, does not have friends and rarely socialises. The clinical report stated that the patient reported that family members visited him after the recent seizure but do not visit often otherwise. The patient started to receive support under the NDIS three years ago and his level of support was recently increased from two days to four days a week. The patient leaves his home when a female cleaner cleans his house once a week.

The treating team detailed the patient's community supports which they believe are sufficient to manage risk. The case manager said the patient sees siblings occasionally but that an enduring

power of attorney (EPOA) was relinquished due to illness and the Office of the Public Guardian (OPG) was appointed. The team noted that the patient does not have a driver's licence, does not drive and has no capacity to impulsively buy a vehicle. They considered that the patient is law abiding and understands that the Department of Transport have restricted him from having a driver's licence.

The patient's guardian told the Tribunal that the OPG was appointed for health care provision which is due for review. The guardian said the patient is engaged with supports which increased after the recent seizure. If the forensic order was revoked and restrictive practices required, the OPG could act, but would require evidence of the need to do so. Supports could also be put in place to ensure compliance with medication if deemed necessary.

The patient talked to the Tribunal about his current circumstances. He said that he keeps busy cooking and washing clothes. He said he was too old to meet a new partner, does not see his family very often and appreciates the involvement of support workers in his life.

The nature of the relevant unlawful act and the period of time that has passed since the act happened

The patient suffered an epileptic seizure while driving more than 10 years ago and struck and killed the victim.

The Tribunal noted the catastrophic consequences of the incident which was preceded by a history of vehicle accidents and medical advice that patient was not fit to drive. The Tribunal also noted that patient has not driven since the index offence and there is no likelihood of him being granted a drivers' license in Queensland during his lifetime.

Summary of evidence and findings

Is the forensic order necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property?

The treating team recommended that the forensic order be revoked, as they had for some time. The ARMC supported revocation. The treating psychiatrist said that the patient's risk of re-offending was very low noting the index offence was a long time ago. The treating team accepts that the patient needs support and supervision, but they are of the view this can be adequately provided by community supports comprising family, GP, the OPG and NDIS supports. While the patient does not recognise his seizure activity, his support staff do. The team indicated that there had been no significant change since the examination report was written and disagreed with some of the conclusions in that report. If the forensic order is revoked the treating team do not consider that they would need to be involved with the patient any longer unless requested.

The patient's legal representative submitted that the forensic order be revoked on the basis that the community supports around the patient were such that the forensic order is no longer required to manage risk. The submissions referred to the recent increase in support from NDIS as well as the support from family, the OPG and GP. It was noted that there have been no serious behaviours of concern and that the OPG can implement restrictive practices if required. The patient's legal representative emphasized the treating team's opinion that the forensic order does not impact on compliance and the evidence that the patient does not drive, own a car or drink alcohol to excess. The patient told the Tribunal that he would like the forensic order revoked as he saw no need for it.

The Attorney-General's representative submitted that the forensic order should be confirmed relying on the evidence that there had been no change in risk since the forensic order was made or the examination report completed. It was submitted that community supports were in fact limited noting that the patient rarely sees his GP or family and his NDIS supports were not extensive. The submission referred to the ongoing verbal aggression, continued daily use of alcohol, poor insight and history of compliance issues. It was noted that while the patient no longer drives, he would like his licence reinstated and the examination report identified that his condition posed a risk of opportunistic, impulsive driving. The Attorney-General's representative noted the history of driving against advice prior to the index offence as well as the continuing denial of seizures and lack of help-seeking. Reference was made to the evidence that the patient's behaviour remains unpredictable and impulsive and the submissions reasoned that given the cognitive decline and unchanged risk profile the forensic order was still required as the only means of coercive treatment available.

The Tribunal considered all the evidence noting the concerns about community support which underpinned the Mental Health Court's decision to make the forensic order, even though at that time it was accepted that the patient was not likely to drive again. The Tribunal had regard to the examination report recommending that the patient not be allowed to access other people's vehicles and that the message that he must not drive requires consistent re-enforcement. The report identified other risks including being assaulted and being involved in an assault and sexual disinhibition which would escalate with non-compliance and any increase in alcohol consumption. The Tribunal was mindful of the points of disagreement between the examination report and the evidence of the treating team.

The Tribunal considered that the central issue is whether the community scaffolding in place since the making of the forensic order and the examination report is sufficient to manage the risk to the safety of the public. At present the treating team have deliberately reduced their involvement with no liaison with GP, no prompting for compliance and few direct contacts. The community supports in place include:

- Monitoring compliance via webster packs and review of anti-epileptic medications by the GP and pharmacist.
- The patient's family's willingness to continue to increase their level of involvement and recent assistance with appointments and response to seizures.
- The appointment of the OPG who indicated an ability to use restrictive practices should the patient become non-compliant with medication, drive, or increase his alcohol consumption; and
- NDIS support workers 4 days per week for 4 hours.

