QUEENSLAND OMBUDSMAN

Forensic Disability Service – second report

A review of the implementation of recommendations made in the 2019 Forensic Disability Service report.

August 2024

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***Leaving Our Mark*, (2023)**
Digital artwork (cover uses elements)
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Nathaniel Chapman is a Goenpul and Yuggera Man, also from the Wambia Tribe in Northern Territory and Waka Waka country in Eidsvold, Queensland.

We acknowledge the Traditional Owners of the land throughout Queensland and their continuing connection to land, culture and community. We pay our respects to Elders past, present and emerging.

Report tabling

The Ombudsman has given this report to the Speaker of the Queensland Parliament for tabling in the Legislative Assembly under s 52 of the *Ombudsman Act 2001*.

Public

This document is released to the public space.
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Snapshot

In 2019, the former Ombudsman investigated the administration of the Forensic Disability Service (FDS). Results of that investigation and recommendations were published in *The Forensic Disability Service Report – An investigation into the detention of people at the FDS* (the 2019 report). This 2024 report reviews the progress of the implementation of recommendations made in the 2019 report.

The Forensic Disability Service

The FDS is a medium-security residential and treatment facility that can accommodate and provide care for up to 10 people who are subject to a Forensic Order (Disability) under the *Forensic Disability Act 2011* (the FD Act).

The FDS was established to provide services, such as improving skills related to daily living and improving insight into offending. Its aim is to rehabilitate people with an intellectual disability who are charged with criminal offences and found to be of unsound mind or unfit for trial.

The FDS is operated by the Department of Child Safety, Seniors and Disability Services (the department) (formerly the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships). An independent statutory position of Director of Forensic Disability (the Director) is tasked with ensuring the protection of the rights of people detained to the FDS.

What we investigated in 2024

This investigation examined:

- the FDS's current levels of compliance with the FD Act
- the implementation status of the recommendations made in the 2019 report
- whether the FDS is compliant with the *Human Rights Act 2019*, which was enacted after the 2019 report.

What we found

The FDS has improved systems and processes by:

- reviewing policies and procedures and publishing them online or on the departmental intranet
- establishing electronic recordkeeping and keeping accurate records of decisions about the management, care and support for people detained to the FDS
- enhancing individual development plans for people detained to the FDS to have a greater focus on rehabilitation and skill development
- establishing processes for transitioning people detained to the FDS into the community.

To continue improving systems and processes, we recommend:

- expanding the recordkeeping system to allow entries to record the use of medication
- tracking program delivery to make it easy to identify and address an individual's treatment needs.

One of the most serious concerns identified in the 2019 report was the use of prolonged seclusion at the FDS. This situation continued on after the 2019 report. We welcome the department's advice that no person currently residing at the FDS is subject to ongoing seclusion on a long-term basis. It is imperative that long term seclusion of the type identified in the 2019 report never occurs again. To support this, we have recommended improvements to the FD Act.

Opinions

Opinion 1

During the period 2021–2022 the seclusion orders did not always include:

- adequate reasoning to show how the decision-maker could have been reasonably satisfied there was an imminent risk of harm and no less restrictive way to protect health and safety, as required by s 61(2) of the FD Act.
- adequate consideration of the cumulative impacts of seclusion on a person who was secluded almost continuously during that period.

For the purposes of s 49(2)(b) of the Ombudsman Act, this is administrative action that is unreasonable, and its effect on the person who was secluded on an almost continuous basis continued to be oppressive.

Opinion 2

Seclusion orders did not always include adequate reasoning to show how, in the circumstances, the decision was compatible with human rights or that the decision-maker had given proper consideration to human rights, as required by s 58(1) of the HR Act.

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

Recommendations

Recommendation 1

a) The Director-General reviews operational practices to ensure they continue to give effect to the policies and procedures issued by the director.

b) The Director-General updates Forensic Disability Service staff induction modules to ensure staff are inducted in the use of the operational practices.

Recommendation 2

The Director expands the individual development plan framework to track program progress in a way that allows easy identification of outstanding treatment needs for people detained to the Forensic Disability Service.

Recommendation 3

The Director reviews the process of program delivery to people detained to the Forensic Disability Service to ensure:

- staff receive adequate training to be able to comfortably deliver content
- there is adequate supervision for clinicians delivering programs.

Recommendation 4

The Director-General and the Director work together to continue expanding the *Forensic Disability Act Information System* to allow entries to record the use of medication at the Forensic Disability Service.

Recommendation 5

The Director-General, in consultation with the Director, amends the *Liaison and Cooperation with Queensland Emergency Services Agencies protocol* to include guidance on how to:

- determine if contacting police or ambulance is necessary
- properly record that decision.

Recommendation 6

The Director continues to progress the transition of all people detained to the Forensic Disability Service (FDS), with a particular focus on developing processes to monitor and prevent the detention of any person at the FDS for extended durations.

Recommendation 7

The Director-General updates the *Conflict of Interest policy* to include guidance about use and maintenance of the conflict of interest register.

Recommendation 8

The department, in collaboration with the Director, updates the outline of responsibilities and the memorandum of understanding to clearly identify responsibilities in relation to conflicts of interest and managing complaints.

Recommendation 9

To ensure transparency of Forensic Disability Service operations, the Director ensures annual reports include current and detailed information about the use of seclusion orders.

Recommendation 10

The Director-General, in consultation with the Director, reviews the FD Act, with a view to seeking amendments that provide:

a) guidance about decision-making in situations where it is considered necessary for seclusion to exceed three hours
b) guidance on reducing and, where possible, eliminating restraint and seclusion
c) escalation of seclusion decisions to more senior officers when the decision results in a person being secluded for a cumulative period of more than three hours
d) rights of external review of longer periods of seclusion
e) clear provision for how people detained to the FDS can obtain support to access review.

Recommendation 11

The Director reviews and updates the policies and procedures governing the use of seclusion, to provide improved guidance about the matters listed in recommendation 10.

Recommendation 12

The Director reviews the *Human Rights Policy*, and provides officers with associated training, to ensure clear guidance is being provided to staff to facilitate the proper recording of:

a) the identification and consideration of all relevant human rights that may be impacted by a decision
b) cogent and persuasive evidence to support any decision to limit a human right.

1. Background

Overview

The Office of the Queensland Ombudsman (the Office) provides advice and information to state and local government entities to help improve administrative decision-making. We identify, investigate, and report publicly on serious systemic issues. We also make recommendations to improve decision-making practices. This is particularly important in ensuring accountability and transparency within a closed environment such as the Forensic Disability Service (FDS).

This investigation examines the FDS's current levels of legislative compliance and the implementation status of the recommendations made in *The Forensic Disability Service Report – An investigation into the detention of people at the FDS* (the 2019 report).

History

Forensic Disability Service

The term forensic disability relates to people who have been charged with criminal offences, but the court has found them to be unfit for trial and/or unable to be held criminally responsible for the alleged offence because of an intellectual and cognitive disability.

As identified in the Anti-Discrimination Commission Queensland's *Submission to the Forensic Disability Bill 2010 Information Paper to the Department of Communities* in October 2010, 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.

Forensic disability is a complex area that spans conventional boundaries between disability, mental health and the criminal justice system. As noted by the Australian Law Reform Commission in its inquiry into *Equality, Capacity and Disability in Commonwealth Laws* (Report no 124, 2014, 199), all Australian states and territories have enacted laws and legal frameworks dealing with fitness to stand trial and mental impairment. However, few jurisdictions have a specialised facility to accommodate people with intellectual or cognitive disability who are unable to participate in a trial or be held criminally responsible and require secure care. This often means people with lifelong intellectual and cognitive disabilities end up either in secure mental health facilities or in prisons, neither of which can provide the specialised approach required.

Queensland was the first Australian jurisdiction to establish a specialised approach for people subject to a forensic order because of their intellectual or cognitive disability and who required secure care. In 2011, the *Forensic Disability Act 2011* (the FD Act) was enacted and the FDS commenced operation.

The FDS is a medium-security residential and treatment facility that can accommodate and provide care for up to 10 people who are subject to a Forensic Order (Disability) under the FD Act. The intent was for the FDS to provide services to rehabilitate and improve skills related to daily living for people with an intellectual disability who are charged with criminal offences and found to be of unsound mind or unfit for trial.

The FDS is operated by the Department of Child Safety, Seniors and Disability Services (the department). An independent statutory position, the Director, is tasked with ensuring the protection of the rights of people detained to the FDS.

