QUEENSLAND OMBUDSMAN
Standing for fairness

The Forensic Disability Service report

An investigation into the detention of people at the Forensic Disability Service

August 2019

Public

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We respectfully acknowledge the Traditional Owners of the lands throughout Queensland and pay respect to them, their culture and their Elders past, present and future.

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August 2019

The Honourable Curtis Pitt MP
Speaker
Parliament House
George Street
BRISBANE Q 4000

Dear Mr Speaker

In accordance with s 52 of the *Ombudsman Act 2001*, I hereby furnish to you my report, *The Forensic Disability Service report: An investigation into the detention of people at the Forensic Disability Service*.

Yours faithfully

Phil Clarke
Queensland Ombudsman

Foreword

The Queensland Ombudsman plays an important role investigating the administrative actions and decisions of public sector agencies, particularly when those decisions impact the lives and human rights of vulnerable people living in closed environments.

This report presents the findings of an investigation into the administrative actions by the Department of Communities, Disability Services and Seniors (the Department) and the Director of Forensic Disability (Director). The Department and the Director share responsibility for the operation of the Forensic Disability Service (FDS), a medium secure 10-bed facility at Wacol, Brisbane. The FDS was established for the involuntary detention and care of people who have been found unfit to stand trial as a result of an intellectual or cognitive disability.

The investigation was initiated as a result of information received by my Office about the quality of care at the FDS. This information raised serious concerns about the treatment of persons detained at the FDS, particularly: the length of their detention, their care during detention, the lack of adequate programs to support their habilitation and rehabilitation, delays in transitioning them from the FDS to less restrictive environments and the use of seclusion and other regulated behaviour controls. The investigation covered the period from the opening of the FDS until late 2018.

Overall, the FDS was found to be significantly non-compliant with legislation designed to safeguard the care, protection and rehabilitation of the vulnerable persons it accommodated. The investigation also found that there was no clear understanding between the Department and the Director about who was responsible for compliance at the FDS. Weaknesses were routinely identified over many years but little action was taken.

The report makes recommendations to both the Department and the Director because of their shared responsibility for ensuring the FDS meets its statutory obligations to care for the very vulnerable people detained there, to protect their human rights and to promote their early transition to supported care in the community.

I have decided to present this report to the Speaker for tabling in the Queensland Parliament because I consider that the issues dealt with are of significant public interest.

I would like to thank the Director of Forensic Disability, the many officers from the Department and other stakeholders who cooperated with the investigation by making themselves available for interview and assisted Ombudsman investigators to gather evidence to inform the investigation. I would also like to thank my staff for their hard work and professionalism in conducting the investigation and preparing this report.

Phil Clarke
Queensland Ombudsman

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Glossary

Term	Meaning
the Administrator	the person appointed to the position of Administrator as at 1 January 2019
ALRC	Australian Law Reform Commission
AMHS	authorised mental health service
ATSILS	Aboriginal and Torres Strait Islander Legal Service
CCTV	closed-circuit television
Centre of Excellence	Centre of Excellence for Clinical Innovation and Behaviour Support
CHART	Clinical, Habilitative and Rehabilitative Team
COAG	Council of Australian Governments
CRPD	Convention on the Rights of People with Disabilities
the Department	Department of Communities, Disability Services and Seniors
the position of Director	the position of the Director of Forensic Disability
the Director	the person appointed to the position of Director of Forensic Disability as at 1 January 2019
DRAMS	Dynamic Risk Assessment and Management System
FD Act	*Forensic Disability Act 2011*
FDAIS	Forensic Disability Act Information System
FDS	Forensic Disability Service
HDPR	Health (Drugs and Poisons) Regulation 1996
HR Act	*Human Rights Act 2019*
IDP	individual development plan
LCT	limited community treatment
MHA 2000	*Mental Health Act 2000* (Qld) (repealed)
MHA 2016	*Mental Health Act 2016* (Qld)
MHRT	Mental Health Review Tribunal
NDIS	National Disability Insurance Scheme
NGO	non-government organisation
OPCAT	Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
OPG	Office of the Public Guardian
OQO	Office of the Queensland Ombudsman
PBSP	positive behaviour support plan
PRN	*pro re nata*
PSRT	Public Safety Response Team
QLS	Queensland Law Society Inc
QPS	Queensland Police Service
QPS OPM	Queensland Police Service *Operational Procedures Manual*
The Park	Centre for Mental Health, Treatment, Research and Education, a specialist psychiatric hospital located in Wacol in close physical proximity to the FDS

Executive summary

The investigation

In 2017, the Queensland Ombudsman received information that raised concerns about the treatment of people detained at the Forensic Disability Service (FDS).

The FDS is a medium secure 10-bed facility situated at Wacol, Brisbane, for the involuntary detention of people found unfit for trial as a result of an intellectual or cognitive disability, and who require secure care. The facility is operated by the Department of Communities, Disability Services and Seniors (the Department) with oversight from the Director of Forensic Disability (the Director).

Two reports delivered to the Queensland Government in 2006 found that people with intellectual and cognitive disability were being detained in secure mental health facilities as a result of a lack of alternative legislative and service arrangements. The seminal report by the Honourable William J Carter QC, *Challenging Behaviour and Disability: A Targeted Response* (the Carter report), recommended that people with intellectual or cognitive disability who interact with the criminal justice system required a different and specialised response. As part of the Queensland Government's response to these reports, the *Forensic Disability Act 2011* (the FD Act) was enacted and the FDS was established in July 2011.

Initial inquiries by the Office of the Queensland Ombudsman confirmed that government and non-government entities had raised concerns about the treatment of people detained at the FDS, and the length of their detention periods. Given the gravity of these concerns, the Ombudsman decided to commence an investigation into the treatment of people within the forensic disability system in Queensland. The investigation commenced on 15 May 2018.

At first, the scope of the investigation was to encompass issues facing the broader forensic disability system. However, based on information obtained during the early phase of the investigation, the scope was refined to whether people detained at the FDS were receiving appropriate care and support in compliance with the FD Act.

The FD Act provides for the involuntary detention, care, support and protection of people with intellectual or cognitive disability at the FDS. This legislation embeds key concepts of the *Convention on the Rights of Persons with Disabilities*, an international human rights treaty, into local legislation that applies at the FDS. The FD Act therefore transforms international human rights objectives into specific legal requirements that must be applied. Guiding principles that recognise the human rights of people detained, and which promote therapeutic outcomes, are incorporated into the legislative scheme, and are also embedded in specific provisions.

Knowledge of concerns

The issues outlined in this report are not new. By the time this investigation commenced, the Department had already generated or received much of the information contained in this report. In fact, the Department has regularly been informed about key issues of concern over the course of several years.

In April 2017, the Department produced a draft bill in response to the statutory requirements to review the FD Act. A consultation draft of this bill was provided to stakeholders for comment.

The Public Guardian's submission to the draft bill raised specific concerns about the treatment of people detained at the FDS and provided specific case examples. In response, the Department appointed an interstate clinician to carry out an investigation into the allegations. The investigation found that three allegations were substantiated, two were partially substantiated and 11 were unsubstantiated. However, outside the prescribed terms of reference, the appointed clinician included general observations that identified significant weaknesses in the operation of the FDS.

The Department then commissioned a second review in partnership with Queensland Health. Professor James RP Ogloff AM, Dr Janet Ruffles and Dr Danny Sullivan, acting for the Centre for Forensic Behavioural Science, Swinburne University of Technology, delivered their report in March 2018 (the Ogloff report). The Ogloff report recommended significant reform to the current forensic disability system in Queensland, and was tabled in parliament during the course of the Ombudsman's investigation in October 2018.

By September 2016, after the FDS had been in operation for more than five years, no person detained at the FDS had been transitioned out of the facility. This triggered a safeguard provision under the FD Act that requires the Director to review a person's detention to determine if they will continue to benefit from the care and support provided by the FDS (referred to in this report as the 5-year reviews).

Six of the Director's 5-year review reports found that the person detained was not expected to benefit from further detention. Two further 5-year review reports found that the person had not benefited from detention at the FDS. The Director provided these reports to the Department.

Since 2014, the Office of the Director has also undertaken audits to assess legislative compliance with the FD Act and to monitor clinical domains that fall within the Director's legislative responsibilities. The Director's audit reports, which were provided to the Department, uncovered widespread legislative non-compliance across key areas of the FDS, including across areas linked to the treatment and support of people detained at the FDS.

Key issues

Within a closed environment that detains people with intellectual and cognitive disabilities, legislative compliance is critical to safeguarding the rights of those detained. However, this investigation found that widespread legislative non-compliance has been an enduring issue since the FDS was established.

Building blocks of good administrative practices not met

The FDS's approach to recordkeeping has not met required standards. This has impacted on the management of risks within a complex environment, and has impacted on the quality of care and support for people detained. The absence of records, paucity of detail, and incomplete or inaccurate content also impacted on the capacity of the investigation to review all aspects of legislative compliance. Some records inspected by the investigation were so poor they undermined the capacity of the FDS to demonstrate the basic level of competence required to administer its legislative functions.

Records and recordkeeping are particularly important in this context. The quality of recordkeeping at the FDS undermined the credibility of the organisation and exposed the people detained at the FDS, its staff and the community to risk.

The investigation identified the lack of an effective and integrated policy framework that supports the FDS to achieve legislative compliance and strategic objectives. This has led to inconsistencies between policies and procedures, as well as confusion around their application.

Concerns with the care and support of people detained

A primary focus of the FDS is to provide evidence-based programs that maximise a detained person's quality of life, reduce the risk of reoffending and increase opportunities for community participation and reintegration, while also ensuring the safety of the community. The FDS was therefore expected to deliver programs specifically designed to meet the needs of people with intellectual and cognitive disability, and to thereby promote a therapeutic, rights-based approach.

Individual development plans must be prepared for every person detained at the FDS. However, individual development plans were found not to meet minimum legislative requirements, particularly in regard to the standard and quality of care. While the standard of individual development plans has improved, deficiencies have had significant impacts on the lived experience of people detained.

The investigation found that the FDS has failed to deliver programs to adequately promote the development, habilitation, rehabilitation and quality of life of people detained. This has impacted on their reintegration into the community, a key objective of the FD Act.

Concerns about risk management plans, which must be in place for each person detained, were also identified.

Detention periods and delays in transition

Although the FD Act contains a legislative obligation to ensure that all detained people have a transition plan in place, the investigation found that transition plans were not developed until 2017, six years after commencement of the FDS. This adversely impacted on the transition of people detained.

Regulated behaviour controls

Regulated behaviour controls, commonly referred to as restrictive practices, can be used at the FDS in limited and prescribed circumstances, and only as a last resort. The FD Act requires that a regulated behaviour control must only occur in a way that has regard to the human rights of the detained person, aims to eliminate the need for its use, and ensures transparency and accountability.

One of the most concerning findings of this investigation was that the FDS had not complied with legislation that restricts the use of regulated behaviour controls.

The FDS is required to keep a register of the use of regulated behaviour controls, a key component of the FD Act's transparency and accountability regime. However, the investigation found that an operable and effective register was not created until 2016, and that, since then, the register contained inaccuracies and was therefore unreliable.

Given the importance of ensuring that medication prescribed for health care was not administered in circumstances that could amount to behaviour control, this issue was also investigated. The FDS was unable to demonstrate compliance with mandatory legislative provisions restricting the use of behaviour control medication at the FDS.

One person detained at the FDS, referred to as 'Adrian' in this report, has been subjected to back-to-back three-hour seclusion orders for more than six years. On reviewing the circumstances of Adrian's case, the investigation found that he had been secluded 99% of the time between admission at the FDS in 2012 and September 2018.

The circumstances of Adrian's case are severe and concerning, and were widely known to the Director and the Department. The Director's 5-year review suggests that the impact of this seclusion on Adrian has been significantly detrimental to his health and wellbeing.

Having carefully examined evidence obtained from the FDS, the Director and the Department, the investigation concluded that the approach to secluding Adrian has been contrary to law, unreasonable, oppressive and improperly discriminatory.

Police attendance and criminal charges

The investigation also found that the FDS has requested assistance from the Queensland Police Service (QPS) to respond to situations involving Adrian. The investigation found that police have attended with police dogs, and that in some of these circumstances, this was likely for the purpose of controlling Adrian's behaviour.

Some people detained at the FDS have been charged with criminal offences for incidents that have occurred between the person detained and FDS staff. All charges brought by the QPS in this context have been discharged by a court on the basis that the person was permanently unfit for trial as a result of the person's intellectual or cognitive disability. The investigation concluded that some people detained at the FDS have been exposed to criminalisation on the basis of their disability.

Recent developments

Human Rights Act 2019

This investigation was completed prior to the enactment of the *Human Rights Act 2019* (HR Act). The HR Act makes it unlawful for a public entity to act in a way that is incompatible with human rights, for example, by failing to give proper consideration to human rights when making decisions.

The application of the HR Act at the FDS will add an additional layer of protections to those that already exist under the FD Act.

New appointments

The persons who occupied the roles of Director and Administrator during the conduct of the investigation were not in those roles as at 1 July 2019. The current Director and Administrator are not the persons referred to in this report.

Causes and conclusions

Contributing factors and indicators

The investigation found a range of system-wide issues had contributed to administrative and operational failures of the FDS. These included that:

- the FDS has not embedded an appropriate and evidence-based approach to behaviour management
- there has been a lack of ongoing clinical expertise at the FDS
- there has not been a consistent, comprehensive and structured approach to the delivery of healthcare services
- there has not been a consistent whole-of-service approach to working with Aboriginal and Torres Strait Islander peoples, families and communities
- despite the high proportion of people detained at the FDS who have a reported history of childhood trauma, approaches to trauma-informed care have not been appropriately considered, implemented or prioritised at the FDS.

Governance and oversight structures

The FDS is operated by the Department with oversight from the Director. Despite clear statutory obligations under the FD Act, the responsibilities of the Department and the Director in the operation of the FDS have not been mutually understood or consistently applied since its commencement.

One of the key themes that emerged throughout the investigation was the Department's expanding and contracting characterisation of its role in the operation of the FDS, and this was reinforced in responses to the Ombudsman's proposed report.

The investigation found persistent disagreement between the Department and the Director about their respective roles and responsibilities in administering the FDS.

The investigation also found that organisational arrangements imposed by the Department did not give effect to the independence of the position of Director, and concluded that administrative decisions of the Department over time have impacted on the capacity of the Director to discharge their statutory obligations under the FD Act.

Opinions and recommendations

As a result of the apparent confusion and lack of agreement about the role of the Department and the role of the Director, this report makes recommendations jointly to the Director and to the Director-General of the Department.

This approach was specifically chosen to ensure that recommendations are implemented effectively. Given the primary capacity of the Department to provide budget and support, the Department has been allocated the responsibility of consulting with the Director, who holds statutory obligations to care for and protect the people detained at the FDS.

Opinions

Under s 49 of the *Ombudsman Act 2001*, I form the following opinions:[1]

Opinion 1

1.1 The policy framework in place at the FDS has failed to integrate organisational and operational procedures issued by the Department and the FDS with policies and procedures issued by the Director about the detention, care, support and protection of people detained at the FDS.

1.2 This led to:

- inconsistencies and a lack of synthesis of policies and procedures
- staff confusion around the application of the policies and procedures.

1.3 Policies issued by the Director about the detention, care, support and protection of people detained at the FDS are not publicly available.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 2

2.1 The information management system in place at the FDS is ineffective in meeting its legislative requirements.

2.2 The approach to recordkeeping at the FDS has not met standards imposed by the *Public Records Act 2002*.

2.3 This has:

- potential impacts on the quality of care and support provided to people detained at the FDS
- reduced the transparency and accountability of the FDS
- in some circumstances, created a risk to the safety of the people detained at the FDS, its staff and the community.

This is administrative action that is unreasonable for the purposes of 49(2)(b) of the Ombudsman Act.

1 For the purposes of Part 6, Division 1 of the *Ombudsman Act 2001.*

Opinion 3

3.1 Individual development plans (IDPs) for people detained at the FDS have not met all legislative requirements imposed by the *Forensic Disability Act 2011* (FD Act).

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

3.2 From the date of commencement of the FDS to February 2018, the FDS's approach to developing and maintaining IDPs has failed to operationalise s 13(1) of the FD Act, which provides that IDPs are designed:

- to promote development, habilitation and rehabilitation of the person detained
- to provide for the care and support of the person detained
- when appropriate, to support the person's reintegration into the community.

This failure has impacted the level of care and support provided to people detained at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 4

4.1 Rehabilitative and habilitative programs of sufficient frequency or quality have not been delivered to people detained at the FDS.

4.2 The lack of sufficient and appropriate programs has not:

- adequately promoted the development, habilitation, rehabilitation and quality of life of people detained
- made a timely impact on reducing the risk profile of people detained
- supported reintegration into the community as intended by s 15(1)(a)(iii) of the FD Act.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 5

5.1 Legislative requirements established by s 20 of the FD Act with regard to authorising limited community treatment (LCT) have not been consistently applied at the FDS.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

5.2 Two people detained at the FDS have had very limited access to LCT. In those cases, the FDS has not demonstrated that LCT opportunities have been regularly considered.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 6

6.1 A comprehensive and integrated approach to risk management for people detained at the FDS has not been developed, implemented or applied at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 7

7.1 The FDS did not have a register of the use of regulated behaviour controls (regulated behaviour control register) as required by s 74 of the FD Act until 2016.

7.2 Since commencement of the current regulated behaviour control register in 2016, accurate details about the use of regulated behaviour controls at the FDS have not always been recorded in the register, as required by the Forensic Disability Regulation 2011.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

7.3 The Director's current approach to public reporting does not adequately address transparency and accountability in the use of regulated behaviour controls at the FDS, as required by s 42(b)(iii) of the FD Act.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 8

8.1 PRN medication may have been administered to people detained at the FDS for the purpose of behaviour control.

8.2 The FDS was unable to demonstrate compliance with mandatory legislative provisions safeguarding behaviour control medication at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 9

9.1 Seclusion has been used for people detained at the FDS as a regulated behaviour control where appropriate approaches to behaviour support have not been effectively adopted or implemented. This is not consistent with s 42 of the FD Act.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

9.2 In relation to decisions to seclude Adrian:

- The FDS has failed to demonstrate that all decisions made to seclude Adrian were made in accordance with the requirements of ss 61–63 of the FD Act.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

- The seclusion of Adrian amounts to permanent seclusion.

This is administrative action that is oppressive for the purposes of s 49(2)(b) of the Ombudsman Act.

- The FDS has failed to comply with requirements to record and retain CCTV footage as required by relevant legislation and policies.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

- The permanent seclusion of Adrian has resulted in a deterioration of his condition and has significantly impacted on his quality of life and human rights.

This is administrative action that is unreasonable, oppressive and improperly discriminatory for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 10

10.1 Despite all charges brought by the QPS against people detained at the FDS, subsequent to their admission, having been discharged by a court as a consequence of the person's intellectual or cognitive disability, there has been no appropriate review of incidents that gave rise to those charges, or identification of systemic issues that may have contributed or improvements in service delivery.

10.2 People detained at the FDS have been exposed to criminalisation on the basis of their intellectual and cognitive disability.

10.3 The FDS did not adequately investigate the complaint made by a person detained at the FDS involving an alleged assault by an FDS staff member.

10.4 In some circumstances, the FDS appears to have requested assistance from the QPS in the management of Adrian that amounted to behaviour control.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 11

11.1 Between the commencement of the FDS and 2017, no IDPs contained a transition plan as required under s 15(1)(b) of the FD Act.

This is administrative action that was contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

11.2 When implemented, transition plans were deficient and ineffective in meeting their prescribed purpose.

11.3 The failure to create and maintain a transition plan of appropriate quality for each person detained at the FDS may have led to unnecessary detention.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

11.4 There is no mechanism to resolve a lack of agreement between the Director and the Chief Psychiatrist to transition a person from the FDS to an authorised mental health service.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 12

12.1 The Department and the Director have not clarified the nature and extent of the FDS's responsibility for one person for whom the FDS is responsible but who is not detained at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 13

13.1 There has not been a consistent, comprehensive and structured approach to the delivery of healthcare services to people detained at the FDS.

13.2 There has not been a consistent, integrated and sufficient approach to providing culturally appropriate care to those detained at the FDS who identify as Aboriginal and Torres Strait Islander people.

13.3 There has not been a whole-of-service approach to the consideration and implementation of principles of trauma-informed care.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 14

14.1 The workplace culture of the FDS does not promote the effective achievement of its purpose and key roles.

14.2 The FDS has not had any complaints management system in place to identify, assess and respond to complaints by or on behalf of people detained at the FDS.

14.3 The FDS has not maintained a conflicts of interest register.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Opinion 15

15.1 The Department's administrative arrangements have hindered the Director's ability to effectively undertake the statutory functions imposed by ss 87–89 of the FD Act.

15.2 The Director's attempts to facilitate the proper and efficient administration of the FD Act as required by s 87(1)c) of the FD Act were ineffective.

15.3 The Director's discharge of the statutory function of ensuring the protection of the rights of people detained at the FDS as imposed by s 87(1)(a) of the FD Act has been limited.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendations

Under s 50 of the *Ombudsman Act 2001*, I make the following recommendations:[2]

Recommendation 1

That the Director-General, in consultation with the Director:

1.1 Undertakes a review of all policies and procedures in operation at the FDS.

1.2 Implements a cohesive, comprehensive and integrated policy framework.

1.3 Ensures all FDS staff are appropriately trained to apply all policies and procedures.

That the Director:

1.4 Ensures that policies about detention, care, support and protection of people detained at the FDS are made publicly available.

Recommendation 2

That the Director-General, in consultation with the Director:

2.1 Ensures that full and accurate records about all administrative decisions made under the FD Act at the FDS are created and maintained.

2.2 Develops and implements an effective electronic record management system at the FDS that ensures:

- decisions made under the FD Act are appropriately recorded; and
- those records can be effectively and accurately accessed, managed and retrieved.

2.3 Ensures information contained in FDS records is available to inform improvements in service delivery.

That the Director:

2.4 Pursuant to s 91 of the FD Act, issues a policy and procedure that ensures records about the detention, care and support of people detained at the FDS adequately protects their rights and interests.

2.5 Audits and reports on compliance by the FDS with relevant recordkeeping standards at least annually.

2 For the purposes of Part 6, Division 1 of the *Ombudsman Act 2001.*

Recommendation 3

That the Director:

3.1 Reviews all IDPs in place at the FDS.

3.2 Ensures that all IDPs demonstrate full legislative compliance, including regular review.

3.3 Ensures that all IDPs operationalise s 13(1) of the FD Act, and are consistent with a contemporary, evidence-based approach to positive behaviour support plans.

3.4 Ensures that IDPs consolidate all existing plans and reports into a single, consistent and comprehensive document easily accessible by all relevant staff.

3.5 Reports, at least annually, on whether IDPs reflect improvements in service delivery to people detained at the FDS.

Recommendation 4

That the Director:

4.1 Reviews the adequacy, appropriateness and quality of programs delivered to people detained at the FDS, and makes recommendations to the Director-General for implementation.

That the Director-General, in consultation with the Director:

4.2 Reviews the staffing profile of the FDS to ensure it has the capacity to manage, implement and deliver appropriate evidence-based programs within a forensic disability setting to an acceptable standard.

Recommendation 5

That the Director:

5.1 Reviews the FDS's approach to authorising LCT to ensure that each decision about LCT assesses and responds to all relevant considerations imposed by s 20 of the FD Act, as well as relevant policies and procedures.

5.2 Regularly audits and reports on the FDS's compliance with s 20(3)(a) of the FD Act in relation to decisions to authorise LCT.

5.3 Where a court or tribunal has authorised LCT, continues to audit and report on whether the FDS regularly undertakes a fresh consideration of whether LCT should be authorised. Where a decision is made not to authorise LCT for a person detained, ensures the reasons for that decision are appropriately recorded.

Recommendation 6

That the Director-General, in consultation with the Director:

6.1 Develops and implements an appropriate and evidence-based risk management framework for people detained at the FDS.

6.2 Provides appropriate training to all staff required to use the risk management framework.

Recommendation 7

That the Director-General, in consultation with the Director:

7.1 Ensures that the FDS's regulated behaviour control register is accurately maintained.

7.2 Arranges for the Public Guardian and the Public Advocate to have regular access to the FDS's regulated behaviour control register.

That the Director:

7.3 Publicly reports on all use of regulated behaviour controls at the FDS at least annually.

Recommendation 8

That the Director-General, in consultation with the Director:

8.1 Implements all recommendations of the Medication report, and regularly audits compliance with the FD Act and other relevant legislation as they relate to the use of medication at the FDS.

That the Director:

8.2 Arranges medication reviews for all people detained at the FDS by an independent psychiatrist and pharmacist, and undertakes reviews of medication as clinically directed thereafter.

8.3 Provides training for all FDS management and staff in relation to the administration of all medications, including behaviour control medication.

Recommendation 9

That the Director:

9.1 Reviews the clinical management of Adrian and makes recommendations with a view to reducing the use of seclusion and improving his quality of life.

9.2 Develops and recommends a service-wide approach to behaviour support across the FDS with a view to reducing the use of regulated behaviour control in accordance with s 42(b)(iii) of the FD Act.

9.3 Reviews the FDS's use of seclusion in line with legislative obligations imposed by the FD Act, particularly ss 61–63.

9.4 Reviews the FDS's management of CCTV images and makes recommendations with a view to ensuring compliance with relevant legislation and policies.

Recommendation 10

That the Director-General, in consultation with the Director:

10.1 Develops policies and procedures about the scope and application of circumstances when the QPS should be called to attend the FDS.

10.2 Ensures that any charges brought by the QPS against a person detained at the FDS results in a review by the FDS to identify opportunities for systemic improvements.

10.3 Immediately eliminates the use of any QPS response, including the use of police dogs or the PSRT team, for behaviour control.

10.4 Evaluates the potential benefit of nominating an FDS staff member/s as a designated QPS liaison officer/s. The FDS staff member/s should be appropriately skilled and trained in both forensic disability and relevant QPS processes with a view to ensuring that:

- the FDS only contacts the QPS in appropriate circumstances
- if QPS assistance is required, it is facilitated appropriately to allow the QPS to undertake its role effectively.

Recommendation 11

That the Director:

11.1 Continues to ensure that the FDS complies with all statutory obligations imposed by the FD Act with regard to transition plans and the transition of people detained.

11.2 Ensures that transition plans developed by the FDS are effective.

That the Director-General, in consultation with the Director:

11.3 Gives consideration to legislative amendments that provide a resolution mechanism where there is no agreement to transition a person between the FDS and an authorised mental health service.

Recommendation 12

That the Director-General, in consultation with the Director:

12.1 Reviews and assesses the current legislative arrangements that apply to the person for whom the FDS is responsible, but who is not detained at the FDS, and ensure that they are receiving care and support in accordance with legislative requirements and policies and procedures issued by the Department.

That the Director:

12.2 Ensures that the full care and support arrangements in place for the person for whom the FDS is responsible, but who is not detained at the FDS, are audited by the Director.

Recommendation 13

That the Director-General, in consultation with the Director:

13.1 Reviews current arrangements with all external healthcare providers, including allied healthcare providers, with a view to ensuring that the FDS provides an appropriate level of access to health care to people detained at the FDS.

That the Director:

13.2 Reviews the current approach to providing culturally appropriate care at the FDS.

13.3 Develops a whole-of-service framework to provide trauma-informed care at the FDS.

Recommendation 14

That the Director-General, in consultation with the Director:

14.1 Reviews the structure, mix of skills and organisational culture at the FDS to align with its legislative purpose.

14.2 Reviews the complaints management policy to ensure it adequately considers the special needs of people detained at the FDS, and ensures that all FDS management and staff receive training about the application of the policy.

That the Director-General:

14.3 Establishes and maintains a conflicts of interest register at the FDS.

Recommendation 15

That the Director-General, in consultation with the Director:

15.1 Clarifies the relationship between the Department and the Director, taking into consideration statutory obligations imposed by the FD Act and legal advice.

That the Director-General:

15.2 Reviews the current classification of the position of Director having regard to the content of this report and the Ogloff report.

That the Director:

15.3 Establishes a web presence for the Office of the Director that reflects the independence of the Office, and provides public access to policies and procedures about the care, support and detention of people detained at the FDS, annual reports and any other appropriate information.

Scope and methodology

The decision to investigate

This investigation was initiated in response to concerns raised with the Queensland Ombudsman about the treatment of people subject to a forensic disability order who were detained at the Forensic Disability Service (FDS).

Publicly available information published by government and non-government organisations (NGOs) echoed those concerns.[3]

The Office of the Queensland Ombudsman (OQO) is the only independent oversight body with jurisdiction over all government agencies connected to the framework of the FDS. Given the clear public interest in ensuring accountability and transparency within a closed environment responsible for the detention, care and support of people with intellectual and cognitive disabilities, the Queensland Ombudsman decided to investigate the alleged issues.

What was investigated

The investigation focused on whether the FDS was providing care, support and protection to people detained in compliance with the *Forensic Disability Act 2011* (FD Act).

The investigation covered the period from commencement of the FDS in July 2011 to the conclusion of the investigation in October 2018.

How the investigation was conducted

The investigation was conducted on the Queensland Ombudsman's own initiative under the *Ombudsman Act 2001* (the Ombudsman Act).[4]

On 15 May 2018, the Directors-General of the Department of Communities, Disability Services and Seniors (the Department) and Queensland Health, the Director of Forensic Disability (the Director), the Public Guardian, the Public Advocate and the Chief Psychiatrist were advised of the commencement of the investigation under s 18(1)(b) of the Ombudsman Act.

The chief executives of relevant NGOs were also notified of the investigation and invited to make submissions and provide information.

3 See generally Queensland Advocacy Incorporated, Submission No 7 to Community Affairs References Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, (2016); Office of the Public Advocate Queensland, Submission No 36 to Community Affairs References Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, (2016); Office of the Public Guardian Queensland, Submission No 56 to Community Affairs References Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, (2016); Queensland Advocacy Incorporated, *Shining light on a closed system through an examination of forensic orders for persons with an intellectual or cognitive disability*, (2015); Office of the Public Advocate, Annual Report 2016–17, 8–9; In the matter of Sukkur Abdus [2016] QMHC p. 10.

4 Ombudsman Act s 12(a)(iii).

The investigation:

- consulted with NGOs and experts identified as relevant to the scope of the investigation, including nominated representatives from the Aboriginal and Torres Strait Islander Legal Service, Queensland Advocacy Incorporated, LawRight, and the Royal Australian and New Zealand College of Psychiatrists
- reviewed a written submission from the Queensland Law Society Incorporated
- obtained and analysed information from the Department, the FDS, the Director, the Coroners Court, the Office of the Public Guardian (OPG), the QPS and other sources
- undertook a site visit to the FDS, which included inspection of the physical facility and inspection of a large volume of files
- interviewed or consulted with the Director, officers from the Department, the FDS, the OPG, the Office of the Public Advocate, the Queensland Mental Health Commission, and other relevant people and entities.

Key terms

The inappropriate use of language to describe people with intellectual and cognitive disabilities can have stigmatising and other harmful effects. In fact, language plays a critical role in shaping our individual and collective views.[5] Careful use of terminology is particularly important where the perpetuation of stigmatising language may place a person, or group of people, at increased risk of social marginalisation.[6]

For these reasons, care has been taken with the words used in this report. Some key terms relevant to the subject matter of this investigation are described or abbreviated below.

Disability

This report will use the definition of disability given in the *Disability Services Act 2006*, which describes disability as a condition attributable to a range of impairments that results in a substantial reduction of the person's capacity for communication, social interaction, learning, mobility, self-care or management, and means that the person requires support.[7]

Disability must be permanent or likely to be permanent.[8]

Forensic Order (Disability) and Forensic Order (Mental Health)

A reference to a forensic disability order or a forensic mental health order refers to a Forensic Order (Disability) or a Forensic Order (Mental Health) under the *Mental Health Act 2016* (MHA 2016) respectively, or any previous version of those orders.[9]

5 Department of Communities, Child Safety and Disability Services, A way with words. *Guidelines for the portrayal of people with a disability*, published on webpage, (2012). https://www.qld.gov.au/disability/documents/community/way-with-words.pdf.
6 Queensland Advocacy Incorporated, *Shining light on a closed system through an examination of forensic orders for persons with an intellectual or cognitive disability*, (2015), p. 3.
7 *Disability Services Act 2006* s 11(1). Definitions of disability vary between legislation, policy and academia, which can make it difficult to obtain accurate data, and can present a barrier to a common, collective understanding.
8 *Disability Services Act 2006* s 3.
9 Under the *Mental Health Act 2000*, forensic disability orders were known as Forensic Orders – Disability.

Person detained at the FDS

This report uses the terms 'person detained at the FDS', or 'people detained at the FDS' where the context permits, in place of the term 'forensic disability client' used in the FD Act. This reflects the nature of the placement as involuntary detention.

The statutory definition of a forensic disability client under the FD Act applies.

Forensic Disability Service

This report uses the term FDS to refer to both the physical place prescribed by the Forensic Disability Regulation 2011 and the administration of the facility.

Mental health condition

The term 'mental health condition' is used as an umbrella term for any mental illness or disorder defined and classified by the Diagnostic and Statistical Manual of Mental Disorders.

Reference to a mental health condition in this report includes the definition of 'mental illness' under the MHA 2016, which defines mental illness as a medical condition characterised by a clinically significant disturbance of thought, mood, perception or memory.[10]

Behaviours of concern

This report uses the term 'behaviours of concern' rather than 'challenging behaviour',[11] given that terminology is now widely preferred in disability sectors.[12] Neither term is defined in relevant legislation.

Behaviours of concern are those behaviours that present a risk to the safety or wellbeing of the person who exhibits them, or to others.[13] Behaviours of concern can affect a person's capacity to participate in and contribute to their community.

Some examples of behaviours of concern include self-harm, breaking things, doing the same thing repetitiously, refusing to do things, screaming or swearing, and hiding away from people. These behaviours can be stressful and upsetting for the person demonstrating the behaviour and for those caring for them.[14]

Positive behaviour support

Positive behaviour support is a contemporary, evidence-based approach used to provide support and intervention for people with and without disability,[15] including people experiencing behaviours of concern. Positive behaviour support is widely used in disability services within Queensland and across Australia. It is both a philosophy of practice and a term used for a range of individual and multisystemic interventions designed to effect change in a person's behaviour and ultimately their quality of life.[16]

10 MHA 2016 s 10.
11 The term 'challenging behaviour' has been found to be problematic in a number of respects and can lead to labelling, stereotyping and diagnostic overshadowing.
12 Jeffrey Chan, 'Challenges to Realising the Convention on the Rights of Persons with Disabilities (CRPD) in Australia for People with Intellectual Disability and Behaviors of Concern', (2015) *Psychiatry, Psychology and Law*, https://www.tandfonline.com/doi/full/10.1080/13218719.2015.1039952.
13 Ibid.
14 Behaviours of concern have been recognised as a 'socially constructed outcome of the person-environment interaction'. An interactive effect between environmental context and behaviours of concern has been widely acknowledged within disability sectors.
15 For example, positive behaviour support has been used as an intervention for children.
16 Victorian Department of Health and Human Services, *Positive practice framework*, Guideline, (2018), p. 12.

Implemented in a partnership approach with the person, their carers and their support network,[17] positive behaviour support relies on three related elements:[18]

- understanding why the person engages in behaviours of concern
- finding the environmental causes for behaviours of concern, and modifying them so that the behaviour is unnecessary
- teaching the person new skills to meet their needs without having to resort to behaviours of concern.

Restrictive practices

Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person. The primary purpose of restrictive practice interventions is to control or manage a person's behaviour to protect them, or others, from harm.[19]

Restrictive practices commonly include the use of seclusion and restraint, which can include physical, mechanical or chemical restraint.[20]

The FD Act uses the term 'regulated behaviour control' to refer to these types of restrictive practices. Given the primacy of that legislation, this report uses the term 'regulated behaviour control,' which is analogous with the term 'restrictive practices.'

De-identification

To preserve the identity of people detained at the FDS, this report does not use their real names.

All references to identifying features of people detained at the FDS have been de-identified. However, in some circumstances, the gender and cultural background of people detained have been preserved due to their relevance to the issues of concern.

During the investigation, officers from a number of Queensland Government agencies provided information to the investigation. Their anonymity has been preserved where possible.

For people adversely named in this report, procedural fairness provisions contained in the Ombudsman Act have been applied.[21]

17 Ibid.
18 Queensland Department of Communities, Disability Services and Seniors, *What is positive behaviour support*, Guideline, (2018). https://www.communities.qld.gov.au/disability/service-providers/centre-excellence/positive-behaviour-support/what-positive-behaviour-support.
19 Department of Social Services, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*, (2014), p. 4. https://www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector; Bernadette McSherry 'Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities', (2017), *International Journal of Law and Psychiatry*, p. 53.
20 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report 124, (2014) 195; Department of Social Services, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*, (2014), p. 4.
21 See Appendix 2.

PART A:
Context

An overview of forensic disability orders and background to the Forensic Disability Service

Background

This report relates to the treatment of people detained at the FDS.

The term forensic disability relates to people with intellectual and cognitive disability who have been charged, but the court has found the person is unfit for trial and/or cannot be held criminally responsible for the alleged offence because of the person's disability. It is important to note that a person to whom the term forensic disability applies has not been found guilty of a criminal offence and has not been sentenced to a defined period of detention.[22]

Forensic disability is a complex area that spans conventional boundaries between disability, mental health and the criminal justice system. All Australian states and territories have enacted laws and legal frameworks dealing with fitness to stand trial and mental impairment.[23] However, most jurisdictions do not have a specialised facility for people with intellectual or cognitive disability who are unable to participate in a trial or be held criminally responsible, and who require secure care.

Secure mental health facilities have been considered inappropriate for people with intellectual and cognitive disability, who have different needs to people experiencing acute mental health conditions. While the nature and impact of mental health conditions can vary across a person's life, intellectual and cognitive disabilities are lifelong impairments and require a specialised approach.

For people with disability in contact with the criminal justice system, those needs are particularly complex.

In response to recommendations from a number of relevant inquiries,[24] Queensland was the first Australian jurisdiction to establish a specialised approach for people found subject to a forensic order as a consequence of their intellectual or cognitive disability and who require secure care. In 2011, the *Forensic Disability Act 2011* was enacted and the FDS commenced operation.

Previous investigations and inquiries in Queensland

To place the operation and administration of the FDS in context, it is helpful to consider the history of relevant inquiries and reforms that preceded the Queensland Government's decision to establish the FDS.

Basil Stafford inquiry

The Basil Stafford Centre was a government-run facility that provided accommodation and care for adults and children with intellectual disability. The facility was the subject of a Criminal Justice Commission inquiry[25] arising from allegations of abuse and gross neglect of clients, and a report was produced in 1995.

22 Anti-Discrimination Commission Queensland, Submission to the Forensic Disability Bill 2010 Information Paper to the Department of Communities, October 2010.
23 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report no 124, (2014), 199.
24 Queensland Health, *Promoting balance in the forensic mental health system*, Report by Brendan Butler, (2006).
25 Criminal Justice Commission, *Report of an Inquiry Into Allegations of Official Misconduct at the Basil Stafford Centre*, (1995).

The inquiry found widespread misconduct related to the abuse and neglect of people with disabilities at the Basil Stafford Centre and recommended its immediate closure. In delivering its findings, the inquiry identified specific features of the institutional environment that gave rise to extreme vulnerability for people with intellectual or cognitive disability. Allegations of assault and abuse were linked to what was described by the report as an 'insidious institutional culture' at the Basil Stafford Centre.[26]

Subsequent to this inquiry, the disability sector in Queensland underwent a period of progressive de-institutionalisation, which echoed changing community attitudes towards large institutional facilities.

In 2000, the Honourable Justice WJ Carter QC led a further Criminal Justice Commission inquiry to review implementation of the recommendations of the Basil Stafford report. The report *The Basil Stafford Centre Inquiry Report: Review of the Implementation of the Recommendations* concluded that considerable changes had taken place.[27]

Butler report

In 2006, His Honour Brendan Butler AM SC undertook a review into Queensland's mental health legislation. The report *Promoting balance in the forensic mental health system – Final Report – Review of the Queensland Mental Health Act 2000 (the Butler report)* considered whether the *MHA 2000* and associated arrangements achieved an appropriate balance between the safety and protection of the community, and the provision of rehabilitation opportunities for patients under a forensic order.[28]

The Butler report identified that, while the primary purpose of the MHA 2000 was to provide for the involuntary assessment and treatment of people with a mental health condition, forensic orders were also being imposed on the basis of a person's intellectual disability. This allowed a person with a disability to be detained in an authorised mental health service for involuntary treatment.

The Butler report found that the detention of people with intellectual disability alongside people with mental health conditions in authorised mental health services was inappropriate, and resulted from a lack of alternative legislative or service arrangements.

In outlining this conclusion, the report comments that:

> The requirement for people on forensic orders to be detained in an authorised mental health service is clearly inappropriate for people with a sole diagnosis of intellectual disability. Mental health services exist to provide treatment for people with mental illness and do not usually have the facilities or expertise to provide appropriate care for people with an intellectual disability, some of whom may have extremely challenging behaviours and may need long term intensive support and secure care. Detention in high secure facilities for people with mental illnesses can be highly detrimental for people with an intellectual disability, placing the person, other patients and staff at risk.

The Butler report recommended a review of relevant provisions of the MHA 2000 as part of any reform to the provision of secure care for people with an intellectual or cognitive disability who demonstrate serious behaviours of concern. This recommendation was supported by the then government.

26 Ibid.
27 WJ Carter QC, *The Basil Stafford Centre Inquiry Report: Review of the Implementation of the Recommendations*, Criminal Justice Commission, (2000).
28 Queensland Health, *Promoting balance in the forensic mental health system*, B Butler AM SC report, (2006), p. 1.

Carter report

Also in 2006, the Honourable WJ Carter QC conducted a review into the care, support and accommodation of people with intellectual or cognitive disability who demonstrated behaviours of concern. The seminal report *Challenging Behaviour and Disability: A Targeted Response* (the Carter report) was tabled in July 2006.

In addressing the terms of reference, the Carter report identified that the Department[29] relied too heavily on restrictive practices. The report also recognised the significant impact restrictive practices have on the human rights of people with disability, and noted the growing evidence base that supported the use of positive behaviour support to address behaviours of concern.[30]

The Carter report delivered a suite of recommendations aimed at 'immediate and substantial' renewal, regeneration and reform of the Department's approach.[31]

In making those recommendations, the report emphasised that fundamental principles of human rights should be embedded into relevant legislation as statutory requirements to mandate compliance. In commenting on the centrality of human rights in disability settings to address the critical issues of the report, Justice Carter wrote that:

> The enlightened and socially responsible legislative principles encapsulated in the Disability Services Act 2006 are the classic antidote to this poisonous mindset. Compliance with these legislative imperatives is therefore not negotiable. Not only do they bind all concerned in delivering disability services, they provide a robust foundation for policy development, for service delivery at all levels and provide the yardstick or measure against which performance, whether at government level or in the workplace, is to be measured.
>
> To insist on these standards is not to set an impossible task or an unattainable objective. One can identify in some of the developmental work of [Disability Services Queensland] and in that of some funded non-government organisations instances where the required standards are maintained as a matter of course or serious attempts made. The concern is to ensure that these legislative requirements are embraced at all levels and, that they increasingly become pervasive and systemic. Excellence is then not merely a working objective; it is and will remain a permanent achievement.

As well as considering issues broadly relating to people who display behaviours of concern, the report specifically considered the interactions of people with intellectual and cognitive disability and the criminal justice system. Echoing the findings of the Butler report, the Carter report also identified that the management of people with intellectual or cognitive disability by authorised mental health services was inappropriate and recommended a different approach.

The report recommended the establishment of a Queensland Centre for Best Practice in Positive Behaviour Support that was intended to develop disability sector expertise in positive behaviour support and provide leadership in best practice. In implementing this recommendation, the government established the Centre of Excellence for Clinical Innovation and Behaviour Support.