The Tribunal considered evidence that the support is in the context of the patient being well functioning and law-abiding. However, the Tribunal noted that while the patient's family are becoming more involved and the public guardian is working to that end, there was evidence that at present they engage only occasionally and there was conflicting evidence as to the regularity of contact with the GP. The Tribunal was also mindful that the treating team's plan is to cease all involvement if the forensic order was revoked and the team's view is that the patient does not meet the criteria for a treatment authority.

Overall, the Tribunal concluded that the totality of the evidence indicated that risks to the safety of community continued to exist because of the patient's permanent cognitive disability combined with limited insight. The risks arise from the patient's behaviour which may result in an impulsive decision to drive someone else's car, assault others or his sexually inappropriate behaviour. The Tribunal was concerned that at the same time the team have reduced contact, it was identified that the patient

requires increased supports which were implemented just prior to the hearing. On balance, the Tribunal concluded that insufficient time had passed since the uptake in supports to be satisfied that risks can be managed only by community scaffolds. The presence of the treating team by way of the forensic order is still warranted to provide oversight and monitor the effectiveness of the community supports. The Tribunal considered all the evidence and the patient's relevant circumstances to find that the order is necessary to protect the safety of the community and decided the forensic order will be confirmed.

Category and conditions of the forensic order

All the evidence before the Tribunal and the submissions from the legal representatives asserted that the risks presented by the patient are being managed. The Tribunal was satisfied that the patient is engaged with care such that there is not an unacceptable risk to the safety of the community by having him treated in the community. Tribunal decided that the category is community and an authorised doctor may, at a future time, change the nature and extent of treatment in the community received by the patient, to the extent and subject to the conditions decided by the Tribunal.

The Attorney-General's representative submitted that the existing conditions should be confirmed. The recommendation and submission by the treating team and the patient's legal representative (that the forensic order was not required) implicitly indicated that no conditions were needed. The Tribunal considered the evidence from the treating team that they have gradually reduced engagement and level of monitoring with a view to ceasing contact altogether. The Tribunal decided to remove the conditions in recognition of the continued progression to voluntary care. The Tribunal considered that this approach is consistent with the least restrictive approach to care.

Human Rights

The Tribunal acknowledges the *Human Rights Act 2019*. In particular, the Tribunal considers that the following human rights under that Act are potentially engaged and limited by the Tribunal decision:

- Section 15 Recognition and equality before the law
- Section 17(c) Medical treatment without consent
- Section 19 Freedom of movement
- Section 25 Privacy and reputation
- Section 31 Fair Hearing

The Tribunal was satisfied that the patient's right under section 31 was not limited given that the patient received the relevant material according to the statutory timeframes, attended the hearing and expressed his views, wishes and preferences and was legally represented.

The Tribunal accepted that the patient is receiving care without his consent limiting his rights under sections 17(c), 15, 19 and 25. Notably, the patient does not want to be subject to the forensic order. Nevertheless, the Tribunal noted that the treating team are providing the least restrictive care with a clear view to establishing sufficient community supports to replace involuntary care. On balance, the Tribunal is satisfied that the limitations are lawful, proportionate to the circumstances and compatible with the *Human Rights Act*. The Tribunal reached this decision because of the risk associated with deteriorations in the patient's mental state secondary to not having his mental condition adequately cared for. The Tribunal therefore considered that the patient's history and the risks of further deterioration necessitate the provision of ongoing care without his full consent.

Conclusions of the Tribunal

The Tribunal considered all the evidence and the patient's relevant circumstances to find that the order is necessary to protect the safety of the community and decided the forensic order will be confirmed. The Tribunal considered the conditions and found that the conditions are no longer necessary.

Accordingly, the Tribunal decided to confirm the forensic order, community category.

Presiding Member

APPENDIX A

Statement of the law regarding Forensic Orders

The main objects of the *Mental Health Act 2016* (**Act**) are set out in section 3(2) and must be achieved in the way outlined in sections 3(2) and 3(3).

Below are extracts of sections from the Act relevant to the Tribunal's review of a forensic order.

432 Matters to which tribunal must have regard

(1) In making a decision under this part in relation to a review of a forensic order (mental health) or forensic order (disability), the tribunal must have regard to the following:
   (a) the relevant circumstances of the person subject to the order;
   (b) the nature of the relevant unlawful act and the period of time that has passed since the act happened;
   (c) any victim impact statement given to the tribunal under section 155 or 742 relating to the relevant unlawful act;
   (d) if the Mental Health Court made a recommendation in the order about an intervention program for the person—the person's willingness to participate in the program if offered to the person.