2019 investigation

The Queensland Ombudsman is the only independent oversight body with jurisdiction over all government agencies connected to the framework of the FDS. In May 2018, the former Queensland Ombudsman initiated an investigation in response to concerns raised about the treatment of persons subject to forensic disability orders who were detained to the FDS.

Concerns raised related to the:

- long-term detention of some people
- overuse of seclusion and medication
- adequacy of programs to support habilitation (helping individuals with disabilities to attain or improve skills and functions for daily living) and rehabilitation
- lack of external releases for activities and engagement
- failure to transition people to supported community care.

The investigation examined whether the FDS was providing care, support and protection to people detained to the FDS in compliance with the FD Act. The investigation covered the period from the opening of the FDS until late 2018 and culminated in August 2019 in the tabling in the Queensland Parliament of the 2019 report.

The former Ombudsman found the FDS to be significantly non-compliant with the legislation designed to safeguard the care, protection and rehabilitation of the vulnerable people it accommodated. The 2019 report made recommendations to both the department and the Director. This was due to their shared responsibility for ensuring the FDS meets its statutory obligations to care for the vulnerable people detained there, to protect their human rights and to promote their early transition to supported care in the community.

The system-wide issues and legislative non-compliance found by the 2019 investigation, that contributed to significant administrative and operational failures at the FDS, are summarised below.

Lack of good administrative practices

The 2019 report identified that the FDS's recordkeeping was inadequate. There was an absence of records, paucity of detail, and incomplete or inaccurate content. This undermined the capacity of the FDS to demonstrate the basic level of competence required to administer its legislative functions and led to inconsistencies between policies and procedures, as well as confusion around their application.

Lack of care and support for people detained

The 2019 report found a range of systemic issues and legislative non-compliance had contributed to administrative and operational failures of the FDS. These included:

- a failure to establish a consistent, comprehensive and structured approach to the delivery of healthcare services
- a failure to deliver adequate education and development programs to people detained to the FDS
- a generally dysfunctional and disorganised management approach.

These failures hampered the reintegration of people into the community, a key objective of the FD Act.

Lack of transition planning

Although the FD Act contains a legislative obligation to ensure all people detained to the FDS have a transition plan in place, the 2019 report found transition plans were not developed for the first six years of the FDS's operation. Transition plans only began in 2017. This adversely impacted on the transition of people detained to the FDS.

Lack of records of regulated behaviour controls

The 2019 report found significant legislative non-compliance by the FDS in relation to the use and recording of regulated behaviour controls. This included:

- failing to record the occurrence of regular medication reviews
- likely administering medication for the purpose of behaviour control against the prescribed purpose
- subjecting at least one person detained to the FDS to almost permanent seclusion for more than six years.

This lengthy seclusion was significantly detrimental to the health and wellbeing of that person. Concerns about the use of ongoing seclusion are further addressed in Chapter 4.

Lack of processes for police attendance and criminal charges

The Ombudsman Act limits the Queensland Ombudsman jurisdiction from extending to Queensland Police Service (QPS) operational matters. Therefore, the 2019 investigation focused on how FDS staff interact with the QPS and on any guidance provided to FDS staff to assist with making informed decisions about seeking QPS assistance.

The 2019 report determined the FDS had no clear process in place to guide staff in deciding when it may be appropriate to contact police to attend the FDS. This resulted in situations where police were called to attend the FDS to control the behaviour of at least one person. This exposed people detained to the FDS to criminalisation based on their disability.

2019 report recommendations

The former Ombudsman made 15 recommendations to the Director-General of the then Department of Communities, Disability Services and Seniors (currently the Department of Child Safety, Seniors and Disability Services, and formerly the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships) and the Director of Forensic Disability (the Director). The Director-General and Director accepted all 15 recommendations.

Current investigation

In late 2022, this Office requested an update on the implementation of the recommendations made in the 2019 report. The department and Director advised that most of the recommendations had been implemented, and that work was continuing on the implementation of an electronic recordkeeping system at the FDS. No qualitative analysis of the implementation of recommendations was undertaken at that time.

Following the 2019 report, and in line with our continued interest in the FDS, in November 2022 we began a new own-initiative investigation under the *Ombudsman Act 2001*, to examine the FDS's current levels of legislative compliance, with both the FD Act and the *Human Rights Act 2019* (the HR Act). We also examined the implementation status of the recommendations made in the 2019 report.

Recent developments

The 2019 report was completed before the full enactment of the *Human Rights Act 2019* (HR Act) and before the full implementation of the National Disability Insurance Scheme (NDIS).

The application of the HR Act at the FDS was anticipated to add an additional layer of protections to those that already exist under the FD Act. Specifically, the HR Act would make it unlawful for a decision-maker to act in a way that was incompatible with defined human rights, particularly by failing to fully consider human rights when making decisions that limited, either wholly or partially, those rights. Concerns about making decisions in a way that is compatible with human rights are further addressed in Chapter 4.

The NDIS is a Commonwealth-administered scheme that provides funding to eligible people with disability for a range of services and outcomes. The availability of NDIS support packages for persons detained to the FDS would become a relevant and important consideration for their ongoing care, support and protection. However, the administrative decision-making of this scheme in respect of people detained to the FDS is not within the jurisdiction of the Queensland Ombudsman.

2. Procedural information

Investigation methodology

The current investigation was conducted informally under s 24(1)(a) of the Ombudsman Act and included:

- review and analysis of relevant legislation, including the *Forensic Disability Act 2011* (the FD Act) and the *Forensic Disability Regulation 2022* (the FD Regulation)
- review and analysis of Forensic Disability Service (FDS) responses to the self-assessment tool devised by the investigation and completed for each person detained to the FDS at that time
- a site visit to the FDS on 23 and 24 February 2023 to informally review FDS systems and processes and gather information as necessary
- analysis of the status of recommendations made in the 2019 report provided through implementation updates from the department
- targeted stakeholder engagement
- written enquiries to the Director and analysis of the responses
- written enquiries to the Director-General of the Department of Child Safety, Seniors and Disability Services (the department) and analysis of the responses.

The period selected as the scope for the investigation was 1 July 2021 to 30 June 2022.

Jurisdiction and procedural fairness

Ombudsman jurisdiction

The Ombudsman is an officer of the parliament empowered by the Ombudsman Act to:

- investigate administrative actions of agencies on reference from the Assembly or a statutory committee of the Assembly; or on complaint; or on the Ombudsman's own initiative
- consider the administrative practices and procedures of an agency whose actions are being investigated and make recommendations to the agency about appropriate ways of addressing the effects of inappropriate administrative actions; or for the improvement of the practices and procedures
- consider the administrative practices of agencies generally, and make recommendations or provide information or other help to the agencies about ways of improving the quality of administrative practices and procedures.

Under s 18(1)(b) of the Ombudsman Act, the Ombudsman can investigate administrative action of an agency if the Ombudsman considers such action should be investigated. As the FDS is an 'agency' for the purposes of s 8 of the Ombudsman Act, the Ombudsman can investigate the administrative actions of the FDS.

Section 49(2) of the Ombudsman Act outlines the matters about which the Ombudsman may form an opinion before making a recommendation to the principal officer of an agency. These include whether the administrative actions investigated are contrary to law, unreasonable, unjust or otherwise wrong.

Although under s 25(2) of the Ombudsman Act the Ombudsman is not bound by the rules of evidence, the question of the sufficiency of information to support an opinion of the Ombudsman requires some assessment of weight and reliability. The standard of proof applicable in civil proceedings is proof on the balance of probabilities. This essentially means that, to prove an allegation, the evidence must establish that it is more probable than not that the allegation is true. Although the civil standard of proof does not strictly apply in administrative decision-making (including the forming of opinions by the Ombudsman), it provides useful guidance.

Where the Ombudsman investigates administrative action on an own initiative basis, s 52 of the Ombudsman Act allows a report on the investigation to be given to the Speaker for tabling in the Assembly, if the Ombudsman considers it appropriate.

Proposed report

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.

Under s 25(2) of the Ombudsman Act, investigators must also comply with these rules when conducting an investigation, and if at any time during the course of an investigation it appears 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 (s 26(3)).

This report was completed as a proposed report in July 2024.

To satisfy these obligations, this Office provided the proposed report to the Director-General of the department and to the Director. The Director-General responded to the proposed report on 23 July 2024 (Appendix A). The Director responded on 25 July 2024 (Appendix B). Where appropriate, the report has been amended to reflect comments made by the Director-General and the Director. The Queensland Ombudsman will monitor implementation of the recommendations.

