EDITORIAL NOTE: CHANGES MADE TO THIS JUDGMENT APPEAR IN [SQUARE BRACKETS].

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IN THE FAMILY COURT
AT MANUKAU

I TE KŌTI WHĀNAU
KI MANUKAU

FAM-2006-092-001669
[2020] NZFC 5981

IN THE MATTER OF	THE INTELLECTUAL DISABILITY (COMPULSORY CARE AND REHABILITATION) ACT 2003
BETWEEN	PAUL HARVEY Applicant
AND	[J] Subject Person who the application is about

Hearing:	21 & 22 July 2020
Appearances:	D La Hood for the Applicant P Gruar for the Subject Person Dr A Ellis for the Welfare Guardian R Fuata'i for the District Inspector
Judgment:	29 September 2020

RESERVED JUDGMENT OF JUDGE G WAGNER

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[1] At the centre of this longstanding matter is [J] aged [in his mid-30s]. [J] is subject to a Compulsory Care Order (CCO) under the Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act).

[2] The application before me is for extension of the CCO. The current order, for 20 months, dates from 13 August 2018. That order was due to expire on 13 April 2020. It was deferred on 24 March 2020 to 14 May 2020; further deferred on 11 May 2020 to 31 July 2020; deferred again on 28 July 2020 to 31 August 2020; and finally deferred on 28 August 2020 to 30 September 2020.

[3] The applicant, Mr Harvey, is [J]'s Care Coordinator. He applies on behalf of the Forensic Co-ordination Service (Intellectual Disability) (FCS(ID)). [J]'s mother, [T], who is [J]'s welfare guardian, opposes the extension.

[4] I heard the matter on 21 and 22 July 2020. Present at the hearing were Mr Harvey represented by Mr La Hood. [T] was present with her counsel, Dr Ellis. Mr Gruar was present as counsel appointed for [J]. Ms Fuata'i was present on behalf of the District Inspector for Mental Health. Mr La Hood and Dr Ellis appeared via AVL from Wellington (given travel restrictions as a result of the Covid 19 pandemic). Various staff from FCS(ID) were also present throughout the hearing.

[5] I reserved my decision at the conclusion of the hearing, specifically until after I had both met with [J] and had received a cultural report on him, commissioned by FCS(ID), which was already well underway.

[6] The day after the hearing I had the pleasure of meeting [J]. Again primarily due to Covid this was also via AVL. I was present in a courtroom at the Manukau District Court alongside [T] and Mr Gruar. [J] was at [a forensic psychiatry Clinic]. He currently resides there, specifically in the [Unit], having been transferred there from the care of [a kaupapa Maori support service][1] (Motuhake Whare) on [at the beginning of] this year (I say more about this below). For our meeting [J] was accompanied by three staff members. His care manager, Katalina Nu'u was also present in the room but not visible on screen (apart from a brief introduction at the outset). [J] was very receptive to meeting me. It was clear he was also really pleased to see his Mum. He was very positive throughout.[2] I also got to meet his large soft

[1] A Regional Intellectual Disability Supported Accommodation Service.
[2] Mr Gruar, who is very familiar with [J], explained afterwards that [J] was particularly upbeat on this occasion.

toy dog, who he calls [name deleted][3], which accompanied [J]. [J] was particularly interested to know from me when I would have a date for when he would be able to return to "number one house" with his Mum.

Brief Background

[7] [J] has been the subject of the IDCCR Act since 2006. A detailed chronology, including the orders which have been made in respect of [J] over the period since 8 February 2006, was filed by Mr La Hood for the present hearing.

[8] [J]'s status under the IDCCR Act, plus an appeal against the making of the CCO dating from 14 October 2016, was the subject of an appeal before Cull J heard over nine days in July 2017. In her judgment delivered on 25 May 2018, Cull J dismissed the appeal.[4]

[9] Cull J's decision, and a further decision of His Honour Judge Goodwin dated 23 August 2018, in which he made the CCO currently under review, are both the subject of an appeal to the Court of Appeal brought by [T]. Effectively, of necessity, given the wide ranging nature of the appeal, this decision will also be the subject of that appeal regardless of the outcome. It is understood that appeal will be heard sometime later this year, perhaps in November.

