**IN THE HIGH COURT OF AUSTRALIA**
**SYDNEY OFFICE OF THE REGISTRY**

**No. S143 of 2014**

**B E T W E E N:**

**HUNTER AND NEW ENGLAND LOCAL HEALTH DISTRICT**
Appellant

HIGH COURT OF AUSTRALIA
FILED
25 JUL 2014
THE REGISTRY SYDNEY

- and -

**SHEILA MARY SIMON**
First Respondent

**WENDY ROSE**
Second Respondent

# APPELLANT'S SUBMISSIONS

## Part I: Certification for publication

1. The appellant certifies that these submissions are in a form suitable for publication on the internet.

## Part II: Issues

2. Whether a common law duty of care to 'prevent harm to a third party' is supported by and consistent with the appellant's statutory obligations under Chapter 4, Part 2 of the *Mental Health Act 1990* (NSW) (**MHA**).

3. For the purposes of s.5B of the *Civil Liability Act 2002* (NSW) (**CLA**):

   a. the specificity with which 'a risk of harm' must be identified; and

   b. the manner in which that section interacts with s.5O of the CLA.

4. The proper construction of s.5O(1) of the CLA and whether the professional service must conform to 'a practice' which was in existence at the time it was provided and which was widely accepted by peer professional opinion as competent professional practice.

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5. The proper construction of s.43(1) of the CLA, and whether a finding of common law negligence can give rise to liability that is *"based on a breach of statutory duty"*.

6. In relation to s.43A of the CLA:

   a. whether it operates as a defence when the basis of the liability was the *"failure of the hospital to continue to detain Mr Pettigrove"* under the MHA; and

   b. whether s.35(3) of the MHA was engaged, and if so, whether not continuing to detain can give rise to 'civil liability'.

**Part III: Judiciary Act 1903, s78B**

7. The appellant considers that notice is not required pursuant to s.78B of the *Judiciary Act 1903* (Cth).

**Part IV: Report of reasons for judgment**

8. There is no authorised report of the decision of the Court of Appeal. It is reported at [2013] Aust Torts Reports 82-158 and its medium neutral citation is [2013] NSWCA 476. The decision of the primary judge is unreported and its medium neutral citation is [2012] NSWDC 19.

**Part V: Relevant facts**

9. On 21 July 2004 at around 8:30 pm Phillip Pettigrove (**Pettigrove**) attacked and killed his friend Stephen Rose (**Rose**) in a motor vehicle parked beside the Newell Highway, about 25 km south of Dubbo, NSW (DC [1]-[2]).

10. Earlier that day Pettigrove had been discharged by a psychiatrist, Dr Coombes, from the Mental Health Unit (**MHU**) at the Manning Base Hospital in Taree (**the hospital**) where he had, since 20 July 2004, been detained and involuntarily admitted under the provisions of Chapter 4, Part 2 of the MHA (DC [2]; CA [5]).

11. The respondents, the mother and sister of Rose,[1] commenced proceedings for damages against the appellant in connection with his death.[2] The respondents alleged that the appellant owed Rose (and them) a duty to prevent Pettigrove

[1] The related proceedings S142 of 2014 involve a nervous shock claim by another sister of Rose.

[2] The appellant is the legal entity responsible for the conduct of the Manning Base Hospital, Taree and the staff who worked there – including Dr Coombes and the 'medical superintendent' under the MHA (CA [7], [193]).

causing physical harm to Rose, which it failed to do and that in consequence they suffered 'nervous shock' brought about by learning of his death. Such a claim engaged, amongst other provisions in the CLA, the provisions of Part 3 – the Part of the CLA that applies to claims for mental harm resulting from negligence.[3]

12. Pettigrove was born in 1962, and had a 20 year history of schizophrenia (DC [9] - [10]; CA [12]). During that time he lived, and was treated, in the community in his home state of Victoria, although there had been at least one episode that had required him to be admitted to a psychiatric unit (CA [29]).