3. Progress since 2019 report

Following the major investigation in 2019, this investigation examined the Forensic Disability Service's (FDS's) current levels of legislative compliance and the implementation status of the recommendations made in the 2019 report. This chapter details the work done by the FDS to improve systems and processes. They reviewed policies and procedures; established electronic recordkeeping; reviewed individual development plans (IDPs) and the planning process; and improved processes for transitioning people from detention into the community. This chapter includes recommendations to build on those positive foundations.

Practices, policies and procedures

In response to recommendations made in the 2019 report, the Director now publishes policies and procedures online. All the 33 current policies and procedures issued by the Director were recently reviewed and will be due again for review in February 2026.

In addition, to clarify the roles and responsibilities of the positions tasked with administering and operating the FDS, the department developed a comprehensive overarching memorandum of understanding (MOU) and an outline of key roles and responsibilities (Responsibilities Outline). These documents do not appear to be published.

Under s 91 of the FD Act, the Director must issue policies and procedures relating to the detention, care, support and protection of people detained to the FDS. The publication of these policies and procedures on the Director's website (www.directorforensicdisability.qld.gov.au/forensic-disability-service) now ensures staff can access this information and increases the transparency and accountability of the detention environment to the public.

The department continues to issue 'operational practices', which are guidelines that give practical effect to policies and procedures issued by the Director. For example, the Director has issued the *Assisting Clients to Meet Their Medical Needs policy*. To support this policy the department has then created three operational practices/overviews:

1. Health Support for Forensic Disability Clients
2. Client Health File
3. Assisting Clients With Medication in FDS.

The 'operational practices' are not published online. However, the department has confirmed that they are saved to a central system drive to allow easy access for FDS staff.

Each of the Director's policies and procedures, and the department's operational practices, includes a section setting out the specific tasks or actions for any given role. This helps to clarify the roles and responsibilities of people who administer and operate the FDS.

A review of a sample of policies, procedures and operational practices, along with information provided by the department and FDS, revealed the following concerns:

- As the distribution list of the MOU and the Responsibilities Outline was unclear, any practical benefit gained from their development was difficult to assess.
- There is a lack of guidance around how to proceed when there is inconsistency or conflict between the Director's and the department's policies and procedures.
- Across a brief review of six FDS staff induction modules, only two references to departmental operational practices were identified. This means it is not always clear how the information in the operational practices is to be applied.

- The Director's *Regulated Behaviour Control: Use of Seclusion procedure* and the department's *Writing Seclusion Orders overview* remain silent about back-to-back seclusion orders. This ignores the reality of how the FDS used seclusion and the impact on individuals.
- The department's *Liaison and Cooperation with Queensland Emergency Services Agencies protocol* fails to guide FDS officers on how to decide whether contacting police or ambulance is necessary and how to document that decision.
- The department's *Conflict of Interest policy* sets out that employee declarations of conflicts must be recorded, but provides no guidance as to how staff should use or maintain the conflict of interest register that was established in January 2020.

Each of the concerns specified above are addressed further in relevant sections of this report.

Recommendation 1

a) The Director-General reviews operational practices to ensure they continue to give effect to the policies and procedures issued by the Director.

b) The Director-General updates Forensic Disability Service staff induction modules to ensure staff are inducted in the use of the operational practices.

Recordkeeping

The department responded to the identified concerns in the 2019 report and committed funding to improve recordkeeping practices. The department has confirmed that manual records have been digitised and all decisions made under the FD Act are now recorded on the electronic Forensic Disability Act Information System (FDAIS).

As a result, the department was able to readily provide requested information to date for this investigation, and the use of FDAIS was observed during the site visit to the FDS.

The investigation observed decisions recorded in FDAIS and found:

- Information had been recorded on FDAIS in a timely manner so that critical information was available to officers across the facility.
- The FDS met the requirement to maintain full and accurate records of key decisions made under the FD Act about the management, care and support for people detained to the FDS.

The regulated behaviour control register and the practitioner register were viewed during the site visit to the FDS. They complied with the prescribed legislative requirements.

Advice from the Office of the Public Guardian (OPG) during this investigation indicates that community visitors have been able to access the regulated behaviour control register, which provides an oversight mechanism for the use and recording of regulated behaviour control.

The Director conducts annual audits and, in line with s 93 of the FD Act, reports to parliament, (through the the Minister for Seniors and Disability Services) on FDS compliance with recordkeeping standards. This is an important mechanism to ensure compliance with recordkeeping standards.

The investigation found recordkeeping practices at the FDS since the 2019 report have significantly improved and appear generally compliant with the provisions of the FD Act. Other recordkeeping related concerns found by the investigation are addressed in the relevant chapters in the report.

Individual development plans

In response to the 2019 report recommendations:

- The Director reviewed all individual development plans (IDPs) in place for people detained to the FDS at that time and worked with the Administrator to implement a process for ongoing monitoring of IDPs.
- A clinician, funded by the NDIS and engaged by the OPG, worked with the FDS team to incorporate positive behaviour support elements into IDPs.
- The Administrator consolidated all relevant plans into a single-document IDP that is uploaded to FDAIS and can be accessed by all staff.
- The Director monitors and audits the effectiveness of the FDS's use of IDPs and reports the findings in annual reports.

This investigation examined IDPs for people detained to the FDS between 1 July 2021 and 30 June 2022 to determine the level of compliance with the FD Act, with a particular focus on transition planning.

While there has been a significant improvement in the quality, use and review of IDPs for people detained to the FDS, the IDPs could more fully capture participation in programs and activities. (This is discussed in Chapter 4.)

Stakeholders, such as OPG officers and the person detained to the FDS, now regularly participate in IDP review meetings.

IDPs are now more comprehensive and include contemporary, evidence-based approaches to positive behaviour support. They focus on meeting individual rehabilitative, habilitative and transitional goals by providing a variety of programs and activities for each person detained to the FDS.

Programs and activities

In completing the self-assessment tool, the department listed the range of programs and activities available for each person detained to the FDS. Further data sought from the department to clarify program participation showed that people detained to the FDS appear to be regularly (generally weekly) participating in a variety of programs, such as:

- Sex Offender Rehabilitation Program-Intellectual Disability – a program for persons with an intellectual disability who present a moderate to high risk of sexual reoffending
- Adapted Dialectical Behaviour Therapy – a program that focuses on quality of life and therapy-interfering behaviours. The program aims to address issues around emotional and behavioural dysregulation that result in offending and challenging behaviours
- Stepping Stones Program – 42 weekly sessions created to address the emotional regulation needs of offenders with an intellectual disability
- literacy and numeracy programs
- physical exercise sessions
- lifestyle support and diversional activities
- volunteer activities
- transition meetings.

The implementation update noted:

- The Director continues to monitor program delivery at the FDS for adequacy and appropriateness, with improvements noted in the delivery of rehabilitation and offence specific programs.
- The Administrator reviewed and updated the FDS staff structure and rostering system to focus on optimising service and support during active hours (6am – 10pm) for people detained to the FDS.

Case notes sighted by the current investigation indicate that, as programs were delivered, content was reviewed or adapted based on individual responses or engagement. However, while completion reports attempted to summarise modules delivered and individual outcomes, it remains unclear how program effectiveness is assessed or how individual progress, or lack of progress is measured.

As a result, there is no easily accessible way to determine an individual's outstanding treatment needs and no recommendations to address outstanding needs. For example, one IDP, signed off by the relevant authorised position on 30 July 2021, included the following note, but contained no further reference to facilitating the follow-up identified as being required:

> ...further follow-up is recommended to confirm if person meets the criteria of a formal diagnosis for Complex Post Traumatic Stress Disorder to support a more effective trauma informed approach to care and facilitate ongoing psychological treatment.

Staffing and rostering were updated to focus on optimising service during active hours, but it was unclear what training was delivered to staff to equip them to deliver program content. It was also unclear how adequate supervision was provided for clinicians delivering programs.

Recommendation 2

The Director expands the individual development plan framework to track program progress in a way that allows easy identification of outstanding treatment needs for people detained to the Forensic Disability Service.

Recommendation 3

The Director reviews the process of program delivery to people detained to the Forensic Disability Service to ensure:

- staff receive adequate training to be able to comfortably deliver content
- there is adequate supervision for clinicians delivering programs.

Limited community treatment

The Director responded to the identified concerns with a review of the limited community treatment (LCT) policy and procedure and introduced ongoing monitoring of these. The Administrator also developed an LCT practice guide to provide direction for FDS staff about planning, authorising, implementing, recording and reviewing LCT events.