Current Application

[10] The current application dated 18 February 2020 pursuant to s 85 IDCCR Act is for an extension of the CCO for the maximum period of 3 years, with [J] remaining as a secure care recipient. The application is supported by reports from three specialist assessors:

(a) Ingalise Jensen (Ms Jensen), report dated 3 February 2020;

(b) Dr Craig Immelman (Dr Immelman), report dated 17 February 2020;

(c) Dr Willem Louw (Dr Louw), report dated 9 April 2020.

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[3] Named after the dog in [a cartoon].
[4] *J v Attorney-General* [2018] NZHC 1209.

[11] At the hearing oral evidence was heard from those three specialist assessors together with the applicant, Mr Paul Harvey, and also from Dr Mhairi Duff. Dr Duff is lead consultant psychiatrist at the [Clinic] with responsibility for the [Unit]. She is [J]'s responsible clinician.

Extension of Compulsory Care Order

[12] Whether the extension of the CCO should be granted requires a consideration of the following:

(a) Eligibility;

(b) Community protection (risk assessment);

(c) [J]'s liberty interest; and

(d) The balance between community protection and liberty interest.

[13] The law and legal test to be applied to the question of whether a CCO is extended are set out in s 85 of the IDCCR Act and in *RIDCA v VM*.[5] These, together with the purposes and principles of the IDCCR Act, form the framework for decision making.

[14] Section 85 of the IDCCR Act states:

> **85 Extension of compulsory care order**
>
> (1) The Family Court may, on the application of the co-ordinator, extend the term of a care recipient's compulsory care order.
>
> (2) If the Court extends a compulsory care order for a care recipient no longer subject to the criminal justice system, the Court must consider and determine whether the care recipient must receive supervised care or secure care.
>
> (3) The Court may order that a care recipient no longer subject to the criminal justice system receive secure care only if it considers that supervised care would pose a serious danger to the health or safety of the care recipient or of others.

[5] *RIDCA Central (Regional Intellectual Disability care Agency) v VM* [2011] NZCA 659, [2012] 1 NZLR 641 [*RIDCA v VM*].

[15] Section 3 of the IDCCR Act states:

3 Purposes

The purposes of this Act are—

(a) to provide courts with appropriate compulsory care and rehabilitation options for persons who have an intellectual disability and who are charged with, or convicted of, an offence; and

(b) to recognise and safeguard the special rights of individuals subject to this Act; and

(c) to provide for the appropriate use of different levels of care for individuals who, while no longer subject to the criminal justice system, remain subject to this Act.

[16] Section 11 of the IDCCR Act states:

11 Principles governing exercise of powers under this Act

Every court or person who exercises, or proposes to exercise, a power under this Act in respect of a care recipient must be guided by the principle that the care recipient should be treated so as to protect—

(a) the health and safety of the care recipient and of others; and

(b) the rights of the care recipient.

[17] The Court of Appeal in *RIDCA v VM* determined the factors and defined the guiding principles in relation to the extension of the CCO of care recipients under the IDCCR Act. In her decision of 25 May 2018, Cull J summarised the Court of Appeal's approach as follows:[6]

> (a) Sections 3 and 11 of the IDCCR Act set out the guiding principles in relation to extension decisions. The question to be determined is whether J no longer needs to be cared for as a care recipient. This is the same question a judge must take into account, when the specialist assessor states their opinion that the care recipient still needs to be cared for as a care recipient. The most recent certificates under s 79, should be taken into account when undertaking the balancing exercise between the community protection interest and the liberty interest of the care recipient.
>
> (b) The judge must be satisfied that the community protection interest cannot be met other than by a CCO, and that is to say the CCO must be the least coercive and restrictive option available.

[6] *J v Attorney-General*, above n 2, at [360]

(c) If a care recipient no longer constitutes a risk of sufficient seriousness to justify the continuation of the CCO, an extension (or continuation under s 104(b)) should be refused.

(d) Because rehabilitation is an important objective of the IDCCR Act, the judge should be informed of the rehabilitation efforts, their outcome, and be advised of the prospects of future rehabilitation.

(e) If the risk posed by the care recipient is unlikely to be reduced through rehabilitative efforts, the judge may take that into account in determining whether the community protection interest continues to be outweighed by the liberty interest of the care recipient.