   Examples of decisions in relation to a review of a forensic order:
   - deciding whether to confirm or revoke the order
   - deciding whether to confirm or change the category of the order
   - deciding whether the person is to receive any treatment in the community
   - deciding whether to change or remove a condition to which the order is subject or to impose a condition on the order.

(2) Subsection (1) does not limit any other provision of this part that requires the tribunal to have regard to a stated matter

433 When reviews are conducted

(1) The tribunal must review (a periodic review) the forensic order:
   (a) within 6 months after the order is made; and
   (b) at intervals of not more than 6 months after the review under paragraph (a) is completed.
(2) Also, the tribunal must review (an applicant review) the forensic order on application by:
   (a) the person subject to the order; or
   (b) an interested person for the person mentioned in paragraph (a); or
   (c) the Attorney-General; or
   (d) if an authorised mental health service is responsible for the person—the chief psychiatrist; or
   (e) if the forensic disability service is responsible for the person—the director of forensic disability.
(3) Further, the tribunal may at any time, on its own initiative, review (a tribunal review) the forensic order.
(4) If the tribunal receives written notice under section 213(3) of the amendment of the forensic order, the tribunal must review (also a tribunal review) the order within 21 days after receiving the notice.
(5) This section is subject to sections 434 to 437 and chapter 16, part 2, division 6, subdivision 2.

441 Decisions

(1) On a periodic review of the forensic order, the tribunal must decide to:
   (a) confirm the order; or
   (b) revoke the order.

Notes:

1 See subdivision 2 for the orders the tribunal may make if it confirms the order.
2 See subdivision 3 for the orders the tribunal may make if the order is a forensic order (mental health) and the tribunal revokes the order.

(2) On an applicant review of the forensic order, the tribunal:
   (a) must decide whether to make the orders sought by the applicant; and
   (b) may make the orders under this division it considers appropriate.

   Example for paragraph (b):

If an applicant seeks an order changing the category of the forensic order from inpatient to community, the tribunal may decide not to change the category of the order, but may order that the person have limited community treatment of a stated extent.

(3) On a tribunal review of the forensic order, the tribunal:
   (a) must decide any particular matter stated in the notice given under section 439(3); and
   (b) may make the orders under this division it considers appropriate.

442 Requirement to confirm forensic order

(1) The tribunal must confirm the forensic order if the tribunal considers the order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property.

(2) Also, during any non-revocation period for the forensic order, the tribunal is taken, for section 443, to have confirmed the order.
   Note:
   The tribunal must not revoke the forensic order during the non-revocation period for the order. See section 452.

(3) Subsection (2) does not apply if the forensic order is a forensic order (mental health) and the tribunal decides to revoke the order under section 457.

444 Change or confirmation of category

(1) The tribunal may change the category of the forensic order.

(2) However, the tribunal may change the category of the forensic order to community, or confirm the category of the order as community, only if the tribunal is satisfied there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

(3) This section is subject to section 445.

445 Inpatient category – orders about treatment in the community

(1) This section applies if the tribunal:
   (a) confirms the category of the forensic order as inpatient; or
   (b) changes the category of the forensic order to inpatient.

(2) The tribunal must do 1 of the following:
   (a) order that the person have no limited community treatment;
   Note:
   An order made under paragraph (a) may not be amended by an authorised doctor. See section 212(2).
   (b) approve that an authorised doctor under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may, at a future time:
      (i) authorise limited community treatment for the person, to the extent and subject to the conditions decided by the tribunal; or
      (ii) change the category of the order to community, subject to the conditions decided by the tribunal;
   (c) order that the person have limited community treatment:
      (i) of a stated extent; and
      (ii) subject to the conditions decided by the tribunal, including whether, or the extent to which, an authorised doctor under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may amend the forensic order in relation to treatment in the community.

(3) The tribunal may make an order under subsection (2)(b) or (c) only if the tribunal is satisfied there is not an unacceptable risk to the safety of the community, because of the person's mental condition, including the risk of serious harm to other persons or property.

(4) In deciding whether the tribunal is satisfied of the matters mentioned in subsection (3), the tribunal must have regard to:
   (a) the purpose of limited community treatment; and
   (b) the fact that:
      (i) if an authorised mental health service is responsible for the person—an authorised doctor may increase the extent of treatment in the community for the person only if satisfied of the matters mentioned in section 212(3); or

(ii) if the forensic disability service is responsible for the person—a senior practitioner under the Forensic Disability Act may authorise treatment in the community for the person only if satisfied of the matters mentioned in the Forensic Disability Act, section 20(2).

446 Community category – orders about treatment in the community

(1) This section applies if the tribunal:
   (a) confirms the category of the forensic order as community; or
   (b) changes the category of the forensic order to community.