All 24 recommendations of the Carter report were supported by the then government.[32]

29 The Department was known as Disability Services Queensland at the time of the report.
30 Hon William J Carter QC, *Challenging Behaviour and Disability: A Targeted Response Report*, (2006); Department of Communities, Child Safety and Disability Services, *Review of the Regulation of Restrictive Practices in the Disability Services Act 2006 and the Guardianship and Administration Act 2000*, Discussion Paper, (undated).
31 Hon William J Carter QC, *Challenging Behaviour and Disability: A Targeted Response Report*, (2006), p. 24.
32 Explanatory Notes, Forensic Disability Bill 2011 (Qld), p. 3.

Relevant national developments

This section provides an outline of relevant developments across Australia that relate to forensic disability and the use of restrictive practices for people who experience behaviours of concern.

The treatment of people within forensic disability systems is an issue of national concern, with a number of reports produced at both state and national level having been directed at this issue.[33]

Australian Law Reform Commission inquiry

In 2013, the Attorney-General of Australia made a referral to the Australian Law Reform Commission (ALRC) to review the laws and legal frameworks within the Commonwealth jurisdiction that deny or diminish the equal recognition of people with disability as people before the law, and their ability to exercise legal capacity.[34]

The *Equality, Capacity and Disability in Commonwealth Laws* report touched on the following matters:

- the test of unfitness to stand trial across state and federal jurisdictions
- the indefinite nature of forensic orders for people with intellectual disability given that disability is, by definition, a permanent condition
- the use of restrictive practices in disability settings.

The ALRC found that regulation of restrictive practices at state and territory level led to fragmentation across legislative frameworks and policy directives. Recommendations were made to the Australian Government and the Council of Australian Governments (COAG) aimed at harmonising relevant legislation, particularly frameworks that allow for authorisation of the use of restrictive practices, to achieve better outcomes.

The report noted that serious concerns had been expressed to the ALRC about inappropriate and under-regulated use of restrictive practices in a range of settings in Australia, including under disability and mental health legislation. The ALRC also noted that, while the laws on mental impairment and fitness to stand trial are designed to be protective, in practice, a finding of unfitness or mental impairment on the basis of an intellectual or cognitive disability can lead to adverse outcomes, including a person with a disability being detained for an indefinite period in prison or a secure mental health facility.[35]

National Framework

In March 2014, to forge a consistent national approach,[36] the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (the National Framework) was endorsed by Commonwealth, state and territory governments. This confirmed national agreement from disability ministers that restrictive practices should only be used where proportionate and justified.

The National Framework recognises that people with disability in receipt of disability services who display behaviours of concern are at risk of being subjected to restrictive practices. Focusing on reducing the use of restrictive practices involving restraint and seclusion, the National Framework prescribes minimum requirements for service provision in the disability sector.

33 See the Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Law*, Final Report, (2014); and Australian Human Rights Commission, Equal before the law – Towards disability justice Strategies, Report, (2014).
34 Letter of reference to the Australian Law Reform Commission from Mark Dreyfus QC MP, dated 23 July 2013.
35 Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Law*, (2014), 7.20; Consultation with the Aboriginal and Torres Strait Islander Legal Service, 31 May 2018.
36 Department of Social Services, *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*, (2014) p. 4.

In supporting the National Framework, state and territory governments also committed to developing a national reporting model to enhance accountability and public transparency, and also provide a national picture and measurement of effectiveness aimed at improving performance.[37]

Senate inquiry

On 2 December 2015, the Australian Senate referred the matter of indefinite detention of people with cognitive and psychiatric impairment in Australia to the Senate Community Affairs References Committee, which conducted an inquiry into the indefinite detention of people with cognitive and psychiatric impairment in Australia (the Senate inquiry).[38]

The terms of reference defined indefinite detention to include all forms of secure accommodation of a person without a specific release date.[39] The detention of a person at the FDS therefore fell within the scope of the inquiry.

The Senate inquiry received 71 submissions. The following stakeholders, identified as relevant to the scope of the investigation, made submissions to the inquiry:

- the Director
- the OPG
- the Public Advocate
- Queensland Advocacy Incorporated
- the Royal Australian and New Zealand College of Psychiatrists.

A number of the above stakeholders specifically raised concerns about the operation of the FDS, particularly in relation to the lengthy detention periods of people detained.[40] In addressing this issue, the Public Advocate's submission presented a comparative analysis between periods of detention in the FDS and estimated sentences that would have been imposed in the mainstream criminal justice system.[41]

The Senate inquiry report identifies deficiencies within current legislative frameworks to adequately respond to the issue of indefinite detention, and presents recommendations to Commonwealth, state and territory governments targeted at systemic reform across and within state jurisdictions. Available information indicates that the Australian Government has not yet responded to recommendations of the Senate inquiry.

Draft national principles

In 2015, a cross-jurisdictional working group was established by the COAG Law, Crime and Community Safety Council to collate and analyse data across all jurisdictions about fitness to stand trial, the defence of mental impairment and interstate forensic transfers.

The working group also developed a national statement of principles relating to people unfit to plead or not guilty by reason of cognitive and mental health impairment (the draft national principles). The draft national principles recognise the rights of people with cognitive or mental health impairments in their involvement in the criminal justice system,

37 Ibid, p. 13.
38 Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (2016). The inquiry lapsed at the dissolution of the Senate on 9 May 2016, but on 13 September 2016, the Senate agreed to re-adopt the inquiry with a reporting date of 29 November 2016.
39 This included detention orders by a court, tribunal or under a disability or mental health Act, as well as detention orders made by a court or tribunal that may be time limited but capable of extension by a court, tribunal or under a disability or mental health Act prior to the end of the order.
40 Office of the Public Advocate, Submission No 36 to Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*, April 2016; Office of the Public Guardian, Submission No 56 to Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*, April 2016.
41 Office of the Public Advocate, Submission No 36 to Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia*, April 2016, p. 13.

and seek to identify safeguards that should be in place.[42] The draft national principles were considered by the Council of Attorneys-General in June 2018, but are yet to be adopted.[43]

Vision for the FDS

In response to recommendations of the Butler and Carter reports, the Queensland Government developed a specialised approach to forensic disability. This included:

- amendments to the MHA 2000 and related legislation, which provided decision-making bodies with an option to impose a forensic disability order for people with a sole diagnosis of intellectual or cognitive disability, as distinct from a forensic mental health order
- enacting the FD Act, which governs the operation of the FDS
- constructing and establishing the physical FDS facility.

The FDS was the first facility in Australia designed for the exclusive purpose of providing secure care to people subject to a forensic disability order, or equivalent interstate order, on the basis of an intellectual or cognitive disability and not a mental health condition.[44]

In presenting the second reading speech of the Forensic Disability Bill 2011 (FD Bill) to the Queensland Parliament in April 2011, the then Minister for Disability Services made the following statement, which frames the vision intended for the FDS:

> A primary goal of the bill is to be consistent with the principles, goals and objectives reflected in the United Nations Convention on the Rights of People with Disabilities. To this end, the focus of the legislative scheme, within the constraints of a detention environment, is on safeguarding rights and freedoms, promoting individual development, enhancing opportunities for quality of life and maximising opportunities for safe reintegration into the community.
>
> Two of the key terms in the bill are 'habilitation' and 'rehabilitation', which are derived from the United Nations convention. Habilitation is about learning skills to enable a person to participate in society and their community. Rehabilitation is about restoring capacity and ability. Together, habilitation and rehabilitation involve individualised approaches, multidisciplinary assessment and intervention so that people with disabilities can develop and acquire skills to better realise their full potential.
>
> ...
>
> The bill incorporates a model that will allow the management of risk for people subject to forensic orders in a manner more appropriate for clients with an intellectual or cognitive disability while also promoting better outcomes for the person. The key elements of the bill reflect this framework. The principles in the bill focus on the concept of habilitation and rehabilitation and promoting individuals' rights and needs and are intended to reflect the objects, goals and principles of the United Nations Convention on the Rights of People with Disabilities and also the *Disability Services Act 2006*.[45]

42 Attorney-General's Department, *Australia's Combined Second and Third Periodic Report under the Convention on the Rights of Persons with Disabilities*, Report, (2018).

43 In 2016, Recommendation 8 of the Senate Inquiry report, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (2016) recommended that the committee endorse and adopt the national principles at its earliest opportunity. In June 2018, the Council of Attorneys-General considered a revised version of the draft and agreed to further consider the draft at its next meeting. However, a communique from the Council's meeting in November 2018 does not include a reference to adopting the national principles.

44 An overview of forensic disability service systems across Australian jurisdictions is provided in the Department's report *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*, and was broadly considered in the Senate inquiry report.

45 Queensland, Parliamentary Debates, Legislative Assembly, 7 April 2011, 1132–5 (the Honourable Curtis Pitt MP).

Forensic disability orders

When a person is charged with committing a serious indictable offence, criminal proceedings will originate in the mainstream court process.[46] If the legal capacity of a person with an intellectual or cognitive disability is in issue, the matter may be referred to the Mental Health Court.[47] This will divert the charges from the mainstream court process into the jurisdiction of the Mental Health Court.[48]

In some circumstances, intellectual or cognitive disability may not be identified or raised before the court, in which case the matter will be heard and determined through mainstream processes.

A diagram outlining pathways through the court framework is provided on page 15.

Decision-making bodies

The Mental Health Court and the Mental Health Review Tribunal (MHRT) are the two primary bodies that make decisions about people with intellectual or cognitive disability in contact with the criminal justice system.[49]

The Mental Health Court[50] is a branch of the Supreme Court that has jurisdiction to determine the state of mind of people charged with criminal offences. The Court can also hear appeals from the MHRT, and has the power to review a person's detention in an authorised mental health service or the FDS to decide whether the detention is lawful.[51]

The Mental Health Review Tribunal is an independent statutory body established to review the involuntary status of people with a mental health condition. The primary function of the MHRT is to review the appropriateness of forensic orders, treatment support orders and treatment authorities made under the MHA 2016.

The basis for imposing a forensic order

Forensic orders can be imposed for people charged with a serious offence who have been found to have been of unsound mind[52] at the time of the alleged offence, or who are unfit for trial.[53]

A person may be found to be of unsound mind[54] if, at the date of the alleged offence, the person was so impaired by their disability or mental health condition that they were

46 The person charged with an offence may be remanded in custody within the general prison population, or granted bail. They may also be involuntarily detained at an authorised mental health service.
47 Section 110(5) of the MHA 2016 provides that a reference may be made by a defendant's lawyer, Legal Aid Queensland, the prosecuting body including the Director of Public Prosecutions, or other relevant person.
48 An indictment may only be subject to a reference to the Mental Health Court where charges relate to state and not federal offences.
49 Courts and tribunals are not within the jurisdiction of the Ombudsman Act. The scope of the investigation was on administrative action by agencies.
50 Constituted by a Supreme Court judge advised by two assisting psychiatrists.
51 MHA 2016 s 673.
52 The ALRC report *Equality, Capacity and Disability in Commonwealth Law Final Report* (2014) found that the term 'unsound mind' is considered 'derogatory, judgmental and stigmatising.' In some jurisdictions, the term 'unsound mind' has been replaced with the term 'mental impairment'.
53 Very occasionally, forensic orders can be imposed by the District or Supreme Court following a jury trial. See ss 613, 645 and 647 of the *Criminal Code Act 1899*. Whether the Mental Health Court or District or Supreme Court will decide on these issues depends on the stage in the criminal process the question of legal capacity arises.
54 Unsound mind has a legislative definition under s 109 of the MHA 2016. This definition includes reference to criteria set out in the *Criminal Code 1899*. Specifically, s 27(1) of the *Criminal Code 1899* establishes the definition of 'insanity'. That term is effectively replaced in the MHA 2016 with the term 'unsound mind'. Legislative provisions relevant to a consideration of whether a person is of unsound mind therefore rely on both the *Criminal Code 1899* and the MHA 2016.

deprived of the capacity to understand what they were doing, control their actions, or know that they should or should not do something.

If the court finds a person to be of unsound mind, the person is not criminally responsible for their actions. Sentencing objectives, including punishment, deterrence and denunciation, therefore do not apply.

A person will be found unfit for trial if the court determines that the person does not have sufficient mental or intellectual capacity to understand the proceedings, instruct their lawyers and make an adequate defence.[55] In deciding whether a person is unfit for trial, the Mental Health Court may consider factors including the person's level of functioning and whether they would be able to follow court proceedings, understand the nature and purpose of a court hearing, and understand the evidence.[56] When the court finds that a person is unfit for trial, a judge will also decide whether the person is likely to remain permanently unfit for trial. As intellectual and cognitive disabilities are considered lifelong conditions,[57] this is a common outcome.

Serious offences

Prior to the enactment of the MHA 2016, forensic orders could be imposed for any criminal offence irrespective of the seriousness of the charge. Subsequent to the introduction of the new MHA 2016, forensic orders can now only be imposed for serious offences.[58] A serious offence is an indictable offence that cannot be heard and determined by a Magistrate.[59]

Given the long-term nature of forensic orders, this means that the unlawful acts for which people have been placed on the order have varying levels of seriousness. This means that detained persons may have been placed on an order for offences no longer recognised as applicable to a forensic order. For example, one person who has been detained at the FDS was initially placed on a forensic order for the offences of common assault and unlawful use of a motor vehicle, and not any serious offence; whereas other people detained at the FDS have been placed on a forensic disability order for serious offences.

Types of forensic orders

If a person is found to be of unsound mind and/or unfit for trial,[60] the Mental Health Court must make a forensic order if the court considers such an order is necessary to protect the safety of the community, including from the risk of serious harm to other people or property.[61] This consideration has been described as the 'principle purpose'[62] of a forensic order.

The court must impose a forensic disability order if the person's unsoundness of mind or unfitness for trial arises as a consequence of an intellectual or cognitive disability, and the person needs care for their intellectual disability,[63] but does not need treatment and care for any mental health condition.[64]

55 *R v Pritchard* (1836) 173 EF 135, [304].
56 As per the six point criteria established in *R v Presser* [1958] ALR 248.
57 While an intellectual or cognitive disorder is considered a permanent condition, the person's experience of their disability can be more or less impactful as a result of environmental factors such as the nature of care and support they may receive.
58 Under the MHA 2016, a 'serious offence' refers to an indictable offence that is an offence under the *Criminal Code Act 1899* (Qld) where the maximum term of imprisonment is more than three years. Note that the Mental Health Court will assess whether the alleged offences constitute serious offences within the meaning of the MHA 2016.
59 Serious offences can include offences such as arson, grievous bodily harm, indecent treatment, robbery, rape, serious assault and manslaughter; but do not include offences such as common assault and most forms of wilful damage.
60 Under s 134(1) of the MHA 2016, where the court finds that the defendant is fit for trial, the court must order that the proceeding against the defendant be continued according to law.
61 MHA 2016 s 134(1).
62 *Re HHR* [2012] QMHC, p. 15.
63 While the MHA 2016 refers only to intellectual disability, this is taken to also include cognitive disabilities.
64 MHA 2016 s 134(3)(b).

A forensic mental health order must be made if the person's unsoundness of mind or unfitness for trial is because of a mental health condition other than an intellectual disability. A forensic mental health order must also be made if a person has a dual disability.[65]

Of the total number of forensic orders currently in force, only 15.2% are forensic disability orders.[66]

The Mental Health Court must also determine whether the category of the forensic order is 'inpatient', which requires that the person be detained in an authorised mental health service or at the FDS.

The Mental Health Court may only make an order detaining a person at the FDS if the Director has provided the Court with a certificate of 'required capacity'. For the FDS to have required capacity, it must have the physical capacity to accommodate the person and the capacity to provide care for the person under the forensic disability order.[67]

If the Court considers there is no unacceptable risk to the safety of the community, including the risk of serious harm to other people or property, the Court can impose a forensic order where the category of the order is called 'community'.[68] This allows the person to reside in the community with supervision and support from an authorised mental health service.[69]

Where a person is subject to an existing forensic disability order, they may also be transferred to the FDS by agreement between the Chief Psychiatrist and the Director pursuant to s 353 of the MHA 2016.

Reviews and appeals

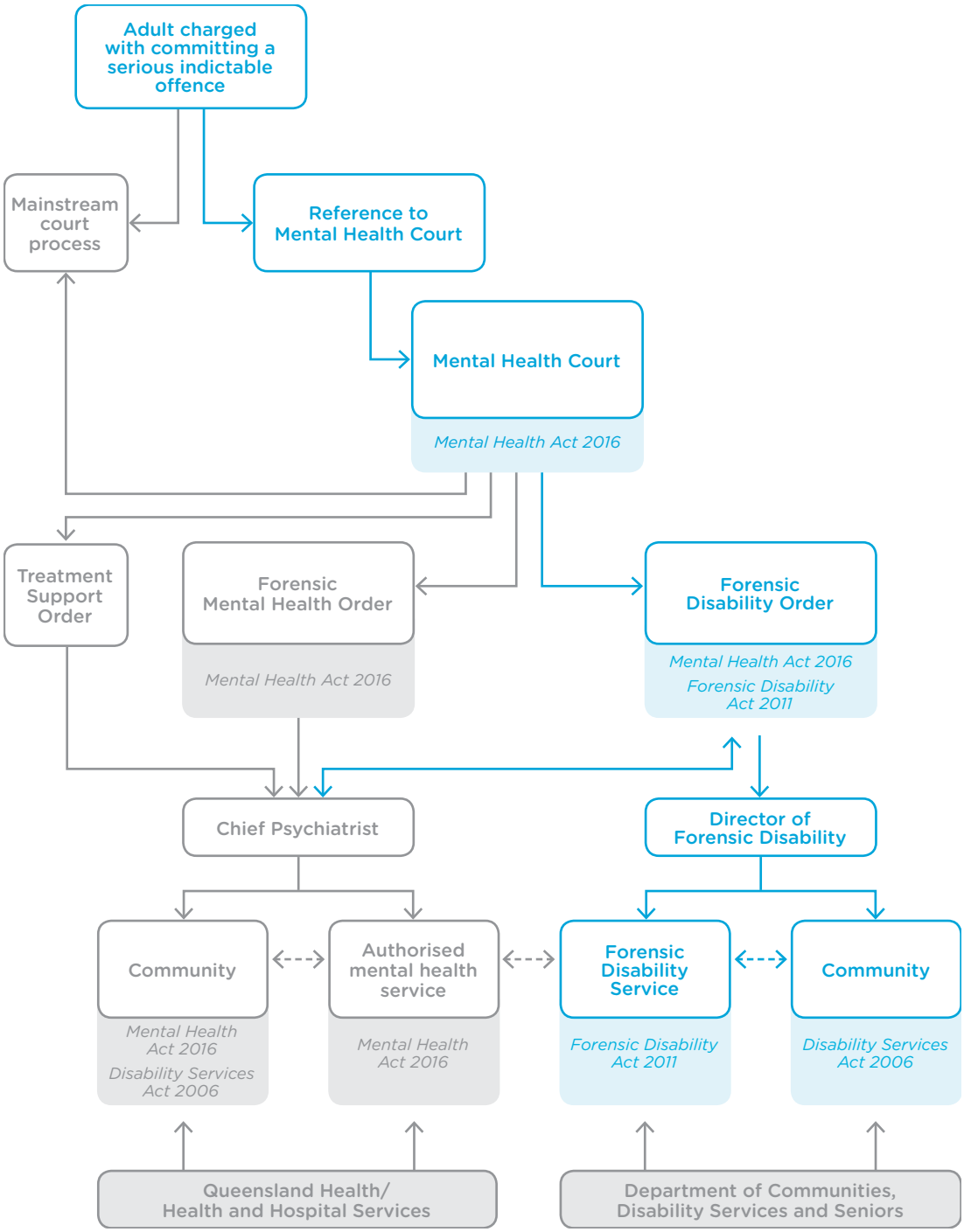
The MHRT must conduct a periodic review of all forensic orders every six months.[70] Prior to a periodic review hearing, a clinical report must be prepared by the authorised mental health service or the FDS and provided to the tribunal. The tribunal can also order an independent report.

The MHRT can also review a forensic order on application of the person subject to the order, the Attorney-General, the Director or another interested person, for example, the appointed guardian or allied person[71] of the person subject to the order.

At each review, the tribunal must decide to either confirm or revoke the forensic disability order. An order must be confirmed if the tribunal considers the order is necessary to protect the safety of the community, including from the risk of serious harm to other people or property.[72] The tribunal therefore undertakes a periodic risk assessment to consider whether detention continues to be justified and, if so, what conditions should apply. General principles under the MHA 2016, including the principle of adopting the least restrictive approach, apply to the MHRT's decision.

65 This allows the person to receive involuntary treatment for their mental health condition provided by an authorised mental health service.
66 Chief Psychiatrist Annual Report 2017–18.
67 MHA 2016 s 147.
68 MHA 2016 s 138.
69 Under s 138(2) of the MHA 2016, the category of the order can be community only if the court considers there is not an unacceptable risk of serious harm to other people or property.
70 MHA 2016 s 413.
71 FD Act s 23.
72 MHA 2016 s 442(1).

Pathway into the Forensic Disability Service



The people detained at the FDS

The following section provides information about the nature of intellectual and cognitive disability, demographics and personal circumstances, and other factors that make the people detained at the FDS particularly vulnerable.

Demographics and personal circumstances

Between commencement of the FDS in July 2011 and the first day of the site visit conducted by the investigation, a total of 12 people have been detained at the FDS.[73] Of those:

- eleven were male and one was female
- six were subject to guardianship orders where the Public Guardian was appointed guardian of last resort
- seven were Aboriginal and/or Torres Strait Islander peoples.[74] Of those people, five had been transferred to the FDS from regional and remote areas in Queensland, and two people identified English as their second language
- at least seven people had been placed in out-of-home care during childhood[75]
- at least five had reported a history of childhood sexual abuse.[76]

Intellectual and cognitive disabilities

The FD Act defines intellectual disability as characterised by 'significant limitations in intellectual functioning and adaptive behaviour'.[77]

Intellectual disability emerges before the age of 18 years and results in a lack of competency in at least two of the following areas: communication, self-care, home living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, or health and safety.[78]

Cognitive disability is a delay, reduction or abnormality of cognitive functions such as learning, reasoning, memory, problem-solving, decision-making, organisation, perception, intellect or attention.

73 In contrast, 103 people subject to a forensic disability order were under the responsibility of an authorised mental health service. The percentage of people under a forensic disability order (as per available data) who have been detained at the FDS is therefore 11.6%.
74 As described in information provided by the Department, this included identifying as Indigenous or confirming Indigenous heritage.
75 Out-of-home care is the care of children aged 0–17 years who are unable to live with their primary caregivers. It involves the placement of a child with alternative caregivers on a short or long-term basis.
76 This information was obtained from reports from the files of people detained at the FDS, including clinical and legal reports, as well as reports authored by the Director and retained on the files of people detained at the FDS. This information was indirect; that is, quoting or citing contents of a source document that was not viewed by the investigation. However, this information was often repeated across a number of documents and records authored by the FDS about the person, including the individual development plans, positive behaviour support plans, MHRT documents and other sources.
77 FD Act s 12.
78 Hon William J Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, (2006).

Mental health conditions

The FDS was intended to support and detain people with an intellectual or cognitive disability and no mental health condition.

In the second reading speech of the FD Act, the Minister for Disabilities stated that:

> The service is a small service. Its program of care and support is specifically designed for people with an intellectual or cognitive disability and no mental illness requiring treatment. This is an important distinction. It means it is not intended for clients with a mental illness or with what is known as dual diagnosis, that is, both an intellectual or cognitive disability and a mental illness requiring treatment. For this reason, before making an order to detain someone in the Forensic Disability Service, both the Mental Health Court and the Mental Health Review Tribunal must consider whether the person has an intellectual or cognitive disability, but does not require involuntary treatment for a mental illness, and whether the person is likely to benefit from the care and support provided in the Forensic Disability Service.[79]

Contrary to this stated intention, a number of people detained at the FDS have received treatment for a diagnosed mental health condition while detained there.[80] These have included mental health conditions such as psychotic and mood disorders.

Treatment of mental health conditions for people with intellectual and cognitive disability at the FDS has resulted in complexities and risk, and is discussed in relation to behaviour control medication in Part B of this report.

Heightened vulnerability

People with disability in closed institutional environments are vulnerable to heightened risk of harm.[81] For people detained at the FDS, that vulnerability often has multiple layers and origins, which can lead to the synergistic effects of multiple disadvantage.[82]

Vulnerability factors arise as a complex interaction between features of the institution and the personal circumstances of those detained. For people detained at the FDS, vulnerability is compounded on the basis of intellectual and cognitive disability and the person's experience of behaviours of concern.

The characteristics of a detention environment elevate risk factors for a person detained. The FDS is a medium secure environment that is relatively closed to the outside world. Inherent power differentials operate between a closed facility and a person detained.

The scope of that power and the manner of its use is modifiable through a number of key safeguards that operate at legislative, policy and administrative levels. Leadership, culture, clear and contemporary policies and procedures, strong recordkeeping, reflective practice, and effective internal and external oversight form the foundations of mitigating inherent risks.

Aboriginal and Torres Strait Islander peoples are over-represented at the FDS compared to non-Indigenous peoples.

Complex needs

This report recognises that people detained at the FDS have highly complex needs, which can be challenging for staff and the facility. The FDS was established to manage those particular needs.

79 Queensland, Parliamentary Debates, Legislative Assembly, 7 April 2011, 1132–5 (the Honourable Curtis Pitt MP).
80 Ibid.
81 Commonwealth Royal Commission into Institutional Responses to Child Sexual Abuse, Final Report: *Volume 15 Contemporary detention environments,* (2017).
82 E Baldry, L Dowse, M Clarence, *People with mental and cognitive disabilities: pathways into prison*, (2012), Background Paper for Outlaws to Inclusion Conference.

Investigative context

Relevant legislation

The FD Act and the Forensic Disability Regulation 2011 set the legislative framework for the detention, care and support of people detained at the FDS.

The FD Act does not apply to people subject to a forensic disability order who are, by order of the Mental Health Court, under the responsibility of an authorised mental health service.

In addition to the FD Act, the following legislation is relevant to the scope of the investigation:

- *Mental Health Act 2016*
- *Disability Services Act 2006*
- *Guardianship and Administration Act 2000*
- *Public Guardian Act 2014*
- *Criminal Code 1899*
- Health (Drugs and Poisons) Regulation 1996.

Key provisions of the FD Act

The FD Act provides for the involuntary detention, and the care, support and protection, of people detained at the FDS, while at the same time:[83]

- safeguarding their rights and freedoms
- balancing their rights and freedoms with the rights and freedoms of other people
- promoting their individual development and enhancing their opportunities for quality of life
- maximising their opportunities for reintegration into the community.

The FD Act contains a number of general principles that apply to administrative decision-making, which include principles of human rights, promoting habilitation and rehabilitation, meeting individual needs and goals, maintaining supportive relationships and community participation, supported decision-making, providing support for exercising rights and confidentiality.

Human rights

The FD Act contains a number of mandatory legislative obligations to ensure that any encroachment on a person's rights is balanced by safeguard provisions.

Human rights are specifically enacted in the following three areas:

- in the principles for administration of the Act, which includes the principle of same human rights[84]
- in setting out how the legislative purpose of the FD Act will be achieved[85]
- in ensuring that regulated behaviour controls (restrictive practices) are only used in a way that has regard to the human rights of the person detained.[86]

83 FD Act s 3.
84 FD Act s 7(a). Same human rights are defined as the right of all people to the same basic human rights.
85 Specifically, s 4(a) of the FD Act provides that the purpose of the Act will be achieved by stating the human rights and other principles applying to the administration of the Act.
86 FD Act s 42(b)(i).

Least restrictive approach

The principle of adopting the least restrictive approach is also a key concept of the FD Act, and applies in the following provisions:

- a power or function relating to a person detained at the FDS must be exercised or performed so that the person's liberty and rights are adversely affected only if it is the least restrictive way to protect the person's health and safety or to protect others, and only if any adverse effect on the liberty and rights of the person detained is the minimum necessary in the circumstances[87]
- regulated behaviour controls can only be used if considered necessary and if they are the least restrictive way to protect the health and safety of a person detained at the FDS or to protect others.[88]

Least restrictive is defined by the FD Act to mean the use of restraint or seclusion that ensures the safety of the person or others, and that imposes the minimum limits on the person's freedom as are practicable in the circumstances.[89]

Reduction and elimination of restrictive practices

The FD Act provides that regulated behaviour control can only be used in a way that aims to reduce or eliminate the need for its use.[90] This enshrines the principles of reduction and elimination of restrictive practices at law, and embeds the commitment of the Queensland Government to reduce and eliminate the use of restrictive practices.

Multidisciplinary model of care

One of the main ways the purpose of the FD Act is to be achieved is through a multidisciplinary model of care and support.[91]

This model of care is designed to promote the continual development, independence and quality of life of a person detained.[92]

Protection of the community

When making decisions under the FD Act, the protection of the community and needs of a victim of any alleged offence should be taken into account.[93]

These important considerations are not mutually exclusive from the key provisions of the FD Act that focus on the care, support and protection of people detained at the FDS.

87 FD Act s 8.
88 FD Act s 42(a).
89 FD Act Schedule 2.
90 FD s 42(b)(ii).
91 FD Act s 4(c), 13(1), 101(3)(a); Explanatory Notes, Forensic Disability Bill 2011 (Qld).
92 FD Act s 4(c).
93 FD Act s 4(d).

Offences and penalties relating to the treatment of people detained

The seriousness of non-compliance with the legislative regime established under the FD Act is emphasised by the inclusion of offence provisions within the Act.

Specifically, the use of regulated behaviour control is safeguarded through the inclusion of offence provisions. These offences relate to the three types of regulated behaviour control that can be authorised under the FD Act and include the offences of:

- administering behaviour control medication to a person detained at the FDS other than as prescribed by the relevant legislative provisions[94]
- using restraint on a person detained at the FDS other than as prescribed by the relevant legislative provisions[95]
- keeping a person detained at the FDS in seclusion other than as prescribed by the relevant legislative provisions.[96]

These offences are punishable by a maximum of 50 penalty units.[97]

The most serious offence under the FD Act is the offence of ill-treatment. The FD Act states that a person must not ill-treat a person detained at the FDS. Ill-treat includes to wilfully abuse, neglect or exploit.[98]

This ill-treatment offence carries a maximum penalty of 150 penalty units or one year's imprisonment.[99]

International obligations

Australia is a party to all major international human rights conventions.

Of these, the *Convention on the Rights of Persons with Disabilities* (CRPD) is the most directly applicable to people detained at the FDS. Australia ratified the CRPD in 2017 and acceded to the Optional Protocol to the CRPD. Together, these instruments are intended to protect the rights and dignity of people with disability.

The explanatory notes for the Forensic Disability Bill 2011 confirm that, in enacting the FD Act, parliament intended to embed human rights principles established under international instruments within Queensland legislation. Specifically, the explanatory notes state that the legislation aims to be consistent with the principles, goals and objectives reflected in the CRPD.[100]

Australia has also ratified the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT), an international human rights treaty that formalises Australia's commitment to ensuring that no person detained in Australia is subject to torture and other cruel, inhuman or degrading treatment or punishment.

94 FD Act s 49.
95 FD Act s 54.
96 FD Act s 60.
97 As at 1 July 2019, the Penalties and Sentences Regulation 2015 provides that a penalty unit value in Queensland is $133.45. Therefore, the total maximum penalty for these offences is $6,672.50.
98 FD Act s 116.
99 Equivalent offences for each of these provisions are contained in the MHA 2016. However, equivalent provisions in the MHA 2016 carry a maximum penalty of 200 penalty units. The Department's s 157 report finds that the penalties under the FD Act could be updated to align with analogous provisions in the MHA 2016.
100 Explanatory Notes, Forensic Disability Bill 2011, p. 4.

Agencies and positions

This section outlines agencies and key roles relevant to the scope of the investigation and highlights relevant statutory responsibilities.

The Department

The FDS is operated by the Department, which is responsible for administering the FD Act.[101] FDS staff are employed by the Department under the *Public Service Act 2008*.

Between 2011 and 2014, the Department was known as the Department of Communities, Child Safety and Disability Services. After a machinery of government change in 2017, the Department became the Department of Communities, Disability Services and Seniors.

The Director of Forensic Disability

The Director[102] is an independent statutory position established under the FD Act. The role carries high level obligations to ensure the protection of the rights of people detained at the FDS.

The Director is appointed by the Governor in Council under the FD Act and not under the Public Service Act.[103] In exercising a power under the FD Act, the Director is not subject to ministerial direction.[104]

The Director reports to parliament through the Minister for Communities, Disability Services and Seniors (the Minister).[105] The Director must provide an annual report on the administration of the FD Act to the Minister, who must table the report in the Queensland Parliament within 14 sitting days.[106]

The statutory functions of the Director include:

- ensuring the protection of the rights of people detained at the FDS
- ensuring that the involuntary detention, assessment, care, support and protection of people detained at the FDS complies with the FD Act
- facilitating the proper and efficient administration of the FD Act
- monitoring and auditing compliance with the FD Act
- promoting community awareness and understanding of the administration of the FD Act
- advising and reporting to the Minister on any matter relating to the administration of the FD Act either on the Director's own initiative, or at the request of the Minister if the matter is in the public interest
- performing other functions given under the FD Act.

The Director must also issue policies and procedures about the detention, care, support and protection of people detained at the FDS.[107]

Where a person has been detained at the FDS for a continuous period of five years, the Director must carry out a review of whether that person is benefiting from the care and support provided by the FDS, consider whether that benefit is likely to continue, and give a copy of the review report to the Administrator.[108]

101 Administrative Arrangements Order (No. 4) 2017.
102 In this report, a reference to 'the Director' includes a reference to the position rather than to any particular person appointed to the role.
103 FD Act s 85(2).
104 FD Act s 89.
105 As previously noted, by order of the Administrative Arrangements Order (No. 4) 2017, the Minister responsible for administering the FD Act is also the Minister for Disability Services.
106 FD Act s 93.
107 FD Act s 91.
108 FD Act s 141.

As well as these specific functions, the FD Act conveys broad powers on the Director to 'do all things necessary or convenient to be done in performing the Director's functions'.[109] This section has been interpreted in legal advice as making the Director 'ultimately responsible'[110] for the involuntary detention of each person detained at the FDS, and for ensuring that the way in which each person is cared for, assessed, supported and protected by the FDS complies with the FD Act.[111]

In response to the proposed report, the Department asserted that, in accordance with legal advice it obtained in 2013, the Department has had a limited role in the operation of the FDS.

In contrast, in the Director's response to the proposed report, the Director took issue with characterisation of the statutory position of the Director as 'ultimately responsible' for the operations of the FDS.

These competing perspectives are outlined in Part C of this report.

The Administrator

The Administrator is responsible for the management of the FDS. The Administrator is employed by the Department and formally appointed under the FD Act by the Director.[112] A person detained at the FDS is in the legal custody of the Administrator.[113]

The Centre of Excellence

The Centre of Excellence for Clinical Innovation and Behaviour Support (the Centre of Excellence) is a unit within the Department established to promote disability sector expertise in positive behaviour support and the reduction in the use of restrictive practices.[114]

Office of the Public Guardian

The OPG is an independent[115] statutory office established under the *Public Guardian Act 2014*, and the position of Public Guardian is a statutory appointment with corresponding statutory obligations.[116]

The OPG has an oversight function to promote and protect the rights and interests of people with impaired decision-making capacity, including adults, and children and young people in the child protection system.[117]

The OPG may have involvement with people detained at the FDS in two ways:

- If the person's decision-making capacity is impaired due to their intellectual or cognitive disability, the Public Guardian may have been appointed as guardian by the Queensland Civil and Administrative Tribunal. The Public Guardian is the appointed guardian for 50% of the people who are or have been detained at the FDS. Delegate guardians can assist their clients within a framework of supported decision-making to help the person with impaired decision-making capacity make decisions about personal, health and legal matters.

109 FD Act s 88.
110 Legal advice dated 5 February 2013, p. 7.
111 Office of the Director of Disability 2014 audit report, p. 27.
112 The role of Administrator is referred to at the FDS as the 'Centre Director.' This report uses the term 'Administrator' to reflect the term used in the FD Act.
113 FD Act s 150.
114 The Centre of Excellence was established in 2008 in response to a recommendation of the Carter report, which recommended the Centre function as an 'overseer of service delivery to ensure that it is ethical, effectively responsible to individual needs and intent only on successful outcomes'. The Carter recommendations detailed 11 functions that the Centre should undertake to ensure the application of human rights and best practice in service delivery to people with intellectual and cognitive disability who experience behaviours of concern, through monitoring, review, relationship building and other functions.
115 *Public Guardian Act 2014* s 15.
116 *Public Guardian Act 2014* s 15 provides that the Public Guardian is not under the control or direction of the Minister.
117 *Public Guardian Act 2014* s 5.

- OPG community visitors are appointed to conduct independent monitoring of visitable sites, including the FDS, to protect and promote the rights and interests of people at these sites.[118]

Office of the Public Advocate

The Public Advocate is an independent statutory position appointed by the Governor in Council,[119] and forms part of the oversight framework to protect people with disability in Queensland. The Public Advocate reports to parliament through the Attorney-General and Minister for Justice, but is not under the control or direction of the Minister.[120]

The Public Advocate has a systemic function to promote and protect the rights of adults with impaired capacity, including protecting adults from neglect, exploitation or abuse,[121] and monitoring and reviewing the delivery of services to such adults.[122]

The Chief Psychiatrist

The Chief Psychiatrist[123] is an independent statutory appointment to protect the rights of patients under the MHA 2016.

The functions and powers conferred on the Chief Psychiatrist under the MHA 2016 are very similar to those conferred on the Director under the FD Act.

The Chief Psychiatrist is responsible for people who receive involuntary assessment, treatment, care or detention in authorised mental health services under the MHA 2016. This includes people subject to a forensic disability order under the responsibility of an authorised mental health service.

Under the MHA 2016, the Director and the Chief Psychiatrist may agree to transfer the responsibility for a person subject to a forensic disability order from an authorised mental health service to the FDS, or vice versa.[124]

Non-government organisations

NGOs play a critical role in safeguarding the rights of people with intellectual and cognitive disabilities.

External and NGO stakeholders that provide legal, advocacy and other services to people detained in a closed facility are well placed to identify and raise concerns, and are therefore critical to adjusting power differentials inherent in the detention environment.[125]

The investigation consulted with NGOs, including Queensland Advocacy Incorporated and the Aboriginal and Torres Strait Islander Legal Service. These organisations provide legal and advocacy services to people detained at the FDS, including representation of people detained at review hearings by the MHRT.

118 The FDS is considered a 'visitable site' for the purposes of the *Public Guardian Act 2014*. When the FD Act was first enacted, the Guardianship and Administration Regulation 2000 was amended to declare the FDS to be a visitable site. Section 39 of the *Public Guardian Act 2014* now provides that visitable sites include the FDS and authorised mental health services.
119 *Guardianship and Administration Act 2000* Chapter 9.
120 *Guardianship and Administration Act 2000* s 211.
121 *Guardianship and Administration Act 2000* s 209(1)(a).
122 *Guardianship and Administration Act 2000* s 209(1)(e).
123 This role is created under the MHA 2016 and was previously titled the Director of Mental Health under the MHA 2000.
124 MHA 2016 s 353(2).
125 The important function undertaken by lawyers and advocates who do not form part of government structures was highlighted in the Basil Stafford report – see Criminal Justice Commission, *Inquiry into Allegations of Official Misconduct at the Basil Stafford Centre* (1995) pp. 391–3.

Overview of recent government action

The investigation observed that, since 2016, the detention of people at the FDS and the operation of the service have been subject to increasing attention, both internally and externally.

This part of the report provides an integrated overview of the entry and exit of people detained at the FDS, relevant actions, appointments, legislative and machinery of government changes, and state and federal inquiries and reports.

The overview shows increasing attention on the operations of the FDS by the Director, the Department, the Public Guardian and NGO stakeholders, set against a changing legislative landscape and increased national attention to relevant issues.[126]

A number of the reports generated by the Director and commissioned by the Department demonstrate that the key issues of concern outlined in Part B of this report were well known to the Director and the Department.

Department's response

In response to the Ombudsman's proposed report, the Department emphasised that increasing attention was at least in part driven by a desire for openness and transparency in the reviews of the FDS that were initiated by the Department.

Draft legislative amendment bill

Section 157 of the FD Act requires that the Minister must review the efficacy and efficiency of the FD Act as soon as practicable three years after its commencement. As soon as practicable after finishing the review, the Minister must table a report in the Queensland Parliament.

In April 2017, the Department produced a draft bill in response to its obligation under s 157 of the FD Act.

A consultation draft of the bill was provided to stakeholders for comment, including the Public Guardian, the Public Advocate and NGOs. In response, stakeholders raised significant concerns about the then operation of the FDS, as well as limitations of the legislative framework.

The Public Guardian submitted that the FDS had failed to meet its key objectives, including a lack of practical recognition and operationalisation of human rights.[127] This submission was based on information obtained through the OPG's role as guardian for people detained at the FDS[128] as well as through its community visitor function, both of which were intended to form part of the oversight of the FDS.[129]

The OPG submission raised serious concerns about the treatment of people detained at the FDS.

The then Director-General of the Department appointed an authorised officer to carry out an investigation into the allegations made in the Public Guardian's submission.[130]

126 Including the issues of indefinite detention, restrictive practices, and the treatment and management of people found unfit for trial.
127 Ultimately, the Public Guardian's submission concluded that the OPG was unable to support the draft bill in its proposed form due to what the OPG considered to be a failure to address key aspects of the FD Act in meeting its purpose.
128 At the time of the submission the OPG was appointed as a guardian of last resort for four people detained at the FDS.
129 Explanatory Notes, Forensic Disability Bill 2011.
130 Under s 106 of the FD Act, the Director or chief executive may appoint a registered health practitioner, speech pathologist, social worker engaged in providing disability services, lawyer or other person to be an authorised officer. Authorised officers appointed under this provision are furnished with investigative powers, including the power to require the FDS to produce documents or stated information by written notice, gain access to and inspect the FDS, and confer alone with people detained.

An interstate clinician, Dr Frank Lambrick, Senior Practitioner of Disability for the Department of Health and Human Services in Victoria, was appointed to carry out an independent investigation (the Lambrick report). The terms of reference for the investigation included each of the concerns raised by the Public Guardian's submission, conducting enquiries to support or refute the concerns, and providing a report detailing whether the concerns were substantiated.[131] Dr Lambrick was given a four-week timeframe to investigate and report.

Department's response

In response to the Ombudsman's proposed report, the Department stated that the timeframe for producing the draft bill was significantly impacted through linking and phasing the review with other legislative initiatives, and listening to and seriously considering the views and opinions of stakeholders and advocates.

Director's response

In response to the Ombudsman's proposed report, the Director submitted that the Department's delay in reviewing the FD Act resulted in a failure to identify key issues that have led to the failings identified in this report.

Lambrick report

The Lambrick report reviewed and analysed the Public Guardian's submission and responded to individual issues raised by the OPG.

Outside the terms of reference, Dr Lambrick outlined a number of general observations about 'key themes' that arose during the course of the review that were considered 'particularly important considerations'.[132] These included the following comments and observations:[133]

- A structured risk assessment and management process was not in operation at the FDS, at the time or in previous years. There was some evidence of structured risk assessment being conducted with individuals, though not in a systemic way and not informing a structured risk management approach. This was considered by the reviewer as particularly concerning given that, when implemented in a systemic and structured way, these approaches effectively facilitate engagement in community-based activities and ultimately release.
- A disconnect was identified between the role of direct support staff and clinical teams at the FDS.
- Paper-based records at the FDS presented difficulties in the monitoring and evaluation of legislatively related activities.
- The original intake of people detained at the FDS was not based on set eligibility criteria focused on risk and treatment need established through a careful contemporary assessment approach.
- Most of the people detained at the FDS were not suitable for a residential treatment facility.
- For two people, detention at the FDS appears to have led to a 'worse outcome'.
- There were a number of legislative inconsistencies between the FD Act and other relevant legislation, particularly the *Disability Services Act 2006*.

The Lambrick report was delivered to the Department in August 2017.

131 Correspondence between the Department and the OPG dated 9 June 2017.
132 F Lambrick, Victorian Department of Health and Human Services, *Review of the Forensic Disability Service*, (2017), p. 14.
133 Ibid.