(f) The weight to be given to the liberty interest is not necessarily static. After the care recipient has been subject to a CCO for a substantial period, the judge may determine that greater weight needs to be given to the liberty interest. The nature of the original offending is relevant to an extension decision in that it may provide the judge with an indicator of the level of risk posed by the care recipient. In a finally balanced case, the fact that an extension would make the period of compulsory care disproportionate to the offending of the care recipient may also be taken into account.

(g) In a case where a judge is satisfied that the community protection interest outweighs the liberty interest of the care recipient, the fact that the period during which the care recipient will remain subject to a CCO would exceed the sentence to which he or she would have been subject to if not intellectually disabled, should not lead to the refusal of an extension. The community protection interest will overwhelm the liberty interest in a case where the minor nature of the offending does not provide an accurate guide to the level of risk posed by the care recipient. In that case, the Court considered it unlikely that a dangerous person could be released because the nature of the offending was taken into account in the risk assessment.

Eligibility

[18] In order to extend the CCO I must first be satisfied that [J] has an intellectual disability as defined by s 7 of the IDCCR Act. Section 7 states:

7 Meaning of intellectual disability

(1) A person has an intellectual disability if the person has a permanent impairment that—

(a) results in significantly sub-average general intelligence; and
(b) results in significant deficits in adaptive functioning, as measured by tests generally used by clinicians, in at least 2 of the skills listed in subsection (4); and
(c) became apparent during the developmental period of the person.

(2) Wherever practicable, a person's general intelligence must be assessed by applying standard psychometric tests generally used by clinicians.

(3) For the purposes of subsection (1)(a), an assessment of a person's general intelligence is indicative of significantly sub-average general intelligence if it results in an intelligence quotient that is expressed—
(a) as 70 or less; and
(b) with a confidence level of not less than 95%.

(4) The skills referred to in subsection (1)(b) are—
(a) communication:
(b) self-care:
(c) home living:
(d) social skills:
(e) use of community services:
(f) self-direction:
(g) health and safety:
(h) reading, writing, and arithmetic:
(i) leisure and work.

(5) For the purposes of subsection (1)(c), the developmental period of a person generally finishes when the person turns 18 years.

(6) This section is subject to section 8.

[19] The question of whether [J] has an intellectual disability was considered by Cull J in her May 2018 decision in a two pronged way as follows:

(a) She dismissed the appeal against Goodwin DCJ's eligibility finding on 27 February 2017; and

(b) Following an independent inquiry, Cull J concluded she was satisfied on the balance of probabilities that [J] has an intellectual disability as confirmed by the evidence before her.

[20] The approach Judge Goodwin took in his 27 February 2017 decision, endorsed by Cull J, was that the criteria for the assessment of whether a care recipient continues to suffer from an intellectual disability is a combination of clinical tests and clinical

observations.[7] A clinician's determination does not have to include psychometric testing.

[21] There are findings as recently as 25 May 2018 and 23 August 2018 that [J] has an intellectual disability as defined by the IDCCR Act. Moreover, as observed by Cull J in her May 2018 decision:[8]

> "The specialist assessors record [J]'s intellectual disability as a permanent impairment."

[22] Dr Duff was asked by Mr Gruar whether, in the context of the last cognitive test having been undertaken in 2016, she would recommend retesting at this point in time. She answered in the negative.[9]

[23] I consider that I am able to conclude that there has been consideration of [J]'s intellectual disability eligibility and that he is a person with an intellectual disability as defined by s 7 of the IDCCR Act. I note there was no significant challenge to this point by Dr Ellis at the present hearing.

Community protection

[24] As noted, for this application [J] has been formally assessed by three specialist assessors:

(a) Ms Jensen in her report of 3 February 2020; and

(b) Dr Immelman in his report of 17 February 2020; and

(c) Dr Louw in his report of 9 April 2020.

[25] The brief for the assessors was to ascertain if there have been clinically significant changes in [J]'s condition and if his status as a care recipient needs to be continued or changed. Dr Louw was also specifically tasked with reviewing/evaluating [J]'s progress in his short time (at that stage) at the [Unit].