The current investigation notes that, for each person detained to the FDS, LCT conditions are determined by the Mental Health Review Tribunal. To assist FDS staff to ensure LCT is well-planned within those conditions and is aligned with any statutory purpose, the Director now publishes the *Community Treatment and Other Leave policy and procedure* and the department also publishes a related *Limited Community Treatment at the Forensic Disability Service operational practice*.

The Director's *2021–22 Annual Report* states:

> A review of LCT undertaken in June 2022 considered legislative compliance as well as any opportunities for quality improvement. Most clients were supported to engage in a range of LCT activities over the 12-month period however, two clients present with unique challenges in relation to accessing the community, and as such, engaged minimally in LCT.
>
> A sample of authorised LCT event plans was reviewed and was found compliant with subsection s20(3)(a) to (f) of the Act. There was also evidence in LCT plans that risks were assessed with consideration of the community and the proposed venue. The review identified risk management plans were in place for all client LCT events.
>
> It was further observed that since the 2020–2021 review, the FDS had focused on improvements in this area through:
>
> - including specific IDP goals and milestones for LCT for each client
> - improving documentation and processes that support LCT
> - identifying opportunities to potentially further streamline the LCT process
> - promoting the role of LCT in generalising rehabilitation and habilitation gains to real world situations, informing future risk management and improving quality of life
> - ensuring staff continue to build skills and capacity to consider and effectively apply risk mitigation strategies on LCT and maximise incidental learning opportunities during LCT events
> - continuing to identify LCT opportunities that can develop in frequency, variety and allow increased independence, where assessed as appropriate and safe to do so.

This investigation did not specifically review current LCT events. However, we note that LCT planning has been adequately integrated into IDPs. This was shown in the self-assessment tool, where the FDS identified that out of seven people detained to the FDS during this investigation, community treatment had occurred for six of them. However, for the seventh person, LCT had not occurred at all in that same period.

For the person detained to the FDS who did not access any LCT during the period examined in this investigation, the Director's *Second Five-Year Review of Forensic Disability Client: A review of … benefit of care and support*, prepared on 5 December 2022, explained that:

- There was some evidence of planning for other LCT activities, though the person has declined to participate in those activities.
- Further planning has occurred to progress alternative arrangements to better meet the person's preferred arrangements to facilitate LCT (i.e. to engage a non-government organisation provider once transition out of the FDS was finalised).

Risk management framework

The FDS has developed and implemented an evidence-based risk management framework for people detained to the FDS. It has provided training to staff required to use the framework.

In 2020, the Director responded to recommendations made in the 2019 report, by publishing three documents designed to guide clinical risk assessment and management at the FDS: the *Clinical Risk Framework*, the *Clinical Risk Assessment and Management Policy* and the *Clinical Risk Assessment and Management Procedure*. Further details about the framework and the related policy and procedure were published in the *2021–22 Annual Report* as follows:

- The framework conceptualises the risk and principles that underpin good risk management and outlines best practice approaches to risk assessment and management
- The policy highlights the importance of standardised, evidence-based clinical risk assessments to assist with identifying dynamic risk factors that are directly linked to criminal behaviour
- The procedure outlines a range of specific static and dynamic risk assessments as well as key focus areas related to management of risk, such as in relation to LCT and daily clinical risk management.

In the *2020-21 Annual Report*, the Director explained that the FDS and the Director had collaborated to revitalise the FDS model of care (MoC). The aim was to align all intervention activities to ensure the FDS was providing a coherent and consistent approach to promoting development, habilitation, rehabilitation, and transition support to people detained to the FDS.

The implementation update confirmed that:

- The FDS completed implementation of the revitalised MoC in June 2022.
- Evidence-based risk management frameworks are now incorporated into all IDPs.

The Director's *2021–22 Annual Report* also referred to the changes made to the MoC. It noted that to meet the requirements of the FD Act in the provision of rehabilitative and habilitative intervention service delivery the FDS:

- offers an intensive, residential treatment option with rehabilitative programs addressing forensic needs to reduce the risk of recidivism, as well as habilitative programs and interventions aimed at increasing quality of life and the ability to function in the community
- reviews indicate promising progress over the past 12 months implementing the new MoC and identified opportunities to build staff capacity through continued training, supervision and practice leadership.

To help embed the new MoC into the FDS, training development is provided for several of the FDS frameworks and programs including:

- positive behaviour support
- trauma-informed care
- risk needs responsivity model
- good lives model.

Use of regulated behaviour controls

The implementation update confirmed that:

- the Director continues to publicly report on all use of regulated behaviour controls at the FDS through the annual reports
- since June 2020, the FDS has maintained an electronic regulated behaviour control register in FDAIS and that register is accessible by both OPG and the Public Advocate (PA).

This investigation sighted the current electronic register. We noted that the easily accessible centralised location of the register on FDAIS has resulted in timely entry of information into the register by FDS staff.

This means FDS staff can now use the electronic regulated behaviour control register as a mechanism to measure, monitor and review data relating to the use of regulated behaviour controls. This informs reflective practice and compliance-improvement activities.

Medication safety and security

The department advised this investigation that implementation of all Medication Report recommendations was completed in January 2020. As a result:

- The operational practice guide was updated with further guidance to FDS staff to assist with medication recordkeeping.
- The Director gave effect to the *Assisting Clients with their Medical Needs policy*.
- A revised *Clarification of Purpose of Medication form* was implemented via which doctors can notify the FDS of the specific purpose for which a medication has been prescribed.
- Treating doctors now conduct three-monthly reviews of medication.
- All staff have received training in any new and amended processes.
- Induction for new FDS staff includes training around how to support people detained to the FDS with their health needs, including with medication.
- Details of any instances of medication error, or where a person detained to the FDS refuses medication, are recorded in FDAIS as an incident report.

Specifically, in relation to the use of medication as regulated behaviour control (RBC):

- The Director notes that FDAIS enhancement is required to be able to record the use of medication as regulated behaviour control within the RBC register.
- The FDS advises that, while awaiting further enhancements to FDAIS, 'interim measures are in place should regulated behaviour medication need to be utilised at the FDS'.
- The Administrator advises that the FDS has an arrangement with a nursing agency to source staff in the event it becomes necessary to administer behaviour control medication (BCM) on-site, that is, for the primary purpose of controlling a person's behaviour, for example, to restrain a person from behaviours of concern. However, this arrangement is only permitted for fixed dose BCM.
- The Administrator confirmed that the FDS would be unable to admit a person if the FDS received notice that the person required behaviour control medication on an as-needed basis (for example, when exhibiting behaviours of concern). The FDS do not employ a suitably qualified practitioner to administer behaviour control medication on-site, so there would be no capacity to be compliant with s 50 as required.

Recordkeeping regarding medications administered to people detained to the FDS has improved since the 2019 report, with clearer guidance to staff assisting with medical needs and regular reviews of medications now routine. However, medication recordkeeping can be fully digitised through further enhancements to FDAIS and this is needed to record the use of medication for regulated behaviour control.

Recommendation 4

The Director-General and the Director work together to continue expanding the Forensic Disability Act Information System (FDAIS) to allow entries to record the use of medication.

Police attendance at the FDS

The 2019 report noted the department's advice that Queensland Police Service (QPS) attendance was not used as a form of behaviour control under the FD Act. However, this appears contrary to a statement in the self-assessment tool completed by the department for one person detained to the FDS which stated:

> On occasions where he engages in behaviours which place himself and other [sic] at imminent risk of harm, the use of seclusion often appears to be an ineffective and … high risk response, instead contacting QPS … appears to be a more appropriate, less restrictive, and less traumatic … strategy.

The department has advised that implementation of recommendation 10 from the 2019 report involved the FDS consulting with QPS to create the *Liaison and Cooperation with Queensland Emergency Services Agencies (Police, Fire and Ambulance) engagement protocol* (the emergency protocol). The emergency protocol provides that twice a year the FDS arranges liaison meetings with the senior sergeant from a nominated police station.

The purpose of these liaison meetings includes:

- improving communication between the FDS and the QPS
- undertaking proactive planning in relation to high-risk people detained to the FDS
- reviewing incidents that involved QPS responses
- reviewing existing protocols and arrangements.

The implementation update proposed that the protocol would include clear guidance about the scope and application of circumstances in which QPS should be called to attend the FDS. However, the current emergency protocol remains silent in terms of providing guidance to staff about how to decide whether it is appropriate to contact police to attend the FDS. Therefore, when QPS attended the FDS, the purpose of their attendance was not always clear and records did not clearly explain why it was appropriate. This meant that it was unclear whether QPS was being called to attend the FDS as a form of behaviour control, for example, in place of seclusion.