Forensic Disability Service system review

In October 2017, the Department engaged a second set of consultants to undertake a full review of the Forensic Disability Service system. The review was jointly commissioned by the Department and Queensland Health, and included broad terms of reference that extended beyond a review of the operation of the FD Act to capture systemic issues facing all people subject to a forensic disability order in Queensland.

Professor James RP Ogloff AM, Dr Janet Ruffles and Dr Danny Sullivan from Victoria were appointed to conduct the review, and delivered their report in March 2018 (the Ogloff report).[134]

As provided by the terms of reference, the focus of the Ogloff review was to consider:

- current services and support provided to all people under a forensic disability order
- interrelationships and connections between the services, systems, legislation and oversight mechanisms of the forensic disability service system
- policies, laws and service delivery that relate to the making, exercising, review and administration of forensic disability orders
- legislative and administrative arrangements for portfolio responsibility for the delivery and operation of the system
- efficacy of the existing oversight and monitoring mechanism and possible systems improvements.

The review did not investigate specific circumstances of individuals who were subject to a forensic disability order at the time.

On 9 October 2018, the Department tabled its report *Section 157: Review of the operation of the Forensic Disability Act 2011 – Final report* (the Department's s 157 report). This report includes a review of the operation of the FD Act, identifying key areas where the FD Act needs to be improved.[135] The Department's s 157 report includes the Ogloff report as an attachment. Given that the two reports are separate and distinct, they will be referenced in this report separately as the Department's s 157 report and the Ogloff report.

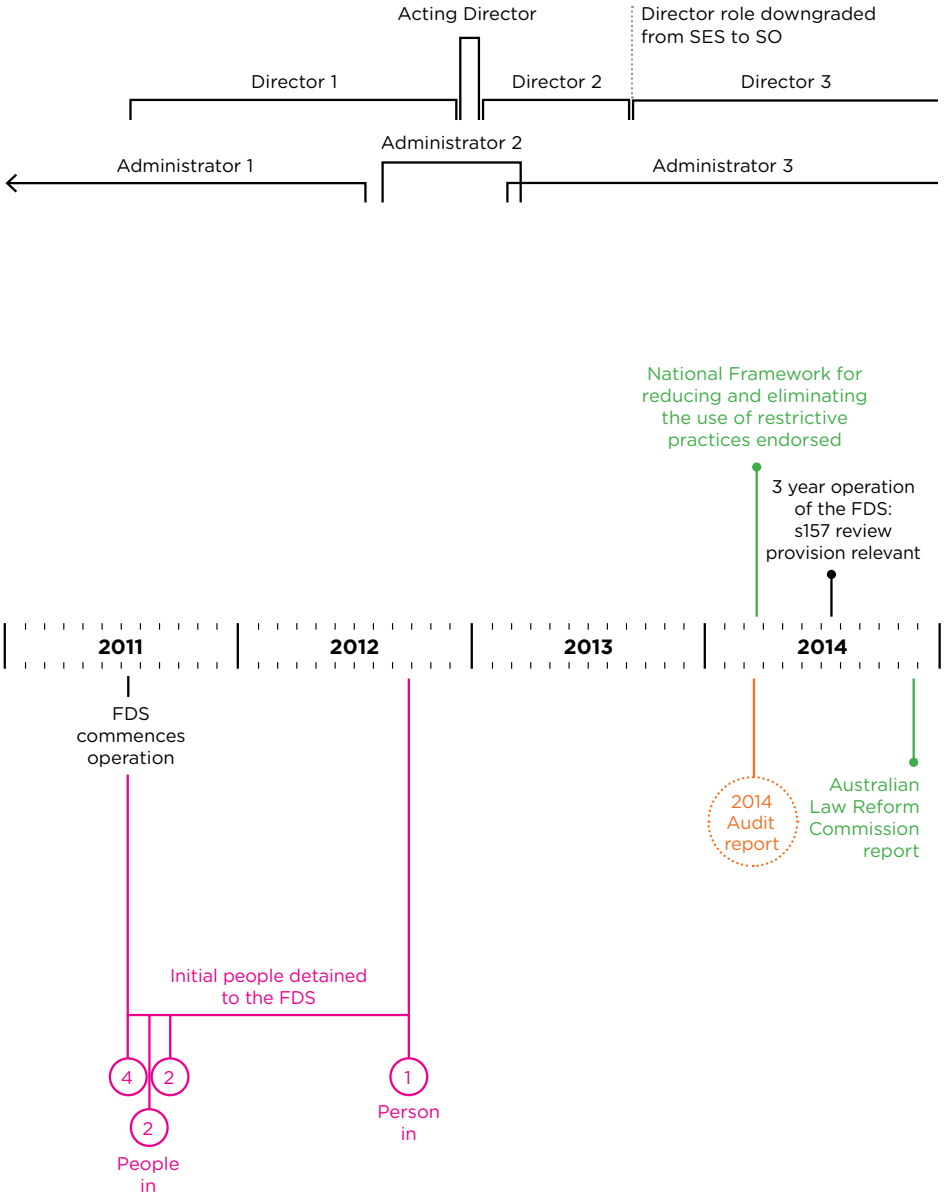
The Department's s 157 report contains a number of findings relevant to the forensic disability service system broadly and the FDS specifically.

The Ogloff report recommended structural reform to the delivery of forensic disability services in Queensland. In this review of the state-wide forensic disability service system in Queensland, the Ogloff report discusses the role and function of the FDS, and outlines a number of key issues that arose from the review. In relation to the FDS, the Ogloff report conveys that a clear and consistent view of stakeholders was that the FDS has not functioned as envisaged.[136]

A diagram outlining the chronology of significant events relating to the FDS is provided on pages 27 and 28.

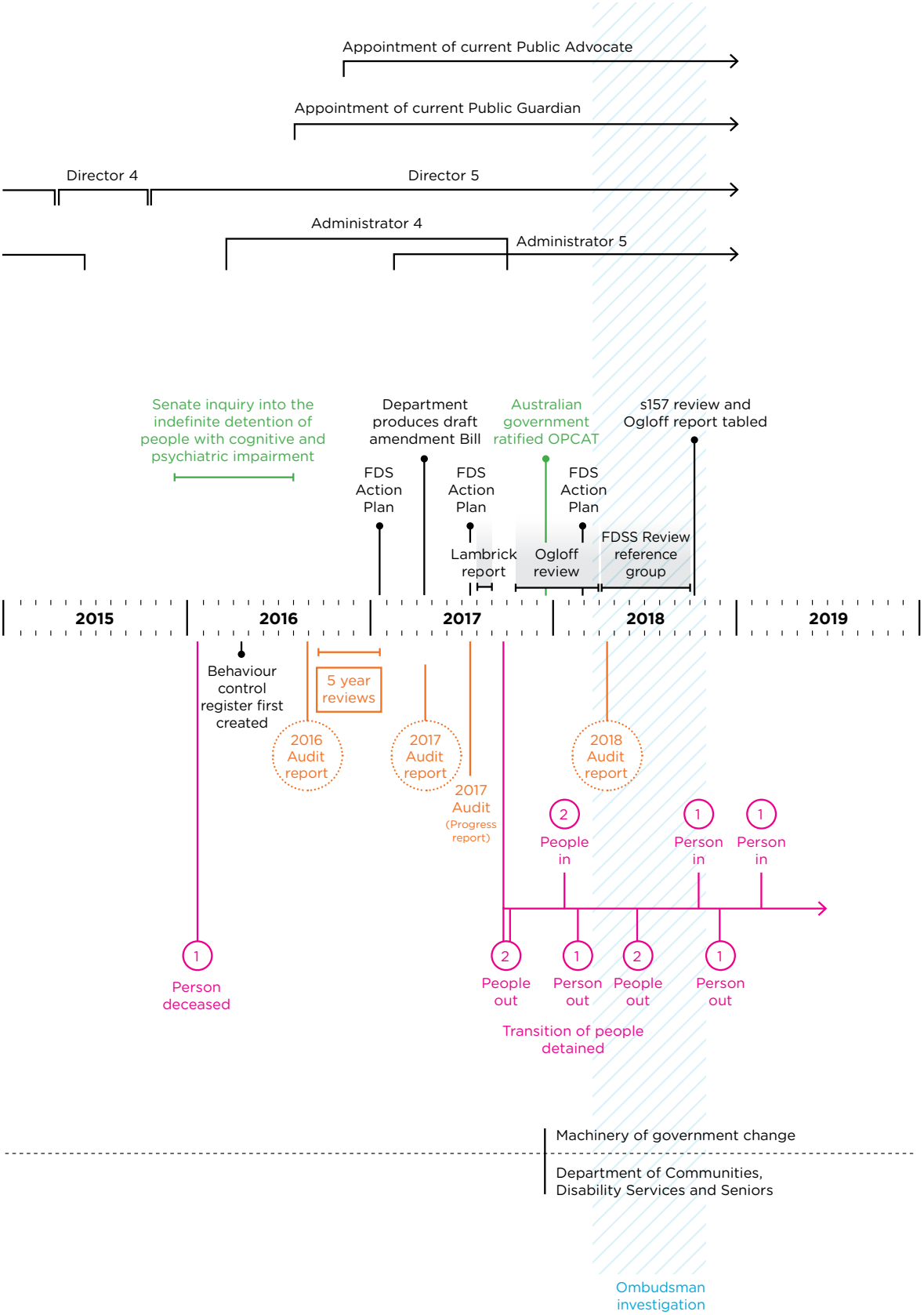
134 This report was prepared under contract to the Queensland Government acting through Queensland Health and the Department of Communities, Child Safety and Disability Services. The report states that the views of the authors do not represent the views of the Queensland Government.
135 Department of Communities, Disability Services and Seniors, *Section 157: Review of the operation of the Forensic Disability Act 2011*, Final Report, (2018), p. 4.
136 J Ogloff, J Ruffles, D Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*, (2018), Unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, pp. 47–51.

Chronology of significant events relating to the FDS



Department of Communities, Child Safety and Disability Services

- Reports by the Director
- Movement of people detained
- Relevant national developments


Appointment of current Public Advocate
Appointment of current Public Guardian
Director 4
Director 5
Administrator 4
Administrator 5
Senate inquiry into the indefinite detention of people with cognitive and psychiatric impairment
Department produces draft amendment Bill
Australian government ratified OPCAT
s157 review and Ogloff report tabled
FDS Action Plan
FDS Action Plan
FDS Action Plan
Lambrick report
Ogloff review
FDSS Review reference group
2015
2016
2017
2018
2019
Behaviour control register first created
5 year reviews
2016 Audit report
2017 Audit report
2017 Audit (Progress report)
2018 Audit report
1 Person deceased
2 People out
1 Person out
2 People out
1 Person out
2 People in
1 Person in
1 Person in
Transition of people detained
Machinery of government change
Department of Communities, Disability Services and Seniors
Ombudsman investigation

Reports produced by the Director

The Director has produced and commissioned a range of reports that relate to the administration of the FD Act at the FDS and the treatment of people detained.

Together with reports commissioned by the Department, reports generated by the Director evidence that key issues of concern were well known and continued over an extended period of time.

Audit reports

In undertaking the Director's statutory function to monitor and audit compliance with the FD Act,[137] the Office of the Director conducted audits and produced audit reports. The purpose of the audits was to assess compliance with legislative obligations and clinical domains that fall within the scope of the FD Act.[138]

Since 2014, the Office of the Director has undertaken its monitoring and auditing function through generating audit reports for provision to the Department. Audit reports are referenced in the Director's annual reports and were obtained by the investigation.

The audit reports, which assess the performance of the FDS through a focus on legislative compliance, repeatedly identify significant concerns about the proper administration of the FD Act. Widespread legislative non-compliance with key areas of the legislation was uncovered. Legislative non-compliance was repeatedly reported in areas linked to the treatment and support of people detained at the FDS.[139]

Each audit focused on two audit domains – legislative compliance and clinical performance.[140] The first audit report established a format that was carried across each of the subsequent reports.

Each audit report makes recommendations to the FDS to address legislative non-compliance and clinical concerns that fall within the scope of the Director's responsibilities. As well as recommendations, the 2017 and 2018 audit reports also included a number of 'actions' described by the Director as requiring immediate attention by the FDS to address legislative non-compliance.[141] Actions were therefore a form of recommendation that were expected to be actioned by the FDS.

In response to the recommendations and actions delivered by the Director in the audit reports, the FDS generated 'action plans' for the 2016, 2017 and 2018 audits.

A total of four audits and one progress audit have been conducted since commencement of the FDS. The first audit was undertaken by the then Director in 2014, three years after the commencement of the FDS. No specific audit report was generated in 2015. Audit reports were subsequently produced by the Director for 2016, 2017[142] and 2018.

137 FD Act s 87(1)(d).
138 As stated in the executive summary in each of the audit reports.
139 Particularly in the areas of IDPs, the use of seclusion, limited community treatment, clinical governance, program development and delivery, and a lack of an evidence-based approach to positive behaviour support.
140 These were considered to be under the Director's scope of responsibilities given that the position of Director is responsible for ensuring that the way the person is cared for, assessed, supported and protected by the FDS complies with the FD Act.
141 At interview, the Director clarified that the 'actions' were those that she required be completed immediately, and that the recommendations were for qualitative improvements.
142 A 2017 progress audit was also undertaken and a report provided. As this report does not follow the same format of the other reports, was prepared to assess the progress of the FDS, and was ultimately succeeded by the 2018 audit, this report focuses on the content of the four major audits.

From 2016 onwards, the Director stated that the audit reports were provided to the Department for provision to the following senior officers:[143]

- Director-General
- Deputy Director-General
- Executive Director of the Centre of Excellence
- Senior Executive Director, Accommodation Support and Respite Services
- Administrator.

Department's response

In response to the Ombudsman's proposed report, the Director-General stated that she was not provided with a copy of the 2018 audit report. The Director-General stated:

> Rather, it appears they were given by the [Director] to the Deputy Director-General (Disability Services), and not progressed to the Minister or I. A search of the Department's document tracking system confirms this position. However, upon learning of the existence of the DFD's 2018 audit, I sought out the report.

5-year review reports

Where a person has been detained at the FDS for a period of five consecutive years, the Director must conduct a review of a person's detention to determine if they will continue to benefit from the care and support provided by the FDS (5-year review).[144] This forms a safeguard against indefinite detention.

'Benefit' is a key term in the legislation,[145] and refers to individual development, opportunities for quality of life, and participation and inclusion in the community.[146] Following a review, the Director must give a report to the Administrator.[147]

Five years after the commencement of the FDS, no person detained at the FDS had been transitioned out of the facility. Therefore, this requirement applied to all nine people who were admitted in 2011 or 2012. Accordingly, the Director undertook 5-year reviews for each of the nine people detained at the FDS and delivered reports.[148] For two people, it was found that they had not benefited from detention at the FDS. For six people, it was found that they were no longer benefiting and unlikely to benefit in the future.

Subsequent to delivery of the 5-year review reports, six people have been transitioned out of the FDS.

143 Senior officers holding those positions had changed over the period of time between the provision of the 2016 audit report and the most recent 2018 report, including a machinery of government change in December 2017.
144 As required by s 141 of the FD Act.
145 Explanatory Notes, Forensic Disability Bill 2011, p. 79.
146 FD Act s 141(6).
147 FD Act s 141(3).
148 Including one person who was not physically detained at the FDS, but who resided in secure accommodation within the Wacol precinct in close proximity to the FDS.

Medication report

In 2017, the Director engaged two pharmacists to review the use of medication at the FDS. The Director's objectives of the review were to:

- review current processes associated with medicines being taken by people detained at the FDS, and consider and recommend processes for compliance with Queensland legislation related to medicines
- review documentation requirements for the use of medicines where staff are required to provide assistance to the person detained, with the aim to identify any inefficiency and to facilitate a more efficient and effective system appropriate to FDS
- develop a model or options for an alternative recording system for the FDS to overcome difficulties identified with the current recording process.

The *Process and Regulatory Aspects for Medicines: Forensic Disability Service Project Report* (Medication report) clarified the legislative basis on which medication was administered at the FDS, and raised a range of concerns about the use of medication at the FDS.

The investigation was advised by the Director that all recommendations of the Medication report had been accepted.[149] In relation to implementation of those recommendations, the Director's 2018 audit report identified that of the 12 recommendations made, 11 had not been fully implemented and were still 'scheduled for completion'.

149 Letter from the Director to the investigation dated 2 November 2018.

The physical facility

The FDS is a medium secure facility designed to provide residential treatment and rehabilitation, located in Wacol, Brisbane, within the Wacol Disability Services Precinct. References to the FDS in this report refer to the physical facility and also to the administration of the facility.

The FDS is operated by the Department and the facility was opened on 18 July 2011.

The Wacol Disability Services Precinct is adjacent to a number of major correctional facilities, including the Brisbane Youth Detention Centre, the Brisbane Women's Correctional Centre and the Wolston Correctional Centre.

The precinct also contains other facilities that are designed to accommodate people who may receive services under the *Disability Services Act 2006*.

The FDS facility consists of an administration building and three accommodation units, referred to by the FDS as 'houses'.[150]

The entrance to the FDS is staffed by security officers. Visitors must sign in, provide identification and wear a visitor's pass. There are no scanners or other security checks to enter the facility. The administration building includes office space and staff facilities. Attached to the administration building is a designated seclusion room.

House 1 and 2 each have a maximum occupancy of four people. House 3 has been subject to capital works to modify the existing accommodation. The investigation was advised that this modification was undertaken to provide for what were described as the 'special needs' of one person detained at the FDS. As a result, only one person currently occupies this house. The current maximum occupancy of the FDS is therefore nine people.

Every house contains separate bedrooms, each with its own toilet, shower area and private 'courtyard', which is an outside area surrounded by high security fencing. Each house has a common living area, kitchen and staff office. A very small room, referred to as a 'comfort' room, is situated near the living area. FDS staff told the investigation that this room was available for detained people to make and receive phone calls.

The Ogloff report tabled in 2018 describes the FDS's physical location and buildings as follows:

> The FDS is set in parkland at the end of a long, winding road through government land in Wacol. The road passes numbers of vacant and decommissioned buildings, some of which appear to be residential units for people with disability which have been heavily modified and have trappings of security. It is comprised of an administration block (which includes a staffed secure gatehouse and a seclusion area) and three 'houses' set around a large central recreation area. The houses are well-appointed, light and spacious, and include kitchens, bedrooms and communal areas.

The 2015 Queensland Advocacy Incorporated report *Shining light on a closed system through an examination of forensic disability orders for persons with an intellectual or cognitive disability* describes the physical location as follows:

> The FDS Unit is a purpose-built, medium secure, highly structured and supervised residential treatment and rehabilitation facility in Wacol, Brisbane, with the current capacity to accommodate and provide care for up to ten individuals. As a medium secure facility, there are security features in place, including fully fenced outdoor areas, locked doors, provision for search and seizure of items from residents, the requirement that all visitors be admitted through central security and refusal of visitors where their visits 'were reported to result in a deterioration of behaviour following visit (sic).'

150 For consistency, this report will adopt the terms used by the FDS to describe each accommodation unit as 'houses'.

...

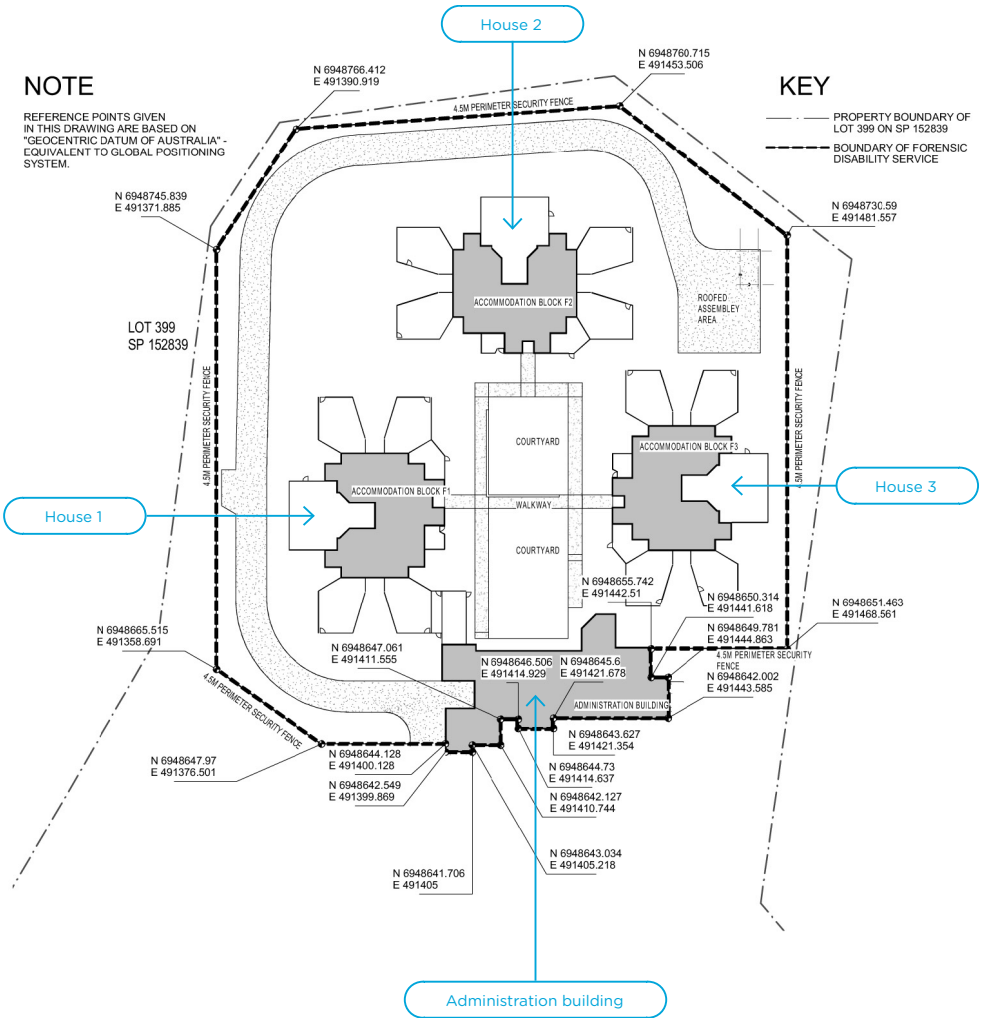
> From the design features and protocols that the FDS Unit operates to the treatment of its residents, there is little to distinguish the lived experience of those detained within the FDS from incarceration within a mainstream prison.[151]

The investigation observed that both those characterisations are accurate. While the facility is clean, modern and has natural light, it also has all the hallmarks of a correctional facility, including secure, bolted down furniture, restrictions on what items can be in a person's possession, high secure fencing around all courtyards, and a range of other security measures analogous with a correctional or detention environment.

The FDS has made limited attempts to reduce the experience of the institutional environment for people detained at the FDS and staff.

Map of the FDS

This image was extracted from the Forensic Disability Regulation 2011. Since declaration of the FDS under that regulation, some changes to the layout have occurred, particularly in relation to the configuration of House 3. Annotations in blue have been added for this report.



151 Queensland Advocacy Incorporated, *Shining light on a closed system through an examination of forensic orders for persons with an intellectual or cognitive disability*, (2015), p. 12.

Key staff at the FDS

At the first day of the site visit conducted by the investigation, the FDS had a total of 69 staff, comprising 52 permanent staff and 17 casual staff. The management team consisted of the Administrator, one Principal Clinician and the Senior Service Manager.[152]

Position of Administrator

The Administrator is the officer responsible for the management of the FDS. The Administrator is employed by the Department and formally appointed under the FD Act by the Director.[153] A person detained at the FDS is in the legal custody of the Administrator.[154]

Statutory obligations imposed on the Administrator by the FD Act include:

- ensuring that policies and procedures issued by the Director are given effect[155]
- ensuring that a person detained at the FDS receives care, support and protection as required by their individual development plan (IDP)[156]
- ensuring that a senior practitioner carries out regular assessments of the person detained as required by their IDP[157]
- keeping a register of the use of regulated behaviour controls[158]
- appointing senior and authorised practitioners
- giving the Director written notice about the use of restraint or seclusion on a person detained[159]
- giving the Director written notice about medication prescribed by a psychiatrist for a person detained.[160]

Unless otherwise stated, all references to the Administrator in this report refer to the Administrator of the FDS as at 1 January 2019.

Senior and authorised practitioners

Senior practitioners are appointed by the Administrator and are authorised to exercise certain powers under the FD Act.

The Administrator can only appoint a person to be a senior or authorised practitioner if they are of the opinion that the person to be appointed has the necessary expertise or experience to undertake the role.[161]

Allied persons

People detained at the FDS may choose a person to be their 'allied person', who can help represent the views, wishes and interests of the person detained about their assessment, care, support and protection at the FDS.

An allied person can be a carer, guardian, relative, friend or other person.[162]

152 As indicated on the FDS organisational chart provided by the Department on the date of the inspection.
153 The role of Administrator is referred to at the FDS as the 'Centre Director'. This report uses the term 'Administrator' to reflect the term used in the FD Act.
154 FD Act s 150.
155 FD Act s 99.
156 FD Act s 18.
157 FD Act s 19.
158 FD Act s 74.
159 FD Act s 72.
160 FD Act s 71.
161 FD Act s 101.
162 FD Act ss 23–25.

PART B:
Key issues of concern

An outline of key issues impacting on the care, support and detention of people detained at the Forensic Disability Service

Policies and procedures

Policies and procedures play a critical role in supporting compliance with legislation and promoting best practice. They should guide and inform decision-making and provide FDS staff with the tools to provide care, support and protection to people detained at the FDS.

The investigation found that policies and procedures in place at the FDS originated from three different sources – the Director, the Department and the FDS.

Policies and procedures issued by the role of Director

The Director has issued policies and procedures about the detention, care, support[163] and protection of people detained at the FDS as required by the FD Act.[164]

Policies recently reissued

Having reviewed all policies issued by the Director since commencement of the FDS, the investigation found that, of the 37 current policies and procedures issued by the Director, 28 had been reissued since July 2017.

For example, in June 2018, the *Notification to Director of Forensic Disability of Critical Incidents Policy* was developed and issued. This policy includes important information about responding to a critical incident. The FDS had already experienced a number of critical incidents at the time the policy was issued.

At interview, the Director was asked about the recent issuing or reissuing of policies and procedures. The Director told the investigation that, although she had been appointed to the position in October 2015, she had not had time to review the policies until mid-2017.[165]

The investigation was told by some FDS staff that they had recently been required to sign 'certification forms' confirming they would comply with the new policies and procedures. A copy of those certification forms was obtained to verify the information. The investigation was also told by some FDS staff that they had not been provided with training or support to implement the updated policies, and that they did not feel confident the required changes could be implemented or given effect.[166] It is uncertain whether the certification forms would therefore have any useful effect.

Director's response

In response to the Ombudsman's proposed report, the Director highlighted that, upon her appointment to the position, her office was involved in undertaking significant work relevant to the Director's statutory obligations, including undertaking the 5-year reviews.

Ombudsman's comment

It is accepted that these responsibilities were considerable and, given the limited resources of the Director's office, would have placed considerable resource demands on her office.

163 The FD Act defines the terms 'care and support' as including the provision of habilitation and rehabilitation, support and other services for the person detained at the FDS.
164 FD Act s 91.
165 Interview with the Director.
166 Interview with FDS staff members.

Policies not publicly available

Policies issued by the Office of the Director are not publicly available. By contrast, policies issued by the Chief Psychiatrist about the management of people under a forensic disability order detained in an authorised mental health service are publicly available. Similarly, the Department publishes policies about important areas of service delivery, for example, the Department's policies on the use of restrictive practices for people with disability.

One of the statutory functions of the Director is to promote community awareness and understanding of the administration of the FD Act.[167] A lack of public access to policies reduces the transparency and accountability of the detention environment. Capacity to discharge this function would be enhanced by the Office of the Director having a web presence.

Policies issued by the FDS

The FDS has issued a range of material that, in substance, contains organisational directives, practice guides or advice relating to important areas of practice. However, these have not always been identified or issued as policies or procedures.

For example, in response to a request for information, the FDS provided documents titled 'practice guide', 'guidelines' and 'advice to staff,' all of which contained information that might have been captured in a policy or procedure. These documents lacked clarity and structure, did not state who had issued or approved the advice, and did not contain relevant information about how they were to be applied. In addition, the documents did not refer to other relevant policies issued by the Director, which is vital to ensure a consistent approach.

The file paths of some documents indicated the files had been saved onto staff members' desktops, rather than in a central location that facilitates access by staff and appropriate recordkeeping.

This issue was recognised by the FDS in documentation provided to the investigation. In response to a request for a list of all current policies, procedures, directives or guidelines issued by FDS management, the Administrator advised:

> Advice is provided by the Administrator to staff on a multitude of matters on a frequent and regular basis and it appears usually by email. This is not tracked and would be difficult to reliably report on across the number of different people who have served as Administrator over time.[168]

Some policies issued by the FDS, and relied on when responding to this investigation, were out of date and included incorrect or superseded information.

Administrator's response

In response to the Ombudsman's proposed report, the Administrator emphasised that, on coming into the role in February 2017, he had identified the need to review policies and procedures in place at the FDS, but had had little capacity to undertake the necessary body of work. The Administrator noted that his time was limited by external demands related to oversight and review of the FDS, and workforce health and safety requirements.

The Administrator also advised the investigation that, in late 2018, an additional position was established to commence a review of all FDS policies and procedures, with an expected completion date of November 2019. The Administrator stated that this work had commenced during the period of the investigation.

167 FD Act s 87(1)(e).
168 FDS response to document request provided to the investigation.

The Department's policies

When information about critical incidents, complaints management, information and communication, and workplace health and safety was requested, the FDS and senior executives of the Department referred the investigation to policies issued by the Department. Those policies were for general application across the Department, including the FDS.

It was unclear at times how those policies harmonised with the Director's policies and those created by the FDS, and whether all or only some of the Department's policies took precedence. FDS staff interviewed conveyed confusion or a lack of awareness in relation to the application of Departmental policies at the FDS.

Summary

The FDS did not have a cohesive and consistent approach to creating and maintaining a strong policy framework to support legislative compliance and to inform staff how to carry out their roles.

In part, the lack of cohesion across policies in operation at the FDS is illustrative of the lack of clarity in operational responsibilities and governance structures, discussed in Part C of this report.

The policy framework has also been impacted by a lack of continuity of staff appointed to key positions, including the roles of Director and Administrator.

Opinion 1

1.1 The policy framework in place at the FDS has failed to integrate organisational and operational procedures issued by the Department and the FDS with policies and procedures issued by the Director about the detention, care, support and protection of people detained at the FDS.

1.2 This led to:

- inconsistencies and a lack of synthesis of policies and procedures
- staff confusion around the application of the policies and procedures.

1.3 Policies issued by the Director about the detention, care, support and protection of people detained at the FDS are not publicly available.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 1

That the Director-General, in consultation with the Director:

1.1 Undertakes a review of all policies and procedures in operation at the FDS.

1.2 Implements a cohesive, comprehensive and integrated policy framework.

1.3 Ensures all FDS staff are appropriately trained to apply all policies and procedures.

That the Director:

1.4 Ensures that policies about detention, care, support and protection of people detained at the FDS are made publicly available.

Records and recordkeeping

As a Queensland Government agency, the FDS must create and maintain full and accurate records of its activities. Records should meet required standards,[169] be capable of demonstrating good administrative decision-making and create a foundation for effective governance. Recordkeeping practices should also evidence and promote a culture of transparency and accountability.

Significant failures in records and recordkeeping were identified during the investigation. Poor recordkeeping practices were widespread across the FDS, including in areas where detailed records were required to demonstrate lawful compliance with critical provisions of the FD Act.

No effective information management

The FDS does not have an effective information management system that ensures records can be reliably created, retained, accessed, searched and retrieved.

Records at the FDS are largely paper-based. They are contained in multiple physical locations across the facility, including within the 'client houses' and the administration building, which decentralises related information. Archived records are contained in an off-site compactus.

The FDS has one electronic recordkeeping system, the Forensic Disability Act Information System (FDAIS), which is primarily used for the management of limited community treatment (LCT). However, the investigation heard the capacity of the FDAIS is limited and underused, and further disperses and fragments the recordkeeping system.

Recordkeeping practices at the FDS create voluminous paper records that do not demonstrate fundamental decisions about a detained person's overall management, care and support. For example, records inspected during the investigation included volumes of handwritten records that documented regular observations of each person detained, but did not contain clear information relating to key decisions about their care. This has reduced the FDS's capacity for reflexive practice and clinical oversight.

The lack of effective information management has also hindered information sharing across the FDS. At times this has resulted in critical information not being communicated or transferred among staff and across the facility. For example, FDS staff told the investigation that, when they begin their shift, they are not always informed of all relevant information from the previous shift, and that in some circumstances this has serious impacts on the performance of their role.[170]

Paper-based systems are also vulnerable to exploitation, as records can be removed or destroyed without the capacity to trace their existence. This issue was raised by FDS staff, who stated that they were concerned that FDS records are open to exploitation and manipulation. One FDS staff member told the investigation that if, in the course of their work, they observed a particular action or inaction and recorded it, it would be very easy for another staff member to remove or destroy the record.

169 This includes legislative requirements imposed by the *Public Records Act 2002* s 7(1) and compliance with the *Records Governance Policy* issued by Queensland State Archives in June 2018, previously Information Standards 31 and 40.

170 While this is a recordkeeping issue, it may also be attributable to other systemic issues including staff performance.

While the investigation was advised that the Department's *Information and Communication policy* applied at the FDS, this policy did not appear to be fully operationalised. For example, in response to a request for information about a positive behaviour support plan, the FDS provided information that was later found to be incomplete. When asked to clarify why the response had been incomplete, the Department advised that an FDS staff member had saved the relevant document on their individual hard drive and had not saved it to any central location. Following the staff member's departure from the FDS, the drafted positive behaviour support plan was not retrievable.

Director's response

In response to the Ombudsman's proposed report, the Director stated that, in November 2017, the FDS provided the Department with a business case for expanding and improving the electronic information management system, but at the time of the Director's response, this has not been supported by the Department.

Records did not meet minimum recordkeeping requirements

Records retained on file about people detained at the FDS were frequently incomplete, missing large amounts of required information, unsigned or incoherent.[171]

Documents sighted by the investigation did not demonstrate a consistent use of terminology or format or, alternatively, presented identical information, suggesting that some documents are pre-populated. Files were not always regularly maintained and review dates had been missed. Some records, including healthcare records, contained the name of the wrong person, indicating a copy and paste approach. Files also contained documents relating to the wrong person.

Subsequent to the site visit by the investigation, a range of documents and information was requested. Responses to those requests included the following concerns in relation to recordkeeping:[172]

- The FDS advised the investigation that some requested documents could not be located. On one occasion, this response was provided even though the requested document had been physically sighted on file at the FDS during the site visit.
- Some information provided was incomplete.
- Some information provided was inconsistent with other information obtained.

The investigation was not confident that a response to a request for information from the FDS contained all relevant information, or that the information was accurate. For example, the FDS was required to provide information about all occasions when the Queensland Police Service (QPS) attended at the FDS. In response, the FDS stated that it did not reliably hold the full information sought and required 'a manual review of paper based records'.[173] When compared against information obtained directly from the QPS, the FDS's account was inaccurate and under-represented the attendance of QPS officers at the FDS. This difference in records is concerning.

171 Multiple examples of these practices were identified through inspection of client files during the site visit, and inspection of hundreds of documents requested and obtained by the investigation that had been generated at the FDS.
172 FDS response to information request dated 16 July 2018.
173 Ibid.

Records reflected systemic concerns

During the course of the investigation, it was often difficult to distinguish whether a particular concern was a result of poor recordkeeping or of a systemic nature, such as ineffective management and legislative non-compliance. At times, the FDS attributed concerns about legislative non-compliance or poor performance to recordkeeping issues, rather than acknowledging underlying issues.

Issues with records and recordkeeping practices have been highlighted in audit reports produced by the position of Director since 2014.

The first audit report in 2014 identified that recordkeeping created some challenges during the audit process and could be improved. The report recommended that the information management and recordkeeping system at the FDS be reviewed and updated.[174]

Subsequent audit reports identified recordkeeping issues that impacted on the audit domains, including IDPs, regulated behaviour control, LCT, risk management and other key areas of service delivery.

Recordkeeping issues were again raised in the Lambrick report commissioned by the Department in 2017. Dr Lambrick commented that:

> ... the recording of legislative related activities such as the use of PRN,[175] behaviour control medication and LCT were paper based only. The reviewer was only able to review examples of these activities due to the volume of paper records involved. This makes it difficult to monitor and evaluate these practices which should be electronically data based to ensure that this can effectively take place.[176]

The Ogloff report also highlighted the importance of capturing and making available comprehensive data for all people subject to a forensic disability order to measure service outcomes, track the trajectories and progress of people detained at the FDS, report against key performance indicators, and engage in effective strategic planning and resource allocation. The report made recommendations to expand existing information and reporting systems with a view to promoting the need for comprehensive data covering all people subject to a forensic disability order.

Summary

Poor records and recordkeeping practices at the FDS pose a risk to the proper operation of the FDS and administration of the FD Act. The absence of records, paucity of detail, and incomplete or inaccurate records impacted on the capacity of the investigation to properly review all aspects of legislative compliance, including those contained in the *Public Records Act 2002*.

These issues have previously been raised with the Department through reports it commissioned, and also in audit reports provided by the Director over a lengthy period of time.

Records and recordkeeping are particularly important at the FDS given its role in supporting and protecting the rights of vulnerable people detained at the service, and also protecting the community. The creation and management of accurate records is fundamental to the proper administration of the FD Act, and in managing inherent risks within a complex environment.

174 2014 audit report, p. 3.
175 Medication can be described either as a fixed dose or to be taken as needed, called PRN or *pro re nata* medication.
176 F Lambrick, Victorian Department of Health and Human Services, *Review of the Forensic Disability Service*, (2017), p. 15.

The quality of recordkeeping at the FDS undermines the credibility of the organisation and exposes the people detained at the FDS, its staff and the community to risk. Poor recordkeeping may have impacted on the quality of care and support provided to people detained at the FDS.

Records inspected by the investigation were so poor they suggested that the FDS was unable to demonstrate the basic level of competence required to administer its legislative functions to an appropriate standard.

Opinion 2

2.1 The information management system in place at the FDS is ineffective in meeting its legislative requirements.

2.2 The approach to recordkeeping at the FDS has not met standards imposed by the *Public Records Act 2002*.

2.3 This has:

- potential impacts on the quality of care and support provided to people detained at the FDS
- reduced the transparency and accountability of the FDS
- in some circumstances, created a risk to the safety of the people detained at the FDS, its staff and the community.

This is administrative action that is unreasonable for the purposes of 49(2)(b) of the Ombudsman Act.

Recommendation 2

That the Director-General, in consultation with the Director:

2.1 Ensures that full and accurate records about all administrative decisions made under the FD Act at the FDS are created and maintained.

2.2 Develops and implements an effective electronic record management system at the FDS that ensures:

- decisions made under the FD Act are appropriately recorded; and
- those records can be effectively and accurately accessed, managed and retrieved.

2.3 Ensures information contained in FDS records is available to inform improvements in service delivery.

That the Director:

2.4 Pursuant to s 91 of the FD Act, issues a policy and procedure that ensures records about the detention, care and support of people detained at the FDS adequately protects their rights and interests.

2.5 Audits and reports on compliance by the FDS with relevant recordkeeping standards at least annually.

Individual development plans

An individual development plan (IDP) is a written plan that must be prepared for every person detained at the FDS. An IDP is integral to a person's care and support while detained in the FDS,[177] and is a central document from which all aspects of the person's management should extend.

IDPs must promote the individual development, habilitation and rehabilitation of the person detained, provide for their care and support and, when appropriate, support the person to reintegrate into the community.[178] IDPs should also be tailored to the individual needs and goals of the person detained, and promote opportunities for quality of life, and participation and inclusion in the community.

Despite clear obligations embedded in the FD Act, IDPs consistently failed to meet minimum legislative requirements and have failed to evidence a sufficient standard and quality. The Director has repeatedly raised these issues in audit reports as ongoing concerns.

While recent reviews have identified some improvement in the level of legislative compliance and quality of IDPs, particularly over the last 12 months, these concerns have been ongoing at the FDS since its commencement. This has had significant impacts on the lived experience of people detained at the FDS, many of whom have been detained for extended periods of time.

Requirements of an individual development plan

An IDP must include:[179]

- an outline of programs and services to be delivered by the FDS to the person detained
- a transition plan
- intervals for reviewing/changing the IDP to ensure it remains appropriate to meet the person's needs
- intervals for conducting a regular assessment of the person detained
- details of any medication prescribed for the person by a doctor, and intervals for regularly reviewing the person's medication (which must incorporate reviews at least every three months).

An IDP must be prepared by a senior practitioner in consultation with the person detained, the person's guardian or informal decision-maker, or any family member, allied person or other relevant person. The views of the person detained must be considered.

IDPs must also be prepared in accordance with policies and procedures issued by the Director,[180] and must take into account any other relevant plans in place for the person detained, for example, a positive behaviour support plan or, if the person has been transferred from an authorised mental health service, any health plan regarding treatment or care.

The FD Act also prescribes statutory requirements about how, when and by whom an IDP can be changed, and contains provisions about how these changes must be communicated. In essence, the IDP should form a 'living document' that responds to a person's individual needs and guides their progress.

177 Explanatory Notes, Forensic Disability Bill 2011, p. 5.
178 FD Act s 13(1)(a)–(c).
179 FD Act s 15.
180 FD Act s 14(2).

The Administrator is responsible for ensuring each person receives care and support under their IDP, and must ensure that regular assessments of the person detained are carried out as required.

Have individual development plans complied with mandatory requirements?

The investigation inspected all IDPs in place for people detained at the FDS at the time of the site visits, reviewed all audit reports by the Director, reviewed information about IDPs in previous reports, and obtained information about IDPs though consultations and interviews.

All five audit reports repeatedly identified IDPs as a key area of concern and reported substantial deficits in legislative compliance. As recently as 2018, the Director reported that:

> [C]oncerns remained in relation to compliance with both the [FD Act] and the policies and procedures issued by the Director. A central issue was the poor quality of the IDPs that did not meet all legislative requirements and were deemed inadequate to meet the purpose of the IDPs as defined in the [FD Act]. Critically, the overall format and approach to the development of IDPs resulted in a confusing document, unlikely to assist the client or staff to understand how support and care should be delivered.[181]

The 2018 audit report identified the following specific issues:[182]

- three-monthly reviews of all IDPs had not been conducted by the FDS as required
- multidisciplinary assessments had not informed the development of IDPs, and did not appear to be occurring effectively or were poorly documented
- goal-setting was not linked to other sections of the plan and was not specific or meaningful
- IDPs were not helpful in identifying programs that should be offered to address offending behaviour, or stipulating/recognising how rehabilitative treatment or supports would be delivered in future
- outdated plans, some two or three years old, continued to be referenced within IDPs
- it was unclear how regular assessments had been undertaken
- people detained at the FDS did not have a good understanding of what their IDP contained, and had not been involved in developing the plans
- there was no evidence that allied people or guardians had been engaged to provide input into the development of IDPs, or that regular meetings had occurred with the person detained at the FDS, their guardians or allied people to discuss the content of the plans.

The previous audit in 2017 found that IDPs had not been reviewed or updated since 2016. Specifically, the Director reported that IDPs were identical to those provided in 2016, and had not been reviewed or updated over the preceding 12 months.[183]

Given that multiple statutory provisions require IDPs to be regularly reviewed and updated, the audit reports evidenced widespread legislative non-compliance.[184] They also raised serious concerns about the nature and quality of care and support provided by the FDS to people with disability who are subject to detention. It is difficult to conclude that the people detained received comprehensive care and support over that 12-month period.

181 Office of the Director of Forensic Disability 2018 audit report, p. 4.
182 These issues have been paraphrased from the 2018 audit report.
183 Office of the Director of Forensic Disability 2018 audit report, p. 4.
184 The Director described the failure to review or update IDPs over a period of 12 months as 'significant issues of non-compliance' with the FD Act.