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[7] *J v Attorney-General*, above n 2, at [198(a)-(b)]
[8] At [198(d)]
[9] NOE pg 127 line 20

[26] At the time of the last review in 2018 [J] was residing at [the kaupapa Maori service]'s Motuhake Whare where he had lived since in or about 2010. More recently he was the sole resident. This was a stand-alone residence re-modelled specifically for [J]. It is apparent from the documents available to me that significant effort was put into developing an individualised programme for [J] taking into account his specific clinical needs and risks. As noted by Ms Jensen in her report:[10]

> "In Motuhake Whare, [J]'s days were highly structured, with clear routines being followed each day and week. Each day of the week had a set activity. The aim was to facilitate contact with his mother, engagement with the community and in a vocational programme (on Wednesdays) and encourage regular physical activity. The primary focus of [J]'s outings was accessing some of his favourite food. The vocational programme involved two staff from Ember working with [J] in the home and at a vocational service in the community. There was a focus on numeracy and if [J] was settled in mood and behaviour, he would attend the vocational base for cooking. If there were concerns about his behaviour, the cooking programme would occur at the residence."

[27] [J] had 2:1 staffing at home and 3:1 out in the community (with provision for a 4th if required). It was described by Dr Duff as a "bespoke, individualised package of care."[11] Dr Immelman described as "striking" the "high level of planning and effort for [J]'s overall care."[12]

[28] In 2019 a positive behaviour support package for [J] was designed by Louisa Medlicott, a clinical psychologist specialising in persons with disabilities, including intellectual disability. It was developed to provide [J]'s then support staff at [the kaupapa Maori support service] with clear and consistent interventions depending on the intensity of presenting behaviour of concern. Almost unanimously, those at the hearing spoke highly of that package, which included components to assist [J] with mood and behaviour regulation and to assist with accurate recording of his behaviour.

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[10] At [16] pg 73 Bundle.
[11] NOE pg 118.
[12] At pg 5 of the report / pg 56 Bundle.

[29] Nonetheless, [J] had to be transitioned from Motuhake Whare to secure care at the [Clinic] [at the beginning of] this year after FCS(ID) felt [the kaupapa Maori support service] was no longer able to safely accommodate [J]. [The service] itself advised it could no longer manage or deliver safe care to [J]. The decision was specifically made to transfer [J] to hospital as it was considered a community environment was not at that point able to keep him safe or secure. Partially, this development followed incidents of [J] absconding in mid-2019. On the first occasion in July, [J] was able to abscond during the night after one of his caregivers fell asleep. [J] was located some hours later at a local school where he had smashed a window. This successful abscond clearly led to a renewed sense of freedom for [J] and appeared to incentivise him to subsequently regularly threaten to abscond and to actually successfully do so on one further occasion.

[30] At the [Unit] [J] is in a separate wing[13] with a 3:1 male staff ratio (2:1 at night). Staff have continued to follow the Louisa Medlicott designed positive behavioural plan. There are two specific protocols in place for recording [J]'s behaviour, namely Incident Summary reports and Incident and Accident forms.

[31] The reports of all three specialist assessors, indeed all witnesses, together with their oral evidence, can be summarised as follows:

(a) There had been no discernible improvement in [J]'s behaviour since the last hearing whilst having care provided at Motuhake.

(b) Indeed, [J]'s presentation and behaviour had regressed, particularly after the successful absconds from Motuhake referred to above.

(c) Between 13 August 2019 and 6 January 2020 there were 40 incident forms completed for [J] whilst at Motuhake[14]. These included such things as six actual assaults against staff, property damage (and threats of), threats to harm others eg threats to "kill palagi" plus threats to harm or kill specific persons, and attempts to gain access to weapons.

[13] Described as a separate or confined "cluster".
[14] Itemised in summary form in Appendix One to Ms Jensen's 3 February 2020 report. Pp 85-86 Bundle.

(d) There were twelve summary of incidents reports from the [Clinic] between 29 January and 29 March 2020.[15] They refer primarily to attempts to and actual uninvited touching of staff members and physical violence towards staff, including violent reactions in response to noise.

[32] All three specialist assessors administered the Level of Service/Case management Inventory (LS/CMI), a risk assessment and case management tool.[16] It was the opinion of all three report writers, and also Dr Duff, that [J] poses an ongoing and significant risk specifically described as "very high".