13. Pettigrove had no history of committing or threatening violence to others (CA [40]).

14. Prior to his admission on 20 July 2004, Pettigrove had resided with Rose in the Coopernook Forest Caravan Park (DC [12]; CA [12]).

15. On 20 July, at about 2:50 am, Rose, concerned about Pettigrove's behaviour, called an ambulance. At 3:50 am Pettigrove was brought into the hospital by ambulance (DC [12]).

16. At about 4:30 am a doctor on duty in the Emergency Department at the hospital telephoned Dr Coombes, a consultant psychiatrist working at the hospital. On the advice of Dr Coombes Pettigrove was admitted and administered anti-psychotic mediation and a sedative (CA [13]). In addition a 'Form 2', pursuant to s.21(1) of the MHA, was completed, providing for the detention and involuntary admission of Pettigrove (DC [12]; CA [13]-[14]).

17. On 20 July, at about 7:45 am, Dr Coombes attended the Emergency Department of the hospital. Dr Coombes found Pettigrove on a trolley and observed and examined him (DC [17]-[22]). Dr Coombes thought Pettigrove should be admitted to the MHU and Pettigrove was transferred there at about 12:30 pm (DC [22]).

18. Later on 20 July Dr Wu, the medical superintendent of the hospital, examined Pettigrove and issued a certificate for the purposes of s.29 of the MHA in which she expressed the opinion that Pettigrove was a mentally ill person (CA [21]).

19. During the course of 20 July, Pettigrove's medical records from the Echuca Mental Health Service were sought and received by the hospital, and they were read by Dr Coombes (CA [22]-[23], [28]).

20. At around 4 pm on 20 July a meeting took place in the MHU involving Dr Coombes, a nurse, Pettigrove and Rose, during which Pettigrove's mother in Victoria was telephoned to discuss Pettigrove's desire to return to Victoria to live with her. It was resolved, with the agreement of all participants, that Pettigrove would be

[3] s.28(1) of the CLA.

discharged the next morning, and that he and Rose would drive to Pettigrove's mother's home in Echuca (DC [2], [27]; CA [23]).

21. Following that meeting, Dr Coombes completed a written advice pursuant to s.33(1) of the MHA (DC [25] – [26]; CA [22]). In that advice Dr Coombes recorded his:

    a. opinion that Pettigrove was *"a mentally ill person"*;

    b. observation that Pettigrove was: *"Unwilling to answer questions but able to ask leave to go to his room. Looked perplexed, bewildered and sitting quietly by himself. No* [sic] *obviously hallucinating but this cannot be excluded"*; and

    c. conclusion that Pettigrove was for: *"admission overnight and transfer to his mother's home in Victoria tomorrow in company of his friend"*.

The 'friend' was Rose, who had volunteered to take Pettigrove when *"well enough to return to Victoria ..."* (DC [26]; CA [5]).

22. It was intended, or at least expected, that Pettigrove would continue with his treatment at that location (DC [2]; CA [2], [23]).

23. At that stage no further examination was contemplated by Dr Coombes prior to Pettigrove's discharge (DC [27]) and no medication was then prescribed for the morning or for use on the trip (DC [27], [37]; CA [26]).

24. It was envisaged that Pettigrove and Rose would depart about 7 am on 21 July, with the aim of completing the trip within the day (DC [27]). As it turned out, Rose was delayed, and did not arrive at the hospital until after 11 am (DC [28]). At around 10:30 am, Dr Coombes observed Pettigrove and they had a 10-15 minute conversation. During that time Pettigrove appeared settled and pleasantries were exchanged (DC [28]; CA [36], [133]). Dr Coombes also provided medication for Pettigrove to take on the road trip (DC [37] – [38]; CA [36]).

25. Nurses observed that upon Rose's arrival to collect Pettigrove, the pair "hugged and greeted each other warmly" (CA [37]).