The Director's 2017 audit report also identified that:

- IDPs were non-compliant with the relevant policy issued by the Director.
- There was no evidence to indicate that IDP review meetings had occurred over the audit period, or that regular assessments of the person detained had taken place.
- IDPs had not been reviewed or updated to reflect changes to LCT.
- IDPs were not written in plain language, and were not easy to read or access.[185]
- There was no evidence that the IDPs had been modified to take into account the communication needs of the people detained.
- There was no direct link demonstrating how assessments of the person detained informed the development of their IDP.

The 2017 audit report also discussed the progress of recommendations made by the 2016 audit report, and concluded that 'little or no progress had been made towards implementation'.

In the previous year, the 2016 audit report[186] identified similar concerns with the quality of IDPs and their level of legislative compliance, and highlighted additional aspects of these plans that required improvement.

The initial audit in 2014 identified that IDPs were 'non-compliant with a number of provisions of the FD Act', and outlined issues that were later repeated in subsequent audits. In addition to those common areas of concern, the 2014 audit report also found that some IDPs referenced programs that did not exist and were not being delivered.

A common finding across the audit reports was that IDPs lacked evidence of collaboration or meaningful engagement between the FDS, the person detained and the person's guardian or allied person. The FD Act envisages that the role of the allied person is to assist in representing the views, wishes and interests of the person detained.[187] In essence, the allied person is an additional safeguard to protect the interests of the person detained and to empower that person to express their views. Failing to engage allied people in the development of IDPs demonstrates a lack of meaningful engagement with the expectations of the FD Act.

The lack of multidisciplinary assessments to meaningfully inform IDPs was raised across all audit reports. This issue is discussed in Part C of this report.

When interviewed during the investigation, FDS staff echoed concerns raised in the audit reports. They also confirmed that issues with IDPs were not only historical, but also chronic and ongoing. FDS staff described the IDPs as:

- poorly written
- not kept up-to-date
- not appropriately communicated
- only in paper form
- difficult to access
- not prepared by FDS staff with an appropriate level of expertise.

One FDS staff member told the investigation that it was hard to conclude that any of the care and support of people detained at the FDS was linked to IDPs, given that an IDP was 'not really a functional document'.

185 Office of the Director of Forensic Disability 2017 audit report, p. 14.
186 Note that these issues are all paraphrases of descriptions provided by authoring Director. Many of these contain exact words or phrases used, however have not been directly quoted to enhance readability and to reduce the issues into dot points.
187 FD Act s 24.

Information obtained from FDS staff who had been employed since its commencement filled the gaps in audit reports by stating that, in the initial phases of the FDS, IDPs were ineffective and not updated for extended periods. One staff member told the investigation that, prior to 2015, there had been no IDPs in place for people detained at the FDS.

The investigation was also told that, more recently, IDPs were frequently changed, but that the changes did not result in any real improvement to the FDS's approach to care and support. The FDS staff member told the investigation:

> Now they've changed it [the IDP] so many times and really what they're doing is changing the format, and it's still, you know, up in the air as to whether they [IDPs] even exist or not.

Staff also said that they had recently been asked by FDS management to change or develop aspects of an IDP despite not being authorised to do so.[188]

Format of individual development plans

In addition to concerns about the substantive content of IDPs, the format of these documents was also problematic. IDPs were not contained in one central location, contained documents that were incomplete or had pages missing, and were difficult to follow.

The Director's 2017 audit report summarises weaknesses in the format of IDPs as follows:

> Overall, the IDP format was unwieldy and difficult to comprehend. To make sense of a plan the reader was required to source information from multiple sections … The current approach has resulted in a disjointed document that lacks meaning and the clarity required to ensure staff, clients and stakeholders are able to clearly understand the status of an individual's pathway through the FDS.

This comment is consistent with the observations of the investigation.

Director's response

In response to the Ombudsman's proposed report, the Director stated she made recommendations and actions in the 2016 audit report to address the identified legislative non-compliance. When her 2017 audit report highlighted the same concerns with legislative non-compliance, the Director submitted that the FDS took action to improve IDPs.

Ombudsman's comment

However, the Director also stated that, in 2018, her audit again found that the quality of IDPs did not meet requirements and she therefore considered them to be non-compliant. From April 2018, the Director arranged an intensive period of work where she redesigned the IDPs and provided a 'model plan' to the FDS. This accords with recent changes to IDPs identified by the investigation.

188 The FD Act s 17(1) requires that only a senior practitioner, or authorised practitioner with delegated powers, can change a person's IDP.

Summary

IDPs have consistently failed to comply with mandatory requirements of the FD Act and to meet their key objectives.

The FD Act provides prescriptive requirements that, properly applied, should have ensured that IDPs formed a roadmap to guide and inform the provision of specialist forensic disability services for people detained. IDPs should also have provided a mechanism to transform the statutory purpose of the FD Act[189] from words into practice.

The FD Act was intended to present a balance between therapeutic objectives of care and support and the safety and protection of the community and the person detained.[190] The failure to implement key legislative provisions that relate to IDPs displaces this balance and has shifted the focus from habilitation and rehabilitation to detention.

This has contributed to and magnified other key issues of concern.

Opinion 3

3.1 Individual development plans (IDPs) for people detained at the FDS have not met all legislative requirements imposed by the FD Act.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

3.2 From the date of commencement of the FDS to February 2018, the FDS's approach to developing and maintaining IDPs has failed to operationalise s 13(1) of the FD Act, which provides that IDPs are designed:

- to promote development, habilitation and rehabilitation of the person detained
- to provide for the care and support of the person detained
- when appropriate, to support the person's reintegration into the community.

This failure has impacted the level of care and support provided to people detained at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 3

That the Director:

3.1 Reviews all IDPs in place at the FDS.

3.2 Ensures that all IDPs demonstrate full legislative compliance, including regular review.

3.3 Ensures that all IDPs operationalise s 13(1) of the FD Act, and are consistent with a contemporary, evidence-based approach to positive behaviour support plans.

3.4 Ensures that IDPs consolidate all existing plans and reports into a single, consistent and comprehensive document easily accessible by all relevant staff.

3.5 Reports, at least annually, on whether IDPs reflect improvements in service delivery to people detained at the FDS.

189 Which includes promoting individual development, enhancing quality of life, and maximising opportunities for reintegration into the community.

190 Queensland, Parliamentary Debates, Legislative Assembly, 7 April 2011, pp. 1132–5 (the Honourable Curtis Pitt MP).

Programs

A primary focus of the FDS is to provide evidence-based programs that maximise a person's quality of life, reduce the risk of reoffending and increase opportunities for community participation and reintegration, while also ensuring the safety of the community.[191] These objectives can be equally promoted through the delivery of effective programs.

The FDS was established, in part, to deliver evidence-based programs specifically designed for the needs of people with intellectual and cognitive disability[192] and to do so by promoting a rights-based approach.[193]

The FD Act anticipates that programs would include:

- rehabilitative programs that target a reduction in criminogenic factors and reduce reoffending[194]
- habilitative programs to help the person detained to keep, learn or improve skills and functioning for daily living, and empower them to exercise greater control over their environment.[195]

However, the investigation identified that the programs offered at the FDS have not met these expectations.

Obligation to deliver programs

Program delivery is a requirement of IDPs.[196] The FD Act states that an IDP must detail programs or services for:[197]

- promoting the development, habilitation, rehabilitation and quality of life of people detained
- reducing the intensity, frequency and duration of behaviours of concern
- when appropriate, supporting the person's reintegration into the community.

Explanatory notes to the FD Act emphasise the importance of program delivery at the FDS, stating that:

> Central to the [IDP] is the inclusion of evidence based programs, interventions and supports that may, for example, include offender rehabilitation programs, specifically designed for people with an intellectual or cognitive disability and therapeutic programs aimed at developing the individual (including self care and daily life skills, personal management and communication skills).[198]

191 Explanatory Notes, Forensic Disability Bill 2011, p. 3.
192 Explanatory Notes, Forensic Disability Bill 2011, p. 23.
193 The FD Act was intended to be consistent with the United Nations CRPD, which promotes the rights of people with disabilities through a focus on a rights-based approach.
194 For example, fire setting prevention programs, sex offender treatment programs and anger management programs.
195 For example, programs to develop life skills and communication skills, and vocational programs to increase occupation and education skills.
196 These provisions have been interpreted by the Director as requiring program delivery. The Department's s 157 review found that provisions of the FD Act should include more granular detail about program delivery.
197 FD Act s 15(1)(a). This provision contains examples of programs or services that may be provided, which include programs for developing communication skills, motor skills, life skills or a combination; and programs that encourage positive behaviour.
198 Explanatory Notes, Forensic Disability Bill 2011, p. 23.

Have programs been delivered as required?

The investigation examined program delivery at the FDS by reviewing reports produced by the Director[199] or commissioned by the Department, and through consultation and interviews.

The Director's audit reports contained detailed information about the delivery of programs at the FDS from 2014 onwards.

The first audit report in 2014 found that the FDS had delivered a limited number of treatment programs, and described the FDS's performance in relation to program delivery as 'poor'.[200] Some people detained had not had any rehabilitative programs delivered during the audit period.

The frequency of program delivery was measured against research literature and clinical standards, and found to be substantially lower than minimum expectations.[201] The 2014 audit report therefore set a target number of sessions per person as a key performance indicator; however, subsequent audits did not report on whether or not this target was achieved.

The 2016 audit reported an improvement in the number of programs delivered to some clients, but found there was no clear, documented link between the actual program being delivered, the needs of the person detained and information that reliably assessed the effectiveness of program delivery.

Improvements in the delivery of rehabilitative programs in 2016 subsequently regressed the following year. The 2017 audit report found that no rehabilitative programs had been delivered to any person detained between March 2016 and February 2017.[202]

The 2018 audit report found that, although a range of programs had been delivered over the audit period, there were concerns with the number of sessions provided, the quality of programs delivered and the approach to program evaluation. The 2018 audit report stated that:

> Given the … program was delivered over only five sessions it is unlikely that any meaningful outcomes could be achieved for clients with an intellectual disability. The need for further adaptations to ensure the program modules are delivered in a manner that better meets the needs of the clients was acknowledged by the facilitators.

It also commented that:

> Overall, it was not evident what programs clients were accessing or how assessment of risk, need and responsivity had been used to inform program delivery. Furthermore, there was no indication that as programs were delivered, content was being reviewed or adapted based on client responses. Whilst completion reports attempted to summarise modules delivered and clients outcomes, it was not always clear how progress, or lack of, was measured. Clients' outstanding treatment needs or recommendations to address outstanding needs were not always clear. Finally, there was no evidence staff had been adequately trained to deliver program content or how supervision was provided to clinicians delivering programs.

199 The Director's audit reports and the 5-year reviews contained detailed information about program delivery at the FDS. Annual reports gave the name and a generic description of programs at the FDS, but did not provide any information or data about the number or frequency of programs delivered.
200 Office of the Director of Forensic Disability, 2014 audit report, p. 36.
201 Ibid.
202 Office of the Director of Forensic Disability, 2017 audit report, 40. This report states: '[t]here were no rehabilitative programs delivered during the audit period. The Senior Practitioner and STL for the CHART team reported that clients at the FDS no longer required rehabilitative programs as they had completed all relevant programs during their detention at the FDS. A program completion report located in a client file indicated the Wise Choices program had been delivered between October 2015 and March 2016 and this appeared to be the last rehabilitative program delivered at the FDS.'

As well as concerns about the frequency of delivery, all audit reports identified ongoing concerns with the quality of programs delivered. Those concerns include:

- Some programs had not been adapted to the needs of people with intellectual and cognitive disorders.
- The effectiveness of programs has not been reliably measured or assessed.
- Some programs had no clear rationale or evidence base for their delivery.
- There was a lack of communication and integration between the FDS staff who delivered the programs and those connected with the daily support and care of people detained, which reduced the opportunity for people detained to integrate what they learnt in programs in daily life and generalise the new skills.
- Some programs were delivered for a period of time considered insufficient to achieve any meaningful outcomes.
- There was no evidence that staff had been adequately trained to deliver programs or that supervision was provided to the FDS staff delivering the programs.

To address the ongoing issues identified, the 2016 audit report recommended that program delivery at the FDS be reviewed. However, the 2017 audit reported that this review had not been undertaken.[203] The same recommendation was therefore repeated in 2017. The 2018 audit report again found that the review had still not been undertaken.[204]

Audit report recommendations about program delivery included:

2016 audit report

> Given programs are a critical element of supporting people's rehabilitation, habilitation and opportunities for transition it is *recommended a closer investigation of program delivery* occur so practice improvement strategies can be identified and to ensure that program delivery reflects the current evidence base. (emphasis added)[205]

2017 audit report

> Programs are a crucial element in supporting the rehabilitation, habilitation and transition of clients. *It is recommended a closer investigation of programs and their delivery occur* at the FDS. This review should ensure that program delivery reflects current evidence based practice, has a focus on program practice improvement and ultimately responds to the current needs of the client. (emphasis added)[206]

2018 audit report

> *A comprehensive approach to delivering rehabilitation and habilitation programs at the FDS should be developed and implemented.* This approach to delivering programs should involve: assessing and responding to client's risk, needs and responsivity and what supports will contribute to a good life; researching the evidence base in relation to rehabilitative programs and determining adaptations required based on individuals' needs; ensuring that assessment outcomes accurately informs progress and outstanding needs of the client; ensuring outcomes from programs inform a client's changing needs and is reflected in transition plans, IDPs and the support provided; ensuring program facilitators are adequately trained and receive appropriate ongoing supervision and support. (emphasis added)[207]

203 Ibid, p. 41. The Director states: '[t]he 2016 audit recommended a review of programs, however the Senior Management Team confirmed there had been no review of programs in the last 12 months.'
204 Office of the Director of Forensic Disability, 2018 audit report, p. 56, where the Director states: '[t]he 2017 audit recommended a review of program delivery be undertaken, however, the Senior Practitioner reported that this had not occurred.'
205 Office of the Director of Forensic Disability, 2016 audit report, Recommendation 42.
206 Office of the Director of Forensic Disability, 2017 audit report, Recommendation 23.
207 Office of the Director of Forensic Disability, 2018 audit report, Recommendation 28.

Repetition of the same recommendation three years in a row demonstrates an ongoing failure by the FDS to recognise and implement those recommendations, or take the issues of program delivery seriously.

During the investigation, information provided by the Director in August 2018 included the following statement:

> There have been a variety of programs facilitated at the FDS since its opening in 2011. These programs address the rehabilitative and habilitative need of clients who reside at the facility and are informed by risk assessment, multidisciplinary case formulation and the client's individual development plan. All clients are encouraged to participate in group treatment however due to responsivity factors, there have been some requirements to provide program material in a one-on-one setting. In addition to group and individual programs, there have been a number of individual counselling sessions which provide the opportunity to more directly address rehabilitative need and for the sake of completeness, have been included in this report. All programs facilitated at the FDS have run their full course to completion and intended treatment targets achieved. (formatting changed)[208]

This statement is inconsistent with the contents of the audit reports, including the 2018 audit report submitted to the Department in April the same year.

The investigation also heard from FDS staff that certain programs had been marked as completed when this was not the case.

One FDS staff member also described an instance when a program had not been delivered as scheduled, and emphasised the stress and disappointment of the person detained when their expectation to participate was not met.

The Ogloff report made the following comments with regard to program delivery at the FDS:

> The delivery of therapeutic programs, including offence-specific and habilitative programs, over the years has been limited, and lacking in co-ordination and consistency. Staff also described a disconnection between direct support staff and members of the team responsible for the development and delivery of programs. This lack of co-ordination and communication between the two teams makes it difficult for direct support staff to reinforce key learnings and treatment themes in clients' day to day environment which is essential if skills generalisation is to occur. The lack of movement of clients through the service has also contributed to a lack of motivation regarding the delivery of programmatic interventions over the years.[209]

These comments support the findings of this investigation.

208 Letter from the Director dated 27 August 2018. The letter encloses the requested information which the Director states was information provided by the FDS.

209 J Ogloff, J Ruffles, D Sullivan, Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System, (2018), Unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, p. 50.

Summary

The FDS is required to deliver programs and services designed to address the particular treatment and habilitation needs of people detained. This aligns with the design of the FDS as a small, specialist facility required to promote the individual development of people detained.

Those expectations are emphasised in s 15(1)(a) of the FD Act.

The failure to provide appropriate programs has limited the access of people detained to appropriate services designed to moderate risk, which can in turn influence decisions about transition.

For some people, the lack of appropriate programs has contributed to a loss or regression of skills,[210] one of the defining characteristics of institutionalisation.

Opinion 4

4.1 Rehabilitative and habilitative programs of sufficient frequency or quality have not been delivered to people detained at the FDS.

4.2 The lack of sufficient and appropriate programs has not:

- adequately promoted the development, habilitation, rehabilitation and quality of life of people detained
- made a timely impact on reducing the risk profile of people detained
- supported reintegration into the community as intended by s 15(1)(a)(iii) of the FD Act.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 4

That the Director:

4.1 Reviews the adequacy, appropriateness and quality of programs delivered to people detained at the FDS, and makes recommendations to the Director-General for implementation.

That the Director-General, in consultation with the Director:

4.2 Reviews the staffing profile of the FDS to ensure it has the capacity to manage, implement and deliver appropriate evidence-based programs within a forensic disability setting to an acceptable standard.

210 5-year reviews conducted by the Office of the Director of Forensic Disability.

Limited community treatment

Limited community treatment (LCT) is the provision of care and support to a person who is detained at the FDS when they are in the community.[211] The purpose of LCT is to support the rehabilitation of the person detained by transitioning them to living in the community.[212]

In effect, LCT allows a person to leave the detention environment to engage with the community for designated periods of time, to gradually reduce their need for detention. LCT can be used to encourage positive behaviour and promote opportunities for participation and inclusion in the community.[213]

The Mental Health Court or the MHRT may order or approve LCT, and can impose conditions and limits.[214]

LCT may be granted to a person detained at the FDS on a supervised basis, usually involving escort by FDS staff, or unsupervised. The amount of LCT a person receives cannot exceed the maximum amount approved by the Mental Health Court or the MHRT.

The investigation identified the following concerns about LCT at the FDS:

- Decisions to authorise LCT have not always had regard to statutory requirements.
- LCT has occurred without an appropriate level of planning and risk assessments.
- LCT has not always been linked to its statutory purpose in the FD Act.
- Two people detained at the FDS have been provided with extremely limited access to LCT, despite their forensic disability order allowing LCT to be authorised.
- More than one person detained at the FDS has absconded or become separated from FDS staff while undertaking LCT.

Requirements for limited community treatment

A senior practitioner with appropriate delegations under the FD Act can authorise LCT if they are satisfied that there is not an unacceptable risk to the safety of the community.[215]

In making a decision about LCT, the senior practitioner must consider the:

- purpose of LCT
- person's mental state (at the time) and their intellectual disability
- social circumstances of the person detained, for example, family support
- person's response and willingness to receiving care and support
- nature of the unlawful act that led to the imposition of a forensic disability order, and the amount of time that has passed since.[216]

If LCT is authorised, the same set of considerations apply to deciding the nature of LCT and conditions that should apply.[217]

211 As defined by the FD Act Schedule 2.
212 FD Act s 20(3)(a).
213 Office of the Director of Forensic Disability, *Community Treatment and Other Leave* policy, dated 20 July 2018, issued by the Director.
214 As per FD Act Schedule 2, LCT can be for a maximum period of up to seven days.
215 Under s 20(2)(b) of the FD Act, a senior practitioner may authorise the LCT only if it has been ordered or approved by the MHRT or the Mental Health Court, and they are satisfied, having regard to prescribed matters, there is not an unacceptable risk to the safety of the community because of the person's intellectual or cognitive disability, including the risk of serious harm to other people or property.
216 FD Act s 20(3).
217 FD Act s 20(4).

The *Community Treatment and Other Leave* policy and procedure were issued by the Director on 19 December 2017 and reissued on 20 July 2018.[218] This policy and procedure prescribe additional matters the FDS must consider when making a decision to authorise LCT, such as considering previous instances of LCT. The new policy and procedure also require the FDS to communicate decisions about LCT to service providers involved in the care of the person detained, and to ensure the person understands what is to happen during LCT.

The policy emphasises that only senior practitioners, and not authorised practitioners, can authorise or approve LCT. It also requires that the FDS demonstrate that opportunities for LCT are regularly considered when LCT has been ordered by the court or tribunal.

Has limited community treatment complied with statutory requirements?

The Director's 2014 audit report found that IDPs did not contain details of LCT ordered by the MHRT and authorised by the FDS senior practitioner, as required by the FD Act. The audit identified concerns that LCT did not reflect the statutory purpose.

The 2014 audit also found that, for at least some people detained, LCT was used to assist in community reintegration, habilitation and transition. However, as transition plans were not in place, the capacity of LCT to lead to actual transition was reduced.

The 2016 audit similarly found limited evidence that LCT activities were linked with the statutory purpose of LCT.

The 2017 audit report found that the FDS had limited capacity to monitor or track the progress of LCT for people detained in the FDS, noting that:

> A lack of specific goals made it difficult to measure progress or determine how LCT activities were contributing to client outcomes. There was limited documentation to suggest formal feedback/review was undertaken regarding the success, challenges or outcomes of the LCT activity. Furthermore, given IDPs had not been reviewed or changed in the past 12 months current LCT activities for some clients were not reflected in the IDP ...

The 2018 audit reported an improvement in LCT plans, and in linking LCT to its statutory purpose. However, the 2018 audit continued to report concerns with linking LCT to measurable goals in a person's IDP. The audit also reported a lack of qualitative reporting about LCT outcomes, which made it difficult for a senior practitioner to be informed about a person's progress and any changes to LCT plans or conditions that may have been required. The Director commented that 'overall, it was not evident that LCT plans had changed based on reports from LCT'.[219] Commenting on the linkages between program delivery, LCT, IDPs and risk management in decisions about LCT, the Director stated that:

> As clients progress through the service and successfully complete rehabilitative programs it is likely their risk to community will decrease and LCT conditions should become less restrictive. Review of the IDPs however, provided no evidence that program outcomes and risk profiles were tracked or monitored to inform LCT decisions. It was also not possible to determine when reviewing IDPs if graduated LCT increases were occurring.[220]

Another ongoing concern raised by the 2014, 2016, 2017 and 2018 audit reports was the extremely limited access to LCT provided to two people detained at the FDS.[221] Recommendations to address concerns with LCT were often repeated across all four reports.

218 The Director's *Community Treatment and Other Leave policy and procedure* superseded those issued by the first Director in 2011.
219 Office of the Director of Forensic Disability, 2018 audit report, p. 28.
220 Ibid, p. 21.
221 FDS response to information request, dated 16 July 2018.

Ultimately the Director's 2018 audit report recommended that, if LCT was not authorised where ordered by the court or tribunal, the FDS must demonstrate regular consideration of LCT opportunities, and justify the decision not to authorise LCT.

The Ogloff report also raised concerns about LCT, and made the following observation:

> In particular, in regards to Limited Community Treatment, staff stated that client leave entitlements are often not documented accurately and the organisation of the necessary paperwork is often chaotic which can cause leave to be delayed.

FDS staff raised concerns with the investigation about the authorisation of LCT by senior practitioners where the LCT event had not been appropriately planned, and where risk assessments of the location, the person and other appropriate details had not been obtained.

The investigation heard that, more recently, management at the FDS encouraged an increase in the number of LCT events, but that FDS staff were concerned this placed them or the community at risk, given increased LCT was not always occurring alongside appropriate programs and other supports.

Information obtained from the QPS confirms that police assistance was required to return a person to the FDS on 24 October 2018. The QPS issued a public appeal to locate the person, who was later identified and returned to detention at the FDS approximately 24 hours later.

Director's response

In response to the Ombudsman's proposed report, the Director stated that:

> The evidence I can provide is that since March 2018 to 7 May 2019 there have been 496 LCT events and risk assessments undertaken prior to LCT. Only eight of these involved a behavioural incident and only one was identified as involving a possible physical contact.
>
> ...
>
> This data indicates that LCT is generally well planned at the FDS.

The Director also stated that, in her view, there was 'no evidence' for the opinion that legislative requirements with regard to LCT have not been consistently applied, stating that no LCT authorised exceeded the amount of leave approved by the MHRT, and that the majority of clients were engaged in regular LCT.

Ombudsman's comment

I note that the Director's response did not directly address issues raised in the Director's 2016 and 2017 audit reports.

Section 20 of the FD Act sets out a range of requirements that must be considered in authorising LCT that had not always been satisfied.

Summary

The investigation found that LCT has not always been linked to its statutory purpose, has not been adequately integrated into the objectives of IDPs, and has not been used to inform and guide transition decisions for people detained at the FDS.

At times, a lack of appropriate planning led to failed LCT events and outcomes that placed the person, FDS staff and the community at risk.

Opinion 5

5.1 Legislative requirements established by s 20 of the FD Act with regard to authorising limited community treatment (LCT) have not been consistently applied at the FDS.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

5.2 Two people detained at the FDS have had very limited access to LCT. In those cases, the FDS has not demonstrated that LCT opportunities have been regularly considered.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 5

That the Director:

5.1 Reviews the FDS's approach to authorising LCT to ensure that each decision about LCT assesses and responds to all relevant considerations imposed by s 20 of the FD Act, as well as relevant policies and procedures.

5.2 Regularly audits and reports on the FDS's compliance with s 20(3)(a) of the FD Act in relation to decisions to authorise LCT.

5.3 Where a court or tribunal has authorised LCT, continues to audit and report on whether the FDS regularly undertakes a fresh consideration of whether LCT should be authorised. Where a decision is made not to authorise LCT for a person detained, ensures the reasons for that decision are appropriately recorded.

Risk management

The FDS was designed to deliver a suite of services targeted at supporting a detained person transitioning into the community, with appropriate assistance, to an acceptable level of risk. Given that people detained at the FDS have been considered by a decision-making body to present risks above the threshold to be safely managed in the community, risk assessment and management is a key consideration for people detained at the FDS.[222]

The management of risk for people with intellectual and cognitive disability who experience behaviours of concern formed a focus of the Carter[223] and Butler[224] reports, both of which made recommendations to improve the assessment and management of risk for people with intellectual and cognitive disabilities.

Risk assessments for people detained at the FDS should be valid and reliable and should inform day-to-day decisions at the FDS, as well as decisions about LCT and transition.[225] However, audit reports produced by the Director consistently raise concerns about the appropriate and adequate implementation of risk management plans.

The Lambrick report also found there has never been a structured risk assessment and management process in operation at the FDS.

While risk management should occur at the FDS on a number of levels across the facility, this section specifically discusses risk management related to the people detained and therefore relates to clinical care and support.

Obligation to manage risk

The FD Act contains obligations about the risk management of a person detained at the FDS. Specifically, all IDPs must include a risk management plan.[226] Risk assessment is considered to be an 'integral part' of a person's IDP.[227]

As well as these provisions, the FD Act requires that a person's IDP must outline proposed arrangements for the provision of programs or services for reducing the intensity, frequency and duration of the person's behaviour that places their health or safety, or the safety of others, at risk.[228]

Risk management is also relevant to decision-making about LCT. Specifically, a senior practitioner must be satisfied there is not an unacceptable risk to the safety of the community if they authorise LCT.[229]

As well as these legislative obligations, the Director has issued policies and procedures about risk management. The *Clinical Risk Assessment and Management policy and procedure* in operation at the FDS were issued by the Director on 20 July 2018. They supersede a policy

222 J Ogloff, J Ruffles, D Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*, (2018), Unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology.
223 Hon William J Carter QC, *Challenging Behaviour and Disability: A Targeted Response*, Report, (2006).
224 Queensland Health, *Promoting balance in the forensic mental health system*, B Butler AM SC report, (2006), pp. 121–123.
225 Office of the Director of Forensic Disability, 2016 audit report, p. 35.
226 FD Act s 15(2).
227 Explanatory Notes, Forensic Disability Bill 2011, p. 23.
228 FD Act s 15(1)(a)(iii).
229 FD Act s 20(2)(b).

issued by the Director on 19 December 2017, which consolidated a previous policy issued by the Department in 2011 and a procedure issued by the FDS in 2011.[230]

The purpose of the Director's policy is to 'ensure evidence-based risk assessments are administered for all clients of the FDS to inform individual program requirements and provide the necessary information to determine the development and implementation of individual risk management plans' and to 'ensure the safety of clients, staff and the community.' For example, the policy provides that, prior to undertaking LCT, a risk assessment of the proposed venue of the LCT must be undertaken.

Has risk management been appropriate?

Audit reports produced by the Director assessed whether the FDS was compliant with the legislative obligation to ensure risk management plans are contained in a person's IDP. Audit reports also evaluated the clinical utility of risk management plans.

The first audit report in 2014 found that risk management plans were not informed by evidence-based risk assessments until 2014. The audit report states that, as the risk management plans had not been developed on an evidence-based risk assessment, 'compliance with the legislation should be questioned in this regard'.[231] It was anticipated that a subsequent audit in April–June 2014 would undertake a qualitative assessment of risk management plans; however, as previously stated, this audit report was preceded by a change in appointment to the position of Director and no further audit was conducted until 2016.

The 2016 audit report found that:

- some risk management plans on file were outdated
- plans often did not demonstrate how risk assessments informed the risk management plans
- there was no evidence that plans were being regularly reviewed or that they responded to current risk factors.

The 2017 audit report found that IDPs did not include a risk management plan as required under the FD Act. The FDS was therefore non-compliant with this legislative obligation. It was also found that recommendations made by the 2016 audit to develop a standalone risk management plan and a monitoring system had not been adequately addressed, and that there were still no overarching plans in place at the time of the 2016 audit. The 2017 audit report stated that:

> In the absence of overarching risk management plans for clients it is unclear how staff are able to make risk management decisions in relation to general day to day management of clients, plan for LCT or provide robust advice in the future management of risk.[232]

As recently as the 2018 audit report, the Director identified that:

- risk management plans were non-compliant with the Director's policy and procedure
- the overall format of risk management plans was complicated and referred to historical strategies that failed to identify current risk management strategies
- the risk management component of IDPs referred to historical, rather than contemporary, risk assessments
- there was no evidence that risk management plans for people detained had been reviewed or updated since their development, or accounted for changes in the behaviour of a person detained or their progress.

230 The Director's policy and procedure, *High risk forensic disability clients*, was also identified as relevant to risk management. This policy only applies to people detained at the FDS who are subject to a forensic disability order on the basis of a prescribed offence.
231 Office of the Director of Forensic Disability, 2014 audit report, p. 35.
232 Office of the Director of Forensic Disability, 2017 audit report, p. 39.

The 2018 audit also commented on the lack of therapeutic support for underlying vulnerabilities that may give rise to increased risk, including the impacts of historical abuse. The Director commented that:

> Limitations of the plan included; (sic) not effectively highlighting clients' cues to engaging in offending/challenging behaviour or how to intervene to reduce the likelihood of this occurring. Additionally, the triggers often included longstanding issues such as, historical abuse which could be considered more of a predisposing factor or vulnerability than a trigger. There was no evidence to indicate how clients were being supported therapeutically to address such vulnerabilities.

Concerns with risk management plans were not confined to people detained at the FDS over a long period of time, but also extended to people who had been admitted to the facility in 2017 or later, stating that:

> For the new client it was not evident how the pre-admission assessments or any other assessments had informed the risk management plan. The risk management plan did not contain key components as outlined in the policy and procedure such as, supervision requirements, avoidance of known triggers/precursors to offending, enhancing protective factors, a clear description of challenging behaviour(s) and strategies to de-escalate the behaviour.

The Lambrick report also provided comment about broader aspects of the approach to risk management at the FDS. Outside the terms of reference prescribed, Dr Lambrick's general observations included the following comment on risk management:

> The reviewer did not find a structured risk assessment and management process in operation at FDS, currently or in previous years. There was some evidence of structured risk assessments being conducted with individuals but not in a systematic way and not informing a structured risk management approach. This is concerning given that training has been provided to FDS staff in this area over the years and when implemented in a systemic and structured way, these approaches effectively facilitate engagement in community based activities and ultimately release decision making.
>
> ...
>
> The reviewer would also recommend that FDS systematically use the Dynamic Risk Assessment and Management System (DRAMS) to also facilitate community access activities. The DRAMS is structure[d] to aid in anticipating where risk might be an issue for a client on a day to day basis and therefore pre-empt additional support or curtailing of the activity, until the client is more suited to engage. It is also a highly useful tool in that it is meant to be used collaboratively with the client thereby giving them operational familiarity with their own day to day risk presentation.
>
> A key feature and strength in effective forensic disability residential settings is the role of direct support staff in reinforcing key treatment themes in day to day settings, which requires a close working relationship with the clinician/clinical team. In reviewing documentation, visiting units, talking to clients and staff, there was very little evidence presented to the reviewer that reflected this process in operation. Feedback regarding a disconnection between the clinical and direct support teams was a theme that arose in this review. Offence specific and related programs are not effective with forensic disability clients when key messages from individual and group treatment sessions do not follow the client into their day to day environment to enable skills generalisation to occur; none of the clients interviewed were able to recount any key messages or strategies from offence specific and related programs.[233]

The current policy and procedure that apply to risk assessments at the FDS were issued by the Director four months after the Lambrick report was delivered to the Department.

233 F Lambrick, Victorian Department of Health and Human Services, *Review of the Forensic Disability Service*, (2017), p. 15.

Use of Dynamic Risk Assessment and Management System

The above extract refers to the use of the Dynamic Risk Assessment and Management System (DRAMS),[234] a psychometric tool developed to measure dynamic risk factors of people with intellectual disability to assess an immediate risk of violence.[235]

The DRAMS is a collaborative tool and is best used directly with the person to whom the tool is being applied.[236] This is outlined in the Lambrick report, which states that the DRAMS is '... meant to be used collaboratively with the client'.

However, FDS staff raised concerns about the consistent and appropriate application of DRAMS. They told the investigation they often fill out the DRAMS tool while in the staff office based on their impressions or observations without interacting with or involving the person detained, and that DRAMS forms have at times been completed during the evening shift, recorded in hard copy, and entered into an electronic system by nightshift staff.

One FDS staff member told the investigation:

> I do know that is actually supposed to be done with the clients apparently. I didn't realise that until much, much later, after I started actually working at the FDS. Typically it's done observational, and every time I fill it out, I go 'how would I know what's in their head?'.[237]

A number of items in the scale include questions that require direct input from the person detained.[238] Applying the tool based only on observations by staff may influence the validity and reliability of the tool.

Summary

The FD Act requires the FDS to include a risk management plan in the IDP for each person detained at the facility. The Director's audit reports have repeatedly raised concerns about the format, content, application and clinical utility of risk management plans at the FDS. These concerns were raised as recently as the Director's audit report in 2018, and extended to people recently admitted to the FDS as well as people who have been detained there over a long period of time.

Concerns were raised with the investigation that the DRAMS tool, which has been in operation at the FDS since commencement, has not been consistently and appropriately applied.

The Lambrick report, which contains expert opinion commissioned by the Department, did not find a structured risk assessment and management process in operation at the FDS, currently or in previous years, and provided an example of how this can impact on decision-making about LCT.

While the audit reports indicate some improvement in the FDS approach to risk management, there are clear indicators that risk management at the FDS has not been effective.

234 L Steptoe, W Lindsay, L Murphy, S Young, 'Construct validity, reliability and predictive validity of the dynamic risk assessment and management system (DRAMS) in offenders with intellectual disability', *Legal and Criminological Psychology* 13 (2008), pp. 309–321.
235 The tool includes a total of 10 variables subdivided into specific items arranged along a continuum, and can be scored by item, by category and as a total score. DRAMS has been found to have good construct validity.
236 L Steptoe, W Lindsay, L Murphy, S Young, 'Construct validity, reliability and predictive validity of the dynamic risk assessment and management system (DRAMS) in offenders with intellectual disability', *Legal and Criminological Psychology* 13 (2008), pp. 309–321.
237 Interview with FDS staff member.
238 For example, items in the DRAMS include 'feeling bad about myself' and 'criminal thoughts' where a response is required in one of four categories including 'none', 'a bit', 'lots' and 'all the time' (similar to a Likert scale).

Department's response

In response to the Ombudsman's proposed report, the Department reiterated that risk varied greatly between people detained at the FDS.

Ombudsman's comment

This appears to be further justification for ensuring a robust approach to risk management at the FDS.

Opinion 6

6.1 A comprehensive and integrated approach to risk management for people detained at the FDS has not been developed, implemented or applied at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 6

That the Director-General, in consultation with the Director:

6.1 Develops and implements an appropriate and evidence-based risk management framework for people detained at the FDS.

6.2 Provides appropriate training to all staff required to use the risk management framework.

Use of regulated behaviour controls

Regulated behaviour controls (also known as restrictive practices) can be used at the FDS in limited and prescribed circumstances, and can only be used as an option of last resort.[239] Under the FD Act, regulated behaviour controls can include behaviour control medication, the use of physical restraints and the use of seclusion.

The FD Act contains significant safeguards on the use of regulated behaviour controls so that they are only used if they are necessary and are the least restrictive way to protect the health and safety of the person detained, or others.[240]

The FD Act also mandates that the use of any regulated behaviour controls must only occur in a way that has regard to the human rights of the person detained, aims to eliminate the need for its use, and ensures transparency and accountability.[241]

The FDS is required to maintain a register of the use of regulated behaviour controls. This section of the report outlines concerns with the operation of the register.

Requirement to keep a register of the use of regulated behaviour controls

The FD Act contains a mandatory requirement that the FDS keep a register of the use of regulated behaviour controls. The behaviour control register must contain prescribed details that itemise every use of regulated behaviour control.[242]

The behaviour control register must include:

- the name and personal details of the person for whom the regulated behaviour control was used
- a description of the behaviour which resulted in the regulated behaviour control being used
- the type of regulated behaviour control that was used
- the reason it was used
- the details and outcome of any medical treatment given to the person detained or any attendance by an external entity, for example, a police officer, ambulance officer or doctor
- the name of the FDS staff member who authorised the use of the regulated behaviour control
- the date and time the use began and ended
- the effectiveness of the use in controlling the behaviour of the person detained
- other relevant details.

The legislative requirement to keep a behaviour control register is a key component of the transparency and accountability regime for the use of regulated behaviour controls for vulnerable people within a closed environment.[243]

239 Office of the Director of Forensic Disability, 2018 audit report; Queensland, Parliamentary Debates, Legislative Assembly, 7 April 2011, pp. 1132–5 (the Honourable Curtis Pitt MP).
240 FD Act s 42(a).
241 FD Act s 42(b).
242 FD Act s 74 provides that the Administrator must keep a register of the use of regulated behaviour controls authorised under the FD Act.
243 Queensland, Parliamentary Debates, Legislative Assembly, 7 April 2011, pp. 1132–5 (the Honourable Curtis Pitt MP); Forensic Disability Bill 2011, p. 43.

The register also provides a mechanism to measure, monitor and review data relating to the use of regulated behaviour controls, which should inform reflective practice and improvements. Data contained in the register should be used to evaluate the FDS's compliance with its statutory obligations and, where possible, to reduce and eliminate the use of regulated behaviour controls.

Given the FDS has been using at least one form of regulated behaviour control since its commencement[244] the investigation expected that a behaviour control register had been kept, as required, since that time.

Did the FDS have a behaviour control register as required?

The FDS did not have a behaviour control register until 2016.[245] This meant that for a period of more than five years, the FDS was not compliant with the legal obligation to maintain the register.

The investigation heard that subsequent to the creation of the register in 2016, FDS administration staff were required to complete the register retrospectively from data contained in paper copies for five previous years.

The investigation also found that, since its creation, the register has not recorded all instances of the use of behaviour control at the FDS, and has therefore been unreliable.[246] This raises compliance issues, and has reduced the capacity of the FDS to accurately report on the use of regulated behaviour control.

Director's response

In response to the Ombudsman's proposed report, the Director submitted that the Director's 2016 audit report found that a behaviour control register was in existence, but that staff struggled to locate it.

The Director subsequently made recommendations that the register be reviewed for compliance with legislative obligations.

Ombudsman's comment

I note the Director's response. However, information obtained by the investigation suggested that any register that may have been created at the FDS prior to 2016 was not operational to an extent that it could reasonably be considered to comply with statutory obligations.

244 As outlined in annual reports produced by of the Office of Director of Forensic Disability since commencement.
245 Discussions with FDS staff during the investigation, including examination of document properties of the Excel spreadsheet that contains the register.
246 As raised by the Office of the Director of Forensic Disability in the 2016 and 2017 audit reports.

Summary

As a result of the FDS's failure to maintain a register of the use of regulated behaviour controls, there were no centralised records of the use of regulated behaviour controls between commencement of the FDS and 2016. Thereafter, the register has been unreliable.

Opinion 7

7.1 The FDS did not have a register of the use of regulated behaviour controls (regulated behaviour control register) as required by s 74 of the FD Act until 2016.

7.2 Since commencement of the current regulated behaviour control register in 2016, accurate details about the use of regulated behaviour controls at the FDS have not always been recorded in the register, as required by the Forensic Disability Regulation 2011.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

7.3 The Director's current approach to public reporting does not adequately address transparency and accountability in the use of regulated behaviour controls at the FDS, as required by s 42(b)(iii) of the FD Act.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 7

That the Director-General, in consultation with the Director:

7.1 Ensures that the FDS's regulated behaviour control register is accurately maintained.

7.2 Arranges for the Public Guardian and the Public Advocate to have regular access to the FDS's regulated behaviour control register.

That the Director:

7.3 Publicly reports on all use of regulated behaviour controls at the FDS at least annually.

Behaviour control medication

A number of types of medication can be administered to people detained at the FDS.

The FD Act divides medications into two primary groups:[247]

- medication for health care
- medication to control a person's behaviour.

Healthcare medication can be prescribed either as a fixed dose, or to be taken as needed, called PRN (*pro re nata*) medication.

Behaviour control medication, also referred to as 'chemical restraint',[248] is administered for the primary purpose of controlling a person's behaviour, for example, to restrain a person from behaviours of concern.

It is important to note that a particular type of medication is not inherently either behaviour control medication or healthcare medication, and that the same medication could be used for both purposes. The determinative factor is whether the primary purpose of the medication is to control a person's behaviour, or to treat a diagnosed mental health condition or other physical condition.[249] The circumstance in which a medication is administered is critical to this distinction.

Medication commonly administered to people with intellectual and cognitive disability as behaviour control medication includes atypical and typical antipsychotics, antidepressants, mood stabilisers and benzodiazepines. The use of multiple medications is common.[250]

As outlined in Part A of this report, the investigation found that, contrary to the stated proposition that the FDS would provide care and support for people with an intellectual or cognitive disability *who do not require treatment for a mental health condition*, some people detained at the FDS have received treatment for a mental health condition. This has included treatment for diagnosed mental illnesses such as psychotic disorders, and mood disorders such as anxiety and depression. This is reflected in the types of medications prescribed to people detained at the FDS and which are therefore on site and in use at the facility.

Legislative requirements for the use of behaviour control medication

The FD Act defines behaviour control medication as the use of medication for the primary purpose of controlling the behaviour of a person detained at the FDS. However, using medication for the health care of a person detained is not behaviour control medication.[251]

Under relevant legislation, 'health care' is defined as care or treatment of, or a service or a procedure for, a person:[252]

- to diagnose, maintain or treat the adult's physical or mental condition
- carried out by, or under the direct supervision of, a healthcare provider.

247 As provided by s 144 of the FD Act, a third type of medication can also be administered at the FDS for the purposes of transporting a person to or from the FDS. This is similar to behaviour control medication but has a specific purpose. This type of medication is not considered in this report.
248 Both within Queensland and across other Australian jurisdictions. For example, the *Disability Services Act 2006* (Qld) uses the term 'chemical restraint' in referring to the use of medications as a form of behaviour control.
249 Chandler, Willmott, White, *Rethinking restrictive practices: A comparative analysis*, (2014).
250 Ibid.
251 FD Act s 44.
252 FD Act s 44(3); *Guardianship and Administration Act 2000* Schedule 2 s 5(1)(a)–(b).