[33] At this hearing Dr Ellis renewed his previous challenge to the use of this tool to predict future risk and also the use of terminology such as "high risk". He submitted the use of such terminology is unhelpful in that it aids demonisation and is not in accordance with best practice. He referred to the Court of Appeal decision in *R v Peta* in the course of which Glazebrook J said:

> "[53]……. When reporting the findings of a risk assessment, comparative categorical labels such as high, moderate or low risk should be qualified by probability statements that give corresponding reoffence rates for groups of similar offenders and the numbers of offenders in each category should be specified… Any category or label, such as low, medium or high, should be used consistently in any report."[17]

[34] Ms Jensen explained at the hearing that when she undertakes a risk assessment, and she believes the same to be for all specialist assessors, it is not just a matter of ticking the boxes and plugging in the numbers. Rather she (and others) are considering the individual as well, which is why in her risk assessment she did consider the LS/CMI, and then she considered all the additional risk factors that she felt were relevant to [J] and his risks. She explained further that the LS/CMI provides a guide or sort of structure to an assessment but then you consider the individual. She explained she also used an override because [J] and his risks are so unique.[18]

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[15] Described at paragraph [23] of Dr Louw's 9 April 2020 report. Pp 45-47 Bundle.
[16] Developed to predict risk of general and violent re-offending and to provide a structured approach to identifying targets for intervention to reduce the individual's risk of re-offending.
[17] *R v Peta* NZ Court of Appeal CA 48/06 28 February 2007.
[18] NOE pp 53-54.

[35] Ms Jensen was pressed to put a number/percentage on the level of risk. She declined, saying to do so would be to pull a number out of the air. She remained firm however that she categorised the risk as "very high", and that on the continuum scale there is nothing higher than that.[19]

[36] Dr Louw explained that the content in his report under the heading 'Risk Parameter Statement' "is a statement that tries to go beyond high or very high risk and communicate what he [[J]] might be at risk of doing, who would be the likely victims and where the unknown triggers *(sic)* so that if whoever manages [J] can use this parameter statement to keep themselves and [J] safe."[20] In his report, Dr Louw had summarised the most likely risk scenarios regarding [J] as follows:

> "[J] is regarded to pose a very high risk of committing future violent offences, including property damage. [J] has a long-standing fixed interest in acting out violent fantasies involving people's feet and heads. [J] struggles to control his impulses to touch others and the most likely victims are care staff. [J]'s unwanted touch and assaultive behaviour can occur without warning or discernible triggers. European and female staff are regarded to be more likely targets for [J]."[21]

[37] All specialist assessors are of the opinion that in the absence of the support and scaffolding he receives [J] would shortly engage in reoffending, especially given his fixation with violence which has remained unchanged over a long period. As put by Dr Immelman[22]:

> "I continue to accept that prediction of the future with absolute certainty is impossible, but in my view there is a near-certainty that [J] would rapidly re-offend if he were to be released from compulsory care, which would allow him to re-enter the Intellectual Disability (Compulsory Care & Rehabilitation) Act 2003. I do not see that this is in his best interests, nor in the interests of public safety."

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[19] NOE pp 56-57.
[20] NOE pg 77 lines 13-17.
[21] At [41] pg 50 Bundle.
[22] Pg 64 Bundle pg 13 of report.

[38] This was confirmed by Dr Immelman at the hearing when asked by Dr Ellis what he meant by "high risk". Dr Immelman replied "It means that it's almost certain in my view that [J] would re-offend if he were released immediately."[23]

[39] The LS/CMI tool received specific attention from Cull J in her May 2018 judgment, and she endorsed its validity.[24] That is currently the best authority for this Court, pending the impending COA appeal. The clear and firm conclusion of all specialist assessors, and Dr Duff, is that the articulated behavioural risks are unchanged. On the evidence before me I agree, and I conclude that [J]'s risk remains in the very high range, and that he continues to present a significant and an ongoing risk to the community.

[J]'s liberty interests and balancing question

[40] Cull J carefully considered [J]'s liberty interests with reference to the s 11 principle[25] including that the liberty interest is not static and greater weight may need to be given to [J]'s liberty needs given he has been the subject of a CCO for some 14 years.[26] Specifically, Cull J considered the two issues of:

(a) The relevance of J's index offending;[27] and

(b) The lowest level of compulsory care required to achieve community protection.[28]

[41] The conclusions Cull J reached were:

(a) The relatively minor nature of the index offending does not provide an accurate guide to the level of risk posed by [J].

(b) [J]'s risks had not changed, even though they were being well managed.

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[23] NOE pg 81 lines 31-32.
[24] *J v Attorney-General*, above n 2, at [392]-[394].
[25] s 11(b) – the rights of the care recipient.
[26] *J v Attorney-General*, above n 2, at [406].
[27] At [408]-[412].
[28] At [413]-[428].

