

## Media release

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For immediate release

### **Ombudsman presents the Forensic Disability Service – second report**

The Queensland Ombudsman's report, *Forensic Disability Service – second report: A review of the implementation of recommendations made in the 2019 Forensic Disability Service report* (the 2024 report), was tabled by the Honourable Curtis Pitt MP, Speaker of the Queensland Parliament on Tuesday 13 August 2024.

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).

In November 2022, the Ombudsman began a new own-initiative investigation under the *Ombudsman Act 2001*, to examine the FDS's current levels of legislative compliance, with both the *Forensic Disability Act 2011* (the FD Act) and the *Human Rights Act 2019* (the HR Act). It also examined the implementation of the 2019 report recommendations.

The 2024 and 2019 reports investigate the treatment of people detained at the FDS, a facility for the involuntary detention and care of people found unfit to stand trial as a result of an intellectual or cognitive disability.

The 2024 report identifies that since the 2019 report, 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, the Ombudsman recommends:

- 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.

The Queensland Ombudsman, Mr Anthony Reilly, said, "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.”

Mr Reilly said, “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.”

## About the Ombudsman

The Queensland Ombudsman is an independent officer of the Parliament.

The Ombudsman ensures public agencies make fair and balanced decisions for Queenslanders by investigating complaints and conducting own-initiative investigations that tackle broader, systemic concerns.

The Ombudsman can investigate complaints about state government departments, local councils and publicly-funded universities.

The Ombudsman can make recommendations to rectify unfair or unjust decisions and improve administrative practice.

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## Key facts about the *Forensic Disability Service – second report*

### What is the Forensic Disability Service?

The Forensic Disability Service (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 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.

### Why did the Ombudsman investigate in 2019?

The 2019 report was initiated as a result of information received by the Office of the Queensland Ombudsman about the quality of care at the FDS.

That information raised serious concerns about the treatment of persons detained to the FDS, particularly: the length of their detention, their care during detention, the lack of adequate programs to support their habilitation and rehabilitation, delays in transitioning them from the FDS to less restrictive environments and the use of seclusion and other regulated behaviour controls.

### What recent developments occurred since the 2019 report?

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.

### What were the main objectives of the investigation?

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

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

### **What does the Queensland Ombudsman investigate?**

This investigation was conducted under the *Ombudsman Act 2001*.

When investigating the administrative actions of public sector agencies, the Ombudsman must consider whether their actions are:

- unlawful, unreasonable or unjust
- based on irrelevant considerations
- based on a mistake of law or fact
- wrong.

The Ombudsman is empowered to make recommendations to the principal officer of an agency that action be taken to rectify maladministration to improve the agency's policies, practices or procedures to minimise the prospect of similar problems reoccurring.

### **What are the key issues in the report?**

- Progress since the 2019 report (see pp. 13-24)
- Use of seclusion (see p. 27-31)

### **Where are the recommendations?**

The Ombudsman formed two opinions based on the investigation and made 12 recommendations for change. The opinions and recommendations are throughout the report with supporting information. A consolidated list is available on pages 4-6 of the report.

### **What response was there from the agencies concerned?**

As required under the Ombudsman Act, for procedural fairness, the proposed report was provided to the Director-General of the department and to the Director. The final report contains their responses as appendices.

Where appropriate, the report has been amended to reflect comments made by the Director-General and the Director.

### **What happens next with the recommendations?**

The Ombudsman:

- does not have the power to enforce recommendations
- will continue to monitor implementation of the recommendations.

[ends]