Establishing a closer relationship between FDS and QPS will likely benefit both staff and people detained to the FDS, by improving communication and enabling joint planning. However, more detailed practical guidance for staff about how to approach the decision to contact police and record that decision, will help ensure a process that safeguards both staff and people detained to the FDS.

Recommendation 5

The Director-General, in consultation with the Director, amends the *Liaison and Cooperation with Queensland Emergency Services Agencies protocol* to include guidance on how to:

- determine if contacting police or ambulance is necessary
- properly record that decision.

Transition from the FDS

The implementation update noted that:

- Four people detained to the FDS have successfully transitioned from the FDS, either to the community or to extended overnight LCT, since the 2019 report.
- Transition planning for each person detained to the FDS is now incorporated within their individual IDP and is reviewed every three months.
- Targeted transition planning occurs for each person detained to the FDS as they progress towards completion of their intervention pathway and/or once suitable accommodation and support pathways are identified.
- Transition is specifically addressed in the Director's five-year reviews for long-term clients.

In response to the proposed report, the department explained that of the seven people detained to the FDS during the investigation period:

- four have successfully transitioned and reintegrated back to community
- one was returned by the Mental Health Court to a health setting that was considered more suitable
- two are proceeding with transitioning to less restrictive settings in the community.

During the investigation, a person with complex needs who had been detained to the FDS for more than 10 years, was transitioned from residing at the FDS to supportive living in the community. Of the people currently residing at the FDS, none has been there for longer than three years, which accords with the aim for the FDS to be a transitional facility.

Since the 2019 report, the NDIS has been enacted. An example of how the NDIS assists people detained to the FDS is through improved relationships funding (IRF).

IRF allows for specialist behavioural intervention support and the development of a positive behaviour support plan (PBSP) to be incorporated into the IDPs. PBSPs are prepared by external NDIS-registered behaviour specialist providers in conjunction with the FDS. They contain strategies to improve the quality of life of the person. Such strategies include preparing for changes in routines to reduce the likelihood of challenging behaviours, establishing consistent therapeutic support, and creating a supportive communication environment.

For people with complex needs who are detained to the FDS, the Office of Public Guardian (OPG) highlights that significant barriers remain that can impede their transition from the FDS to the community. These include:

- a lack of suitable accommodation options which meet individual disability, behavioural, and forensic risk support needs
- the willingness of authorised mental health services to accept the transfer
- funding gaps.

In relation to funding gaps, the OPG points out there can be gaps between the level of support required by the person (to meet Mental Health Tribunal conditions placed on the Forensic Order that may relate to offending behaviours), and the person's funded level of NDIS-assessed disability support.

The NDIS does not fund support to mitigate offending risk or criminogenic behaviours; but the Mental Health Tribunal, in adhering to the mental health statutory framework, approves limited community treatment or supports transition to community, only if it considers offending risk has been mitigated and there is no unacceptable risk to community safety.

The OPG suggests that a joint stakeholder approach for funding is needed between state (health, justice and disability services) and federal agencies (National Disability Insurance Agency). This will ensure access to an appropriate level of long-term funding to facilitate and support transition out of the FDS and into the community for people with complex needs.

The FDS is closer to achieving its goal of being a transitional facility. The FDS now makes transition planning part of each individual development plan and includes stakeholders in managing the transition progression, especially for people with complex needs.

Recommendation 6

The Director continues to progress the transition of all people detained to the Forensic Disability Service (FDS), with a particular focus on developing processes to monitor and prevent the detention of any person at the FDS for extended durations.

Legal responsibility for persons not at FDS

The Director advised us that the person referred to in the 2019 report, who was legally under the responsibility of the FDS, but was not housed at the FDS, was transitioned out of FDS responsibility in July 2021.

In response to the proposed report, the department has advised it received legal advice in relation to the person referred to in the 2019 report. The legal advice included a clear description of the roles and responsibilities of the FDS and the Senior Practitioner in relation to the client not residing at the FDS as the time. The department also advised the legal advice remains current and would apply if the circumstances were repeated for any future clients.

During the investigation period, all people detained to the FDS were residing at the FDS.

Health care

In the implementation update, in relation to the provision of health care to people detained to the FDS, the department advised:

- The Director's *Assisting Clients to Meet Their Medical Needs policy* and *Trauma Informed Care policy* remain in effect.
- The Director continues to monitor the FDS approach to meeting the cultural needs of people detained to the FDS through IDPs. For example, they identify the support required for individual cultural needs and specific cultural goals.
- The FDS is subject to the department's cultural capability action plan.
- Induction for FDS staff includes a positive behaviour support session. This is followed by online modules for positive approaches to behaviour, safer de-escalation, and understanding trauma and trauma-informed approaches.

A review of the provision of healthcare to people detained to the FDS was not a focus of the current investigation. However, the investigation notes the improvements since the 2019 report.

Organisational culture

The department's implementation update advised:

- A new operational and service structure and a new rostering system were implemented on 21 June 2021.
- The new staffing profile focuses on ensuring services and support are optimised for clients during active hours (6am – 10pm).
- The Director's *Management of Complaints about the Care Support and Protection of Forensic Disability Clients policy* remains in place.
- A conflict of interest register was established by January 2020.
- The *Conflict of Interest policy* is published on the department's intranet, though it makes no direct reference to any conflict of interest register.
- Staff are currently up-to-date with compulsory conflict of interest training.

An organisational culture review was not a focus of this investigation. However, it is pleasing to note the implementation of the 2019 report recommendations.

Recommendation 7

The Director-General updates the *Conflict of Interest policy* to include guidance about use and maintenance of the conflict of interest register.

Governance structures

Relationship between department and Director

Since the 2019 report, the department and the Director have taken action to clarify the relationship between them in the context of the statutory obligations imposed by the FD Act.

In June 2020, the department and the Director developed an outline of responsibilities, to summarise FDS functions and obligations and to clarify whether the department or the Director is responsible for any given function.

In May 2024, they also executed a memorandum of understanding (MOU) between them to formalise the agreement between the department and Director about their respective roles and responsibilities.

However, both the outline of responsibilities and the MOU:

- fail to identify who is responsible for the conflicts of interest register
- fail to include any reference to complaints, despite the Director's *Management of Complaints about the Care Support and Protection of Forensic Disability Clients policy* specifying certain responsibilities for each of the Administrator of the FDS and the Director in the context of handling complaints.

Recommendation 8

The department, in collaboration with the Director, updates the outline of responsibilities and the memorandum of understanding to clearly identify responsibilities in relation to conflicts of interest and managing complaints.

Content of audits and annual reports

The Director continues to conduct audits of various FDS processes and functions and continues to report on these in the annual reports.

The independent role of Director carries high level obligations to protect the rights of people detained to the FDS. One such obligation is in s 93 of the FD Act, which requires the Director to provide an annual report on the administration of the FD Act to the relevant minister (currently the Minister for Seniors and Disability Services), for tabling in the Queensland Parliament.

This investigation determined that information in the Director's annual reports directly matches the information and findings as reported to the department in the Director's three most recent audit or compliance reports, about the conducting of searches, the completion of IDP's and the use of positive behaviour support and trauma-informed care.

This demonstrates the transparency and accountability of the information being reported with respect to those audits. However, concerns remain around the transparency of the information reported in the Director's annual reports in relation to the use of seclusion. Table 1 sets out the Director's statements in reference to the almost permanent seclusion experienced by one person during the decade-long duration they were detained to the FDS.

In each report, the Director explains that ongoing opportunities have been presented to the person to reduce the use of seclusion, encourage appropriate engagement with others, and engage with activities. However, as the person was secluded almost continuously, it is difficult to understand how the opportunities were provided.

The content included in each report appears to be heavily templated, with similar but vague statements and descriptions that appear to minimise events at the FDS. For example, despite the person's seclusion remaining almost permanent, the Director's annual reports described the person's seclusion in statements such as 'Seclusion has been used more extensively for the person…' or that 'seclusion was a more consistent feature for the person…'.