(c) Although [J] would remain subject to a CCO well in excess of a sentence for the index offending, the community protection continues to be outweighed by [J]'s liberty interest.

(d) The status of secure care is not disproportionate to the needs of community protection.

[42] Cull J clearly found that the community interest protection factor outweighed [J]'s liberty interests, and that on the evidence before her at the time a secure care order was not disproportionate to the community needs. Goodwin DCJ's conclusion was the same a few months later, despite perceptible improvements in [J]'s behaviour at the time.

[43] As noted above however, there has regrettably been a decline in [J]'s behaviour since that time. At this juncture I discuss issues canvassed at some length by Dr Ellis at the hearing around [J]'s care plan and what was portrayed as demonisation of and attribution of blame to [J] for his behaviours.

[44] There was criticism from Dr Ellis of the [mode of] incident reporting. A large number of the incident reports recorded in the specialist assessors reports were put to the specialist assessors and Dr Duff, alongside the proposition that [J]'s support team had caused [J]'s reaction/behaviour through their own in/action, rather than [J] being responsible or "guilty". Dr Duff preferred to categorise the incident records more neutrally as "a description of what happened."[29] She later agreed with the description put her by Mr Gruar as the incident forms "seeking a way of explaining the behaviours, rather than apportioning guilt on his [[J]'s] part".[30]

[45] Dr Ellis also took issue with aspects of [J]'s care plan. One specific example was the recent, new strategy noted by Dr Louw of [J] being given the choice to decide whether to interact with staff. Dr Ellis gave this aspect some attention, suggesting that that should always have been the case as it accords with [J]'s right to be consulted and to express his free choice. Dr Duff answered this when she said the following:

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[29] NOE pg 111 line 26.
[30] NOE pg 124 lines 7-9.

> "… We are tasked with producing a care and rehabilitation plan and we are required to provide care and the care therefore does also,….. for example, if he said, "I don't want to wash again," then it wouldn't be reasonable for us to leave him to be dirty, to become infected in his skin, to become sick and to die in our care because he expressed a choice that he didn't want to do that. So, there is a degree of paternalism within the care and rehabilitation plan but there is a duty of care and we do have a duty of care to try to provide the best care that we can for [J] as for everybody else."[31]

[46] Dr Ellis took issue with the characterisation of [J]'s particular interest in women's feet as necessarily having a sexual element. Whilst there is in my view sufficient evidence to indicate there is a sexual element to it (even if that is not [J]'s conscious intent), I accept Mr La Hood's submission that that is not in fact directly relevant. What is important is, sexual motivation or not, the relevant behaviour is violent.

[47] I do not agree with Dr Ellis' characterisation of others attributing blame to [J] for his various actions. Indeed I was struck by the compassion and respect which each of the experts/professionals showed and expressed towards [J]. There was no hint of judgement or blame of [J] for his various behaviours. Rather there seemed to be a unanimous drive, despite the long journey [J] and others have been on for many years now, to continue to try to understand the triggers for [J]'s behaviour and to provide the very best level of care and support for him as possible. As a number of the witnesses pointed out, despite the best of intentions human error is inevitable, and this needs to be taken into account in [J]'s ongoing rehabilitation including assisting him to respond appropriately when such things occur.

[48] A consideration of the specialist assessors reports and the oral evidence, subject to cross-examination before this Court, satisfies me that there is no change since the High Court gave consideration to the balancing of the community interest and [J]'s liberty interest, nor since Goodwin DCJ considered this issue for [J] some three months later. Indeed, the improvements Judge Goodwin was able to identify have

[31] NOE pg 112 lines 16-24.

regressed and the evidence is clear that [J] continues to pose a very high risk and his ongoing rehabilitation will be an ongoing, long term process.

[49] Whilst Mr Gruar characterised [J]'s return to the hospital environment as a retrograde step, and that may well be accurate, it is unfortunately necessary given the decline in [J]'s behaviour and the difficulty staff at Motuhake Whare appear to have had in consistently implementing the Louisa Medlicott plan. It is considered by Mr Harvey and the experts that the time at [the Unit] will be important to consistently implement and bed in the strategies inherent in that plan, so that [J] has an improved quality of life when he and the public are ready for his move back into the community.