(2) The tribunal must:
   (a) order that an authorised doctor or a senior practitioner under the Forensic Disability Act must not change the category of the order to inpatient; or
   (b) approve that an authorised doctor under section 212 or a senior practitioner under the Forensic Disability Act, section 20 may, at a future time, change the nature or extent of treatment in the community received by the person, to the extent and subject to the conditions decided by the tribunal.

   Example of a change of extent of treatment in the community:
   changing the category of the forensic order from community to inpatient, with or without limited community treatment

447 Conditions

(1) The tribunal may:
   (a) change or remove a condition to which the forensic order is subject; or
   (b) impose a condition on the forensic order.

(2) Without limiting subsection (1), the tribunal may impose a condition that the person must not contact a stated person, including, for example, a victim of the relevant unlawful act.

(3) However, the tribunal may not impose a condition on the forensic order that requires the person to take a particular medication or a particular dosage of a medication.

450 Making of treatment support order

(1) The tribunal must decide to make a treatment support order for the person if the tribunal considers a treatment support order, but not a forensic order, is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property.

(2) For making a treatment support order under subsection (1), sections 144 and 145 apply as if:
   (a) a reference in the sections to the Mental Health Court were a reference to the tribunal; and
   (b) a reference in the sections to the person the subject of the reference were a reference to the person subject to the forensic order.

451 Making of treatment authority or no further order

(1) If the tribunal considers that neither a forensic order nor a treatment support order is necessary, because of the person's mental condition, to protect the safety of the community, including from the risk of serious harm to other persons or property, the tribunal may:
   (a) make no further order for the person; or
   (b) make a treatment authority for the person.

(2) The tribunal may make a treatment authority for the person under subsection (1)(b) only on the recommendation of an authorised psychiatrist who considers, after examining the person, that:
   (a) the treatment criteria apply to the person; and
   (b) there is no less restrictive way for the person to receive treatment and care for the person's mental illness.

(3) The treatment authority must state the following:
   (a) the category of the authority;
   (b) the authorised mental health service responsible for the person;
   (c) the nature and extent of any limited community treatment the person is to receive;
   (d) any conditions the tribunal considers necessary for the person's treatment and care, other than a condition requiring the person to take a particular medication or a particular dosage of a medication.

(4) The tribunal may decide the category of the treatment authority is inpatient only if the tribunal is satisfied that 1 or more of the following can not reasonably be met if the category of the authority is community:

(a) the person's treatment and care needs;
(b) the safety and welfare of the person;
(c) the safety of others.

(5) However, if the person is a classified patient, the tribunal must decide the category of the authority is inpatient.

(6) In deciding the nature and extent of any limited community treatment under subsection (3)(c), the tribunal must have regard to the purpose of limited community treatment.

(7) If the tribunal decides the category of the treatment authority is community, the tribunal must decide whether an authorised doctor may, at a future time, reduce the extent of treatment in the community received by the person.

(8) The treatment authority is taken to be a treatment authority made under section 49 by the authorised psychiatrist mentioned in subsection (2).

(9) Despite subsection (8) and section 413(1), the tribunal must review the treatment authority:
(a) within 6 months after the authority is made; and
(b) within 6 months after the review under paragraph (a) is completed; and
(c) at intervals of not more than 12 months after the review under paragraph (b) is completed.

(10) Sections 53 and 59 apply to the treatment authority as if a reference in the sections to the authorised doctor were a reference to the authorised psychiatrist mentioned in subsection (2).

(11) As soon as practicable after the treatment authority is made, the authorised psychiatrist mentioned in subsection (2) must decide the nature and extent of the treatment and care to be provided to the person under the authority.

452 Orders with non-revocation period

(1) The tribunal must not revoke a forensic order under division 4 during any non-revocation period for the order.

(2) Subsection (1) is subject to section 457.

453 Order for person temporarily unfit for trial

(1) This section applies to a person subject to a forensic order if:
(a) a finding of unfitness has been made in relation to the person; and
(b) the proceeding against the person in relation to which the finding of unfitness was made has not been discontinued under section 490 or 491.

(2) The tribunal must not revoke the forensic order unless a treatment support order is made for the person under section 450.
Note:
If, on a review under part 6, the tribunal decides the person is fit for trial, the forensic order ends on the person's appearance at the mention of the proceeding for the relevant offence. See section 497(2).

454 Order for person charged with prescribed offence

(1) This section applies if a forensic order for a person was made on a reference in relation to a prescribed offence allegedly committed by the person.

(2) The tribunal must not revoke the forensic order unless:
(a) the person has been examined, under an order made under section 721, by an examining practitioner; and
(b) the tribunal has obtained and considered the examining practitioner's written report on the examination.

(3) This section is subject to section 452.