Table 1: Director's statements in relation to seclusion

2019–2020	• During 2019–20, two clients were subject to seclusion. One client was secluded on one occasion for a brief period. For another client, seclusion was a more consistent feature due to the client's high level of complexity and risk however, there have been ongoing opportunities presented to the client to reduce the use of seclusion, encourage appropriate engagement with others, and engage with activities including LCT. • … the level of detail and clarity varied across orders and authors. Opportunities for improvement were noted within the relevant documentation regarding the level of detail provided in some instances.
2020–2021	• During 2020–21, one client was subject to seclusion. Seclusion has been used extensively within this client's model of support due to the significant dynamic risk and complexity presented. Despite the use of seclusion, there have been ongoing opportunities presented to the client to reduce the use of seclusion, encourage appropriate engagement with others, and engage with activities including LCT. • It was identified that there could be improved documentation of the less restrictive strategies that have been tried prior to ordering seclusion. • … it was recommended that the Senior Practitioner provide greater detailed strategies in the client's IDP regarding how to avoid, reduce and eliminate any further use of seclusion for better compliance with s 73 of the Act.
2021–2022	• Seclusion has been used more extensively for one client due to the significant dynamic risk and complexity presented. Despite the use of seclusion, ongoing opportunities have been presented to the client to reduce the use of seclusion, to encourage appropriate engagement with others, and to engage with activities including LCT. A Plan for the Reduction and Elimination of Use of Seclusion is also in place for this client. • During 2021–22, four clients were subject to seclusion. … More specifically, over the twelve-month period, one client was placed into seclusion on 15 occasions, one client … on three occasions, and another client … on three occasions. These instances of seclusion ceased when the clients were assessed as no longer an imminent risk… • … a need to better document consideration of "no less restrictive way" as part of decision making was identified in some instances.

The annual report provides information on the statutory responsibilities and key activities of the Director and outlines the function and operation of the FDS and its compliance with the relevant legislative provisions, governance and administration as contained in the FD Act. Therefore, it is important that the information being reported accurately reflects actual FDS operations.

Recommendation 9

To ensure transparency of Forensic Disability Service operations, the Director ensures annual reports include current and detailed information about the use of seclusion orders.

4. Use of seclusion

One of the most serious concerns identified in the 2019 report was the use of prolonged seclusion as a form of regulated behaviour control at the FDS.

The 2019 report identified that seclusion is designed as a time-limited response intended to allow a person to regain control of their behaviour, and that it has been found to cause adverse effects, including distress and compromising therapeutic relationships.

However, the 2019 report found that one person detained to the FDS had been subjected to almost continuous seclusion for six years between 2012 and 2018. The report stated that the approach to secluding this person was, amongst other things, oppressive.

This situation continued after the 2019 report, including during the period of this investigation (from 2021–2022). An ABC report in October 2023 indicated that the situation was ongoing at that time.

However, in December 2023, the department advised that no person currently residing at the FDS is subject to ongoing seclusion on a long-term basis. This is a welcome development.

As part of its responses to the self-assessment tool, the FDS also advised that IDPs now include a 'seclusion reduction plan'. This plan details strategies for avoiding, reducing or eliminating any further use of seclusion and is contained within an overarching positive behaviour support plan (PBSP). The PBSP is a broader plan containing strategies designed to improve the quality of life of the person, including:

- preparing for changes in routines to reduce the likelihood of challenging behaviours
- establishing consistent therapeutic support
- creating a supportive communication environment.

The Director has also issued policies and procedures that relate to seclusion. On 1 February 2023, the Director reissued the *Regulated Behaviour Control: Use of Seclusion* procedure.

Review of application of the FD Act to seclusion decisions

The use of seclusion at the FDS is governed by the FD Act.

Under s 46 of the FD Act, 'seclusion' of a person detained to the FDS is defined as:

> ... the confinement of the client at any time of the day or night alone in a room or area from which the client's free exit is prevented.

Section 61(2) of the FD Act strictly regulates the use of seclusion. In every decision to authorise seclusion, the decision-maker must be reasonably satisfied that:

> a) the seclusion is necessary to protect the client or other persons from imminent physical harm; and
>
> b) there is no less restrictive way to protect the client's health and safety or to protect others.

Each seclusion order may only be authorised for a maximum of three hours.
As a consequence, if seclusion is considered necessary to continue for a further period of time, a new order of up to three hours is required.

Given the seriousness of the power to seclude another person, it should only be used as a last resort where there are no other less restrictive ways to protect a person's health and safety (ss 42(a)-(b)). It must also be used in a way that:

- is in accordance with human rights
- aims to reduce or eliminate the need for its use
- ensures transparency and accountability.

Given the serious impacts of seclusion decisions, we reviewed a sample of seclusion orders made during the investigation period, between July 2021 and June 2022, to assess whether they complied with s 61(2) of the FD Act.

The seclusion orders that we reviewed were made in relation to three people. One of them was the same person referred to in the 2019 report, who was subject to almost continuous seclusion for six years from 2012 to 2018.

Most of the orders reviewed contained a high degree of repetition. For example:

- There were identical spelling or grammatical errors in the same words or phrases in the same places in multiple orders, or little variation in wording when outlining presenting risks.
- The orders showed a reliance on historical risk factors to continue the seclusion, despite observations indicating an absence of imminent risk.
- The orders noted that clinical risks associated with the isolation and deprivation of human contact due to ongoing seclusion included deterioration of the person's psychological and psychosocial wellbeing and reinforcement of maladaptive coping strategies.
- There was a failure to adequately detail how the decision-maker had arrived at the conclusion that the limitation to human rights was reasonable and justifiable.
- There was a lack of documented strategies in place to show that there had been attempts to reduce, eliminate and avoid seclusion for people detained to the FDS.
- Circular reasoning was used to justify the use of seclusion, such as orders stating 'As per IDP, seclusion remains the least restrictive strategy', but to demonstrate why seclusion is the least restrictive strategy, the IDP refers only to historic risk factors and that the person has declined to be released from seclusion.

Imminent physical harm

The first requirement of s 61(2) is that the seclusion is necessary to protect the person detained or other people from imminent physical harm. However, the orders reviewed showed a reliance on historical risk factors to continue the use of seclusion, as observations indicated an absence of imminent risk.

Some of the orders for the person previously subjected to almost continuous seclusion included statements contrary to a view that there was an imminent risk of harm, such as:

> - Client is currently in bed
> - Client is content completing independent activities
> - Client is engaged with staff at the window servery
> - Client currently talking to staff at the servery and appears to be settled
> - Client is currently settled despite discomfort (from physical ailment)
> - Client spent the previous period helping staff prepare his dinner and have his meal
> - Client appears to be in a settled mood and is engaging well
> - At time of assessment client had been engaging appropriately with staff members.

No less restrictive way available

The second requirement of s 61(2) is that there is no less restrictive way to protect the person's health and safety or to protect others. However, in the orders reviewed, there was limited documentation to demonstrate strategies to attempt to reduce, eliminate and avoid seclusion for people detained to the FDS. This aligned with the department's advice to the investigation in its response to the self-assessment tool was that 'No least restricted [sic] options trialled'.

In the case of the person previously subjected to almost continuous seclusion, some of the orders used circular reasoning or hypothetical scenarios to justify the use of seclusion. For example:

- As already noted above there were orders stating, 'As per IDP, seclusion remains the least restrictive strategy'. However, to demonstrate why seclusion is the least restrictive strategy, the IDP refers only to historic risk factors and that the person has chosen to continue seclusion.
- It was not always clear what other less restrictive options have been trialled. Instead, the person's apparent choice to remain in seclusion and historic risk factors were cited as reasons to support the decision to continue the person's seclusion.
- Some orders stated that evidence suggested if staff were to end seclusion, despite the person's request not to, there would likely be a behaviour escalation in which the person would cause harm to himself and others. The order would then note that as that (anticipated, but hypothetical) behaviour escalation would cause further restrictions to be placed upon the person, seclusion would no longer be the least restrictive practice, and thus the decision would be made that seclusion should be continued for the current period.

Considering cumulative impact of ongoing seclusion

Currently, s 62(2)(c) of the FD Act requires only that the written authorisation of seclusion must not exceed three hours. There is no further guidance for staff in the FD Act, nor in departmental or FDS policies or procedures, about what to consider in situations where seclusion does exceed three hours. As a result, where seclusion is ongoing, it is unclear how this is factored into the FDS' subsequent decisions to continue seclusion.

Between 14 July 2021 and 19 April 2022, the person subjected to almost continuous seclusion had only three breaks from seclusion as follows:

- 18 July 2021: 1 minute seclusion break to allow cleaning by staff after fire sprinkler went off accidentally.
- 11–12 August 2021, 5.15pm to 12.38pm: 7.5 hour seclusion break for the person to attend Princess Alexandra Hospital due to dental pain.
- 17 September 2021, 11.30am to 1.25pm: Almost 2 hour seclusion break to attend FDS sitewide social gathering.