Behaviour control medication can be administered to a detained person without their consent,[253] whereas healthcare medication can only be administered with the consent of the person detained or their appointed guardian.

In recognition of the elevated status of behaviour control medication as a form of regulated behaviour control, the FD Act contains additional controls to safeguard its use. Specifically, the FD Act prescribes that:[254]

- behaviour control medication can only be administered by a doctor or a registered nurse to a person detained at the FDS
- the doctor or registered nurse can only administer behaviour control medication if it has been prescribed by a psychiatrist specifically as a regulated behaviour control
- the medication must be administered in accordance with the psychiatrist's directions, including directions about the dose, route and frequency and any restrictions on its use.

If behaviour control medication is prescribed, an FDS senior practitioner must ensure details of the medication are recorded in the person's file and IDP.

If behaviour control medication has been administered, the person must be observed in accordance with the directions outlined by a psychiatrist.[255] The doctor or registered nurse who administered the medication must ensure that details are recorded in the person's file outlining the name of the medication, the date and time it was administered, the name of the FDS staff member who administered it and the circumstances in which it was administered.[256]

Behaviour control medication must only be used as a last resort and in a way that has regard for the human rights of the person detained, aims to eliminate the need for its use, and ensures transparency and accountability in the use of restrictive practices.[257]

Emphasising the importance of compliance with legislative provisions, the FD Act makes it an offence for a person to administer behaviour control medication to a person detained at the FDS other than as provided under the FD Act.[258]

As outlined in the previous section of this report, the use of behaviour control medication must also be recorded in the behaviour control register.[259]

What the investigation was told about behaviour control medication

The investigation was advised by the Director and the Administrator that there has never been any use of behaviour control medication at the FDS.

In support of this statement, the Administrator told the investigation that the behaviour control register has never recorded the use of behaviour control medication as a regulated behaviour control. As outlined in the previous section, this register has been found to be unreliable.

FDS staff also told the investigation that no medications have ever been prescribed by a doctor or psychiatrist for a person detained at the FDS for the identified purpose of behaviour control medication.[260]

253 FD Act s 53.
254 FD Act s 50.
255 FD Act s 50(c).
256 FD Act s 51(2).
257 FD Act s 42(b).
258 FD Act s 49.
259 FD Act s 74(1).
260 FDS response to document request, dated 16 July 2018.

Given the potential for PRN medications, prescribed for the purpose of health care, to be administered in circumstances that may amount to behaviour control, the administration of medications at the FDS was considered by the investigation.

Concerns raised by the role of Director

The first annual report of the Office of the Director for the 2011–12 financial year raised concerns about the use of medication at the FDS. The report stated that:

> There has been no reported use of behaviour control medication [at the FDS]. However, a review undertaken by the Office of the Director of Forensic Disability has raised matters that require further clarification and monitoring, in particular the number of prescribed psychotropic medications without clear evidence of a diagnosed mental illness.
>
> The Forensic Disability Service has reviewed all client files and clarified clients' mental health diagnoses. The Office of the Director of Forensic Disability continues to monitor this issue.[261]

The same report also includes the following comments:

> The Office of the Director of Forensic Disability has undertaken a thorough audit of client health files and continues to work collaboratively with the Forensic Disability Service towards compliance with the Forensic Disability Act 2011.
>
> Issues raised by the Director of Forensic Disability included the:
>
> - possible use of medication for behaviour control without proper documentation and approval
> - lack of documented medication regimes in clients' individual development plans
> - discrepancies between the documentation of a client's diagnosis within a client's plan, the medication list, PRN medication support plans and PRN records of progress.
>
> These issues are currently being resolved by the Forensic Disability Service and monitoring is continuing to ensure full compliance with the Act.[262]

These comments confirm the then Director's concerns about the potential improper use of healthcare medication for behaviour control, and raised the issue publicly. This Director left the position shortly after the tabling of the report in February 2012, and these issues were not directly addressed in subsequent annual reports tabled by the Office of the Director.

However, subsequent audit reports provided by the Director to the Department, but not included in the Director's annual reports, have raised related concerns.

The first audit report in 2014 directly addressed risks associated with the administration of medication for health care where the same medication can be administered for the purpose of behaviour control.[263] The report states that the then Director was advised by the FDS that behaviour control medication was not in use. His report raises the following concerns:

> The diagnoses underlying medication prescription is a critical clinical and legislative issue. Where medications are prescribed as a regulated behaviour control, they must be reported to the Director. Where prescribed for a co morbid mental illness, no such requirement exists however people must not be detained to the FDS if they require involuntary treatment for such an illness. A number of clients are on significant psychotropic medications. In many circumstances, the purpose for which these medications have been prescribed is listed in the health care file, however this is not always the case.

261 Office of the Director of Forensic Disability annual report 2011–12.
262 Ibid, p. 14.
263 That report also found that medications were recorded inconsistently between the IDP and health files, making it 'unclear exactly which medications [are] prescribed to the clients'; and also that medication review dates were either not being met or were not adequately recorded.

> Further, a number of the clients prescribed psychotropic medications do not have a mental illness recorded in their IDPs along with their diagnosis of intellectual disability. Whilst the purpose for which most medications have been prescribed is recorded in client medication lists and diagnosis of some mental illnesses can be found in various places (such as the client personal information list) in client health care files, there is no one place where diagnoses are consistently recorded. Given that there have been no notifications of prescription of behaviour control medication pursuant to s.71, clear documentation of client diagnosis is essential in order for the Director to be satisfied that all medication is prescribed for health care purposes rather than for the purposes of controlling client behaviour.[264]

A number of recommendations are made in the 2014 audit report to address these concerns.[265] Given the findings and recommendations of subsequent audit reports, however, it is clear these recommendations were not fully implemented by the FDS. This was a missed opportunity for the FDS to meaningfully address these concerns. As outlined in Part C of this report, there was considerable turnover in the role of the Director during the time period, which predates the appointment of the Director.

While audit reports authored by the Director in 2016, 2017 and 2018 do not directly address issues raised by previous directors about the administration of healthcare medication for the purpose of behaviour control, they do raise concerns that IDPs did not always include current, consistent and up-to-date details of medication prescribed for a person detained at the FDS, contrary to the legislative requirement to do so.

For example, the most recent audit report in 2018 identified that IDPs did not always include details of prescribed medications, as required, and did not record whether medication reviews were occurring every three months, as required.[266] To address this issue, the 2018 audit report recommended that:

> IDPs must record the details of any medication, including behaviour control medication, prescribed or administered to a client at the FDS.[267]

Issues raised with the Department by the role of Director since commencement of the FDS provide a clear picture that, at best, the system for the management of medication at the FDS has been insufficiently robust to appropriately manage high-risk psychotropic medication prescribed to vulnerable people in detention. At worst, they raise concerns that medication has been administered for the purpose of behaviour control and was non-compliant with legislative provisions that safeguard its use.

Director's response

In response to the Ombudsman's proposed report, the Director stated that:

> The Ombudsman appears to confuse the use of PRN for behaviour control medication. PRN is not a type of medication but the mode of administration i.e. when necessary. PRN can be prescribed for a range of diagnosed conditions such as, anxiety or to aid sleep. It is only behaviour control where a prescribing Doctor or treating physician states this as its purpose.

264 Office of Director of Forensic Disability, 2014 audit report, p. 25.
265 The 2014 audit report recommended that each person detained at the FDS undergo a full documented medication review of all prescribed psychotropic medications by a psychiatric register or consultant psychiatrist, at the direction of the Director pursuant to s 145(3) of the FD Act, which provides that, if requested by the Director, a senior practitioner at the FDS must ensure that a doctor carries out an immediate review of a person's medication. It was also recommended that a system be implemented to ensure medication listed in client IDPs are updated as appropriate, and that a clear account of the voluntary/involuntary nature of treatment requiring informed consent be provided and included in each person's IDP.
266 FD Act s 15(3)(b).
267 Office of the Director of Forensic Disability, 2018 audit report, p. 24.

Ombudsman's comment

At interview, the Director was asked whether she would agree that there is a tension between the use of behaviour control medication and the use of PRN medication in some circumstances. The Director stated that:

> I think that there, there's a tension between what the doctors say it's being used for and what it might actually be used for. I can, I'll never be able to prove that, but …

When asked if that was her suspicion, the Director responded:

> Yes, okay, if you want to say that, yeah.

The Director's two statements to the investigation appear to convey different messages about the distinction between PRN medication and behaviour control medication.

Findings of the Medication report

In June 2017, the Director engaged two consultant pharmacists to provide expert advice on the use of medication at the FDS. The consultants provided their report *Process and Regulatory Aspects for Medicines: Forensic Disability Service* (the Medication report) in September 2017.

The Medication report made two important findings:

- the FDS had been non-compliant with the legal obligation to ensure that PRN medication is only administered if a person detained at the FDS makes a request for assistance to take medication prescribed to them
- the FDS did not have a model for the use of behaviour control medication which would authorise the FDS to administer behaviour control medication lawfully.

In response, the Medication report determined that medication can only legally be administered to a person detained at the FDS in the following two ways:

- by a registered doctor or nurse
- by FDS staff members (who are generally not registered doctors or nurses) who can administer medication.

The first option has never been used at the FDS, but the second option is commonly used.

The Medication report recommended that the FDS recognise that the legal mechanism for FDS staff to assist people detained at the FDS with their medication exists in the 'carer' provisions of the Health (Drugs and Poisons) Regulation 1996 (HDPR).[268] As this recommendation was accepted by the Director,[269] the HDPR applies at the FDS.

268 As promulgated under the *Health Act 1987*. The purpose of the HDPR is to set out requirements on endorsement holders (that is, people provided with authority, approval, a licence, permit, etc.) concerning scheduled drugs and positions and imposes obligations around storage, recordkeeping and sale.
269 Letter from the Director of Forensic Disability dated 2 November 2018.

Request for assistance

Under the HDPR, a carer[270] (that is, an FDS staff member who is not a registered doctor or nurse) who has not been endorsed by the HDPR can only help a person detained at the FDS to take a controlled drug prescribed and dispensed to them if:[271]

- the assisted person (the person detained at the FDS) asks for the FDS staff member to help them take the dispensed medicine
- the FDS staff member helps the assisted person to take the dispensed medicine as directed on the label.

The consultants identified that the FDS was non-compliant with these provisions. The report states that:

> Provision for use of medicines within [the] FDS where a doctor or nurse is not administering the medication relies on *Carer* provisions of the *Health Drugs and Poisons Regulation 1996*. These require a *carer* to be asked by an assisted person (FDS client)-to assist them with their prescribed medication (Section 74 for controlled drugs, section 183 for restricted drugs, and section 270 for poisons).
>
> If this criterion is met (and documented) the carer does not require an endorsement under the *HDPR*. If this criterion is not met, no authority exists for FDS staff to hold or handle a client's medications.
>
> For these provisions to apply, allowing the *carer* to assist with medications, there needs to be documentation either that the client has made a request for assistance with their medications, or if the client is unable to make that request, a substitute decision-maker has made such a request in the interest of the client.
>
> This is a request to assist with taking medications that have been prescribed rather than a consent to be treated – which is a separate issue related to the occasion of care.
>
> Obtaining a request to assist with medications may involve applying provisions for an alternative decision-maker under various other legislation e.g. [the FD Act], the *Public Guardian Act 2014*, the *Powers of Attorney Act 1998*, [and the] *Disability Services Act 2006*.
>
> An *allied person* under the *FDA* would appear one who could reasonably support the client's interests by signing the request for assistance, although other substitute decision-makers who are able to make a decision on behalf of and in support of the client could make the request.
>
> Under the *HDPR "carer"* provisions, three important factors are a) The request for assistance, b) that all the medications are dispensed and directions on the label are followed and c) there is an assumed requirement that the assisting person be a competent responsible adult.
>
> **Currently FDS appears to comply with b) and c) but importantly not with a) of the carer provisions. It is recommended that the a) provision be addressed as a matter of urgency.[272]**

The importance of the request for assistance is emphasised at multiple points in the Medication report. The authors expressly state that 'this report goes to some length to explain the relevance and importance of the FDS obtaining the request for assistance from its clients'.[273]

270 While the term 'carer' is specifically defined under the FD Act, the HDPR does not define the term given the broader applicability of the Regulation to a number of settings, and refers simply to a 'person'. The Medication report notes that use of the term 'carer' in the report applies the provisions of the HDPR rather than the definition of 'carer' under the FD Act.
271 Health (Drugs and Poisons) Regulation 1996 s 74(2)(a).
272 Emphasis and formatting are as they appear in the Medication report.
273 Medication report, p. 12.

The report also found that procedures in place at the FDS about assisting detained people with their medication had not been appropriately reviewed or updated. The Medication report states that:

> The 'Forensic Disability Service Procedure – Assisting Clients with medications' is a 17 page document which was provided along with background information to the reviewers. It does not appear to have been updated since 2011. Some of the information is misleading or outdated, though other content is valuable.
>
> This is listed as being prepared in December 2011, and due for review by 1 July 2013. It does not appear to have been reviewed since 2011.
>
> Whilst the document continues to contain much relevant and useful information, it also contains a range of references to situations, personnel, or facilities that do not appear to exist at present. For example- it refers to use of Clinical Nurse Consultants in a range of situations; makes mention of a controlled drugs safe, which does not appear to exist, (but should be used if usage of controlled drugs (S8) becomes more than extremely isolated occasions); it refers (p9) to a tablet being "dispensed into a clean, dry medicine cup". The advice is sound, but "dispensed" is a protected term under the *HDPR* and the term "placed" should be used.
>
> The document needs a thorough rewrite to avoid desirable content being confused with misinformation.[274]

Although the Medication report made recommendations to address this issue, the FDS provided the investigation with the same 17-page procedure dated December 2011 that was identified by the Medication report.

Capacity of the FDS to lawfully administer behaviour control medication

The second key finding of the Medication report[275] is that the FDS did not have the staffing structure to allow FDS staff to administer behaviour control medication in a way that would meet mandatory legislative requirements imposed by the FD Act.

The Medication report found that, at the time, the FDS did not have a registered doctor or registered nurse on staff, and that the FDS was therefore unable to comply with the provisions of the FD Act that safeguard the use of behaviour control medication. Specifically, the report states that:

> **At present it would not appear possible for *behaviour control medication* to be used on-site at the FDS in accord with the provisions of the FDA [FD Act].[276]**

The Medication report recommended that the FDS develop a model for the use of behaviour control medication that complies with legislation. The report provided a number of options for the FDS to consider adopting.

The report also made recommendations that the FDS delineate between behaviour control medication and healthcare medication to enhance identification of the distinct differences in processes that must be followed for the two different types of medication.

274 Ibid, p. 38. A comparable best practice model in relation to assisting clients with taking medication was also identified for guidance, which provides specific guidelines for carers to assist people in administering medication appropriately.
275 As relevant to the discussion of behaviour control medication.
276 Emphasis and formatting are as they appear in the Medication report.

Response to the Medication report

The Director reissued a policy titled *Regulated Behaviour Control policy* on 9 June 2017. This policy provides directions about the use and administration of behaviour control medication at the FDS and therefore responds to the findings of the Medication report.

On receiving the Medication report in early September 2017, the Director provided the report to the FDS Administrator and senior executives of the Department, but did not provide any instructions or additional information about how the recommendations of the report should be applied, or other directions.

Two months later, the FDS responded by requesting further direction as to what action it should take in response to the report. The Director asked the FDS to 'develop the strategy as to how it will implement the recommendations' of the Medication report.

In the 2018 audit report, the Director reviewed the implementation of recommendations in the Medication report. Ten of the 12 recommendations had not been fully completed. It was therefore difficult for the investigation to conclude that all recommendations of the Medication report have been appropriately and effectively implemented.

Director's response

In response to the Ombudsman's proposed report, the Director highlighted that the Medication report was commissioned on the basis of concerns held by the Director and the FDS about the reporting requirements for medication in place at the FDS. The Director also stated that the Medication report was submitted to the FDS with the explicit expectation that the recommendations of the report would be actioned, and outlined that, in her view, it was not the role of the Director to operationalise the recommendations, but that this obligation fell to the Administrator of the FDS and senior clinical staff.

Ombudsman's comment

This report addresses the roles and responsibilities of the Director and the Department, including its officers, at Part C of this report.

Has the FDS used behaviour control medication unlawfully?

The investigation obtained information to suggest that PRN medication has been administered at the FDS in circumstances that may amount to behaviour control medication.

Files inspected by the investigation during the site visit contained notations that gave cause for concern, including one comment that stated:

> PRN for the purpose of behaviour control medication will be authorised by the Senior Practitioner.[277]

This comment appears to anticipate that PRN medication might be used at the FDS and could potentially be authorised by a senior practitioner. The *PRN Medication Support Plan* included the following documents obtained by the investigation:

277 Extract from document titled *PRN Medication Support Plan*, as accessed from client files at the FDS by OQO investigators, July 2018.

Queensland Government

Forensic Disability Service

PRN Medication Support Plan

Client:	[redacted]	**Date of birth:**	[redacted]
Medication: *(trade & generic name)*	Olanzapine Wafer 5 mg [redacted]	**Reason for PRN medication:**	Anxiety & Agitation
Health Care Professional:	[redacted]	**Contact Number:**	[redacted]
Date Prescribed:	6/2/13 and 6/05/13	**Review Schedule:**	Fortnightly

History:

[redacted] is prescribed Olanzapine to assist with the management and treatment of anxiety and panic attacks, which may be symptomatic of deterioration in his mental well-being and increased level of agitation.

How client will indicate need for PRN medication:

[redacted] is able to verbalise when he requires this medication and will ask staff.

Staff should be aware of the following visual and verbal cues which are attributed to high levels of agitation.

- Manic episodes
- Inability to regulate behaviour
- explicit sexualised behaviour directed at staff and/or clients
- Swearing and loud vocalisations screaming and running around the unit
- Physical aggression directed towards staff, others or property
- Pacing the unit and threatening to abscond
- Making verbal and physical threats of violence directed at staff and/or clients

NB:- Staff are to assess all of the above and provide [redacted] alternative coping strategies before administering PRN medication.

If [redacted] is exhibiting behaviours like those listed above and he does not ask for medication support staff are to offer PRN Olanzapine each morning and night.

Directions for use:

Staff will support [redacted] to take his medication by;-

- Remove tablet from its blister pack
- Dispense the medication into a medicine pot or onto his hand .
- Ensure [redacted] has dry hands, encourage [redacted] to remove the Wafer and place it in his mouth.
- Encourage [redacted] not swallow the wafer whole. Allow it to dissolve in his mouth without chewing.
- Observe the client closely as they take the medication to ensure that it properly dissolved
- To eliminate the risk to a client of receiving the wrong or incorrect medication, all staff administering medication must follow the **"Six Rights of Safe Medication Administration"** this is located within the Procedure manual **"Assisting Clients with Medication"** ***(p17)***

- **[redacted] is to receive 1x10mg Wafer of Olanzapine(Morning)**
- **[redacted] can have 1 x 5mg Wafer of Olanzapine after 4 hours if unsettled or staff to offer at night. (Record in Clinical notes if offered but refused.)**

[redacted] can receive further doses at 4 Hour intervals with a maximum of 15mg within a 24 hour period.

Emergency Care Instructions:

Should staff observe any adverse reactions to the PRN medication they are to contact the Emergency Services in the first instance (0000) and seek medical assistance. Staff must also inform the Senior Practitioner and provide information.

Medication Warnings:

Side effects of Olanzapine include: back pain; constipation; cough; diarrhea; dizziness; drowsiness; dry mouth; headache; increased appetite; lightheadedness; nausea; pain, redness, sore throat; stuffy nose; tiredness; vomiting; weight gain.

Queensland Government

Forensic Disability Service

PRN Medication Support Plan

Client:	[redacted]	**Date of birth:**	[redacted]
Medication: *(trade & generic name)*	Olanzapine Wafer 5 mg And Olanzapine Wafer 10mg	**Reason for PRN medication:**	Anxiety & Agitation

Accountability:

During office hours Operational staff and PO3 staff must ensure that all primary preventative strategies have been explored prior to PRN being administered. The authorised practitioner will ultimately authorise the use of PRN medication for the treatment of a recognised medical condition or underlying mental illness. PRN for the purpose of behaviour control will be authorised by the Senior Practitioner.

Recording:

Staff are to ensure that they have signed the medication chart, including the time and date given to the client.
Staff are to document the reason why PRN administered within the progress notes.
Staff are to complete a BR1 where required.
Staff administering the medication must update handover sheets with relevant information

Plan written by:	Signature	Position	Date
[redacted]		[redacted]	6/5/13
Endorsed by:	**Signature**	**Position**	**Date**
[redacted]		[redacted]	6/5/13

Plan Review *(insert review details only for plans that do not require alteration)*

Plan reviewed by:	Signature 1	Signature 2	Position	Date
[redacted]	[redacted]		[redacted]	15/5/18 30/8/18 27/11/18

These documents raise concerns about the circumstances in which PRN medication was administered to a person detained at the FDS.

At interview, FDS staff were asked about their understanding of the distinction between PRN medication administered for health care – specifically mental health care – and the administration of the same PRN medication for the purpose of behaviour control.

In response, one staff member said that:

> [The distinction is] academic, because if it's designed to actually manage their behaviour, it's, you know, designed to manage their behaviour. Saying that it's only for treatment of a mental health issue is just, just playing with words on paper really … I think there's a, kind of a misconception that medication for behaviour control only comes if you've held them down and jabbed them with a needle, is sort of the way it seems to be looked at.

The same FDS staff member provided an example of the circumstances in which PRN medication might be used, stating that:

> … for most people it is, you know, you're looking a little bit stressed, or you're yelling at me, that's not okay, you know, how about we try this and this, and generally, I mean, all the clients with their PRN medication, there's a plan, or there should be a PRN plan, and that entails what you're supposed to do before you use this medication. You know, you're supposed to work through, these clients have behaviour management issues, so they know, okay, well, when you're feeling this way, what's the best thing you can do, we'll try this, and then we'll try that, and then we'll try this as kind of the end result.

Another FDS staff member said that the distinction between PRN medication and behaviour control medication is 'just basically what you're going to call it on paper.' That FDS staff member also told the investigation that the general overarching position of FDS management was that no behaviour control medication was in use at the FDS. The FDS staff member said, '[t]hat's the line that comes from the top down, we don't do that.'

Another FDS staff member recalled an instance where a person detained at the FDS was prescribed Epilim, a drug used in the treatment of epilepsy, even though the person had not (to the knowledge of the staff member) been diagnosed with epilepsy.

In relation to the recording of medical information in files, the investigation was also told that:

> Yeah, I think medical files are incredibly confusing, and it results in a lot of missed medications, or you can't give a medication because the doctor has prescribed it and has written it in to say, say if it was antibiotics they've prescribed, and they've written it into the PRN section rather than the shortterm medication section, so then the 006[278] can't help dispense that medication until the book goes back to the doctor to be signed off. It's like, well, they needed to start their antibiotics, but you can't under the way they've structured it. So it's a very archaic system …

This raises concerns with the proper management of medication at the FDS and the capacity for exploitation within a high-risk environment.

278 This refers to the position of Forensic Officer and Shift Coordinator, who is classified at the OO6 level under the Queensland Public Service classification level.

Consent for treatment

A further issue identified by the investigation that arises from the finding that people detained at the FDS have received treatment for a diagnosed mental health condition relates to the voluntary or involuntary nature of that treatment.

This issue was initially raised in the Director's 2014 audit report, after the FDS had been in operation for five years, with the following comment:

> ... urgent clarity is required regarding the voluntary / involuntary nature of treatment, and the nature of the regime for ensuring informed consent is provided.

In relation to this issue, the following recommendation was made:

> A clear account of the voluntary / involuntary nature of treatment, and the regime for ensuring informed consent for treatment be provided and current working mental health diagnosis(es) be included in each client's IDP.

Neither the Department nor the FDS formally responded to this recommendation, which means it is unclear whether it was appropriately addressed. Subsequent audit reports have also failed to address this recommendation.

Currently, the FDS seeks consent from the person detained or their guardian to treat a person for a diagnosed mental health condition. The investigation heard that some people had been receiving the same treatment involuntarily at an authorised mental health service but that, on transfer to the FDS, the treatment was provided by consent from the person's guardian.

The question of what constitutes full and informed consent from people with intellectual and cognitive disabilities and a co-occurring mental health condition who are subject to involuntary detention has not been well clarified by the FDS since its commencement. This has provided a further layer of concern about the administration of medication at the FDS, particularly the administration of PRN medication which can have the effect of sedating or subduing a person, or otherwise controlling their behaviour.

Summary

The issues identified by the investigation in relation to the use of medication at the FDS raise serious concerns about the proper administration of the FD Act and the human rights of the people detained.

In summary:

- People detained at the FDS have received treatment for mental health conditions, including diagnoses of serious mental illnesses.
- The FDS has been non-compliant with its legal obligation to ensure PRN medication is only administered when a request for assistance is made by the person detained.
- The FDS has not developed a model that provides for the lawful administration of behaviour control medication.
- The investigation identified circumstances where the FDS documented the administration of PRN medication in contexts that amounted to behaviour control medication.
- The use of medication in circumstances that amount to behaviour control did not meet legal obligations imposed by s 50 of the FD Act.
- Issues around informed consent to treatment of mental health conditions have not been well defined.

Opinion 8

8.1 PRN medication may have been administered to people detained at the FDS for the purpose of behaviour control.

8.2 The FDS was unable to demonstrate compliance with mandatory legislative provisions safeguarding behaviour control medication at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 8

That the Director-General, in consultation with the Director:

8.1 Implements all recommendations of the Medication report, and regularly audits compliance with the FD Act and other relevant legislation as they relate to the use of medication at the FDS.

That the Director:

8.2 Arranges medication reviews for all people detained at the FDS by an independent psychiatrist and pharmacist, and undertakes reviews of medication as clinically directed thereafter.

8.3 Provides training for all FDS management and staff in relation to the administration of all medications, including behaviour control medication.

Seclusion

Seclusion is one of the three forms of regulated behaviour control that can be authorised at the FDS. Under the FD Act, seclusion is defined as the confinement of a person detained at the FDS, at any time of the day or night, alone in a room or area from which the person's free exit is prevented.[279]

Depending on the context, terms such as segregation, environmental restraint and solitary confinement can be used to describe conditions similar to seclusion.[280]

The FD Act strictly regulates the use of seclusion by prescribing the circumstances in which it can be authorised. Any decision to use a regulated behaviour control at the FDS must be as a last resort, rather than standard practice or a planned response,[281] and be for the shortest amount of time possible.

Seclusion is designed as a time limited response that intends to allow a person to regain control of their behaviour. More recently, however, research and clinical practice have questioned the effectiveness of the use of restrictive practices, including seclusion, in disability settings to control or manage a person's behaviour.[282] Seclusion has also been found to cause adverse effects, including distress and compromising therapeutic relationships.[283]

Legislative requirements for the use of seclusion

The statutory purpose of legislative provisions that relate to regulated behaviour controls is to 'protect the rights of forensic disability clients' to ensure behaviour control is only used in prescribed circumstances.[284]

In relation to seclusion, the FD Act prescribes that a person detained at the FDS may only be placed in seclusion at the FDS if a senior practitioner is reasonably satisfied that seclusion is necessary to protect the person detained or other people from imminent physical harm, and there is no less restrictive way to protect the client's health and safety or to protect others.[285]

A senior practitioner must be reasonably satisfied of both of these requirements in every decision to authorise seclusion.[286] If a senior practitioner is reasonably satisfied, they must complete a written order that states the following details:[287]

- the reasons for the seclusion
- the time the order is made
- the time the authorisation ends, which can only be for a maximum of three hours after the order is made

279 FD Act s 46.
280 Solitary confinement is often used in the context of correctional settings.
281 Office of the Director of Forensic Disability annual report 2017–18; Office of the Director of Forensic Disability, 2018 audit report; Queensland, Parliamentary Debates, Legislative Assembly, 7 April 2011, pp. 1132–5 (the Honourable Curtis Pitt MP); Explanatory Notes, Forensic Disability Bill 2011.
282 E Rickard, J Chan, B Merriman, 'Issues Emanating From the Implementation of Policies on Restraint Use with People With Intellectual Disabilities', (2013), *Journal of Police and Practice in Intellectual Disabilities*, 10(3), pp. 252–259.
283 J Allan, G Hanson, N Schroder, A O'Mahony, R Foster, G Sara, 'Six years of national mental health seclusion data: the Australian experience', (2017), Australasian Psychiatry, 25(3), 277; B McSherry, 'Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities', (2017), *International Journal of Law and Psychiatry*, pp. 39–44.
284 FD Act s 42.
285 FD Act s 61(2).
286 One exception exists under s 64 of the FD Act, which provides that an authorised practitioner, rather than a senior practitioner, can place a person in seclusion in urgent circumstances. Additional provisions apply.
287 FD Act s 62(2).

- special measures necessary to ensure the proper care and support of the person detained at the FDS while secluded
- whether it is necessary to continuously observe the person while they are in seclusion or, if not, intervals for observation that are no longer than every 15 minutes.

The FDS must ensure a person's reasonable needs are met while in seclusion. Reasonable needs include providing sufficient bedding and clothing, sufficient food and drink, and access to toilet facilities.[288]

If seclusion is used at the FDS, the person's IDP must include strategies for avoiding, reducing and eliminating any further use of seclusion.[289]

As with all forms of behaviour control at the FDS, the legislative purpose embedded in the FD Act specifically for the use of regulated behaviour controls applies. This includes the principle of the least restrictive approach. It also requires that the use of restrictive practices must only occur in accordance with human rights, must aim to reduce or eliminate the need for its use, and ensure transparency and accountability.[290] The general principles of the FD Act, as well as principles for exercising powers and performing functions under the FD Act, also apply.

The FD Act also provides that the Director may order the immediate release of a person from seclusion,[291] but this power has not been used.

Emphasising the importance of compliance with legislative provisions, the FD Act makes it an offence for a person to seclude a person detained at the FDS other than as provided under the FD Act.[292]

As well as legislative obligations, the Director has issued policies and procedures that relate to seclusion. On 29 July 2017, the Director reissued the policy and procedure on regulated behaviour controls, which includes policy directions about the use of seclusion. These supersede policies and procedures that had not been updated since 2011.

A new policy on the therapeutic management of challenging behaviour was issued by the Director on 14 June 2018.[293]

Use of seclusion at the FDS

The investigation identified serious concerns about the lawful and reasonable use of seclusion at the FDS, including:

- general concerns about the use of seclusion by the FDS that do not comply with all legislative requirements
- specific concerns about the use of seclusion for one person detained at the FDS, referred to in this report as 'Adrian'.[294]

In relation to general concerns about the use of seclusion, audit reports authored by the Director have identified that seclusion has been authorised when strategies to reduce the use of seclusion were not in place or, if strategies had been recorded, they were not linked to the IDP in place for the person who had been in seclusion and were not incorporated into their care and support.

288 FD Act s 69.
289 FD Act s 73.
290 FD Act s 42(a)–(b).
291 FD Act s 66.
292 FD Act s 60.
293 The policy supersedes a policy previously issued by the FDS in 2011.
294 This report calls the detained person 'Adrian' to protect his identity. The use of the pseudonym 'Adrian' is consistent throughout this report.

The Director has previously identified breaches of legislative compliance in the use of seclusion for people detained at the FDS on this basis, as well as non-compliance with other requirements.[295]

Seclusion of Adrian

In relation to Adrian, the investigation found that he had been subject to back-to-back three-hour seclusion orders for more than six years.

The investigation found that Adrian has been secluded for 99% of the time between admission in September 2012 and 18 June 2018.

The circumstances of Adrian's case are severe and concerning, and constitute administrative action that gives rise to serious human rights concerns, including indicators of systemic abuse.

Adrian – a case study

Adrian has an intellectual disability as well as a form of chromosomal disorder, both diagnosed in early childhood. Adrian's intellectual disability results in significant global deficits in his cognitive, language, motor and social development. As a child, Adrian was subject to significant emotional, physical and sexual abuse both at home and by carers in out-of-home care.

From an early age, Adrian developed behaviours of concern that were particularly complex, and throughout his childhood those behaviours intensified. Adrian's records also indicate that support plans were never adequately or appropriately implemented by staff and carers, and instead punishment and punitive consequences were used. From early adulthood, Adrian has been continuously accommodated in a secure environment.

For a number of years, Adrian was accommodated at the Basil Stafford Centre. At this facility, Adrian's behaviours of concern increased, and he was involved in critical incidents. Although undertaking some community treatment involving outings and planned recreational activities, Adrian was otherwise confined to his accommodation area at all times. An assessment for Adrian recommended a less restrictive living environment, increased community access, increased family contact, physical activities, staff training and accountability systems, and other therapeutic approaches to manage his behaviour and reduce reliance on restrictive environments. However, in 2006, the Carter report, which included a case study about Adrian, highlighted that the restrictive environment imposed and lack of community access were at odds with the recommendations of the previous assessment.

In 2012, while on community treatment, Adrian was left unsupervised in the community and was involved in an incident that led to Adrian being charged with serious criminal offences. He was arrested and remanded in a maximum security unit in a mainstream facility. Some months later, Adrian was transferred to the FDS. The Mental Health Court found Adrian unfit for trial as a consequence of his intellectual disability. All charges were withdrawn and a forensic order was imposed.

Upon admission, Adrian was placed in a seclusion unit that had been specifically constructed for his use. Since then, Adrian has been in seclusion at the FDS for 99% of the time over a period of more than six years. The custom-built seclusion area includes a living area, a bedroom with shower and toilet, and a small concrete undercover yard. Adrian communicates with staff through a servery window, which is a narrow horizontal slot through which meals and other items are passed. If his behaviour escalates, staff cover the slot and drop a temporary opaque screen, removing all capacity for human contact. While

295 For example, the 2018 audit report identified that one person was placed in seclusion by a person not authorised to do so. That report also identified 'significant issues of non-compliance in relation to the use of seclusion'.

the FDS records Adrian participating in activities such as art, craft and cooking, these are all conducted with staff on the outside of the seclusion unit and Adrian on the inside. Adrian's limited opportunity for meaningful human interaction has been reported to have had a grave impact on his wellbeing.

Adrian is monitored every 15 minutes, 24 hours a day, through staff observations and the use of closed-circuit television (CCTV) and infra-red cameras. Approximately 16 CCTV cameras are installed throughout the unit, including in the toilet and bathroom, living area and bedroom, and along perimeter fences. As a result of Adrian's privacy concerns, he erected a tent-like structure in his concrete courtyard area using ropes and a tarp provided by FDS management for this purpose. The investigation heard that Adrian lived and slept in the 'tent' for a period of between three and six months, including spending time there during the day, and that the mattress inside was putrid and mouldy. Ultimately the tent was removed by police. At the time of the site visit, Adrian had taped black paper over external glass in the seclusion unit.

A positive behaviour support plan drafted for Adrian in 2017 states that 13 out of 15 FDS staff members had said they were not comfortable breaking seclusion due to concerns for their personal safety. Other documents state that seclusion breaks were not being offered to Adrian every three hours as required. Adrian now refuses seclusion breaks, which is characterised by the FDS as 'self-secluding'. Adrian's guardian, community visitors and FDS staff told the investigation that, in their view, Adrian is refusing seclusion breaks because of his lack of self-determination as a person.

The investigation heard that FDS staff are concerned for Adrian's overall health and wellbeing, and said that Adrian does not shower or brush his teeth daily, does not follow a regular eating pattern and can miss meals for several days in a row, lives a sedentary lifestyle, has poor posture and other ergonomic concerns, and is not able to be regularly shaved, or have his hair and nails cut.

The Lambrick report provides an overview of the specific complexity of Adrian's case, stating that:

> [Adrian's] presentation and circumstances are enormously complex and perhaps the most complex and concerning case within the reviewer's range of experience. His circumstances are the product of many years of restriction that commenced well before his intake into the FDS.

Despite this, as outlined in this report, the FDS has not provided evidence-based and consistent positive behaviour support for Adrian as would be expected for people with behaviours of concern. One positive behaviour support plan for Adrian states that, at times, FDS staff have failed to follow procedures in place when Adrian's behaviours escalate, and instead stated they would respond to Adrian by threatening to call the police dog squad. The author of one draft positive behaviour support plan stated that this response was 'aversive and is not aligned with positive behaviour support strategies or recommended for future use'.

The Queensland Police Service (QPS) has been called to attend the FDS on multiple occasions (sometimes with police dogs) in response to Adrian's behaviours of concern that persist or escalate, and when those behaviours present a risk to the safety of FDS staff or a self-harm or suicide risk to Adrian himself. On five separate occasions, Adrian has also been charged by the QPS with criminal offences against FDS staff. After being listed at either the Magistrates or Mental Health Court, all charges brought by the QPS against Adrian since admission have been dismissed, struck out or withdrawn on the basis that Adrian is unfit to plead on a permanent basis or is of unsound mind. In September 2018, police were called to the FDS for Adrian. On that occasion, five Public Safety Response Team (PSRT) police officers attended with a police dog, which physically entered Adrian's seclusion unit. Records created by FDS staff state that Adrian was found crying in the foetal position.

The impacts of seclusion and detention on Adrian are described by the Director in the 5-year review report, which highlighted the deterioration that has resulted from Adrian's prolonged detention. The Director concluded that the FDS has failed to provide Adrian with access to rehabilitative and habilitative programs that have improved his quality of life, and that his prolonged detention at the FDS has resulted in his deterioration. The Director writes that:

> [The psychologist] raised concerns in relation to [Adrian's] often dishevelled appearance, his poor personal hygiene and his detachment from others. [The psychologist] reported: "these are behaviours that have manifested since his admission to the FDS and reflect problems with apathy and declines in mental state. Moreover, his behaviours reflect his sense of hopelessness and institutionalisation." It was suggested that [Adrian's] prospects of positive treatment outcomes and improvements in self-regulation and adaptive functioning are likely to continue to deteriorate.
>
> [Adrian] is living a depressed existence, which does not afford him regular sleep patterns, health and nutritious diet, daily exercise, daily access to sunlight or meaningful social communication. In addition, he has taken to rumination and negative thought patterns. He has no physical contact with others and is separated from his loved ones.

Adrian's treatment at the FDS has been described to the investigation as 'brutalisation'.

Knowledge of concerns

Audit reports evidence failures in relation to the use of seclusion in Adrian's case and confirm that the Director and the Department were aware of the severity of the issue.

Audit reports detail ongoing concerns that Adrian's seclusion is non-compliant with the requirements of the FD Act, is inconsistent with the objectives of the FD Act, and gives rise to ongoing human rights concerns. Extended extracts from each audit report are included in this report to illustrate the seriousness of the issues.[296]

The first audit in 2014 reported that:

> [Adrian's] seclusion records for the January – March 2014 quarter indicate that [Adrian] spent the majority of the quarter in seclusion. The FDS has provided data regarding the number of breaks in seclusion during the quarter and this confirms [Adrian] is almost permanently secluded. Pre-typed seclusion order forms specify the reasons for seclusion as "Seclusion to continue as per clinical plan to minimise imminent risk of harm to self or others. This remains the least restrictive practice." [Adrian] remains permanently in seclusion, with staff instructed to interact with him through his servery window and to break seclusion when he feels relaxed and comfortable. The IDP notes that one of [Adrian's] goals is to be able to spend increased amounts of time in the company of FDS staff and clients. The IDP also states that use of seclusion should follow the seclusion practice guide attached to [Adrian]'s IDP. There is a "Practice Guide – Use of Seclusion and Self-isolation with [Adrian]" is specified in the IDP to have been last reviewed in December 2012, but a copy updated on 21 April 2014 has subsequently been sent to the Director.
>
> Despite being in sustained seclusion due to "behaviours of concern" there is no behaviourally based plan in place to remediate these behaviours.
>
> Section 61 requires that seclusion must only occur where there is a reasonable belief on the part of the practitioner that the seclusion is necessary to protect the client or another person from imminent physical harm and there is no less restrictive alternative. The use of prepopulated seclusion forms, not adequately linked to a risk assessment, is not adequate to satisfy the requirement of a reasonable belief of imminent physical harm. Further, the absence of any form of behaviour management plan precludes the conclusion that less restrictive alternatives have been planned and actively considered.

296 To reduce the length of the material, these extracts have been selected from longer text. Care has been taken to ensure that these comments remain in the context in which they appeared in the original reports.

> It is noted that the FDS has conducted a static risk assessment and continues to conduct regular acute dynamic risk assessments for [Adrian]. It may be that the acute dynamic risk assessments establish there is an ongoing imminent risk of physical harm. However, given ongoing seclusion presents significant human rights implications and secluding a person other than in accordance with the Act is an offence, it is essential that each seclusion order is clearly linked to an assessment of risk. The presence of a behaviour plan of the highest possible quality linked to (sic) evidence based risk assessment must also be developed as a minimum requirement in this case.
>
> The fact that [Adrian] is secluded for the majority of the night and day is also of significant concern to the Director. Whilst seclusion forms are signed by a Senior Practitioner every three hours, this ongoing seclusion is not in accordance with the intent of the [FD Act] that seclusion occur for a maximum period of three hours. Given that seclusion records indicate [Adrian] remains almost permanently in seclusion, the seclusion practice guide should be reviewed. It is recommended that a full review of the seclusion practice guide, the breaking seclusion management plan, associated risk assessment protocol and a behaviour support plan be collaboratively reviewed and developed between a Principal Clinical Advisor to the Director and the FDS Principal Clinician. This must be viewed as the highest possible priority.
>
> The register of regulated behaviour control has not been completed in relation to the seclusions of [Adrian], as is required by s. 74 of the [FD Act].

This extract outlines that, in 2014, the Director found, based on evidence obtained during the audit, that Adrian's seclusion was non-compliant with legislative obligations. Recommended actions to address legislative non-compliance were considered the 'highest possible priority'; however, as is demonstrated through extracts from all subsequent audit reports, those concerns were not effectively addressed. The Director left the role in 2015 and a subsequent audit was not undertaken until 2016.

The 2016 audit report identified the seclusion of Adrian as one of the key areas of concern, and found that there had been no reduction in the use of seclusion for Adrian. This report was provided by the Director to senior executives of the Department.

The 2017 audit report again highlighted the use of seclusion as a 'key area of ongoing concern', found ongoing concerns with the use of seclusion for Adrian and again raised issue with the proper administration of the FD Act. The Director addressed this audit report to senior executives at the Department.

In relation to the recording of each seclusion order in the behaviour control register, the 2017 audit report found that:

> Additionally, from line 480 to line 887 the [behaviour control register] was also pre-populated with details for [Adrian]. Pre-populating the [behaviour control register] conflicts with the principles of the [FD Act] and makes assumptions that [Adrian] will remain permanently in seclusion.
>
> It appears the [behaviour control register] was completed by Administration Officers with information taken from the seclusion orders. There is no evidence to suggest there was oversight occurring by either the Administrator or the Senior Practitioner to ensure compliance with the [FD Act] and the [*Forensic Disability Regulation 2011*].

The executive summary of the most recent audit report in 2018 again highlighted the use of seclusion as a key concern, using similar language to that in previous audit reports to describe the concerns. The 2018 report included the following comments:

> Seclusion continued to occur on a daily basis for one client without evidence that legislative requirements and policies (sic) procedures were always being adhered to. Critically, there was a lack of documented strategies in place to reduce, eliminate and avoid seclusion for this client.
>
> ...

In relation to the seclusion of [Adrian], there were numerous issues of non-compliance with legislation identified during the audit. The main issues included:

- The client being secluded without any evidence to assist the Senior Practitioner or the Authorised Practitioner to determine that there was: an imminent risk of physical harm; and no less restrictive way to protect the client's health and safety or to protect others.
- The client being secluded because they did not want to be released from seclusion.
- The client being secluded because insufficient staff were rostered on to manage the client when not secluded.
- The client not being observed as required by sections 72 and 70 of the Act.
- A failure to develop and implement strategies to reduce the use of seclusion in the future.
- A failure of the FDS to provide the Director of Forensic Disability with Seclusion Orders in a timely manner.