[50] Mr La Hood's submission is correct that it is not for me to determine where [J] should reside, only if the CCO should be secure in nature or community/supervised. Dr Louw put it succinctly at the hearing when he said "He [[J]] should always be at the right place for his risk and his need, so he shouldn't be in a less restrictive place if he is high risk and high need".[32] In the terms of s 85(3) of the IDCCR Act, I consider that supervised care would pose a serious and unacceptable danger to the safety of both [J] and the community. It follows that the conclusion I reach is that the current level of secure care is warranted.

[51] Whilst other possible statutory remedies were mooted by Mr Gruar, such as a personal order under the Protection of Personal & Property Rights Act 1988 and/or the Mental Health (Compulsory Assessment and Treatment) Act 1992, it was the unanimous view of all involved at the hearing that these would not be appropriate either from a jurisdictional view point or given the lack of compulsion in terms of requiring [J] to remain at a particular residence. And whilst it is the strong wish of [T], and of [J] himself,[33] that [J] be allowed to return to [T]'s home, that too is not possible under a secure CCO. Dr Ellis raises the point that this and so many other options are not viable simply because of a lack of funding. That may well be an appropriate criticism, but that is beyond what I am able to deal with and determine in the course of the current application.

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[32] NOE pg 78 lines 5-6.
[33] [J] is not aware that his mother no longer resides at what he calls "number one house".

Cultural Report

[52] Although there has already been an internal cultural assessment, resulting in a cultural advisor available to [J] and appropriate activities, it is somewhat startling that it has taken so long for an external cultural assessment to be commissioned for [J]'s benefit viewed against the length of time [J] has been in care. The report now available is authored by Dr Sione Vaka dated 10 August 2020. I have read that report. I consider it will be a valuable resource for [J] and all those tasked with planning and providing care for him. Again, those who gave evidence at the hearing unanimously agreed that such cultural input was of critical importance to [J], particularly given his strong identification with his [Pasifika] heritage. Given the careful attention to the care provided to [J], I am confident that the education and recommendations provided by Dr Vaka will be incorporated into [J]'s care and rehabilitation plan and that this will be attended to promptly. Albeit perhaps outside his brief, it is noteworthy that Dr Vaka concurred with the three specialist assessors at this hearing that an extension of [J]'s care is necessary due to risks he poses to the community.

Length of order and start dates

[53] The order sought is for three years. The maximum period is sought because, on the one hand, it is submitted that the evidence shows clearly [J] is very unlikely to rehabilitate in a lesser period of time to a level where his care might be changed to supervised. Secondly, it is submitted that reviewing the CCO more regularly is in fact detrimental to [J] as it serves to destabilise his progress and rehabilitation.

[54] That is certainly the unanimous review of the three specialist assessors and Dr Duff. Ms Jensen explained it at the hearing in this way:

> "There's a couple of reasons. Firstly, I think any rehabilitation will be very slow.… that by going to the [Unit]… there's going to be a period of him being unsettled by that and then hopefully a period of stabilisation and then again plans for him to be moved again into the community at some point in the future. I think realistically it will take three years, it could take longer. There's been numerous, many many attempts to try and rehabilitate [J] and… I think any

> progress is going to be very very slow going. … he has the six months review anyway so it is every six months he'd be reviewed by a specialist assessor. I think if there's shorter orders, my concern is that he becomes quite focussed on the end of the order and then there is often a period of him being quite unsettled and are destabilised by that, and in a way I'm not really sure it's in his best interests."[34]

[55] Again, though acutely mindful of the length of time [J] has been subject to a CCO, that must be balanced against the evidence of regression over the last review period and a need for resetting, if you like. On top of that is the experts' view that the review process can prove unsettling and destabilising for [J] and the efficacy of the care he receives.

[56] For these reasons I am satisfied that it is appropriate to extend the CCO and it is appropriate to do so for the maximum three year period. As noted by Mr La Hood and Mr Gruar in closing submissions, it is open to Mr Harvey, in consultation with others, to move [J] from secure to supervised care over the relevant period if that becomes appropriate.

Conclusion and orders

[57] I make the following orders:

(a) An extension of the CCO from 13 April 2020 for a period of 36 months.

(b) The order is to be a secure CCO.

G Wagner
Family Court Judge

[34] NOE pg 55 lines 20-33.