For all other times during this period, the same person was subject to hundreds of consecutive seclusion orders, each lasting three hours. As this person had been subject to almost continuous seclusion since 2012, seclusion had been authorised by an ongoing stream of tens of thousands of consecutive three-hour orders for around 10 years.

It is not apparent how each previous order was considered when deciding to impose a further three-hour seclusion order. It is reasonable to expect that subsequent orders should have considered the proposed three-hour seclusion period, as well as the cumulative periods of seclusion which the person had already experienced.

FD Act amendments to improve governance of seclusion

The sections of the FD Act governing the use of seclusion have not changed since the 2019 report. These sections are clearly inadequate, as they do not provide guidance or guardrails on the use of repeated seclusion orders to continue seclusion beyond a period of three hours.

It is imperative that the FD Act be improved to seek to avoid the recurrence of ongoing, continuous seclusion in the future.

The FD Act should be reviewed and amended to address this situation, including:

- providing guidance about decision-making in situations where it is considered necessary for seclusion to exceed three hours
- escalation of seclusion decisions to more senior officers when the decision results in a person being secluded for a cumulative period of more than three hours
- allowing for rights of external review of longer periods of seclusion
- clear provision for how people detained to the FDS can obtain support to access review.

Legislative amendments can take time to be implemented. While waiting for legislative amendments, current FDS and departmental policies and procedures governing the use of seclusion should be reviewed so that they better address the issue of ongoing seclusion.

Any changes to the FD Act or policies and procedures should also accord with the *National Safety Priorities in Mental Health: a national plan for reducing harm*, which included reducing the use of, and where possible, eliminating seclusion and restraint.

The sections governing the use of seclusion in the *Mental Health Act 2016* may also be useful for comparison.

On the basis of the above information, I have formed the following opinion and make the following recommendations.

In reaching this opinion, I note that in the 2019 report the Ombudsman expressed the opinion that subjecting a person to almost continuous seclusion for six years from 2012 to 2018 was oppressive.

Opinion 1

During the 2021–2022 period, seclusion orders did not always include:

- adequate reasoning to show how the decision-maker could have been reasonably satisfied there was an imminent risk of harm and no less restrictive way to protect health and safety, as required by s 61(2) of the FD Act.
- adequate consideration of the cumulative impacts of seclusion on a person who was secluded almost continuously during that period.

For the purposes of s 49(2)(b) of the Ombudsman Act, this is administrative action that is unreasonable, and its effect on the person who was secluded on an almost continuous basis continued to be oppressive.

Recommendation 10

The Director-General, in consultation with the Director, reviews the FD Act, with a view to seeking amendments that provide:

a) guidance about decision-making in situations where it is considered necessary for seclusion to exceed three hours
b) guidance on reducing and, where possible, eliminating restraint and seclusion
c) escalation of seclusion decisions to more senior officers when the decision results in a person being secluded for a cumulative period of more than three hours
d) rights of external review of longer periods of seclusion
e) clear provision for how people detained to the FDS can obtain support to access review.

Recommendation 11

The Director reviews and updates the policies and procedures governing the use of seclusion, to provide improved guidance about the matters listed in recommendation 10.

Applying the *Human Rights Act 2019* to seclusion decisions

The 2019 report was completed before the full enactment of the *Human Rights Act 2019* (HR Act).

Section 58 of the HR Act requires government agencies to act and make decisions in a way that is compatible with human rights, and to properly consider human rights when making decisions. This is in addition to the FD Acts' own requirements that human rights impacts be considered.

The HR Act makes clear that rights can be limited, but only after careful consideration and only in a way that is necessary, justifiable and proportionate.

As explained in the Queensland Human Rights Commission's guide on the HR Act for public entities, s 13(2) of the HR Act provides guidance on when human rights may be limited. It lists the following factors for consideration:

a) the nature of the human right
b) the nature of the purpose of the limitation
c) the relationship between the limitation and its purpose, including whether the limitation helps to achieve the purpose
d) whether there are any less restrictive and reasonably available ways to achieve the purpose
e) the importance of the purpose of the limitation
f) the importance of preserving the human right, taking into account the nature and extent of the limitation on the human right
g) the balance between the matters mentioned in paragraphs (e) and (f).

The Director has published a policy regarding Human Rights which states:

> FDS staff should clearly document how they gave proper consideration to human rights before deciding to limit a client's human rights, or taking action which limits human rights.
>
> ...
>
> Where a decision limits a human right, it does not automatically mean that the decision is incompatible with human rights. For example, the decision may be authorised by law, and as such, demonstrably justifiable in our free and democratic society. However, where a decision is made that limits a client's human rights, this may only occur after careful consideration and where the decision maker is satisfied that the decision is justifiable and the least restrictive course of action.

To assess how the HR Act has been applied to seclusion decisions, we reviewed a sample of seclusion orders across 2021 and 2022.

The review found that the FDS used six broadly similar paragraphs to explain how the human rights of people detained to the FDS were considered in making the decision to approve seclusion orders. Three of these paragraphs were used on repeated occasions.

One order, dated 24 December 2021, gave no consideration to the person's human rights.

In the other 14 orders:

- there was identification of the human rights that may be impacted by the decision
- it was usually explained that the seclusion was approved to ensure the health and safety of the person who is detained, as well as other people (visitors, staff) and property
- it was usually stated that there were no other less restrictive and reasonably available strategies that could have been used to achieve the same purpose and ensure people were kept safe. However, little information was then provided as to what other strategies were tried nor why they were not viable, other than the person wishes to remain in seclusion
- the decision-maker states they have decided that any limitation to the person's human rights is reasonable and justified.

However, apart from two occasions there are no other reasons provided to explain why such limitation is reasonable. For the two occasions where it is stated that the limitation is reasonable:

- the person has access to a large living area, natural light, fresh air, adequate sustenance, and was able to engage face-to-face with staff at any time
- a hypothetical scenario suggested that the person would cause harm if released from seclusion and, for that reason, the limitation caused by seclusion should continue.

The examples reviewed lacked adequate explanations or reasons. This means it is not possible to assess whether those seclusion decisions satisfied the requirements of the HR Act that a human right only be limited to the extent that is reasonable or demonstrably justifiable.

It is also not possible to comment on whether the FDS has made those decisions in a way that is compatible with human rights, as required by the HR Act.

The FDS policies about implementing the HR Act should be amended to emphasise the importance of recording clear reasoning for decisions that discharge its obligations under the HR Act. This includes clear reasoning about why the limitation to the person's human rights is reasonable and justified. Training should also be provided to staff about how to implement these requirements when making decisions.

I have formed the following opinion and make the following recommendation.

Opinion 2

Seclusion orders did not always include adequate reasoning to show how, in the circumstances, the decision was compatible with human rights or that the decision-maker had given proper consideration to human rights, as required by s 58(1) of the HR Act.

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

Recommendation 12

The Director reviews the *Human Rights Policy*, and provides officers with associated training, to ensure clear guidance is being provided to staff to facilitate the proper recording of:

a) the identification and consideration of all relevant human rights that may be impacted by a decision

b) cogent and persuasive evidence to support any decision to limit a human right.

Appendix

Appendix A: D Mulkerin response to A Reilly, 23 July 2024

Queensland Government

Your reference: 2022/08221

Office of the
Director-General

Department of
Child Safety, Seniors and Disability Services

Mr Anthony Reilly
Queensland Ombudsman
investigations@ombudsman.qld.gov.au

Dear Mr Reilly

Response to proposed Forensic Disability Service second report

Thank you for your letter of 4 July 2024 regarding your office's investigation of the implementation of recommendations made in the 2019 Forensic Disability Service report and the proposed report for this investigation.

I appreciate the time you and your team made available to brief the department on the proposed report. Following this meeting Mr Matthew Lupi, Deputy Director-General, Disability Accommodation, Respite and Forensic Services, sought to clarify a few aspects of the report with Ms Tracy McNally, Acting Principal Investigator. These matters included:

- Clarifying that the snapshot reference to publishing operational practices would be updated to be consistent with wording on page 7.
- Discussing the use of the phrase "no longer detaining" on pages 14 and 18.

I understand that in addition to this the department has provided your office with a further three documents that relate to the Conflict of Interest Policy and the Memorandum of Understanding with the Director of Forensic Disability. I note these additional documents may assist to deal with some of the matters raised in the proposed report including Recommendation 7 and, as such, the final report may be updated accordingly.

Our formal response to the Proposed Report is attached.

I understand the Director of Forensic Disability will be providing a separate response in her capacity as an Independent Statutory Officer.