Prior to a client being secluded, it is a fundamental requirement that the Senior Practitioner or the Authorised Practitioner are satisfied that there is an imminent risk of physical harm to the client or others and that seclusion is the least restrictive way to protect the individuals. There was minimal evidence of Seclusion Orders or release from seclusion forms identifying any risk of imminent physical harm. The forms commonly recorded "As per IDP, seclusion remains the least restrictive strategy". However, the IDP was silent on the use of seclusion and did not record that seclusion was the least restrictive option.

There were examples of seclusion being used where the client did not want to be released from seclusion including, the Seclusion Orders and Seclusion Release Decision Making Outcome forms indicating the client declined to break seclusion and no other explanation was recorded. Additionally, clinical notes and seclusion orders frequently indicated there were no current behaviour issues displayed by the client but seclusion continued.

These records suggest that despite the client remaining settled for 24 hours and the client's DRAMS not indicating current risk, the client remained secluded. It is difficult to understand how in those circumstances a Senior Practitioner or an Authorised Practitioner could have been reasonably satisfied there was an imminent risk of harm.

In addition to the lack of justification for seclusion, operational staffing issues were often recorded as a rationale for why the client could not be released from seclusion. Seclusion Orders and Seclusion Release Decision Making Outcome forms often documented that insufficient staff were rostered on to manage the client without the use of seclusion.

Although seclusion forms allowed for the recording of strategies to reduce the future use of seclusion, there was little evidence of this occurring. When strategies were recorded responses, simply included:

- "Implement PBSP. Meet the safe & required staffing ratio to offer seclusion releases and support the client in house. Develop plans that increase the client's quality of life". (31 January 2018).
- "Implement PBSP. Develop plans to increase the client's quality of life. Fulfil safe staffing ratio to offer seclusion release". (31 January 2018).

These responses provided little evidence that staff had developed plans for the client, implemented the PBSP, or provided the resources required, including staffing ratios for the client to be released from seclusion.

The Director also addressed this audit report to senior executives at the Department up to and including the Director-General.

Recommendations of the audit reports

Recommendations and actions contained in the audit reports that specifically relate to Adrian's seclusion include the following:[297]

2014 audit report

A full review of the seclusion practice guide, breaking seclusion management plan, associated risk assessment protocol and development of a behaviour support plan occur collaboratively between the Principal Clinical Advisor to the Director and the FDS Principal Clinician.

Seclusion orders by the Senior Practitioners (Limited Powers) for [Adrian] be clearly linked to risk assessments completed for [Adrian], led by [Adrian's] Senior Practitioner.

2016 audit report

Recommendation 16: It is recommended staff are provided with refresher training in the legislative requirements of the Act and policies and procedures in relation to seclusion.

Recommendation 18: In relation to the seclusion of client [Adrian] it is recommended:

- strategies currently in place be reviewed with a focus on identifying approaches to avoid, reduce and eliminate the use of seclusion
- direction is provided to staff who authorise seclusion regarding how they must assess imminent risk at the time that they authorise an order
- seclusion orders are sent through to the Director of Forensic Disability on a daily basis.

2017 audit report

Action 13: The Administrator must ensure each practitioner with the power to place a client in seclusion undergo refresher training to ensure they understand their powers, the requirements of [FD Act] and the relevant policies and procedures in relation to the use of seclusion as a regulated behaviour control, and a record kept as evidence.

Recommendation 6: In relation to the seclusion of client [Adrian] it is recommended:

- strategies currently in place be reviewed with a focus on identifying approaches to avoid, reduce and eliminate the use of seclusion
- direction is provided to staff who authorise seclusion regarding how they must assess imminent risk at the time that they authorise an order.

2018 audit report

Action 23: The Administrator must ensure each practitioner with the power to place a client in seclusion is adequately trained and understands the functions of their role to ensure they understand their powers, the requirements of the [FD Act] and the relevant policies and procedures in relation to the use of seclusion as a regulated behaviour control.

Action 24: Other than in unforeseen circumstances the Administrator should ensure there is sufficient staff at the FDS so clients are not secluded due to a lack of staffing.

Action 27: As previously recommended, it is imperative in the seclusion of client [Adrian], that:

- strategies currently in place be reviewed with a focus on identifying approaches to avoid, reduce and eliminate the use of seclusion;
- direction is provided to staff who authorise seclusion regarding how they must assess imminent risk at the time that they authorise an order.

297 Formatting of some recommendations has been altered.

Recommendations made by the audit report about the use of seclusion for Adrian are repeated in almost identical terms between 2016 and 2018.

As well as the above recommendations, each audit makes additional recommendations and actions to address legislative non-compliance in the use of seclusion for Adrian, which included the failure to:

- observe Adrian as required
- provide seclusion orders to the Director as required
- record the use of seclusion in the behaviour control register.

Information obtained by the investigation

The investigation requested and obtained documents in relation to the seclusion of Adrian. This allowed investigators to make an independent assessment of the administration of the FD Act in relation to Adrian's circumstances.

The investigation obtained the following:

- seclusion orders for the month of June for 2016, 2017 and 2018
- incident and behaviour reports generated for the month of June for 2016, 2017 and 2018
- documents relating to the use of CCTV footage in the seclusion area
- all IDPs and positive behaviour support plans, including drafts, and superseded and current versions
- incident reports, including behaviour reports and critical incident reports
- legal documents prepared for courts and the MHRT
- court and MHRT orders.

The investigation undertook:

- inspection of Adrian's client file, including clinical and health files
- inspection of the perimeter of the area in which Adrian is secluded
- interviews with FDS staff, the Administrator, the Director, officers from the OPG and other relevant people.

How long has Adrian been in seclusion?

To obtain a picture about the nature and duration of Adrian's seclusion, the investigation requested itemised details of all seclusion breaks since Adrian's admission to the FDS, which included all LCT activities.[298]

Information provided to the investigation by the FDS confirms that, between Adrian's admission on 24 September 2012 and the date of the request on 18 June 2018, Adrian was secluded 99% of the time.[299]

The investigation was advised by the FDS that information provided had been extracted from the behaviour control register, which has been found to under-report the use of regulated behaviour control.

298 Court and tribunal orders made for Adrian have allowed for LCT to be undertaken as escorted or supervised absences for a maximum period of between four and seven hours per week, which must be supported by four staff members, including three males.

299 Data provided by the FDS about the number and duration of seclusion breaks was analysed by the investigation, which showed that seclusion was broken for a total duration of 3,088 minutes, which is equivalent to 2.1 days over a period of 2,092 days.

Records detail that, between the above dates, Adrian had 810 seclusion breaks totalling 3,088 minutes. Analysis of the data showed that 59% of all breaks were for one minute or less.

It is important to note that a seclusion break may include any circumstance where the definition of seclusion is not met. A seclusion break can therefore be recorded where an FDS staff member enters the seclusion area even for a brief period, for example, to provide Adrian with an item, remove an item, clean an area or otherwise interact with him. The recording of a seclusion break therefore does not necessarily mean that Adrian is physically leaving the seclusion area.

The 5-year review authored by the Director in 2017 analysed seclusion breaks to assess whether there had been an increase or decrease in the FDS's use of seclusion since Adrian's admission. The 5-year review found a marked decrease in the average time Adrian spent out of seclusion at the time of conducting the review in April 2017, compared to initial reports from 2012 and 2013. The Director reported that, in the first six months following admission, seclusion breaks were 'steadily increasing and were at times of up to 60 minutes', but that by 2014, the seclusion breaks had 'become more irregular'. The Director reported that recent figures demonstrated a 'significant regression in approach and practice in supporting [Adrian]' and 'a pattern of steadily decreasing time out of seclusion', and that currently, '[Adrian] is in seclusion the majority of the time'.

Adrian's access to limited community treatment

Although conditions attached to Adrian's forensic disability order allowed the FDS to authorise LCT for between four and seven hours per week, the FDS has rarely allowed this. In fact, LCT has only been authorised for Adrian a total of 15 times since his admission over 6.5 years ago. The total amount of LCT that the FDS has approved for Adrian is 32 hours.

Of Adrian's 15 LCT events, four included a recreational activity at the Wacol precinct. Three included what was referred to as a 'bus ride and lunch' or 'bus ride and BBQ'. All other LCT events were referred to as 'bus rides'. As further details were not provided, it was difficult to establish whether the LCT was linked to the statutory purpose of supporting a person's transition.

Two further occasions were reported by the FDS as LCT, including the transfer of Adrian from the FDS for medical treatment. These were excluded from the analysis on the basis that medical treatment does not fall into the definition of LCT set out in s 20(3)(a) of the FD Act.

An outline of the number and duration of Adrian's LCT events is provided below.

Year	Number of LCT events	Approximate total duration
2018 (as at July 2018)	1	less than 2 hours
2017	3	5.5 hours
2016	6	16.5 hours
2015	2	4 hours
2014	2	2 hours
2013 (since admission)	1	2 hours
TOTAL	**15**	**32 hours**

Have decisions to seclude Adrian been lawful?

Given that Adrian has been in seclusion almost continuously since his admission to the FDS, there are more than 18,000 decisions authorising his seclusion.[300] On each occasion, a written order was required to have been created by a senior practitioner.

Seclusion orders at the FDS are paper records only, and retained in a compactus at the FDS or stored off-site.

The investigation obtained copies of seclusion orders for the month of June in 2016, 2017 and 2018. Analysis of the orders indicated:

- most orders contained a high degree of repetition of words used to describe the presenting risk
- some orders included typed entries where justifications for the authorisation of seclusion appear to have been pre-populated
- some seclusion orders contained information that was contrary to a view that Adrian was presenting with an imminent risk of harm. For example, these seclusion orders contained multiple instances of the following types of comments:

  'Risk is currently low, client currently in bed'

  'Client settled and continued to spend time on his own doing art'

  'Appropriate engagement with staff'

  'Settled mood, spent time playing cards with staff'

Adrian's seclusion was also continued in instances where the seclusion order only referenced historical risk factors. In fact, all seclusion orders reviewed by the investigation included a statement about Adrian's historic risk factors, often including the phrase 'Client has an extensive history of violence and aggressive behaviour towards others'.

The format of the FDS's seclusion order requires a senior practitioner to complete information under the heading 'outline clinical risks associated with secluding the client'. FDS senior practitioners often noted psychological and psychosocial impacts of isolation and deprivation of human contact as a clinical risk associated with seclusion. The investigation's assessment of seclusion orders also indicated:

- repetition of the same reason with little variation in wording across seclusion orders made between at least 2016 and 2018
- reliance on historical risk factors without any record to reflect a fresh consideration of any imminent risk[301]
- every seclusion order had an 'in' and 'out' section that reflects the intention of seclusion as a brief intervention. However, forms inspected by the investigation did not contain any entries in these sections given that Adrian was effectively in permanent seclusion.

FDS staff told the investigation that seclusion records were signed by a senior practitioner retrospectively, that is, after the seclusion period had already taken place. This is contrary to requirements of the FD Act.

300 This figure reflects the estimated number of seclusion orders made between the date of admission on 24 September 2012 and 30 June 2018.
301 See section on risk management in this report.

Legal advice obtained by the Director

In September 2018, the Director sought urgent legal advice about Adrian's seclusion by the FDS and whether it was justifiable for the Director not to order Adrian's immediate release from seclusion.[302]

In providing instructions, the Director provided the legal advisors with the following material:

- relevant email correspondence with the FDS
- Adrian's 5-year review as well as the 5-year review addendum report
- correspondence between the Director and the Chief Psychiatrist about the potential transfer of Adrian to an authorised mental health service
- previous legal advice obtained by the position of Director in 2013, which provided advice about statutory obligations imposed on the Director by the FD Act.

On the basis of the material provided by the Director, legal advice was provided on the lawfulness of the seclusion authorisations for Adrian. Specifically, the advice stated:

> There is no indication in the material provided that a senior practitioner has not acted in accordance with the requirements of Chapter 6, Division 3 in continuing to approve [Adrian's] seclusion.[303]

However, the Director did not provide the legal advisors with a copy of the 2016, 2017 and 2018 audit reports, as extracted above, or records from Adrian's client file that were relied upon by the Director to form the conclusions of the audit reports.

The Director's reports had already identified ongoing concerns about the lawful use of seclusion prior to seeking legal advice.

Observation of Adrian while secluded

The FD Act provides for the use of seclusion for a maximum period of three hours. Given the high-risk factors associated with the use of seclusion, including suicide and self-harm, the FD Act prescribes that a person in seclusion must be observed continuously or at intervals of no more than 15 minutes.[304]

Seclusion orders for Adrian state that he should be observed every 15 minutes. Observations are conducted by staff outside Adrian's seclusion area by observing Adrian through the servery window or Perspex screen. Given that the entirety of the seclusion area is not visible to staff from outside, CCTV cameras have been installed for the purpose of observing Adrian. At night, infra-red cameras are used. Both the CCTV and infra-red cameras screen real-time footage of Adrian into an office situated just outside the seclusion area in House 3.

The legislative requirement to observe a person in seclusion every 15 minutes has led to ongoing privacy concerns for Adrian, given that he has been in seclusion for more than six years. Information obtained by the investigation indicates that Adrian finds the use of cameras in all private spaces intrusive and troubling.

Adrian's behaviour reports document his distress caused by the privacy concerns, and indicate it has been associated with an escalation in his behaviours of concern.[305] Adrian has raised his privacy concerns with his guardian and an OPG community visitor, who have raised them with the FDS.

302 Section 66 of the FD Act provides the Director with the power to order that a person detained at the FDS who is in seclusion be immediately released from seclusion.
303 Legal advice dated 13 September 2018, p. 8.
304 FD Act s 62(2)(f)–(g).
305 For example, one behaviour report dated 14 July 2017 noted that '[Adrian] spoke about wanting to cover the door … and feeling as though he does not have any privacy due to the presence of cameras in his areas'.

Every person has the right to privacy. In this context, that right is in conflict with the legal obligation to observe a person in seclusion to ensure their safety. The tension between these two considerations arises as a consequence of the use of seclusion for an unintended duration.

The investigation requested all FDS policies and procedures relating to the use of CCTV cameras. The FDS provided 20 documents that relate to the use of CCTV in the seclusion area occupied by Adrian that could be considered policy directives, and had been drafted or issued by various staff at the FDS.[306] A review of the documents highlighted the lack of clarity and consistency.

The investigation was told that CCTV footage at the FDS is not recorded or retained. This omission contravenes the Department's policy relating to security, storage and retention of CCTV footage.[307]

Organisational factors

Organisational culture towards the use of restraints and seclusion can influence whether or not seclusion is used.[308] The use of seclusion in disability settings has also been found to be related to the quality of behaviour support plans in place for a person who is secluded.[309] The use of seclusion has been found to have traumatising and other harmful effects, both on the person secluded and staff.[310]

A number of organisational factors may have influenced use of seclusion for Adrian. Specifically, the FDS:

- did not question the use of seclusion as necessary
- considered seclusion to be legitimate and effective
- did not have good quality behaviour support plans that were well adopted and implemented
- normalised permanent seclusion, for example, by using the name House 3 and '[Adrian's] room' rather than accurately describing the space as a seclusion area.[311]

A number of factors suggest that there has been considerable organisational cost associated with the use of seclusion for Adrian, including financial costs, WorkCover claims, absenteeism,[312] workplace-related volatility and staff turnover.

306 A document titled *CCTV management plan in House 3* was created in October 2013, which appears to respond to privacy concerns through outlining projected objectives of reducing the reliance on CCTV in observing Adrian. The plan sets a benchmark to reduce CCTV use by 25% in the first month, 50% in six months, and 75% within 12 months. When compared against documents recording the use of CCTV also obtained by the investigation, it is clear that CCTV use has not been reduced as projected.

307 *Camera Surveillance Systems and Privacy – IPP5*.

308 B McSherry, 'Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities', (2017), *International Journal of Law and Psychiatry,* pp. 39–44.

309 Webber, Richardson, Lambrick and Fester, 'The impact of the quality of behaviour support plans on the use of restraint and seclusion in disability services', *International Journal of Positive Behaviour Support* (2012). This research found a decreased use of seclusion with increased quality of behaviour support plans.

310 Office of the Chief Psychiatrist, policy issued 2017; B McSherry, 'Regulating seclusion and restraint in health care settings: The promise of the Convention on the Rights of Persons with Disabilities', (2017), *International Journal of Law and Psychiatry*, pp. 39–44; K Chandler, L Willmott, B White, 'Rethinking restrictive practices: A comparative analysis', *Queensland University of Technology Law Review*, p. 14(2).

311 J Chan, J LeBel, L Webber, 'The dollars and sense of restraints and seclusion', (2012) *Journal of Law and Medicine*. The article found that the name or title of a building can influence its use, and the words 'seclusion unit' should be used.

312 FDS staff told the investigation that some staff would deliberately avoid having to undertake shifts that included working in 'House 3', including calling in sick to avoid work. At times this resulted in the staff who did attend not being able to offer a seclusion break due to understaffing.

Summary

The investigation identified significant and ongoing concerns about the use of seclusion for Adrian. In Adrian's case, it was identified that:

- the use of seclusion has effectively been permanent, contrary to the intention of relevant provisions of the FD Act
- the length of time that Adrian has been in seclusion may have significantly harmful effects on his wellbeing
- there are a range of indicators that suggest seclusion for Adrian has been used at the FDS other than for its intended purpose
- decisions to authorise Adrian's seclusion have not always demonstrated compliance with mandatory legislative provisions
- seclusion records at the FDS cannot reasonably demonstrate that seclusion was always the least restrictive approach.

Overarching principles of human rights, promoting habilitation and rehabilitation, meeting individual needs and goals, maintaining supportive relationships and community participation, and empowering a person to be involved in decision-making and exercising their rights are all principles that apply to the administration of the FD Act. Those principles have not been promoted or applied in relation to the seclusion of Adrian at the FDS.

Repetition of the same recommendations in Directors' audit reports over consecutive years indicates that recommendations did not achieve change.

During the course of the investigation, the Director and senior officers of the Department repeatedly emphasised the complexity of Adrian's case and the extent of his behaviours of concern. These considerations remain unchallenged and do not displace the FDS's obligation to ensure the lawful administration of the FD Act.

Adrian has not been provided with appropriate care and support through IDPs, behaviour support, LCT, risk management and program delivery. In the context of these failings, the seclusion of Adrian over an extended period of time has had a significantly detrimental impact on him.

Issues with seclusion were identified by the Director in audit reports provided to senior executives of the Department.

Department's response

In response to the Ombudsman's proposed report, the Director-General stated that she was not provided with a copy of the audit reports and said:

> Rather, it appears they were given by the [Director] to the Deputy Director-General (Disability Services), and not progressed to the Minister or I. A search of the Department's document tracking system confirms this position. However, upon learning of the existence of the DFD's 2018 audit, I sought out the report.

Opinion 9

9.1 Seclusion has been used for people detained at the FDS as a regulated behaviour control where appropriate approaches to behaviour support have not been effectively adopted or implemented. This is not consistent with s 42 of the FD Act.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

9.2 In relation to decisions to seclude Adrian:

- The FDS has failed to demonstrate that all decisions made to seclude Adrian were made in accordance with the requirements of ss 61–63 of the FD Act.

This is administrative action that is contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

- The seclusion of Adrian amounts to permanent seclusion.

This is administrative action that is oppressive for the purposes of s 49(2)(b) of the Ombudsman Act.

- The FDS has failed to comply with requirements to record and retain CCTV footage as required by relevant legislation and policies.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

- The permanent seclusion of Adrian has resulted in a deterioration of his condition and has significantly impacted on his quality of life and human rights.

This is administrative action that is unreasonable, oppressive and improperly discriminatory for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 9

That the Director:

9.1 Reviews the clinical management of Adrian and makes recommendations with a view to reducing the use of seclusion and improving his quality of life.

9.2 Develops and recommends a service-wide approach to behaviour support across the FDS with a view to reducing the use of regulated behaviour control in accordance with s 42(b)(iii) of the FD Act.

9.3 Reviews the FDS's use of seclusion in line with legislative obligations imposed by the FD Act, particularly ss 61–63.

9.4 Reviews the FDS's management of CCTV images and makes recommendations with a view to ensuring compliance with relevant legislation and policies.

Criminal charges and police attendance

A number of people detained at the FDS have been charged with criminal offences following interactions with an FDS staff member. Charges have been filed at court, and proceeded through the criminal justice system. If the charges were for a serious offence they were referred to the Mental Health Court for determination, otherwise, they were heard and determined by the Magistrates Court.[313]

The investigation found that all criminal proceedings brought against people detained at the FDS were concluded on the basis that the person detained at the FDS was unfit for trial. Given that most people detained at the FDS have been found permanently unfit for trial as a consequence of an intellectual or cognitive disability, this outcome appears foreseeable.

The investigation also found that the FDS has requested assistance from the QPS on multiple occasions to respond to a range of situations. This has included the use of police dogs and the attendance of the PSRT.

Criminal charges against people detained

The investigation sought to establish the number and nature of criminal charges brought against people detained at the FDS subsequent to their admission. The FDS was requested to provide particulars of all criminal charges brought against people detained in relation to incidents at the FDS, including details about the status and outcome of those proceedings.

In response, the investigation was advised:

> Forensic Disability Service (FDS) does not reliably hold the full information sought. FDS is aware of charges that lead the person to be referred to FDS. FDS might also be advised in referral reports of a client's further offence history. However this is sporadic. FDS will be aware of any new charges laid against a client while they are detained to FDS, and might make submissions to the court in regard [to] the client, but will not necessarily be advised of the status or outcome of charges.
>
> FDS is not entitled to seek this information in regard [to] people who are no longer Forensic Disability Clients.

The investigation sought to obtain further information by:

- obtaining and reviewing information directly from the QPS
- reviewing information provided by request from the Director, the OPG and other sources
- conducting interviews and enquiries with FDS staff, QPS officers, OPG staff and other relevant people.

Information obtained by the investigation indicates that charges have been brought by the QPS against at least four of the 12 people who are or have been detained at the FDS, equating to one-third of the FDS cohort. One person has been charged on five separate occasions, and another on at least two separate occasions. As outlined, all criminal charges were finalised on the basis that the person was permanently unfit for trial as a consequence of their intellectual or cognitive disability. This raised concerns about placing further resource demands on the judicial system.

313 In accordance with relevant provisions of the *Criminal Code 1899* and the MHA 2016.

Administrator's response

In response to the Ombudsman's proposed report, the Administrator stated that the FDS could have 'at best provided an incomplete and perhaps dated advice' in relation to the information sought.

Ombudsman's comment

This response serves to illustrate recordkeeping failures already outlined in this report.

Information about criminal charges of a person detained at the FDS, while at the FDS, should be retained on file for each person detained, and should have been easily and readily accessible. Inspection of the client files at the FDS revealed communication on file from the Administrator to at least one detained person advising of the person's upcoming court dates, and therefore, at least some of this information was known to the FDS.

Right of FDS staff to complain

The investigation examined the appropriateness of criminal charges and police attendance against people with intellectual and cognitive disability in the context of key concerns already identified with the operation of the FDS.

FDS staff have the same right as any other member of the community to make a complaint to police. It is also acknowledged that all workplaces, including the FDS, owe a non-delegable duty of reasonable care to protect staff from harm. This report does not include any opinion that would preclude FDS staff from making a complaint to police. In certain circumstances, that may be an appropriate course of action.

However, criminal charges appear to have been repeatedly brought by the QPS in a context where the FDS has not fully met its obligation to provide an appropriate standard of care and support for people detained.[314]

Concerns raised

No audit report authored by a Director identifies or discusses the criminal prosecution of people detained at the FDS. However, the Office of the Director's annual reports for 2015–16 and 2016–17 contain relevant information under the heading 'Notices under section 237[315] of the *Mental Health Act 2000*'.[316] The 2015–16 annual report stated that:

> During 2015–16, the Director issued a Director's Notice in relation to one forensic disability client who was served with a notice to appear in relation to a charge of alleged assault.[317]

314 Concerns about the reasonable and appropriate use of IDPs, program delivery, LCT, risk management and behaviour support have been outlined.

315 Section 237 of the now repealed MHA 2000 was located under Part 2 of the Act, which was titled 'Procedures for particular involuntary patients charged with offences'. The section provided that, where the Administrator becomes aware that a person is charged with a simple or indictable offence and the person is either subject to a forensic order or is an involuntary patient, the Administrator must give notice to the Director, who must then notify the chief executive for justice and the person subject to the forensic order or involuntary order. This provision is not contained in the current MHA 2016.

316 Although the MHA 2016 came into effect in March 2017, the Office of the Director of Forensic Disability annual report 2016–17 referenced the MHA 2000 without reference to the MHA 2016. Those provisions do not apply under the MHA 2016.

317 Office of the Director of Forensic Disability, annual report 2015–16, p. 14.

Under the same subheading, the 2016–17 annual report states that:

> During 2016–17 the Director issued five Director's Notices. The charges were served on four forensic disability clients with one client being subject to two separate charges for assaulting support staff.[318]

At interview, the Director confirmed that she was aware of police attending at the FDS and that this could result in charges being brought by the QPS against people detained.

The 5-year review reports authored by the Director, which review the criminal and detention history of the people detained at the FDS, do not contain details of criminal charges being commenced, or the outcome of those charges.

The issue was subject to comment by the Mental Health Court in a reported judgement delivered in 2013, two years after commencement of the FDS. In the matter of *Re Horner* [2013] QMHC 17, the Mental Health Court heard two charges of separate incidents of alleged assault against two FDS staff by a person detained at the FDS. The Court found that the defendant was not of unsound mind at the time of the alleged offences, but was permanently unfit for trial. Accordingly, the Court ordered that the proceedings be discontinued.

The judgement cites advice given to the Mental Health Court by an assisting psychiatrist, who stated:

> We heard that a positive behaviour support program had been instituted in their facility [the FDS], which has been designed for this very purpose, but clearly it has not produced the results that one would have hoped for and were expected, and the fact that whilst this is the second time [the defendant] has been brought to a court process … with the hope that … the express hope that by involvement in the court process, it would be an incentive, if you like that would be useful in trying to help [name of defendant] learn and accept the consequences of his behaviour.
>
> That is clearly – has been clearly stated as … the end point of … what [the doctor] hoped to achieve. I think when it becomes an end in itself, one has to be very careful about the means that you use and in this case, I don't think the end justified the means.[319]

A second assisting psychiatrist provided the following advice about the clinical utility of a reference to the court:

> The first thing that needs to be said, in my view, is that the question of unsoundness or fitness for trial is based on the clinical state and circumstances, rather than on whether there is any clinical utility, with respect to whether charges should proceed; that is, *using the court as a behavioural therapeutic tool,* where there [are] other ways of managing a behavioural program.[320]

Since this case in 2013, there have been multiple incidents of charges being brought by the QPS against people detained at the FDS. This has occurred in an environment characterised by an ongoing failure to deliver appropriate behaviour support to people detained.

318 As the annual report does not stipulate the date of the four sets of alleged offences, it is unclear whether these fell under the MHA 2000 or if they arose subsequent to the introduction of the MHA 2016. It is also noted that, given the outcome of each of those matters, it would be appropriate to have referred to the matter as an allegation.
319 *Re Horner* [2013] QMHC 17, p. 15.
320 *Re Horner* [2013] QMHC 17, p. 18. Emphasis in this quotation has been added.

Concerns about the use of criminal charges against people detained at the FDS were also raised by the Public Guardian. The OPG's submission about the draft bill makes the following statement:

> The OPG also recommends that every IDP incorporate a positive behaviour support plan for the client. This is due to concerns regarding inappropriate behavioural management practices within the FDS. For example, several clients residing in the FDS have been charged with criminal offences on the basis of complaints made by FDS staff relating to alleged incidents that have occurred within the FDS. It is the OPG's view that there is a failure by these staff to engage with positive behaviour strategies prior to police being contacted as a response to known challenging behaviour.

In forming a view about this statement, the Lambrick report reviewed relevant incident reports, behaviour reports, community visitor site visit reports, Guardianship running notes and records of discussion with key informants and concluded:

> Allegation is substantiated with respect to the fact there have been a number of incidents of criminal charges been made in relation to FDS clients since 2011. While this allegation is confirmed it must be noted that it is standard practice in disability services for staff to report incidences of client to staff assault to the police in consultation with line management. It should be noted that the consistent use of positive behaviour support strategies would serve to minimise the likelihood of incidences escalating to this level and while it is not a requirement under the FD Act for the development of positive behaviour support plans, the research literature would strongly support the development and implementation of these plans based on function behaviour assessment.[321]

Policy awareness

The investigation interviewed a number of FDS staff to obtain their perspectives about reporting incidents to the QPS. The investigation was told that some individual FDS staff had made complaints to police due, in part, to a lack of responsivity of the FDS management to provide appropriate support. In some circumstances, those complaints were lodged with police after the incident, rather than in the context of police being called to the FDS at the relevant time.

The FDS staff who provided information to the investigation were not aware of any policy that provided instructions on making decisions to contact police. It was also identified that there was no clear management structure for decision-making in relation to when to contact police, or any consistency of process for responding to critical incidents that included appropriate debriefing, review and reporting processes that could lead to better safety outcomes. The investigation was advised by the Department that its corporate and executive services policy titled *Work health, safety and wellbeing* applied.[322] However, FDS staff did not appear to be aware of the application of this policy at the FDS.

FDS staff consistently reported concerns about a lack of professional and appropriate responses by FDS management to critical incidents and safety concerns.

One FDS staff member said that they felt the response they received from QPS was better than the response they received from their workplace, stating:

> But I went ahead and wanted to report to the police because I felt that management at the time were brushing it under the table …

321 Lambrick report pp. 4–5. Note that the Lambrick report did not review materials obtained from QPS.
322 Department of Communities, Child Safety and Disability Services, Corporate and Executive Services Policy, *'Work health, safety and wellbeing'*, approved 4 January 2016.

When asked if they were aware of the policy in reporting or following up on matters reported to the police, the FDS staff member said:

> We have a lot of policies, and just recently, we've had, I don't know, maybe nine new policies that we have to read and sign that we've read and understood them, and the policy booklets are quite large, and they keep updating and changing. So I, I can't say that I've recalled that policy really clearly.

The FDS staff member told the investigation they felt that the team that was responsible for assisting a person to return to work after any incident or injury was poorly managed, and that they did not feel supported by the FDS with regard to reporting, debriefing or other strategies to ensure a safe and supportive workplace. This FDS staff member stated that:

> Yeah, yeah. So I didn't go, I, I didn't go to the police because I'm looking for him to be, I don't know, a longer sentence or anything like that. For me, it was more about making certain that my assault is captured somewhere in the legal paperwork ...
>
> The police made me feel supported ... They listened to me. They called me back to see how I was going. They actually recognised what happened to me ...[323]

FDS staff described the management approach for following up any critical incidents as 'haphazard', 'chaotic' and a 'tick box approach'. There appeared to be a lack of fundamental recognition of the complexities of potential harm that may be caused to an FDS staff member, and a lack of experience in successfully mediating positive outcomes for staff with sensitivity and respect.

There was also no indication that the person detained at the FDS had been engaged in thorough, appropriate and consistent debriefing strategies by FDS management, or that approaches to behaviour support had been reconsidered, altered or adjusted following incidents.

QPS's response

In response to the Ombudsman's proposed report, the QPS stated that, while it was not in a position to comment specifically on the development of FDS policies and procedures, the QPS is committed to providing effective policing responses to vulnerable people in the community and would welcome the opportunity to engage in consultation with the FDS at its request in the development of policies and procedures in circumstances where QPS may be called to attend.

The QPS also noted that it has recently developed a 'vulnerable persons' framework' promoting the principles of a holistic and person-centric response to vulnerable members of the community who come into contact with police.

QPS stated that:

> The QPS supports any opportunity for the improvement of processes and procedures which promote safe and just treatment of clients within the FDS. The QPS itself is currently undertaking a review of the Mental Health Intervention Program for the purpose of strengthening responses to persons with mental illness across Queensland who come to the attention of police. The QPS welcomes the opportunity to explore how it may assist the FDS in undertaking a review of FDS clients who have charges brought by QPS.

323 Interview with FDS staff member dated 24 August 2018 at Brisbane.

Administrator's response

In response to the Ombudsman's proposed report, the Administrator said that FDS staff were required to report any incident within the Department's records, including client files, work injury reporting and behaviour incident reports, and during debriefing.

The Administrator also observed that, in his experience since commencement in the role in February 2017, FDS staff would make a decision to report to police that was 'independent of any advice' to do so by FDS management.

The Administrator also outlined that, in his view, this was a human resources, work health and safety, staff performance or industrial matter that was out of scope of the investigation and should not be included in the report. The Administrator stated that, in his view, this matter did not relate to the care and treatment of people detained.

The Administrator also stated that:

> When Police attend FDS there has been most often no physical contact between QPS and client. QPS presence has generally been sufficient to lead clients to calm.

Ombudsman's comment

Despite the Administrator's comments, the investigation found that debriefing strategies were inadequate.

QPS attendance at the FDS to deal with behaviours of concern is clearly an issue that relates to the care and treatment of people detained at the FDS.

Whether or not there is physical contact between QPS and people detained at the FDS is irrelevant.

Complaints to police by the person detained

People with intellectual disability living in the community are over-represented as victims of crime. Recent academic literature identifies that people with intellectual disability are significantly more vulnerable to violent and sexual victimisation than the wider community.[324]

Where the complainant has an intellectual or cognitive disability, successful criminal prosecutions are extremely difficult to obtain. A person with an intellectual or cognitive disability may also be less likely to complain to police.[325]

Information obtained from the QPS indicated that, in 2017, a person detained at the FDS made a complaint to police in relation to an alleged assault by an FDS staff member. Contact with the police was facilitated by a family member of the person detained. The initial complaint was described in QPS materials as follows:

> Informant has contacted [QPS] to state that her [family member, name of person detained] has told her he was assaulted by a staff member at the Forensic Disability Service. [Name of person detained] was allegedly pushed to the floor, kneed in the chest and has had a hand placed around his throat by a staff member [redacted] – has bruising to chest. Apparently [the person detained] was taken to the [redacted] Medical Centre in [redacted] for treatment.[326]

324 B Fogden, S Thomas, M Daffern, J Ogloff, 'Crime and victimisation in people with intellectual disability: a case linkage study', *BMC Psychiatry* 16:170, (2016) https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-016-0869-7

325 This is one reason why an effective process for the identification and assessment of complaints by people with intellectual or cognitive disability detained at the FDS should be developed.

326 Information obtained from QPS.

The investigation sought further information in relation to this allegation from QPS and the Department.

The investigation was informed by QPS that records indicated this matter had been finalised on the basis that it was unable to be substantiated.

Information was therefore requested from the Department about the investigative process and outcome of the internal investigation. In response, the Department stated that the Administrator undertook a 'preliminary informal enquiry into the incident', but that 'after the preliminary enquiries the Administrator made the decision that there was no basis to further investigate and no further action was taken'. The Department also stated that:

> At no time did [the Administrator] brief Senior Management or the Ethical Standards Unit on the matter, it appears that after initial enquiries the decision-maker formed the view that no further action was required.

No records were provided to the investigation that evidenced any internal investigation had been undertaken by the FDS or the Department. This was an inadequate response to a complaint made about a very serious allegation.

At the time of the allegation, there was no complaints management process in operation at the FDS. This allegation was a matter that should have, at the very least, constituted a formal complaint and been referred to the Director for investigation.

Section 116 of the FD Act provides that it is an offence to ill-treat a person detained at the FDS. While it is not suggested this incident gives rise to this offence, this example illustrates the barriers that might apply to any successful prosecution under this section of the Act.

Administrator's response

In response to the Ombudsman's proposed report, the Administrator stated that:

- the matter was not raised by the detained person directly to the FDS
- the Administrator arranged for a medical examination
- the two staff on shift were 'asked for account' but there was no evidence that an alleged assault occurred
- the Administrator sought 'legal advice' but was advised that he had no evidence to provide to police
- the statement of the detained person was 'found to be not reliable given he regularly made such complaints against staff without any evidence being available to support his claim'
- the Administrator advised the Department and the Director about the allegation made by the client's legal representative by email in which he described the actions he had undertaken.

Ombudsman's comment

Differing versions about this incident were provided to the investigation. The Department states that the Administrator did not brief senior management or the Ethical Standards Unit about the matter. The Administrator states that he advised the Department and the Director about the allegation.

Police attendance at the FDS

The investigation also found that QPS has been contacted by staff at the FDS who have requested assistance with responding to or managing a range of situations that involved the escalation in behaviours of concern by a person detained at the FDS.

QPS attendance at the FDS can be categorised as having the following purposes:

- to escort a person to or from the FDS
- in response to a person absconding while on LCT, including for overnight periods. This issue has been outlined in relation to LCT
- in response to a request for assistance from the FDS.

The investigation was told that there was no designated contact person responsible for determining when to contact police, or trained in any police liaison role.

The Queensland Police Service *Operational Procedures Manual* (QPS OPM) is a manual developed by QPS to provide guidance and instructions to members of the QPS about aspects of operational policing. The current public edition, the QPS OPM Issue 69, was last revised on 25 January 2019. Chapter 6 of the QPS OPM contains guidance and direction on special considerations police should have when they have interactions with people with special needs, for example, children, people with disability, people from culturally and linguistically diverse backgrounds, and people experiencing mental health conditions or homelessness.

The QPS OPM[327] contains a specific subsection relating to the FD Act, which does not appear to adequately reflect the position that the FDS is a specialist facility for the detention, care and support of people with an intellectual or cognitive disability found to be unfit for trial as a consequence of that disability.

QPS's response

In response to the Ombudsman's proposed report, the QPS stated that concerns raised by the investigation about the QPS OPM were noted, and undertook for its QPS Domestic, Family Violence and Vulnerable Persons Unit to review whether an amendment to the OPM may be appropriate in the circumstances. In providing this indication, QPS noted that:

> The QPS recognises the importance for police officers to be aware of the needs of persons with intellectual and cognitive disabilities. There are legislative provisions which govern interactions between police officers and people with a range of special needs and the QPS also offers a range of resources for its members in this regard.

Ombudsman's comment

The QPS's intention to review the OPM is welcomed.

327 *Operational Procedures Manual*, Issue 70, Public Edition, Chapter 6 – Special Needs, 6.7 Forensic Disability Act, p. 35.

Police attendance for Adrian

The FDS has contacted the QPS for assistance for more than one person detained. However, this mostly occurred in relation to assistance with Adrian, and will be discussed in that context.

The investigation found that QPS has responded to requests for assistance by the FDS in relation to Adrian more than 25 times. The attendance has frequently included the use of police dogs. Given Adrian is in continual seclusion, police have attended at the seclusion area.

In some circumstances, the FDS may have held real concerns that Adrian's behaviour posed an immediate risk to himself or staff. The presentation of that threat is repeated in consistent terms across reports that give rise to QPS contact.

The QPS has also been contacted by the FDS when Adrian has engaged in behaviours of concern that give rise to property damage, namely, kicking the fence, rather than a threat of harm.

In other circumstances, the FDS has contacted the QPS for assistance with matters to manage Adrian's behaviour, for example, to escort him from one seclusion area to another. QPS material has included notations made by QPS officers receiving a request for assistance from the FDS that state that, prior to police attendance, Adrian was 'no threat to himself or others at this stage'.[328]

Information obtained from the QPS database that relates to multiple and separate records of police attendance for Adrian included the following comments:

- Offender is fearful of dogs, therefore dog squad should attend if any further incidents.
- The Oxley DDO telephone number has been provided to DSQ staff. If police are contacted then ALL OTHER AVENUES OF RESOLUTION HAVE BEEN EXHAUSTED.
- [Adrian] is also petrified of dogs and will calm down immediately.
- Offender hates dogs and it works every time.

While no observation is made about the nature of the police response when requested to attend by the FDS, some of these comments suggest that the QPS has been contacted by the FDS in relation to a request for assistance in circumstances that amount to behaviour control.

During the course of the investigation, a critical incident occurred where the QPS was called to the FDS and attended with a police dog. This incident demonstrated an elevated response where the police dog physically entered Adrian's seclusion area.

The Ombudsman notified the Director-General of this concern. The Director-General advised the investigation that the Director was requested to 'identify whether there is further support that the Department could provide to improve the living conditions and circumstances of the client'.[329]

328 QPS materials dated 26 December 2012, emphasis that appears was in original document.
329 Letter from the Director-General, undated.

The Director provided a letter of response directly to the Ombudsman that included the following three paragraphs:

> To place this in some context I think it is important for your investigation to know that [Adrian] is a very challenging individual with complex and dangerous behaviours, who over the period 2012–2018 has been involved in 563 behaviour incidents at the FDS. The intensity of some of these behaviours have been so immense that to date the reinforcement and damage caused by this one client has been calculated to be in the region of $1,077,586.08.
>
> In respect of the specific deployment of the team to FDS – I have not been able to establish if FDS staff have ever specifically requested this team, but I have found no evidence to suggest they have. Nonetheless, [a senior officer of the QPS] was contacted for information in relation to the deployment of the PSRT team and stated that it would not matter what FDS staff requested – it was entirely QPS' decision how they respond to requests for assistance and they had a duty of care to the person involved, the police attending and to the public to use whatever means necessary to uphold personal and community safety. While QPS might respect FDS indicating a preference it would carry no weight in their final decision.
>
> In relation to the incident … my understanding is that the [Public Safety Response Team] was deployed to assist FDS to safely manage [Adrian's] highly escalated behaviour and to enable staff to enter his room to remove items that he was threatening to use to harm himself.

It is accepted that QPS is responsible for the resources deployed based on professional judgement of the situation. However, concerns raised by the investigation relate to management of the interface between the QPS and the FDS.

At interview, the Director confirmed that she was aware that police have attended at the FDS in relation to Adrian and that the attendance had included police dogs. The Administrator also confirmed that he was aware of this practice, and described the use of police dogs as 'effective'.[330] When asked to clarify for whom police dogs were effective, the Administrator explained that in his view they were effective for 'everyone'.

Current and former senior officers of the Department indicated at interview that they were not aware that police dogs had attended at the FDS.[331]

330 Interview with FDS Administrator.
331 Interview with Executive Director, interview with Deputy Director-General, interview with former Director-General.

Administrator's response

In response to the Ombudsman's proposed report, the Administrator outlined general commentary about the risks that, in his view, Adrian presents. The Administrator pointed to risk assessments undertaken by the FDS.

The Administrator also made the following comments:

> A critical comment is made: "QPS have also been contacted by the FDS when Adrian has engaged in behaviours of concern that give rise to property damage, namely kicking the fence, rather than a threat of harm." The use of "rather than a threat of harm" emphasises the criticism, but completely demonstrates ignorance of the risk this man presents and the circumstances. Again why would investigators author this without researching the circumstances fully? When "Adrian" kicks the fence he is actually destroying the fence. It is a galvanised steel dense mesh fence as is also used in prisons. However "Adrian" is strong enough to kick enormous holes in this fence such that he is able to crawl through the fence. Once through the fence he could be able to access staff or clients, or by breaching one further fence then members of the public. In such circumstances he would be likely to face legal consequences in regard to escaping his detention.[332] Surely the investigators would not wish to suggest that we should allow the client free movement or escape from legal detention such that he could access others and harm them? Of course not. Any review of FDS care and treatment of clients here would confirm that it is expected that the lawful detention imposed by the court needs to be maintained until the Mental Health Review Tribunal supports a transition to another environment and agrees to a change of status to his Forensic Order (Disability).

In response to the comment that the Administrator stated that he found the use of QPS for Adrian effective, the Administrator stated that:

> I really struggle to see why this would be regarded as an adverse comment. My statement is one of fact. When police or police dogs attend FDS, "Adrian" will respond by calming, ceasing his efforts to harm others or harm himself or destroy property, and will cease efforts to breach security such that he then cannot access the general public supporting their ongoing safety, and he generally becomes remorseful.
>
> ...
>
> It seems bizarre that the investigators even make note of the presence of police dogs. The report acknowledged advice for the QPS that dogs involvement in any response is an operational decision that they make.

Ombudsman's comment

This report has commented on the validity and effectiveness of the FDS's approach to risk assessments.

The Administrator's response reflected a focus, identified through the course of the investigation, on the containment of Adrian. Part C of this report outlines that positive behaviour support has not been consistently applied. The first positive behaviour support plan was implemented for Adrian in 2017.