I look forward to receiving your final report, at which time we will respond specifically to each recommendation, including our proposals to implement them.

Should you require any further information or assistance in relation to this matter, please contact Mr Matthew Lupi on 3097 6346 or email to Matthew.Lupi@dsdsatsip.qld.gov.au.

Yours sincerely

Deidre Mulkerin
Director-General

23 / 7 / 2024

Enc (1)

Attachment 1

Response to Proposed Report – *Ombudsman Act 2001* (Qld) s50

Forensic Disability Service – second report

The department welcomed this investigation and visit to the service from the Ombudsman in February 2023. Significant work had been undertaken to respond to the recommendations of the Ombudsman's 2019 Report following an extensive own-initiative investigation in 2018.

We welcome the findings of this report and the conclusions that significant improvements have been made since 2019. As a result of the implementation of recommendations from that report there has been marked improvement in many areas and most notably in the effective care, treatment and transition of clients. This second report shows that the benefits of the first investigation are being realised.

The department is particularly proud of the achievements that we have made in relation to the effective treatment, rehabilitation, transition and reintegration into the community of clients over the past five years. Pleasingly, of the seven clients at the Forensic Disability Service (FDS) during the 2021-22 period of this investigation, four have successfully transitioned and reintegrated back to community, one was returned by the Mental Health Court to a health setting that was considered more suitable and the remaining two are well on their way to transitioning to less restrictive settings in the community.

Opinions

The department notes the opinions related to the use of seclusion orders and the need to improve assessment, documentation and importantly considering Human Rights in the context of cumulative harm where orders are used frequently with any client.

The department will respond fully to Recommendations 10, 11 and 12 in partnership with the Director of Forensic Disability upon receipt of the Final Report.

Progress since 2019 Report

Practices, policies and procedures

Operational practices are reviewed every two (2) years or sooner if there are emerging issues and changes in policies issued by the Director of Forensic Disability. They are easily accessible to all staff electronically and in hard copy. (Refer Page 7)

Staff receive thorough training through induction on the practices and complete a Policy, Procedure and Operational Practice (PPOP) workbook which is an assessment-based tool to reinforce staff understanding of operational practices. Responses are reviewed and assessed by an Operational Team Leader, with feedback provided and included in performance discussions with staff. (Refer Page 8)

Individual Development Plans (IDPs) and Programs and Activities

I am pleased that you were able to observe the improvements made to IDPs and the Clinical Services and Programs delivered at the FDS. (Refer Page 9)

Attachment 1

I can advise that further changes have been made since your investigations began in early 2023 that address some of the areas you have highlighted as areas for improvement. Specifically:

- The process for IDPs was updated in 2023 and came into effect over the last six months.
- IDPs now include the program offered to and delivered for each client. The clinical assessment informs the plan and program offerings to respond to the identified rehabilitation and habilitation needs and this is now outlined in the clinical treatment plan that covers specific program provision and treatment for each client.
- These details are added to the client's individual treatment goals with progress or changes updated ongoing in their treatment plan.

Medication safety and security

I note the observation of improvements to record keeping regarding medications administered to clients. The current electronic record keeping system, Forensic Disability Act Information System (FDAIS), already has capacity to record all regulated behaviour control decisions including recording where medication is administered for behaviour control. (Refer Page 13)

There were no instances where medication was approved for or used for behaviour control. If there were there is existing capacity to record this in FDAIS.

That said, the department supports increasing the functionality of the system to include record keeping for all medications administered to clients including those not for regulated behaviour control.

Police attendance at the FDS

The advice provided by the department in 2019 around police attendance was specific to one client at that time. The statement, that the use of police for that client during the period of 2011 to 2018 (the review period) was not a form of behaviour control was correct.

The later reference to police attendance (2022) was for a different client and was deemed necessary at that point to respond to significant risk to staff, public and client safety. All other strategies to manage and regulate the client behaviour at the time had been unsuccessful.

The two statements are not incompatible or contrary. The comment in 2022 does not invalidate the earlier statement as they were specific to an individual at a point in time. (Refer Page 13)

Legal responsibility for person not at FDS

The department did receive legal advice that included a very clear description of the roles and responsibilities of the FDS and the Senior Practitioner in relation to the client not residing at the FDS at the time. This advice remains current and would apply if the circumstances were repeated for a client into the future. (Refer Page 15)

Appendix B: E Lane response to A Reilly, 25 July 2024

Director of
Forensic Disability

Your reference: 2022/08221
Our reference: DFD COM 009-2024

25 July 2024

Mr Anthony Reilly
Queensland Ombudsman
GPO Box 3314
BRISBANE QLD 4001

Sent by email: investigations@ombudsman.qld.gov.au

Dear Mr Reilly

Investigation of the implementation of recommendations made in the 2019 Forensic Disability Service (FDS) report

Thank you for the opportunity to provide a comment on the proposed report.

I welcome your report and recommendations. I note your recognition of improved systems and processes and recommendations for continuous improvement. I am committed to supporting improvements at the Forensic Disability Service (FDS), within the functions of my role.

The Director of Forensic Disability has issued policies and procedures that align with the *Forensic Disability Act 2011* (FDA) and provide guidance in relation to areas of practice that you have highlighted in your report including individual development planning, use of regulated behaviour control, transfer of responsibility and exit from the FDS and human rights. Policies and procedures were updated in January 2023 and are due for review by 2026. However, where it is identified that clarification or improvements may assist in better supporting the proper administration of the FDA, I am supportive of reviewing and updating policies and procedures as required.

The Director of Forensic Disability has developed a compliance and monitoring framework that is reviewed annually. The framework is underpinned by principles of risk, proportionality, transparency and accountability, and impartiality and objectivity. In

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undertaking compliance and quality improvement activities, the Director seeks to understand how legislation and policies and procedures are given effect and makes recommendations to ensure compliance and for quality improvement. Your report includes a range of findings and recommendations in practice areas that align with compliance monitoring and quality improvement activities that have been, and will continue to be, undertaken by the Director of Forensic Disability, including individual development planning, rehabilitative programs, assisting clients with their medical needs and regulated behaviour control. These activities provide a platform to engage with the FDS to develop and monitor continuous improvement actions to ensure the protection of the rights of clients and that clients' involuntary detention, assessment care and support complies with the FDA.

The Director of Forensic Disability recognises the importance of progressing safe transition for clients and preventing extended stays and continues to engage with the FDS and other relevant stakeholders to ensure that there is an ongoing focus on working towards client transition.

I support your recommendation in relation to reviewing the *Forensic Disability Act 2011* (FDA). A review of the operation of the FDA was undertaken in 2018 by the Department of Communities, Disability Services and Seniors and proposed that a number of amendments be considered to enhance the legislative framework. A further review of the FDA would assist in identifying any amendments that may be required, including in relation to the use of seclusion.

In progressing any recommendations, there is a commitment by the Director of Forensic Disability to work with the Department to clarify and identify each of our roles in undertaking and/or supporting activities that will contribute to ongoing improvements at the FDS.

Yours sincerely

Elizabeth Lane
Director of Forensic Disability
Queensland Government

Glossary

Term	Meaning
the Administrator	The person appointed to the position of Administrator
A-DBT	Adapted Dialectical Behaviour Therapy
AMHS	Authorised mental health service
AWOP	absent without permission
BCM	Behaviour control medication, medication used for the primary purpose of controlling the behaviour of a person detained to the FDS
CCTV	Closed-circuit television
CHART	Clinical, Habilitative and Rehabilitative Team
CRPD	Convention on the Rights of People with Disabilities
the department	Department of Child Safety, Seniors and Disability Services, formerly the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships
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
the Director-General	Director-General, Department of Child Safety, Seniors and Disability Services
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
IRF	Improved relationships funding
LCT	Limited community treatment
MHA 2000	*Mental Health Act 2000* (Qld) (repealed)
MHA 2016	*Mental Health Act 2016* (Qld)
MHRT	Mental Health Review Tribunal
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organisation

Term	Meaning
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
The Park	Centre for Mental Health, Treatment, Research and Education, a specialist psychiatric hospital located in Wacol in close physical proximity to the FDS
PBSP	Positive behaviour support plan
PSRT	Public Safety Response Team
QAI	Queensland Advocacy for Inclusion
QPS	Queensland Police Service
QPS OPM	Queensland Police Service *Operational Procedures Manual*
RBC	Regulated behaviour control
SORP-ID	Sex Offender Rehabilitation Program - Intellectual Disability
SDA	Specialist Disability Accommodation

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