It is also noted that there are three fences containing Adrian in his seclusion unit, which is located within the medium secure FDS.

Responses from the Director and the Department to the Ombudsman's correspondence in relation to this issue illustrated the confusion that emerged throughout the investigation about who is responsible for the operations of the FDS. It also emphasised the Department's recent approach of referring responsibility to the Director.

332 The investigation notes that s 145A(c) of the Criminal Code states that offences relating to escape from lawful custody do not apply to the custody of a forensic disability client at the FDS as referenced in the FD Act.

Director's response

In response to the Ombudsman's proposed report, the Director disputed the Director-General's characterisation of the request made to her during the investigation in relation to the critical incident, stating that she had been asked by the Director-General to respond to issues raised by the Ombudsman about the QPS attendance with police dogs to assist in the management of Adrian.

The Director also confirmed her earlier position that she disagreed with any allegation that QPS and police dogs had been used as a form of behaviour control, and stated that in her view police attendance has only been accessed by the FDS as a 'necessary emergency response to a critical and serious challenging behaviour where all other attempts to keep Adrian and others safe have not been successful'.[333]

The Director again highlighted her view that Adrian poses immediate risk to others and that his circumstances are particularly complex.

Ombudsman's comment

The Director referred to general information about behaviour incidents and the percentage of times these have resulted in police attendance; however, the investigation was not provided with any specific information or evidence from the Department, the FDS or the Administrator that was relevant to a consideration as to the purpose and nature of contact with police.

Complexity is not a justification for legislative non-compliance. The FDS was established for the very purpose of addressing those complexities in the context of people with disabilities who display behaviours of concern and require secure care.

333 Director's response to the Ombudsman's proposed report, dated 24 May 2019.

QPS's response

In response to the Ombudsman's proposed report, the QPS provided the following response:

> The QPS is not in the position to comment specifically on the development of FDS policies and procedures. However, the QPS is committed to providing effective policing response to vulnerable persons in the community and would welcome the opportunity to engage in consultation with the FDS at its request in the development of policies and procedures in circumstances when the QPS may be called to attend.

QPS also stated that:

> The QPS is not in the position to comment specifically on FDS behaviour management practices. However, the QPS is committed to working collaboratively with government, non-government and community groups to improve policing responses to vulnerable persons. In recent times the QPS has supported the implementation of the co-responder model. This model is a collaborative initiative that involves police officers and mental health clinicians working together to provide a triage response to persons experiencing mental health crisis. This strategy has produced a number of positive results including de-escalation and prevention of crisis situations.
>
> Police have a duty to respond to incidents in the fulfilment of safe and secure communities and are guided by best practice procedures. The QPS welcomes further opportunities to become involved in partnerships that contribute to effective policing responses to vulnerable persons. This may include exploring initiatives to work with the FDS, for example, on developing a triage based response to FDS clients to minimise harm that the person may pose to themselves, or those around them and importantly, to support responses that reduce potential criminalisation of this group.
>
> ...
>
> The QPS is not in the position to offer commentary on the roles and responsibilities of FDS staff. The QPS acknowledges concerns raised by the Ombudsman of the criminalisation of persons with intellectual disability. The QPS is receptive to exploring opportunities for strengthening partnerships between the QPS and the FDS. For example, the QPS has embedded, across its Districts, Mental Health Intervention Coordinators who work with Queensland Health and Queensland Ambulance Service personnel to find local solutions to local mental health issues. Coordinators meet regularly to identify issues, discuss complex cases, develop preventative interventions (such as pre-crisis plans) and identify alternative referral pathways and review procedures. In addition to this, the QPS works collaboratively with the Queensland Forensic Mental Health Unit as part of a joint initiative (the Police Communications Centre Mental Health Liaison Service) to provide direct mental health assistance through the communications centre to police when responding to crisis situations. There may be opportunities to explore how existing resources may be utilised to support police engagement with the FDS.

Ombudsman's comment

The QPS's response that it is receptive to exploring opportunities for strengthening partnerships between the QPS and the FDS is noted.

Summary

The attendance of the QPS and criminal charges against detained people raise concerns about the criminalisation of people with intellectual and cognitive disability who are subject to detention.

Opinion 10

10.1 Despite all charges brought by the QPS against people detained at the FDS, subsequent to their admission, having been discharged by a court as a consequence of the person's intellectual or cognitive disability, there has been no appropriate review of incidents that gave rise to those charges, or identification of systemic issues that may have contributed or improvements in service delivery.

10.2 People detained at the FDS have been exposed to criminalisation on the basis of their intellectual and cognitive disability.

10.3 The FDS did not adequately investigate the complaint made by a person detained at the FDS involving an alleged assault by an FDS staff member.

10.4 In some circumstances, the FDS appears to have requested assistance from the QPS in the management of Adrian that amounted to behaviour control.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 10

That the Director-General, in consultation with the Director:

10.1 Develops policies and procedures about the scope and application of circumstances when the QPS should be called to attend the FDS.

10.2 Ensures that any charges brought by the QPS against a person detained at the FDS results in a review by the FDS to identify opportunities for systemic improvements.

10.3 Immediately eliminates the use of any QPS response, including the use of police dogs or the PSRT team, for behaviour control.

10.4 Evaluates the potential benefit of nominating an FDS staff member/s as a designated QPS liaison officer/s. The FDS staff member/s should be appropriately skilled and trained in both forensic disability and relevant QPS processes with a view to ensuring that:

- the FDS only contacts the QPS in appropriate circumstances
- if QPS assistance is required, it is facilitated appropriately to allow the QPS to undertake its role effectively.

Transition

The FDS was intended to operate as a transitional facility. The FD Act contemplates the provision of intensive support to people subject to a forensic disability order who require secure care, with a view to assisting them to transition to a less restrictive environment, including supported care in the community.

Transition planning was identified as an important part of a person's IDP, which was to be developed in consultation with the person, their family and their informal support network.[334]

No person detained at the FDS was transitioned between the first admission in July 2011 and September 2017, a period of over six years. Since September 2017, five people have transitioned out of the FDS.

Statutory obligations

The FD Act contains a specific obligation to ensure that transition plans are in place for all people detained at the FDS, as well as other legislative provisions that emphasise that the FDS has a transition focus.

The requirement to have a transition plan is contained in the legislative obligations for IDPs, which must include an outline of the proposed plan for the person's transition to participation and inclusion in the community.[335] This is in keeping with one of the objectives of an IDP, which is to support a person's reintegration into the community when appropriate.[336]

The IDP is considered an integral part of a person's care and support while detained in the FDS. It must be developed and regularly reviewed and, where appropriate, must include planning to allow for a person's participation and reintegration into the community.[337] Transition planning is regarded as an 'integral part of the plan'.[338]

An IDP must be regularly reviewed and, if necessary, changed to ensure it continues to be appropriate for promoting the person's development and independence, and supporting the person to participate and be included in the community.[339]

Transition is also emphasised in other sections of the FD Act.

One of the statutory purposes of the FD Act is to maximise the opportunities of a detained person for reintegration into the community.[340] That purpose is to be achieved in four key ways, and includes providing a multidisciplinary model of care designed to promote, among other things, a person's independence.[341]

Support and services provided to a person under the FD Act must promote the person's opportunities for participation and inclusion in the community.[342] This is reiterated through the statutory purpose of LCT, which is to support the person's rehabilitation by transitioning the person to living in the community with appropriate care and support.[343]

334 Explanatory Notes, Forensic Disability Bill 2011, p. 4.
335 FD Act s 15(1)(b).
336 FD Act s 13(1)(c).
337 Explanatory Notes, Forensic Disability Bill 2011, p. 5.
338 Ibid, p. 23.
339 FD Act s 15(1)(c).
340 FD Act s 3(d).
341 FD Act s 4(c).
342 FD Act s 7(b).
343 FD Act s 20(3)(a).

Importantly, s 141 of the FD Act imposes a requirement for the Director to review a person's benefit from care and support provided by the FDS. This provision applies when a person has been detained at the FDS for a continuous period of five years. This provision operates as a safeguard against indefinite detention where a person has not transitioned.

Policies and procedures

The following FDS policies and procedures were identified as relevant:

- *Transition and Exit from the FDS policy* – issued on 18 September 2017, supersedes the Client Entry and Exit from the FDS policy dated 1 July 2011
- *Transition and Exit from the FDS procedure* – first issued on 18 September 2017 and as a new procedure does not supersede any previous procedure.

The stated purpose of the current policy is to:

- promote a focus on transition at the FDS to ensure it functions as an effective and purposeful service to transition and exit clients to the community
- outline the functions of the MHRT in the process of transition and the role of the Director's five-year review in ensuring clients are not indefinitely detained at the FDS beyond what is deemed beneficial.

The policy states that transfer decisions must consider the prevention of prolonged and indefinite detention.

Have transition plans been effective?

The investigation found that transition plans were not in place until sometime between February and July 2017, six years after commencement of the FDS.

The Director's 2014 audit stated that:

> No client has a transition plan and this may have contributed to a lack of comprehensive strategies to assist clients with community reintegration.[344]

This issue was raised by a community visitor who reported the issues in the community visitor site report as ongoing until 1 May 2015.[345]

The 2014 audit report recommended that IDPs be reissued and linked directly to transition plans.

The Director's 2016 audit report again found that 'a review of all client IDPs identified that no transition plans had been developed for clients'.[346] The 2016 audit report also states:

> The current lack of transition plans for clients suggests the 2014 audit report recommendation had not been progressed. Further, with the exception of two clients, there was a lack of evidence to indicate discussions had occurred with the Department of Community, Child Safety and Disability Services regional service delivery in relation to client transition.

344 Office of the Director of Forensic Disability, 2014 audit report. When making the observation that no client had transition plans, the audit report states that '… most client IDPs do contain general strategies regarding use of LCT to assist clients to reintegrate into the community and also reference LCT Management Plans'. The report also identifies that LCT had been limited for some people. Subsequent audits found that LCT did not contain linkages to the purpose of LCT.
345 F Lambrick, Victorian Department of Health and Human Services, *Review of the Forensic Disability Service*, (2017), p. 6.
346 Office of the Director of Forensic Disability, 2016 audit report, p. 46.

> IDP review meeting minutes reflected very little time was spent discussing transition planning. MHRT reports or program completion reports did not provide clear recommendations regarding additional steps or planning that would need to occur to reduce risk and support transition from the FDS.[347]

The 2016 audit report again recommended that transition plans be developed for each person detained at the FDS, and specifically recommended that they form part of a person's IDP to ensure compliance with the FD Act.

In 2017, the Director again found that transition plans had not been developed. The report states that:

> There was no evidence transition plans for any client have been developed and the FDS is therefore non-compliant with section 15(1)(b) of the Act.[348]

Accordingly, the Director made the following recommendation and action:

> **Action 22:** The FDS must urgently develop a transition plan for each client's transition into the community.
>
> **Recommendation 33:** It is recommended a framework and/or process is to be developed to guide FDS staff to develop and implement transition plans.[349]

The Director's audit progress report in July 2017 reported that Action 22 had been implemented, but that Recommendation 33 was categorised as 'in progress'. The quality of the transition plans was not assessed.[350]

Prior to undertaking the audits in 2016 and 2017, the Director had undertaken 5-year reviews for eight people detained in the FDS, and recommended that all people should transition from the FDS. Each 5-year review contained specific recommendations to progress future supports.

In September 2017, the Director reissued the *Transition and Exit from the FDS policy* and issued a new procedure, the *Transition and Exit from the FDS procedure*. Together these documents provide policy directions that require the FDS to focus on transition planning prior to a person being detained at the FDS, and have an ongoing focus on transition, including reviewing progress against the transition plan every three months.

The Director's 2018 audit report confirmed that transition plans were in place for all people detained, except one person who was first transferred to the FDS in January 2018. As a transition plan was not in place one month after that person's admission, this demonstrated non-compliance with the Director's policy and procedure issued in September 2017.

The Director's 2018 audit was the first audit to assess the quality of the transition plans. Overall, the audit identified concerns with the quality of the transition plans that had been developed. The Director stated that:

> The transition plans appeared to be more of a summary of relevant information to assist the transition planning process rather than any attempt to capture specific actions or plans to progress the client's transition … A lack of clear goals makes identifying actions and subsequent timeframes difficult. Consequently, transition plans on client files did not include any detailed information or actions outlining how transition for clients would be progressed. Furthermore, even for those clients who had already transitioned at the time of the audit or were in the process of a graduated transition the transition plan reviewed did not reflect the current status of their transition.

347 Office of the Director of Forensic Disability, 2016 audit report, p. 46.
348 Office of the Director of Forensic Disability, 2017 audit report, p. 45.
349 Ibid.
350 This was not the focus of the Director's 2017 mid-point audit, which reviewed the status of implementation of the actions and recommendations of the 2017 audit report.

> The transition plans reviewed were confusing and this may be partially attributed to the plan containing sections that did not link.
>
> The client's involvement in the transition plan was not evident and given the current format of the plan it is unlikely that it would assist clients to understand what needs to occur for them to transition from the service.

Accordingly, the Director appropriately recommended that the policy and procedure must be followed,[351] as well as the following two recommendations:

> The transition plan should be a meaningful document that reflects the client's progress and any outstanding rehabilitative and habilitative needs, current assessed risk and their participation and inclusion in the community, it should also identify the actions to progress transition and include what actions key stakeholders will undertake and time frames for this to occur.
>
> The client and stakeholders should be involved in contributing towards the transition plan and supported to understand its content.

As well as the advice in the audit reports, concerns about the transition of people detained at the FDS were raised through the Lambrick report in 2017 and the Ogloff report in 2018.

Consideration of transition plans by the Lambrick report was confined to concerns raised in relation to one person detained at the FDS, rather than all. That report discussed systemic challenges to the proper operation of the FDS and noted that, at the time of the report in August 2017, all people detained at the FDS had transition plans in place.

The Ogloff report highlighted the concern in relation to periods of detention and lack of transition. The report states that:

> … unacceptably lengthy detention times have been the norm, with the original intake of nine clients all being detained for more than five years, including one client who died whilst a client of the service in January 2016. This goes against the purported strong rehabilitative focus of the FDS (as opposed to offering a place of indefinite containment) and its aim of reintegrating clients to the community, having benefitted from the focused interventions offered by the service.[352]

Finding of the 5-year reviews

As outlined, s 141 of the FD Act requires the Director to review the benefit to each person from care and support provided by the FDS, and to consider whether the benefit is likely to continue if the person continues to be detained at the FDS.[353] This provision is activated when a person has been detained at the FDS for a continuous period of five years.[354]

Under the FD Act, 'benefit' means a benefit by way of individual development, and opportunities for quality of life and participation and inclusion in the community.[355]

Given people were first detained at the FDS in 2011 and one person in 2012, and had not transitioned by 2017 and 2018, s 141 of the FD Act became relevant for all nine people originally admitted to the facility.[356]

351 This recommendation was an action made by the Director as requiring immediate attention.
352 J Ogloff, J Ruffles, D Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*, (2018), Unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, p. 47.
353 FD Act s 141(2).
354 Section 141(5) of the FD Act provides that any LCT, temporary absence or any period for which an authorised mental health service was responsible for the person under s 147 of the MHA 2016 are to be included in working out whether a person has been detained at the FDS for a continuous period of five years.
355 FD Act s 141(6).
356 Including the person detained outside the FDS; however, in light of the scope of the investigation, this person has not been included in this analysis.

The Director conducted thorough reviews and delivered a report to the Administrator accordingly.[357] As this was the first review of its kind since commencement of the FDS, the Director established a format for undertaking the review which was carried across each of the reports. The Lambrick report commented that the 5-year review reports authored by the Director were very comprehensive and clearly outlined the history of service provision for each person detained at the FDS, and the degree of benefit from placement at the FDS within the context of individual development from rehabilitation and habilitation opportunities, quality of life, and participation and inclusion in the community.

After assessing each of the above areas, the Director's 5-year review reports provide information about the status of the person's readiness for transition, what, if any, progress had been made towards transition planning, and other information about what would be required to transition the person out of the FDS.

The reports then provide conclusions and recommendations made by the Director to the FDS. In six of the reports, the Director concluded that the person was 'no longer benefiting' from their detention at the FDS and the environment and service model was unlikely to provide benefit in the future. Two reports concluded that the person 'has not benefited' from their detention at the FDS.

The following table summarises the admission date, date of the 5-year review, Director's recommendation and date of transition for people detained at the FDS to whom the 5-year review process applied.

Person	Admission	Date of 5-year review	Finding	Date of transition
1	22 August 2011	30 September 2016	No longer benefiting	30 November 2018
2	2 September 2011	27 January 2017	No longer benefiting	2 February 2018
3	16 August 2011	27 January 2017	No longer benefiting	26 June 2018
4	25 July 2011	30 September 2016	No longer benefiting	22 September 2017
5	18 July 2011	30 September 2016	**Has not benefited**	**Currently detained**
6	25 July 2011	30 September 2016	No longer benefiting	5 October 2017
7	19 September 2011	11 November 2016	No longer benefiting	27 June 2018
8	24 September 2012	21 April 2017	**Has not benefited**	**Currently detained**

The Director's 5-year reviews recommended that all people detained at the FDS transition either into the community or to an authorised mental health facility as a matter of priority. However, the actual transition date of clients occurred 12 or more months later. Two people remain detained at the FDS.

The 5-year review reports did not indicate at what point in time over the five-year period the person stopped receiving any benefit from their detention at the FDS. Given the lack of baseline data, this would not have been possible to accurately identify retrospectively, but raises an important question about detention periods.

357 The FD Act s 141(3) provides that the Director must provide a copy of the 5-year review reports to the Administrator.

Non-agreement to transfer

Although the 5-year review reports recommended that all detained people be transitioned, there was a delay of a year or more before people detained were transitioned out of the FDS.[358]

Section 353 of the MHA 2016 provides the legal mechanism for the Director and the Chief Psychiatrist to agree to transfer a person to or from the FDS. Specifically, the provision provides that:

> The chief psychiatrist and the director of forensic disability may agree to transfer the responsibility for the person from an authorised mental health service to the forensic disability service, or vice versa.[359]

The investigation identified that, after the Director had recommended the transfer of people detained at the FDS to an authorised mental health service, agreement could not be reached between the Director and the Chief Psychiatrist. In one document seen by the investigation, the Chief Psychiatrist cited a lack of consultation and transitional planning undertaken by the FDS as reasons for the non-agreement to transfer.

The reasons for the Director's application to transfer, and the reasons for refusing to accept transfer, have not been subject to investigation and are outside the scope of the investigation.

In other jurisdictions, equivalent legislation allows an application to be made to the originating court to vary an order, providing a mechanism to resolve non-agreement. This also provides vulnerable people subject to detention with access to review by a court.

In Queensland, s 673 of the MHA 2016 provides that the Mental Health Court may, on application by a prescribed person or on its own initiative, review a person's detention in a relevant service to decide whether the person's detention is lawful. However, this section does not apply if the person's detention in the relevant service has been ordered by the Mental Health Court. Arguably, this may exclude applications to review detention where a person has been ordered by the Mental Health Court to detention at the FDS. Research by the investigation did not identify publicly available judgements of the Mental Health Court that provide guidance on judicial interpretation of this provision.

Review of an original order would allow for an airing of matters relevant to the quality of care and support provided by the FDS in an open court setting. This would also provide a forum for raising arguments for or against a person's continued detention at the FDS.

358 The investigation did not consider circumstances of people post transition.
359 MHA 2016 s 353.

Broader issues

As well as non-agreement for transfer, a number of other barriers to transition were identified by the Ogloff report. These barriers identified that a lack of graduated step-down processes have impacted on transition, as well as the interface between the Department, Queensland Health and community-based services, and the impact of Queensland's transition to the National Disability Insurance Scheme (NDIS).

The Ogloff report presented a range of broader interface issues that fall outside the scope of the investigation, but which have impacted on the transition of people detained at the FDS. The Ogloff report commented that:

> The difficulty of transitioning clients from the service has been compounded by the isolation and separation of the FDS from the wider disability and mental health sectors, having been established in the absence of a coherent service strategy and with no clear linkages and exit pathways for clients to the wider service system. Additionally, the carving out of the small group of clients detained to the FDS from the wider service system in which the majority of people on Forensic Orders (Disability) fall under the responsibility of Queensland Health has created significant systemic barriers to transition. The siloed operation of the FDS means that the transition of a client from the FDS to the community requires the agreement of the Chief Psychiatrist, despite the current lack of a formal interface between the Director of Forensic Disability and the Office of the Chief Psychiatrist.

The Department's s 157 review recommends that the five-year review period be reduced to a period of three years. While consideration of that recommendation falls outside the scope of the investigation, the recommendation would go part way to addressing some of the concerns identified in this report.

Director's response

In response to the Ombudsman's proposed report, the Director emphasised the barriers to transition faced by people detained at the FDS. Some of the Director's comments echoed issues about transition raised by the Ogloff report. The Director also commented about the lack of step-down facilities, a lack of expertise to support clients returning to regional areas, interface issues between the FDS and authorised mental health facilities, as well as a lack of alternative accommodation options available for some people. The Director noted these difficulties have been particularly pronounced in complex cases.

The Director also submitted that transition of people detained in the FDS has been adversely impacted by a reluctance of the Department's regional services to engage in transition planning. In the Department's s 157 review it notes that there remains uncertainty about the intensity of supports the NDIS will fund for the forensic disability cohort.

Ombudsman's comment

In conducting its s 157 review of the legislation, the Department identified transition planning as an area of potential improvement, and found that to better promote opportunities for people detained at the FDS to be reintegrated into the community, legislative provisions about IDPs in the FD Act should clarify that a person's transition from detention in the FDS to the community should be a paramount goal.

Summary

Failure to transition people from the FDS is one of the key concerns raised by stakeholders with this Office.

Five years after the commencement, none of the original people detained at the FDS had been transitioned out. It is very likely that failure of the FDS to create transition plans in accordance with its legal obligation has resulted in unnecessary detention for some people.

The findings of the 5-year reviews raise a number of serious concerns about the appropriateness of lengthy detention periods for people with intellectual and cognitive disability detained at the FDS.

Opinion 11

11.1 Between the commencement of the FDS and 2017, no IDPs contained a transition plan as required under s 15(1)(b) of the FD Act.

This is administrative action that was contrary to law for the purposes of s 49(2)(a) of the Ombudsman Act.

11.2 When implemented, transition plans were deficient and ineffective in meeting their prescribed purpose.

11.3 The failure to create and maintain a transition plan of appropriate quality for each person detained at the FDS may have led to unnecessary detention.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

11.4 There is no mechanism to resolve a lack of agreement between the Director and the Chief Psychiatrist to transition a person from the FDS to an authorised mental health service.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 11

That the Director:

11.1 Continues to ensure that the FDS complies with all statutory obligations imposed by the FD Act with regard to transition plans and the transition of people detained.

11.2 Ensures that transition plans developed by the FDS are effective.

That the Director-General, in consultation with the Director:

11.3 Gives consideration to legislative amendments that provide a resolution mechanism where there is no agreement to transition a person between the FDS and an authorised mental health service.

Person not physically detained at the FDS

The scope of this investigation was limited to people who are or have been detained at the FDS. However, the investigation became aware of one person who is physically located in a restrictive environment operated by the Department and situated on the Wacol precinct some 30 metres from the physical location of the FDS.

In 2012, the Mental Health Court found this person permanently unfit for trial as a consequence of an intellectual disability and ordered that they be detained for care in the FDS. This person is considered a 'client' of the FDS as defined by s 10 of the FD Act, but is subject to restrictive practices under the *Disability Services Act 2006*. However, the nature of the involvement between the FDS and the person was not clear.

Each of the Director's audit reports acknowledges that this person is under the responsibility of the FDS, but their circumstances were excluded from the audit on the basis that they were managed under complex legislative arrangements.[360] The Director completed a 5-year review for this person when they had been considered to be a 'client' of the FDS for a continuous period of five years.

A number of officers of the Department expressed confusion about the responsibility for this person and their circumstances.

During the course of the investigation, concerns were raised about the conditions under which this person is being accommodated. The community visitor has raised concerns about this person's access to health care and the restrictive nature of their living environment. Information obtained from the QPS indicates that the QPS has been requested to provide assistance in relation to this person, including in relation to emergency health concerns.

Given the lack of clarity about the interface between the two legislative regimes, it is important that the legislative responsibilities for this person be clarified and reviewed.

360 Office of the Director of Forensic Disability, 2018 audit report; Office of the Director of Forensic Disability, 2017 audit report; Office of the Director of Forensic Disability, 2016 audit report; Office of the Director of Forensic Disability, 2014 audit report.

Opinion 12

12.1 The Department and the Director have not clarified the nature and extent of the FDS's responsibility for one person for whom the FDS is responsible but who is not detained at the FDS.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 12

That the Director-General, in consultation with the Director:

12.1 Reviews and assesses the current legislative arrangements that apply to the person for whom the FDS is responsible, but who is not detained at the FDS, and ensure that they are receiving care and support in accordance with legislative requirements and policies and procedures issued by the Department.

That the Director:

12.2 Ensures that the full care and support arrangements in place for the person for whom the FDS is responsible, but who is not detained at the FDS, are audited by the Director.

PART C:
Causes and conclusions

An outline of system-wide factors that contributed to the key issues of concern; and conclusions about failings of the governance structure

Contributing factors and indicators

The investigation identified a range of systemic factors that overlay key issues of concern. These factors have had a compounding effect and have impacted on the detention and treatment of people detained at the FDS.

Behaviour management

While not required under the FD Act, an appropriate and evidenced-based behaviour management framework is clearly required for the FDS to meet minimum clinical standards in the care and support of people detained at the FDS. This is particularly important for people detained who display behaviours of concern.

The need to implement appropriate behaviour support at the FDS is supported by numerous reports completed by the Director, experts commissioned by the Department, and stakeholders.

The FDS has not implemented an appropriate behaviour support approach. Instead of a focus on positive behaviour support, the FDS has focused on behaviour control. As recently as 2018, the Director's audit report stated that:

> An evidence based positive behaviour support approach is not embedded in the FDS and approaches to behaviour support were found to be ad hoc. Where positive behaviour support plans (PBSP) had been developed, they did not appear to be sufficiently implemented by staff. Behaviour support strategies were often found in multiple documents or plans, and at times offered contradictory advice to staff regarding how to best support a client. Finally, behaviour reporting and data available from incidents did not appear to be informing the functional behaviour assessment and subsequent multicomponent intervention required by positive behaviour support.[361]

Three people detained at the FDS who displayed challenging behaviours, some of whom required the use of regulated behaviour control, did not have any behaviour management plans in place.

The Director's 2014 audit report assessed behaviour management plans using an evidence-based tool for evaluating quality.[362] Behaviour intervention plans were found to be either non-existent or 'weak' when compared to similar plans in Queensland and other states. The report stated that:

> The FDS plan scores differ significantly from both the Victorian disability sector and participants at Centre of Excellence training. There is not a significant difference between the FDS and the Queensland disability sector plans. This means that the FDS behaviour management plans compare poorly to all available data, excluding the Queensland normative sample. Prior to the FDS data being available, the Queensland normative sample was the lowest plan quality score known to the Director.
>
> The quality of behaviour management plans at the FDS is poor and the best available objective analysis suggests that they are not likely to facilitate any positive behavioural change.

361 Office of the Director of Forensic Disability, 2018 audit report, p. 6.
362 The *Behaviour Support Plan Quality Evaluation Scoring Guide* Version 2 (Browning-Wright 2007).

The audit report states that the Director was actively involved in significant work being undertaken to redesign IDPs. However, the Director left the position the following year. No follow up audit was undertaken in 2015, and this work is not referenced in the next audit which was delivered by the Director in 2016.

Lack of relevant expertise

Proper administration of the FD Act requires that the FDS be staffed by multidisciplinary professionals who hold appropriate qualifications and experience in their respective disciplines.[363] Those qualifications and experience should be specifically relevant to people with intellectual and cognitive disability who experience behaviours of concern, or more specifically, forensic disability.

However, the investigation found a lack of relevant clinical expertise at the FDS.[364]

For periods of time, there was no psychologist employed in any position, including the position of Senior Clinician and Principal Clinician. The FDS has never employed a clinical psychologist, psychiatrist, doctor, behavioural specialist or speech pathologist.

The investigation found that the qualifications required of healthcare professionals authorised to make decisions under the MHA 2016 are different to the qualifications required of FDS staff authorised to make equivalent decisions under the FD Act.

These issues were addressed in a written submission received from the Queensland Law Society Inc (QLS) which stated that:

> There is also the overall observation [from QLS members] that there is quite a world of difference in specialty between 'mental health' and 'disability services', and the current structure of Forensic Disability relies heavily on the co-operation of Authorised Mental Health Services, who have a mental health treatment focus, which is quite different from disability which has a support and care focus.

The QLS submission also stated that:

> QLS is concerned that the care provided to persons the subject of a Forensic Order (Disability) (FDO) is inadequate and not appropriately tailored to meet the requirements of the Forensic Disability Act 2011 (Forensic Disability Act) or in compliance with obligations pursuant to the *Mental Health Act 2016* (Mental Health Act).

Quality of health care

As a 24-hour facility, the FDS is responsible for providing appropriate health care to people detained at the FDS.[365]

People with intellectual and cognitive disability, particularly those who have come into contact with the criminal justice system, have higher health needs than the general population. Limited literacy, and communication and cognitive impairments may lead to people with intellectual and cognitive disabilities experiencing difficulties understanding the importance of a healthy diet, disease screening and personal hygiene, and can lead to an under-reporting of health concerns. People detained at the FDS therefore rely on FDS staff to monitor, identify and respond to many of their personal health needs.

363 See FD Act ss 4(c), 13(1), 101(3)(a).
364 Although it is noted that clinical expertise appears to have increased over the last 12 months.
365 This section focuses on the provision of health care other than mental health care.

Health care at the FDS is provided by community-based healthcare providers. At the time of the Medication report, no permanent medical or nursing staff were employed at the FDS, and there was no senior practitioner who was a doctor or a registered nurse.[366] Medical practitioners are contracted to the FDS, including psychiatrists and general practitioners, or an after-hours locum.

The FDS has also previously obtained healthcare services, including mental healthcare services, through the Park Centre for Mental Health, Treatment, Research and Education (the Park), a specialist psychiatric hospital located in Wacol in close physical proximity to the FDS. The Park has almost 150 beds, including medium and high security programs for people involuntarily detained. Between commencement of the FDS and 2017, the Specialist Disability Services Assessment and Outreach Team provided services to people detained at the FDS, including psychiatric services. Since then, services from Queensland Health have been provided by a psychiatrist employed at the Park.

However, there does not appear to be a consistent, comprehensive and structured approach to the delivery of healthcare services to people detained at the FDS, including dental, optical, dietary, podiatry, speech pathology and physiotherapy needs.

FDS staff told the investigation that some people detained at the FDS had not always had their personal hygiene and self-care needs met. A staff member expressed concerns about irregular showering/bathing, and unkempt hair, nails and feet.

The 5-year review reports authored by the Director indicated that a number of people detained at the FDS were reported to suffer vitamin D deficiency and constipation, for which medications were prescribed. It was also reported that a number of people required assistance with managing dietary and exercise requirements. Inspection of the files of some people detained at the FDS suggested considerable weight gain subsequent to their admission.

The Medication report commissioned by the Director identified a number of concerns with the current arrangements between the FDS, prescribing GPs, and the dispensing pharmacists and pharmacies. The authors of the Medication report had consulted with a GP who provides services to a person detained at the FDS, who stated:

> [The GP] saw value in the continuity achieved with clients having services provided by one practitioner, and consistent consultants rather than a random selection of medical practitioners.[367]

The *Health Act 1937* is the primary legislation which gives authority to the FDS to be in possession of and use most medications.[368] Medications at the FDS are stored either in a locked filing cabinet or a locked refrigerator in the office of each of the 'houses'. Medication is dispensed from a pharmacy in the Wacol area.

An FDS staff member told the investigation that one person, for whom a mental health condition had been diagnosed, had been admitted to the FDS in 2018 but had not been admitted with prescribed medications. As a result, the person experienced a delay before the administration of their regular medication was resumed. This type of concern was reflected in the Medication report, which stated that:

> Reviewers were advised that thus far, clients have largely come from another facility, often QHealth, which has usually provided a medication history, but not a current medication administration record, and rarely, medications – both issues with potential to contribute to medication errors (possibly ongoing) depending on the time of the transfer.

366 Medication report, p. 19.
367 Medication report, p. 3.
368 Medication report, p. 13.

> Charting of medications has been arranged by FDS staff at the time of admission, using whatever medical officers are available – eg contracted psychiatrist/s, GPs, or calling an after-hours locum. This has reportedly met with some resistance from medical officers who have little/no knowledge of the resident; can be inconvenient, and allows little opportunity to confirm the accuracy of the history.[369]

Culturally appropriate care

Indigenous people are significantly over-represented among the people detained at the FDS. Of the 12 people who are or have been detained, eight identify as Aboriginal or Torres Strait Islander.

The experience of detention is likely to be different for Aboriginal and Torres Strait Islander people,[370] and for some, detention at the FDS has resulted in dislocation from their homes in regional and remote areas of Queensland. Dislocation from country has been found to increase vulnerability to abuse and decrease reporting of concerns or complaints, and can lead to other harmful effects.[371]

People detained at the FDS have the right to culturally appropriate and clinically relevant care. One of the general principles for the administration of the FD Act is that services provided should be responsive to individual needs and goals. This includes taking into account a person's physical, age-related, gender-related, religious, cultural, language, communication and other needs, which include needs arising because of a person's community of origin.[372]

As well as legislative obligations imposed by the FD Act, best practice requires the FDS to actively seek to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people detained at the FDS.

The investigation did not identify any policies or procedures, best practice guides or other material developed by the Director, the Department or the FDS that evidenced a thorough, meaningful and consistent approach that guides the FDS to ensure that culturally appropriate, safe and respectful care is provided to Indigenous people detained.

The capacity of the FDS to provide appropriate care is significantly impacted by the dislocation of people detained at the FDS from their country and community of origin. As outlined, some Indigenous people detained at the FDS have been transferred to the facility in Wacol, Brisbane, from regional and remote areas in north and far north Queensland.

The Aboriginal and Torres Strait Islander Legal Service (ATSILS) provides legal services to Indigenous people detained at the FDS, including representing clients at review hearings before the MHRT. ATSILS staff told the investigation that the FDS did not have arrangements in place to ensure that Aboriginal and Torres Strait Islander people detained at the FDS were provided with culturally safe and appropriate care until sometime in 2016. Prior to that, ATSILS staff had undertaken extensive advocacy beyond the scope of their legal service responsibilities to advocate for the provision of programs, culturally appropriate care and ultimately, transition of their clients out of the FDS.

369 Medication report, p. 29.
370 Ed Heffernan, Kimina Andersen, Elizabeth McEntyre and Stuart Kinner, 'Mental Disorder and Cognitive Disability in the Criminal Justice System', Chapter 10 in Working Together: *Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practices* (eds Pat Dudgeon, Helen Milroy and Roz Walker), p. 166.
371 Ibid.
372 FD Act s 7(c).

ATSILS staff told the investigation that one of their Indigenous clients had not verbally communicated since being transferred to the FDS, given there had been no Indigenous support person present. Cultural communication barriers resulted in the client being unable to verbally communicate for an extended period of time. This concern had not been appropriately identified by the FDS.

The investigation was also told that another ATSILS client suffered from a vision problem, which was not identified for an extended period of time. When ATSILS became aware of the problem, arrangements were made for an Indigenous doctor to attend and provide culturally appropriate medical care. The Indigenous person detained at the FDS had surgery for a cataract and this treatment restored their vision.

ATSILS staff also told the investigation that their office was concerned that reports provided to the MHRT were prepared by unqualified FDS staff. As a result, ATSILS began commissioning their own reports from independent experts and engaging in significant advocacy before and after MHRT hearings. The investigation was also told that referrals to ATSILS were ad hoc, and there was no process in place to ensure that people transferred to the FDS who identified as Indigenous were referred to ATSILS for representation or support.

Over the last 12 to 18 months, the FDS has made some attempt to address these concerns. This has primarily included engaging with culturally appropriate service providers, such as external Indigenous healthcare providers, and increasing culturally relevant programs. However, these efforts do not appear to have been consistently applied and do not evidence a whole-of-service approach to working with Aboriginal and Torres Strait Islander people, families and communities.

Trauma-informed care

Trauma-informed care is an organisational orientation to understanding the impacts of trauma so that all staff in an organisation, whether clinical or non-clinical, direct care, support or executive leadership, undertake their tasks and interaction with clients with an understanding of the impacts of trauma and strategies to minimise the possibility of re-traumatising the person with a trauma history.[373] Trauma-informed service delivery recognises the distinct impacts of trauma and seeks to incorporate that understanding in the provision of care by having regard to a person's need for safety, transparency, empowerment, choices, pathways to recovery, capacity to collaborate and cultural safety.[374]

Interviews indicated that FDS staff appeared to be aware of the need for trauma-informed practice, but that the approach had not been effectively embedded in the FDS. IDPs and positive behaviour support plans drafted for people detained in the FDS included some references to the person's experience of childhood trauma, but did not include strategies to inform approaches to care and support that recognised or addressed their trauma history.

Despite the high proportion of people detained at the FDS who have a reported history of childhood trauma, approaches to trauma-informed care have not been appropriately considered, implemented or prioritised at the FDS.

373 A Quadara and C Hunter, *Principles of Trauma-informed approaches to child sexual abuse: A discussion paper*, Royal Commission into Institutional Responses to Child Sexual Abuse, (2016), Sydney, p. 6.
374 Ibid.

Opinion 13

13.1 There has not been a consistent, comprehensive and structured approach to the delivery of healthcare services to people detained at the FDS.

13.2 There has not been a consistent, integrated and sufficient approach to providing culturally appropriate care to those detained at the FDS who identify as Aboriginal and Torres Strait Islander people.

13.3 There has not been a whole-of-service approach to the consideration and implementation of principles of trauma-informed care.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 13

That the Director-General, in consultation with the Director:

13.1 Reviews current arrangements with all external healthcare providers, including allied healthcare providers, with a view to ensuring that the FDS provides an appropriate level of access to health care to people detained at the FDS.

That the Director:

13.2 Reviews the current approach to providing culturally appropriate care at the FDS.

13.3 Develops a whole-of-service framework to provide trauma-informed care at the FDS.

The FDS workplace

Culture and management

The investigation was informed of a range of concerns about the organisational structure and management at the FDS. Concerns focused on non-responsive and unsupportive management, a lack of clear reporting or management structures, lack of role clarity, and a lack of communication and consultation across all areas of the FDS. Staff also raised concerns about the competency of key managers at the FDS, and the integrity with which they discharged their roles.

The Ogloff report provided the following comments from FDS staff about workplace culture and management that had been raised during the review:[375]

> The organisational structure of the FDS is unclear. Staff expressed considerable confusion regarding the roles and responsibilities of the various positions in the staffing profile, resulting in tension, conflict and disengagement.
>
> ...
>
> ... A number of staff articulated frustration that the current staffing model does not provide opportunities for staff to apply their skills and expertise to effectively meet client needs, with the speciality of positions getting lost over time.
>
> ...
>
> In addition to a lack of role clarity, there has, until recently, been a lack of clear organisational policies and procedures to govern practice (or inconsistent adherence to existing policies), such as admission and discharge processes (including eligibility criteria), risk assessment and management, and critical incident debriefing. In regards to the latter, staff report that, generally, they are not provided with the opportunity to debrief following an incident, contributing to the view that staff are not supported and missing the opportunity to share lessons learned and improve practice.
>
> Similarly, while relevant policies and procedures have recently been reviewed and reissued, staff identified some continued concerns regarding practices around clinical documentation. In particular, in regards to [LCT], staff stated that client leave entitlements are often not documented accurately and the organisation of the necessary paperwork is often chaotic which can cause leave to be delayed.
>
> There is a general lack of communication and consultation across all aspects of the service ... Staff reported limited opportunities to communicate with other staff across the service in regards to, for example, transition planning or IDPs. This contributes to the sense of isolation and disconnection experienced by FDS staff, and a lack of cohesiveness across the service.
>
> There is a lack of regular practice supervision provided to staff, and limited opportunities for staff training and professional development. There is also a tokenistic approach to performance management, with limited feedback or performance reviews provided to staff.
>
> There has been a considerable turnover of senior staff since the establishment of the FDS ... frequent changes in senior management have been accompanied by some inconsistency in approach to the FDS' model of care over the years, resulting in confusion and conflict amongst staff, whilst the lack of permanency in positions has resulted in staff disengagement and a lack of continuity of care.

375 J Ogloff, J Ruffles, D Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*, (2018), Unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, pp. 48–50.

> The delivery of therapeutic programs, including offence-specific and habilitative programs, over the years has been limited, and lacking in co-ordination and consistency. Staff also described a disconnection between direct support staff and members of CHART, the team responsible for the development and delivery of programs. This lack of co-ordination and communication between the two teams makes it difficult for direct support staff to reinforce key learnings and treatment themes in clients' day to day environment which is essential if skills generalisation is to occur. The lack of movement of clients through the service has also contributed to a lack of motivation regarding the delivery of programmatic interventions over the years.
>
> [The workplace culture was] ... variously described by FDS staff as 'toxic', 'dysfunctional', and 'disorganised'. Additionally, intimations of disharmony, bullying and unhappiness were conveyed.[376]

The observations of the Ogloff report are consistent with information obtained by this investigation. The Ogloff report found that the workplace culture within the FDS was 'characterised by a sense of hopelessness on the part of both staff and clients'.[377]

These concerns were reiterated by FDS staff who participated in interviews with the investigation, and were also evident in other information collected by the investigation across a range of sources.

The concerns were also referenced at interviews with senior staff of the Department, one of whom stated that:

> ... what had become apparent to me was that the service delivery environment had become intensely institutionalised, for want of a better word, in the sense that there were multiple grievances of staff against management, management struggling to effectively hold staff accountable, there were essentially the same cohort of clients that had gone in and there'd been very little progress on any of their five year review reports to look at transition, and, in fact, there wasn't even a very effective focus on transition.[378]

That senior staff member also told the investigation:

> ... it just appeared to me to be just a very troubled environment with industrial, staffing, vacancies, and really no meaningful kind of leadership or energy towards the client matters around transition ... We had a number of Ethical Standards misconduct investigations that related to both poor practice but also potentially negligent care and other things that we needed to work through.[379]

The investigation was also concerned about the approach taken by the Administrator in response to the investigation. A site visit was conducted during the early phase of the investigation. The week prior to the arranged visit, a telephone call was received from an FDS staff member who wished to remain anonymous. The caller stated that, in their view, FDS management were seeking to 'sanitise' the inspection.[380] In explaining this position, the caller stated that a number of people detained at the FDS were arranged to be out of the facility during the visit, and that few permanent staff had been rostered on for the dates of the visit. This was consistent with other information received by the investigation.

An email sent to FDS staff by the Administrator made suggestions about what staff should say to the investigation. A copy of the email was obtained, and contained the following comment:

> So to ensure that our work is presented well I request that you prepare by ensuring that client files are up to date; there are no loose documents lying about where they might be seen by people not intended to read them; that we all comply with our own policies and procedures; and we all continue to actively contribute to client programs activities and finally outcomes ... Nothing out of the ordinary there really.[381]

376 Ibid, p. 48.
377 Ibid, p. 28.
378 Interview with senior officers of the Department.
379 Ibid.
380 Intake call received by the OQO Intake Team, 8 March 2019.
381 Email to FDS staff from Administrator dated 21 June 2018 at 3.55 pm.

Administrator's response

In response to the Ombudsman's proposed report, the Administrator confirmed that he had, in the body of the email, encouraged FDS staff to speak with the investigation and point out that 'staff were going to be observed', but that he rejected the FDS staff member's characterisation of this approach as sanitisation. The Administrator provided further details to demonstrate that the approach during the presence of OQO investigators did not demonstrate a significant departure from usual processes at the FDS.

The Administrator emphasised the challenges that he was faced with on commencement in the role at the FDS in February 2017.

The Administrator also outlined the work he had undertaken as Administrator at the FDS to improve the workplace as a whole.

The Administrator also asserted that this issue was essentially a human resources matter, was 'somewhat removed from the brief of your investigation' and that there was, in his view, no demonstrated link between the issues raised about staff culture and management and the care and treatment of people detained.

The Administrator also submitted that the Department had demonstrated an intention to address issues with culture and management, and it has sought to improve the FDS workplace and workplace culture as a whole.

Ombudsman's comment

The investigation observed that the Administrator sought to present a universally positive view of the FDS, rather than engage with the complex and serious issues that were clearly present in the operation of the FDS.

The investigation found that, as at February 2017, the FDS was failing to meet key legislative obligations.

The investigation identified a clear link between approaches to leadership, management and the culture at the FDS, and the care and support of people detained.

Complaints management

All Queensland Government agencies are required to establish and operate complaints management systems.[382] However, the FDS has not had a complaints management system in place since its commencement.

On 29 June 2018, the Director responded to the investigation's request for information by stating that:

> No complaints in relation to any person subject to a Forensic Order (Disability) under the responsibility of the Forensic Disability Service have been made to my Office.[383]

The investigation subsequently became aware of concerns raised by people detained, or their guardian, that should have been assessed as complaints. All of those complaints or concerns were raised prior to the request for information.

382 *Public Service Act 2008* s 219A.
383 Letter from the Director to the investigation dated 29 June 2018.

The Director issued a new policy titled *The Management of Complaints about Care and Support and Protection of Forensic Disability Clients* dated 14 June 2018. The policy attached a template form titled *Notification of Complaint Management Form*.

The investigation also identified a generic complaints management policy issued by the Department, but this did not have specific application to the FDS or people with intellectual and cognitive disability, and is inconsistent with the new policy issued by the Director.

While the new policy issued by the Director includes directions to ensure that a person detained at the FDS who wishes to raise a complaint is assisted by the FDS to do so, the policy does not consider specific applications for people with intellectual and cognitive disability who are likely to experience barriers to raising complaints. The policy also fails to consider culturally appropriate complaint procedures for Aboriginal and Torres Strait Islander people.

Appropriate access to complaints management is critical to ensuring that expressions of dissatisfaction made by vulnerable people are identified and addressed. This is particularly important given the multiple challenges that people detained at the FDS would face in making complaints to the QPS.

Director's response

In response to the Ombudsman's proposed report, the Director outlined a number of ways in which she has facilitated interactions with people detained at the FDS to ensure they are able to raise concerns.

The Director also highlighted that, prior to development of the new policy, there was no complaints management framework in place. In relation to the new policy and procedure, the Director stated that:

> Embedded within this policy are guidelines that the Director should be informed of any complaints made by a client, their guardian, or any other person on behalf of the client regarding the provision of care at the service. Also a newly developed process with expectations the FDS address any such complaint in a timely manner and report actions taken to the Director. This includes the creation of a 'Feedback and Complaints' register, 'Notification of Complaints Management' forms and timeframes for complaints to be reviewed and actioned. Further, the complainant is expected to be provided with information as to how the complaint has been addressed, any follow up actions that will resolve the complaint, and their feedback sought in relation to how satisfied they are in the resolution of the complaint.

Ombudsman's comment

The investigation established that an effective complaints management system was not operative at the FDS during the investigation.

Issues relevant to the interface of the Department's complaints management policies and the Director's policy were not addressed in the Director's response.

Managing conflicts of interest

All chief executives, senior executives and public service employees are required to disclose an interest that conflicts, or may conflict, with the performance of their official duties.[384] To manage those declarations, all agencies are required to have a process for the identification and management of conflicts of interest.

The investigation received concerns that FDS staff, staff at the Department who were seconded to the FDS, and staff at the Office of Director seconded from the FDS may have had actual or perceived conflicts of interest that had not been appropriately identified and managed. The investigation requested a copy of the FDS's conflicts of interest register. In response, the Department indicated that the FDS did not have any such register.[385]

It therefore follows that there has been no way to assess whether conflicts of interest have been declared and appropriately managed and resolved according to the *Code of Conduct for the Queensland Public Service*.

Opinion 14

14.1 The workplace culture of the FDS does not promote the effective achievement of its purpose and key roles.

14.2 The FDS has not had any complaints management system in place to identify, assess and respond to complaints by or on behalf of people detained at the FDS.

14.3 The FDS has not maintained a conflicts of interest register.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 14

That the Director-General, in consultation with the Director:

14.1 Reviews the structure, mix of skills and organisational culture at the FDS to align with its legislative purpose.

14.2 Reviews the complaints management policy to ensure it adequately considers the special needs of people detained at the FDS, and ensures that all FDS management and staff receive training about the application of the policy.

That the Director-General:

14.3 Establishes and maintains a conflicts of interest register at the FDS.

384 *Public Service Act 2008* ss 102, 186; *Code of Conduct for the Queensland Public Service*.
385 Email from senior officer of the Department dated 31 October 2018.

Governance structures

Having identified ongoing legislative non-compliance in key areas of the FDS, the investigation considered the effectiveness of governance structures in place.

The Department operates the FDS and is responsible for administering the FD Act. The FDS therefore sits within the Department's organisational arrangements.

As outlined, the Director is an independent statutory position established by the FD Act, and has oversight of the FDS as well as a monitoring function.[386] The role carries high-level obligations in order to ensure the protection of people detained at the FDS.

The Public Guardian, including the community visitor program, is also intended to form part of the oversight framework,[387] as are periodic reviews of forensic disability orders by the MHRT.[388]

Position of Director

The Director is appointed by the Governor in Council under the FD Act and not under the *Public Service Act 2008*.[389] The FD Act establishes the independence of the Director. In exercising a power under the FD Act, the Director is not subject to ministerial direction.[390]

As outlined in Part A, the Director has the following statutory functions:

- ensuring the protection of the rights of people detained at the FDS under the FD Act
- ensuring the involuntary detention, assessment, care, support and protection of people detained at the FDS complies with the FD Act
- facilitating the proper and efficient administration of the FD Act
- monitoring and auditing compliance with the FD Act
- promoting community awareness and understanding of the administration of the FD Act
- advising and reporting to the Minister on any matter relating to the administration of the FD Act, either on the Director's own initiative or, if the matter is in the public interest, at the request of the Minister
- other functions given to the Director under the FD Act.

While appointments to the position of Director can have a maximum term of five years under the FD Act,[391] there has been considerable turnover in the role.

386 See FD Act ss 85–94.
387 Explanatory Notes, Forensic Disability Bill 2011, p. 6. The Explanatory Notes outline that the Public Guardian would provide oversight through the OPG's capacity to investigate any abuse, neglect or exploitation of an adult with impaired capacity; and that the community visitor program would provide oversight through their function to investigate and provide reports to safeguard the interests of those detained. At the time, the position of Public Guardian was then the position of Adult Guardian.
388 Explanatory Notes, Forensic Disability Bill 2011.
389 FD Act s 85(2).
390 FD Act s 89.
391 FD Act s 86.

Relationship between the Department and the Director

History of the position

Statutory obligations imposed on the position of Director under the FD Act have remained unchanged since commencement of the FD Act. However, administrative arrangements for the position of Director within the Department have changed in structure and application across the term of the position.

From commencement of the FDS in 2011 until 2013, a position titled 'Chief Practitioner – Disability' administered the statutory requirements of the Director under the FD Act, including undertaking the functions and exercising the powers of the Director under the FD Act. The position also incorporated a second function, which was to provide specialist expertise and clinical advice to the Director-General of the Department to inform policies, programs and services for people with disabilities, particularly in relation to complex clinical matters.

The investigation was told that, in practice, the Chief Practitioner – Disability had substantial input into the care and support of people subject to a forensic disability order in authorised mental health facilities and living in the community across Queensland, rather than only those detained at the FDS.

After the first Chief Practitioner – Disability left the position, the Department obtained legal advice about the role and responsibilities of the position of Director under the FD Act. Legal advisors provided the following advice:[392]

- The Director is responsible for the detention, assessment, care, protection and support of people detained at the FDS and must ensure that the FDS is managed and operates in a way that complies with the FD Act.
- The Director, and not the Minister or Director-General, is ultimately responsible for ensuring that the day-to-day operations of the FDS comply with the FD Act, insofar as those operations relate to the detention, assessment, care, support and protection of forensic disability clients subject to matters outside the Director's control.
- The Director is responsible for ensuring that a person's involuntary detention at the FDS, and the way in which the person is cared for, assessed, supported and protected by the service, complies with the FD Act.[393]
- The role of Director is clearly independent from the Minister, but given the statutory obligations imposed under the FD Act, could not be considered independent of the FDS.
- The Director's role is not limited to observing the conduct of the service and reporting to the Minister when things 'go wrong', but rather, the Director must also take an active role in the management and operations of the service to ensure that things do not 'go wrong'. The legal advice states that things will 'go wrong' where the detention, assessment, care, support and protection of clients stops complying with the FD Act.
- There may be some matters which hamper the FDS's compliance with the FD Act that are outside the control of the Director. In those circumstances, while the Director would still have to do what he or she could to ensure compliance with the FD Act, it would be appropriate for the Director to consider whether to report the matter to the Minister in accordance with s 87(1)(f)(i) of the FD Act.

392 Legal advice dated 5 February 2013, pp. 6–7.
393 Noting that, under s 88 of the FD Act, the Director 'has the power to do all things necessary or convenient to be done in performing the Director's functions'.

- The Director is 'ultimately responsible' for ensuring that the day-to-day operations of the FDS comply with the FD Act insofar as they relate to the detention, assessment, care, support and protection of people detained at the FDS, and the FD Act invests broad powers in the Director to do so.

From September 2013, the statutory requirements of the role of Director established under the FD Act were transitioned to a standalone position.[394] The additional functions initially held by the Chief Practitioner – Disability were transferred to the Centre of Excellence, within the Department.

The standalone position of Director was reclassified equivalent to the position of Administrator.

Organisational arrangements obtained from the Department indicate that, after this change to the position in 2013, the Office of the Director was repositioned inside the Department's organisational structure and is shown as reporting to the Centre of Excellence, with a reporting chain ultimately to the Director-General.[395] Prior to that change, the role had been positioned outside the Department's organisational structure.

Subsequent to 2013, the role of Director has been moved to various locations within the Department's organisational structure, with up to four levels in the reporting chain between the Director and the Director-General of the Department. Organisational structures established after 2013 remove any structural distinction between the Office of the Director and the FDS.

Outcomes of changes to the position of Director

Administrative arrangements for the position of Director from 2013 onwards have had the following impacts:

- Classification of the Director equivalent to the Administrator did not give effect to the higher responsibilities imposed on the Director by the FD Act, which clearly require a hierarchical relationship between the two positions.
- Administrative arrangements from 2013 onwards imposed a reporting structure that has not given effect to the independence of the position of Director.
- Restricting the functions of the Director to the responsibilities imposed by the FD Act with limited opportunity for input into the broader forensic disability service system.

Classification of the Director and Administrator at level

Classification of the Director and Administrator at the same level does not accord with the statutory position under the FD Act, which allocates a hierarchy between the statutory positions of the Director and the Administrator.

A range of indicators identified that classification of the Director and the Administrator at level has been ineffective and has reduced the Director's capacity to discharge statutory obligations to an acceptable level.

Across the course of the investigation, it was difficult to articulate differential responsibilities between the Director, the Department and the FDS, and to understand who was ultimately in control of the FDS. In fact, the nature of the relationship between the three entities appeared to shift during the course of the investigation. This observation was illustrated by the submissions of the Department and the Director to the proposed report.

394 The Department advised the investigation this change was reflected in payroll records, which coincides with the structural change as per the organisational arrangements chart dated 28 November 2013. That organisational chart indicates that the position of Director reported to the Centre of Excellence.
395 Department of Communities, Child Safety and Disability Services organisational arrangements, dated 23 November 2013.

The equivalence of the positions of Director and Administrator was described by a senior executive director of the Department as 'less than ideal'.[396] It was also stated that:

> At different times … it wasn't well understood in terms of the primacy of [the Director's] role compared to the primacy of the regional or Departmental role.[397]

The Director also agreed that there were weaknesses in the structure, and at interview commented that:

> I've had to very much assert my, my powers under the Act to say that no, we're not just having a relationship, I have certain powers and functions and I need you to do A, B or C. It's not a problem at the moment, but it has been in the past when, you know, you have, well, sort of egos that might decide that … you're only at the same, you're only being paid at the same level as me, and I've had to say it doesn't matter if I'm paid at the cleaner's level, these are my powers and my functions and these are what I need, these are the things I need to occur.[398]

Department's response

In response to the Ombudsman's proposed report, the Department stated that it will review the available legal advice, and work with the Director and the Minister to review and confirm the Department's organisational chart to ensure it provides the best possible representation of all statutory roles and responsibilities.

Independence of the Director

While the Department was aware of its obligation to maintain the independence of the position of Director, it has not always given effect to the independence of the position of Director.

This issue was addressed at interview, where the investigation was told that:

> I get a sense from the people I've talked to about this, was that [the Department's legal advice] was not accepted by the hierarchy of the Department as being the advice they wanted to accept, so they kept operating as if this never existed.[399]

It was further observed that, prior to the machinery of government change in December 2017:

> … it appears that there was this view [in the Department] that … that was advice, but we will proceed until apprehended.

The investigation was also told that, until recently, the Department almost saw the Director 'as an employee of the Department', but that more recently there had been more rigorous discussion with the Director-General about the accountabilities and obligations of the Department compared to the Director.

Reporting structures were explored during interviews with the Director, the Administrator and senior executives at the Department.

When the Director was asked whether she had ever briefed the Minister on her own initiative,[400] the Director responded that, initially, she would brief the Deputy Director-General and was told that the Deputy Director-General would then brief the Director-General, who would then brief the Minister. The Director stated that this was the Department's 'preferred route' of communication prior to the machinery of government change in December 2017.

396 Interview with senior officers of the Department.
397 Ibid.
398 Interview with Director of Forensic Disability.
399 Interview with a senior officer of the Department.
400 Under s 87(1)(f)(i) of the FD Act, the Director is entitled to brief the Minister on own initiative.

The Director went on to say that this reporting structure changed 'fairly recently',[401] and that she now provides monthly reports directly to the Minister. When asked to estimate approximately when this change took place, the Director stated:

> … just in the last month I received a letter from the Minister asking me to report directly to her on a monthly basis, which is very good, and that was just really in relation to several areas, the, just the transition of clients from the service. I can't remember the, the types of programs we run and, yeah, those kind of things.[402]

The Director also commented that there was 'a perception that perhaps the Director's role lacks influence', and that:

> The Department is more likely to listen to other statutory officers than they would listen to me perhaps, you know. I don't necessarily think that is the case, but I think that's the perception …

The investigation also identified that organisational arrangements of the Department have presented difficulties in the Director's capacity to discharge statutory functions imposed by the FD Act.

This is borne out through the Director's request for legal advice while undertaking 5-year reviews in September 2016. During that process, the Director sought urgent legal advice, including advice about her capacity to compel the provision of information from the Department. Advice was provided about:[403]

- what powers the Director's position held in respect of compelling public servants from the Department to provide certain information to assist her in performing her functions under the FD Act
- what, if any, remedies were available to the Director for non-compliance with such requests
- advice about the independent status of the Director's office and the independence of the Director's reports.

The advice states that the Director had instructed her legal advisors that obtaining information for the 5-year reviews had proved difficult and had 'delayed and hindered the accuracy of [her] reporting'.[404] The legal advice also noted:

> You also, in preparing your reports, have had cause to question what, if any, input that Disability Services or offices from the Department of Communities should have into the final versions of those reports.[405]

In responding to these instructions, the legal advice sets out the powers of the Director under the FD Act, emphasising that s 88 of the FD Act – which states that the Director has the power to do all things necessary or convenient to be done in performing the Director's functions – should be interpreted as giving the Director 'broad powers' to properly fulfil the statutory functions under the FD Act, which extended to the ability to request information from officers of the Department.

At interview, the Director stated she had sought the advice due to challenges she faced in obtaining the information required to undertake the 5-year reviews and complete the subsequent reports.

When asked to clarify the reasons for providing those instructions, the Director did not provide further details, but characterised the FDS's response to her requests for information as 'slow and unresponsive'.[406]

401 Interview with the Director.
402 Ibid.
403 Legal advice provided to the Director dated 30 September 2016, p. 1.
404 Ibid, p. 2. This direct quote is a paraphrase of the Director's instructions to her legal advisors.
405 Ibid, p. 2.
406 Interview with the Director.

Director's response

In response to the Ombudsman's proposed report, the Director stated that she was aware of numerous attempts by the Department to control and influence previous Directors, and that the Department had continued to make attempts to influence her and the information she provided in various forums and reports.

Ombudsman's comment

The investigation found that the Department had not always given effect to the independence of the position of Director.

As well as the issues outlined above, the staffing and location of the Office of the Director indicated a deterioration of substantive independence, including:

- staffing positions that reported jointly to the Director and the Department
- transition of staff between the Department, the FDS and the Office of the Director
- location of the Office of the Director within the Department
- views and values about the people detained at the FDS being shared with the Department, which were in opposition to views and values held by relevant stakeholders.

Limited ambit of responsibilities

As a standalone position under the FD Act since 2013, the position of Director has been restricted to statutory oversight of the administration of the FD Act at the FDS, rather than also providing advice and having input into forensic disability across the state. While this does not alter the statutory obligations of the Director imposed by the FD Act, the decision to change the ambit of the position reconstructed the way the role operates, and was therefore relevant to consider.

The investigation found that the limited ambit of responsibility has been subject to judicial comment in reported judgements published in 2015 and 2016.

In the judgement of *MAB* [2015] QMHC 10, delivered in October 2015, the court was considering imposing a forensic disability order for a person found permanently unfit to stand trial. The Director elected to be a party on the reference to the Mental Health Court, filed material and made submissions. However, the court found there was 'no sensible prospect' that the person would ever be detained at the FDS, given that, at that time, the FDS was at full capacity and had not provided a certificate of capacity. The court considered whether, in those circumstances, the Director had the right to elect to become a party before the Mental Health Court.[407]

Her Honour Judge Dalton commented on the statutory functions of the Director as follows:

> The Director of Forensic Disability elected to be a party to this reference on 12 November 2014; filed material, and appeared and made submissions on the hearing of the reference. The Director of Forensic Disability is created by the FD Act.[408] Section 87 of the FDA provides that the Director has a function to ensure the protection of the rights of forensic disability clients – s 87(1)(a). A forensic disability client is defined at s 10 of the FDA as an adult with an intellectual or cognitive disability for whom a forensic order is in force for the person's detention in the forensic disability service. The forensic disability service is defined by s 95 of the FDA as a place declared by regulation. Regulations define the service as a 10 bed unit near Ipswich. So, while the word 'service' is used in the name of the forensic disability service, in fact it is not a service; it is a place. Thus, while the FDA

407 And therefore had an interest in the proceeding at common law.
408 References to the FD Act in the judgement have been changed from 'FDA' to 'FD Act' in keeping with the abbreviations used in this report.

> runs to some 160 odd sections, together with some schedules, it appears that the ambit of responsibility of the Director of Forensic Disability is very limited. That Director has no statutory function to protect MAB's rights. Indeed, I cannot see that the Director has any function in relation to MAB at all. I cannot see that the Director could be an appropriate person to pursue [the independent Court-appointed expert psychiatrist] concerns.[409] The situation would be otherwise if MAB were a forensic disability client as defined. I reserve for another day the question of whether or not the Director of Forensic Disability has any ability to elect to be a party to a matter where, as in this case, there is no sensible prospect that the defendant is ever going to be detained in the forensic disability service, or be liable to be detained in that service. It is difficult to see what interest the Director could have in the matter before the Court.

Subsequent to that judgement, in January 2016, the Director sought legal advice about the Director's entitlement to appear before the court where the matter under deliberation related to a person with an intellectual disability, and where the imposition of a forensic disability order was being considered.

This issue was then ventilated before the court in June 2016 in the decision of *In the Matter of Sukkur Abdus* [2016] QMHC 10, where Her Honour Justice Dalton concluded that the Director has the right to elect to become a party to a reference in the Mental Health Court only where the Director has an interest in the proceeding at common law. In effect, this decision confirmed that the Director only has the right to appear in matters that directly concern a person's detention at the FDS.

In forming this conclusion, Her Honour Justice Dalton commented that, in almost three years presiding on the Mental Health Court, a certificate of capacity has never been provided to the court by the Director, even in the rare circumstances where the person subject to the reference suffered from such an extreme disability that the Court was considering detaining the person in the FDS.[410]

Her Honour Justice Dalton also made the following comments:

> ... [U]ntil my decision in *MAB*, the Director of Forensic Disability routinely elected to appear, by counsel, in cases concerning children with intellectual disabilities, and adults with intellectual disabilities which could not conceivably warrant detention in the 10-bed unit. The Director's appearance was generally unhelpful to the Court, as might be expected from a person with no interest in the proceeding. The Director filed material which originated from the Department of Communities. That department has responsibility for the intellectually disabled living in the community, but is not given a right to appear in the Mental Health Court. The Director of Forensic Disability could take no responsibility for the content, timeliness or usefulness of the material, for it was not that Director's material. The Director of Forensic Disability would not oblige or assist the Court by undertaking to perform any action which would either assist the Court hearing or assist the disabled person – when such issues arose the Director's position was that he or she had no relevant power. As the transcript in MAB shows, the Director was unwilling, or unable, even to produce a draft order in cases where it appeared: the provisions of the draft order and its execution were in the realm of the Director of Mental Health, not the Director of Forensic Disability.

409 Paragraphs 5–8 of the judgement include an extract of the psychiatric report submitted by independent Court-appointed expert who, having conducted the assessment, outlined concerns about the potential financial abuse of MAB by family members.

410 *In the Matter of Sukkur Abdus* [2016] QMHC 10.

Prior to the Department separating the two functions previously assumed by the Chief Practitioner – Disability, that role had input into the management of people under a forensic disability order. The investigation was told that legal counsel for the Chief Practitioner – Disability would regularly appear before the Mental Health Court for matters where a forensic disability order was being considered.

The reported judgements of *MAB* and *In the Matter of Sukkur Abdus* flow on from a fundamental change in the functions of the position of Director in 2013, which did not result in a change in the practice of appearing before the Mental Health Court in relation to forensic disability matters.

In communication with the investigation, the Director highlighted that a lack of linkages between the FDS and the broader systems of health and disability had restricted the effectiveness of her role and the FDS.[411]

This issue was raised in the Ogloff report, where it was reported that one stakeholder described the FDS as an 'orphan' with no community team, and no clear linkages and exit pathways for people to transition to the wider service system. In commenting on the fragmentation and lack of clarity around governance structures for the forensic disability cohort more broadly, the Ogloff report states that:

> The confusion is further compounded by the division that has been legislatively drawn between the small proportion of the forensic disability cohort detained to the FDS (who fall under the responsibility of the Director of Forensic Disability) and the vast majority of Forensic Orders (Disability) that are managed in the community under the responsibility of the Authorised Mental Health Services (which disclaim specialist skills to manage clients with forensic disability) and the Department of Health, with clinical oversight provided by the Chief Psychiatrist. Despite this shared responsibility for the forensic disability cohort, there are no formal mechanisms for communication and coordination across the two legislative offices. Additionally, the separation of the forensic disability cohort into these two groups means that there is a lack of whole-of-system practice leadership, monitoring, direction and oversight. As a result of this division in governance and oversight, significant confusion, inertia and fragmentation has developed amongst the services involved in the provision of support and care to the forensic disability cohort.
>
> ...
>
> Under the current legislative arrangements, despite the specialist nature of the office, the Director of Forensic Disability has no role in relation to the care and support of the majority of people on Forensic Orders (Disability) who instead fall under the oversight of the Chief Psychiatrist under the Mental Health Act 2016 (Qld). This would seem to be inconsistent with the purpose and intention of the Carter Report, which advocated for specialist forensic disability services that deemphasised the medical model.[412]

The limited ambit of responsibilities of the Director was subject to consideration in the Department's s 157 review, which found that the Director's powers should be expanded to include investigative powers. The Ogloff review recommended that the role of Director be returned to a position that carries oversight of all people under a forensic disability order in Queensland, rather than only the FDS. In commenting on this recommendation, the Department's s 157 review stated that opportunities to improve, strengthen or expand the role of the Director would need to be considered in the context of 'any new service delivery model for forensic disability services in Queensland'.[413]

411 Letter from the Director of Forensic Disability to the investigation.
412 J Ogloff, J Ruffles, D Sullivan, *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System*, (2018), Unpublished report, Centre for Forensic Behavioural Science, Swinburne University of Technology, p. 48.
413 Department of Communities, Disability Services and Seniors, *Section 157: Review of the operation of the Forensic Disability Act 2011*, Final Report, (2018), p. 28.

The Director's audit and annual reports

One of the key indicators of the Directors' limited ability to discharge key legislative requirements is the lack of progress on recommendations and actions as outlined in audit reports.

Significant legislative non-compliance is raised across all audit reports, and should have resulted in the rectification of issues raised, particularly when the legislative non-compliance in question raises human rights concerns.

Instead, the same issues are often repeated in very similar language across the four audit reports, over a period of more than five years. Recommendations and actions made by the Director are often repeated in language that at times is identical to the previous years.

The repetition of issues across the audit reports between 2016 and 2018 indicate that the Director did not ensure that the involuntary detention, assessment, care, support and protection of people detained at the FDS always complied with the FD Act, as required by s 87(1)(b).

There is significant disparity between the contents of the audit reports provided to the Department and the contents of the annual reports tabled in the Queensland Parliament. The annual reports present a considerably different picture of substantive issues and salient features of the FDS, and fail to report key issues of concern.

This suggests that the Director was publicly reporting a view that was inconsistent with views privately reported to the Department.

The investigation was also concerned that the annual reports did not include sufficient information to demonstrate transparency and accountability with regard to the operation of the FDS.

For example, the Director's annual reports do not include data about the use of regulated behaviour controls. The initial 2011–12 annual report, authored by the first Chief Practitioner – Disability, did report on the use of regulated behaviour controls at the FDS.[414] However, this is the only annual report produced by any Director that does so. By comparison, the annual report of the Office of the Chief Psychiatrist reports on the use of restrictive practices, including providing data in relation to five-year trends.[415] Specifically, the Chief Psychiatrist reports the number of seclusion authorisations made under the MHA 2016, including information about the person responsible for authorising the restrictive practice.

This information elevates transparency and accountability, and should be included in all annual and audit reports.

Director's response

In response to the Ombudsman's proposed report, the Director stated that, during the initial phase of her appointment, she held 'great concerns' about the role the Department appeared to be playing in the decisions and reporting of the Director, including the annual reports. The Director provided multiple examples of concerns she held about the Department's attempts to influence her annual reports.

414 However, the data reported in the annual report appears to be inconsistent with other information obtained by the investigation.
415 Chief Psychiatrist annual report 2017–18.

The role of the Public Guardian

The OPG was intended to form part of the statutory oversight framework for the FDS.[416]

In discharging its legislative functions under the *Guardianship and Administration Act 2000*, the OPG has consistently raised concerns about the treatment of its clients and the operation of the FDS.

However, the relationship between the FDS and the OPG has not been managed by the FDS in a way that appropriately recognised or gave effect to the important role of the OPG in oversight of the FDS. The management of this stakeholder relationship by the FDS has, at times, reflected a defensive and adversarial one, rather than a collaborative approach aimed at addressing concerns raised by the OPG about the treatment of people with intellectual and cognitive disability.

Information requested and obtained from the OPG indicated that the community visitor program operated by the OPG and the Public Guardian has consistently raised issues of concern with the FDS and the Department. As outlined in Part A of this report, the Public Guardian elevated those concerns to the Director-General.

The investigation also identified evidence that the responses to concerns raised by the OPG with the FDS and the Department were, at times, not undertaken in the spirit of collaboration. Staff of the OPG had raised concerns and complaints with the FDS that had not always received adequate attention, exploration or any outcome.

As noted, the FD Act explanatory notes set out that the Public Guardian is required to form part of the oversight framework of the FDS. In 2017, the Office of the Director and the FDS received requests for information from the OPG in accordance with the OPG's statutory obligations. In June 2017, the Director sought legal advice in relation to requests for information that had been received from the Public Guardian. Having set out relevant provisions for the *Guardianship and Administration Act 2000* and the *Public Guardian Act 2014*, the legal advice concludes that the Administrator of the FDS should provide information requested by the community visitor from the OPG, and that, 'in the spirit of cooperation', the Director should also provide any material already provided to the MHRT to the Public Guardian as requested.

416 Explanatory Notes, Forensic Disability Bill 2011.

Department's response

In response to the Ombudsman's proposed report, the Department submitted that it had a limited role in the responsibility for the operation of the FDS, but rather the Director and the Administrator, who hold statutory responsibilities under the FD Act, were responsible for all high-level obligations in relation to the FDS.

In supporting this position, the Director-General relied on the legal advice obtained by the Department in 2013, that describes and analyses the roles and responsibilities of positions relevant to the operation of the FDS.[417] Specifically the roles of Director, Administrator, senior practitioners, authorised practitioners, practitioners, authorised officers, the Minister and the Director-General are analysed.

The Director-General's submission highlighted that the Director is an independent statutory officer and restated the obligations imposed on the Director and the Administrator under the FD Act. The submission emphasised the following extract from the legal advice ...:

> It is clear from the provisions summarised that the [D]irector, and not the Minister or Director-General, is *(subject to matters outside the [D]irector's control, which are discussed below)*[418] ultimately responsible for ensuring that the day to day operations of the service comply with the FD Act, insofar as they relate to the detention, assessment, care, support and protection of forensic disability clients.
>
> ...
>
> The [D]irector's role is therefore not limited to observing the conduct of the service and (for example) reporting to the Minister when things 'go wrong'; the [D]irector must also take an active role in the management and operations of the service to ensure that things do not 'go wrong'. It is therefore to be expected that the [D]irector will take steps to ensure that he or she is informed about how the service is being conducted. Without taking such steps, the [D]irector will not be able to discharge his or her function in s 87(1)(b) (or the function in s 87(1)(c) of 'facilitating the proper and efficient administration of the Act').[419]

The Director-General also submitted that:

> While I am unable to comment on my predecessor's actions in response to this advice, it has been highly influential in my interactions with the Minister, DFD and Administrator in relation to the administration of the FD Act and the independent role of the DFD, which I have attempted to show due respect.
>
> In practice, adherence to this legal advice has meant that my Department has managed the appropriation and allocation of funding to support the operation of the FDS by the DFD, and provided and maintained the physical facilities and core corporate support. My Department has also led strategic and legal policy initiatives relating to the broader forensic disability service system. (This work was fully explained in my letter to you dated 22 June 2018 ...)
>
> While arrangements have varied over time, since the most recent machinery of government changes, the key liaison point for the DFD has been my Senior Executive Director with primary responsibility for the Department's Accommodation Support and Respite Services.
>
> While my Senior Executive Director and I have been available to provide any support required or requested by the DFD, we have no ability to exercise a function or power under the FD Act that exclusively belongs to another statutory officer, such as the DFD.
>
> Therefore, I ask that you review the [proposed] report with a view to aligning references to the roles and responsibilities under the FD Act as described by the [legal advisor].

417 The Department's 2013 legal advice was sought and received after the first Director left the position.
418 Emphasis has been added to words that were contained in the original legal advice, but were not included in the Department's extract of the advice.
419 Legal advice dated 5 February 2013, p. 7.

Ombudsman's comment

In essence, the Department submitted that it was not responsible for the failings of the FDS and had a limited role in the operation of the facility.

This position was reiterated throughout the detailed response from the Director-General.

The investigation found that the Department's role in the FDS has not been well defined, and that administrative actions of the Department have not given effect to the 2013 legal advice or the FD Act.

The Department's 2013 legal advice provides a static description and analysis of the allocation of responsibilities under the FD Act. However, while this legal advice remains static, the Department's approach to the advice and operationalising the FD Act has not been consistent.

I accept the inherent challenges in the administration of the FD Act in relation to primacy of the role of the Director for the proper administration of the FD Act, and the independence of this position given that the FD Act sits under the Department's administrative arrangements.

It is clear that officers of the Department, as an enduring institution, had knowledge of issues raised by the Director, and hold the operating budget for the FDS.

Director's response

In response to the Ombudsman's proposed report, the Director submitted that, in essence, the Department is and has been responsible for the operation of the FDS. The Director submitted that the day-to-day operation does not fall within the Director's jurisdiction.

The Director also provided information that alleged she was aware of numerous attempts by the Department to attempt to 'control and influence' previous Directors.

The Director also stated that the position of Director had previously been recruited from within the Department and that, in the Director's view, there was a clear indication that 'at some time the Director was simply seen as a Departmental junior officer'. The Director also stated that, until her appointment, the Department had 'complete control' over who was placed in the role of the Administrator. However, the Director stated that she has previously refused to make a permanent appointment to the role of Administrator.

The Director also outlined difficulties she had encountered with previous Administrators, which were, in her view, 'compounded by both roles being graded at the same level', and the Administrator being formally referred to at the FDS as the 'Director of the Forensic Disability Service'.

The Director stated that the Department 'continues to make attempts to influence' the Director's position, but that she has not been subject to influence. In providing support for this position, the Director outlined a number of barriers to discharging her statutory obligation.

The Director also submitted that, when appointed as Director, she had inherited a service that was operating from a very low base and had not met its intended purpose or vision.

The Director did not accept that the annual reports produced by her lacked transparency, and stated that each annual report reported on audits undertaken by the Director.

Ombudsman's comment

Many of the Director's perspectives in her response to the Ombudsman's proposed report were not provided during the investigation.

The responses of the Department and the Director to the proposed report indicate that there is no shared understanding about the role of the Department and the role of the Director.

This investigation found that the Department's approach to the statutory position of the Director has been inconsistent.

Summary

Organisational arrangements imposed by the Department have not given effect to the independence of the position of Director. This has impacted on the Director's capacity to discharge the statutory requirements of the role.

The Director's annual reports have not included sufficient detail of issues about the operation of the FDS, and this has reduced transparency and accountability.

The relationship between the FDS and the OPG has not been appropriately managed by the FDS.

Opinion 15

15.1 The Department's administrative arrangements have hindered the Director's ability to effectively undertake the statutory functions imposed by ss 87–89 of the FD Act.

15.2 The Director's attempts to facilitate the proper and efficient administration of the FD Act as required by s 87(1)c) of the FD Act were ineffective.

15.3 The Director's discharge of the statutory function of ensuring the protection of the rights of people detained at the FDS as imposed by s 87(1)(a) of the FD Act has been limited.

This is administrative action that is unreasonable for the purposes of s 49(2)(b) of the Ombudsman Act.

Recommendation 15

That the Director-General, in consultation with the Director:

15.1 Clarifies the relationship between the Department and the Director, taking into consideration statutory obligations imposed by the FD Act and legal advice.

That the Director-General:

15.2 Reviews the current classification of the position of Director having regard to the content of this report and the Ogloff report.

That the Director:

15.3 Establishes a web presence for the Office of the Director that reflects the independence of the Office, and provides public access to policies and procedures about the care, support and detention of people detained at the FDS, annual reports and any other appropriate information.

Has the FDS achieved its aim?

The FDS was established in response to recommendations of the Carter and Butler reports, which identified that the forensic mental health system is not suitable for people with intellectual and cognitive disability.

The Carter report specifically recommended that the Mental Health Court be provided with an alternative that would provide for specialised care of people with intellectual and cognitive disability within the forensic system. In making the recommendations, the report warned against repeating the ills of the past, and emphasised the need to reform the Department's approach to the use of regulated behaviour controls, also known as restrictive practices, for people with behaviours of concern.

The opinions of this report outline that the expectations of the Carter report have not been addressed.

In the second reading speech of the FD Act, the then Minister for Disability Services stated that:

> A primary goal of the bill is to be consistent with the principles, goals and objectives reflected in the United Nations Convention on the Rights of Persons with Disabilities. To this end, the focus of the legislative scheme, within the constraints of a detention environment, is on safeguarding rights and freedoms, promoting individual development, enhancing opportunities for quality of life and maximising opportunities for safe reintegration into the community ...

These aims are enacted in the specific provisions of the FD Act.

However, the FDS has failed to fulfil the aims and objectives of the legislation.

The Criminal Justice Commission inquiry into allegations of misconduct at the Basil Stafford Centre observed that:

> In many cases, there has been a wide divergence between the noble and enlightened aims, practices and procedures promoted and adopted by the Department, on paper, and the day to day realities of the lives of some of the Centre's clients, the level of care afforded to them.[420]

Despite significant resources and the passage of almost nine years, the investigation found that the operation of the FDS has been characterised by widespread legislative non-compliance, which has impacted on the lived experience of the vulnerable people it set out to support.

420 Criminal Justice Commission, *Report of an Inquiry Into Allegations of Official Misconduct at the Basil Stafford Centre*, (1995), p. 391.

Appendices

Appendix 1: Issues outside the scope of the investigation

The *Human Rights Act 2019* was enacted after the completion of the investigation. Accordingly, the obligations contained in the HR Act have not been considered in the context of the FDS.

The following issues were also identified as broadly relevant to the subject matter of the investigation, but not directly within scope:

- the level of oversight for people subject to a forensic disability order under the responsibility of an authorised mental health service
- the potential for indefinite detention under forensic orders
- over-representation of Aboriginal and Torres Strait Islander people on forensic disability orders
- increasing number of forensic orders being imposed
- potential application of forensic orders to children
- fragmentation of legal frameworks that apply to people under a forensic disability
- intellectual and cognitive disability rates in mainstream prison populations.

On 21 December 2017, the Australian Government ratified the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT). OPCAT is an international human rights treaty that aims to prevent the abuse of people in detention, which will include the FDS. After the introduction of the OPCAT, the FDS will be subject to regular and rigorous inspections that will focus on ensuring service provision meets international standards for the treatment of people detained.

Appendix 2: Jurisdiction and procedural fairness

Jurisdiction

The Queensland Ombudsman (Ombudsman) is an officer of the Queensland Parliament authorised by law to deal with complaints about the administrative actions of Queensland Government agencies, which includes government departments and public authorities. Under the Ombudsman Act, a public authority includes an individual holding an office established under an Act and an individual holding an appointment made by the Governor in Council.[421]

The Department and the Director are therefore considered agencies for the purposes of the Ombudsman Act. The Public Guardian, the Public Advocate and the Chief Psychiatrist[422] are also considered agencies for the purposes of the Ombudsman Act. It therefore follows that the Ombudsman may investigate administrative actions of these agencies.

The Ombudsman cannot investigate administrative action taken by a tribunal, legal adviser to the State or member of the police force.[423] Accordingly, while this report makes reference to and obtained information from courts, tribunals and the QPS, administrative action of these entities was not investigated.

Under the Ombudsman Act, the Ombudsman has authority to:

- investigate the administrative actions of agencies on complaint or on the Queensland Ombudsman's own initiative (that is, without a specific complaint)
- make recommendations to the principal officer of the agency subject to the investigation that the Queensland Ombudsman considers appropriate
- consider the administrative practices of agencies generally and make recommendations, or provide information or other assistance to improve practices and procedures.

The Ombudsman Act outlines the matters about which the Ombudsman may form an opinion and make recommendations where the Ombudsman considers the administrative action was:[424]

- contrary to law
- unreasonable, unjust, oppressive or improperly discriminatory in the particular circumstances
- in accordance with a rule of law or a provision of an Act or a practice that is or may be unreasonable, unjust, oppressive or improperly discriminatory in the particular circumstances
- taken for an improper purpose, on irrelevant grounds or having regard to irrelevant considerations
- an action for which reasons should have been given but were not given
- based wholly or partly on a mistake of law or fact
- was wrong.

421 Ombudsman Act s 9.
422 As referred to in Part A of this report.
423 Ombudsman Act s 16.
424 Ombudsman Act s 49(2).

In conducting an investigation, the Ombudsman is not bound by the rules of evidence, but must comply with natural justice.[425]

The investigation is guided by the civil standard of proof, the 'balance of probabilities'. This means that, to meet the requisite standard, the evidence must establish it is more probable than not that the allegation is true.

Forming the opinions in this report therefore involved assessing the weight, reliability and sufficiency of information obtained. It also involved taking into consideration the nature and seriousness of the administrative action in question, the quality of the evidence, and the gravity of the consequences for the people involved in the matters under investigation.

In expressing an opinion that an agency's administrative actions or decisions are 'unreasonable', the popular, or dictionary, meaning is applied. The doctrine of legal unreasonableness applied by the courts when judicially reviewing administrative action does not apply.

Procedural fairness

The terms 'procedural fairness' and 'natural justice' are often used interchangeably within the context of administrative decision-making. The rules of procedural fairness have been developed to ensure that decision-making is both fair and reasonable.

The Ombudsman must also comply with these obligations when conducting an investigation. Specifically, the Ombudsman Act provides that, if at any time during the course of an investigation it appears to the Ombudsman that there may be grounds for making a report that may affect or concern an agency, the principal officer of that agency must be given an opportunity to comment on the subject matter of the investigation before the final report is made.

In satisfying this requirement, relevant sections of the Ombudsman's proposed report were prepared and provided to the following individuals and entities:

- the Department
- the Director
- the Administrator
- the Queensland Police Service
- the Public Guardian
- appointed guardians for people detained.

Responses to the Ombudsman's proposed report were received from:

- the Director-General of the Department, on 14 May 2019
- the Director, on 24 May 2019
- the Administrator, on 7 May 2019
- the OPG, on 8 May 2019.

425 Ombudsman Act 2001.

Adverse comment

If the Ombudsman proposes to make an adverse comment in a report about a person, the Ombudsman must provide the person with an opportunity to make submissions about the proposed adverse comment before the report is prepared.

This report contains adverse comment about the following people:

- the Director
- the Administrator.

In accordance with s 55 of the Ombudsman Act, both people were provided with a reasonable opportunity to respond to the adverse material in a draft version of the proposed report. Responses were received from both people.

After considering the submissions, where the Ombudsman proceeded to make adverse comments contained in this report, the person's defence has been fairly stated.

Response by the Administrator

A s 55 notice of adverse comment was provided to the Administrator, including relevant extracts. The Administrator's response included 25 pages, and has therefore not been presented in full. Contents of the Administrator's response were considered to fall into the following two categories:

- the Administrator's defence to sections of the report that were considered to contain adverse comment about the Administrator's performance of the role
- the Administrator's commentary and allegations about the nature and conduct of the investigation.

As the submission relates to content that was considered to form part of the Administrator's defence, that defence has been fairly stated at the relevant section of this report.

Contents of the response that were considered to form commentary or allegations about the nature and conduct of the investigation are summarised as follows:

- the investigation has been fundamentally flawed and biased, and the motivations and purpose of the investigation are questionable
- there has been a fundamental alignment of interests between the Office of the Queensland Ombudsman and the Office of the Public Guardian
- the report is flawed, unethical and lacking in credibility, represents a misuse of power and should not be published
- the proposed report fails to provide natural justice
- he has been unfairly treated in the report, and that this could be considered to be institutionalised bullying and harassment.

Response by the Director

A notice of adverse comment was provided to the Director in relation to comments contained in this report that could be considered adverse to the Director's performance of her role. The Director was also asked to respond to the full report from the perspective of the statutory role of Director under the FD Act.

As the Director's response relates to content that was considered to form part of the Director's defence, that defence has been fairly stated at the relevant section of this report.

The Director rejected the opinion that her attempts to facilitate the proper and effective administration of the FD Act were ineffective. The Director also rejected the view that the FDS was still failing to fulfil its legislative aims and objectives.

Contents of the response that were considered to form commentary or allegations about the nature and conduct of the investigation are summarised as follows:

- the report was poorly researched and full of negative assumptions
- the report validates the Director's view of bias, which had previously been raised by the Director during the course of the investigation
- the report was not evidence-based and is, in her view, non-compliant with the objectives of the Ombudsman Act
- the report only raises historical issues that are no longer relevant and does not acknowledge positive changes that the Director has implemented.

Ombudsman's comment

The Queensland Ombudsman rejects any allegation of bias or lack of independence in the conduct of this investigation.

There were no conflicts of interest, actual or perceived, by any Queensland Ombudsman officer who was involved in the conduct of this investigation.

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