26. Pettigrove and Rose departed the hospital around 11.30 am (CA [36]).

27. At about 8:30 pm that evening, approximately 25 km from Dubbo, the car was stopped to enable Pettigrove to relieve himself. Upon returning to the car, Pettigrove set upon Rose, and killed him (DC [1]-[2]; CA [6], [218]).

28. Pettigrove told the police that he attacked Rose on impulse – because *"something inside me said to do it"* or because he believed that Rose had killed him in another life (DC [2]; CA [6]). There was no suggestion that there had been, before this episode, any altercation between the two (CA [6]). Subsequently, Pettigrove committed suicide (CA [6]).

**Disposition in the Courts below**

29. The respondents' claims for damages failed in the District Court.

30. Although the primary judge assumed a duty of care, he dismissed the respondents' claims for two reasons: first, for the purposes of s.5B of the CLA the primary judge concluded that the appellant was not negligent because *"the risk of harm was not foreseeable and not so significant that a reasonable person would have taken precautions against it"* and that it was *"not probable that harm would occur if care was not taken"* (DC [85]); and, secondly, by operation of s.5O of the CLA (DC [93], [97]).

31. The Court of Appeal allowed the respondents' appeal. A majority found a common law duty of care, but there was no agreement as to the existence, or content, of the relevant duty of care.

32. Beazley P held that the appellant owed Rose (and the respondents) *"a duty of care to take reasonable care to avoid foreseeable harm to* [Rose]*"* (CA [2]). Her Honour further defined the duty owed to Rose to be a *"duty of care not to release Mr Pettigrew* [sic]*, who was a mentally ill person, into Mr Rose's care, or at least his sole care, for the purposes of conveying him to Victoria where it was intended or, at least, expected that he would undergo further psychiatric treatment"* (CA [2]).

33. Macfarlan JA accepted the respondents' argument, holding that the hospital owed Rose *"a common law duty to take reasonable care to prevent Pettigrove causing physical harm to Mr Rose"* (CA [10(a)], [101], [108]).

34. The majority also concluded that breach of duty had been established, and that the statutory defences under ss.5O, 43 and 43A of the CLA were not made out.

35. Garling J, in dissent, concluded that no common law duty of care of the kind alleged was owed. His Honour upheld the primary judge's conclusions that the relevant risk of harm was the risk of homicide to Rose, and that was not a risk against which precautions were required to be taken (CA [279]). His Honour also upheld the appellant's defence under s.43A of the CLA but did not address the further defences under ss.5O and 43 of the CLA.

**Part VI: Argument**

**Duty of care**

36. Whether there is a common law duty of care in a case involving a public authority vested with statutory powers involves the application of a number of well-established principles.

37. First, a statutory power vested in a body, the exercise of which could prevent harm to persons, is insufficient to impose a duty of care to those persons.[4] Secondly, whether a duty of care is owed involves a multi-faceted enquiry, involving consideration of the salient features of the relationship, including the nature and extent of the *"control exercised by the authority over the risk of harm that eventuated"*, vulnerability and consistency of the asserted duty with the legislative regime.[5] Thirdly, whether a common law duty of care is owed by a public authority *"turns on a close examination of the terms, scope and purpose of the relevant statutory regime"*.[6]

38. The appellant submits that the application of these principles to the facts in this case demonstrates there is no common law duty of care of the kind found by the Court of Appeal.

**The statutory framework**

39. Chapter 4, Part 2 of the MHA dealt with the detention and involuntary admission of persons who were mentally ill or mentally disordered. A relevant object of the MHA was to facilitate the provision of hospital care for mentally ill or disordered persons *"in a limited number of situations, on an involuntary basis"* and to provide an opportunity for such persons to have access to appropriate care *"while protecting the civil rights of those persons"*.[7] Further, the express intent of Parliament was that the MHA be interpreted and its functions, as far as was practicable, performed, so that persons *"receive the best possible care and treatment in the least restrictive environment"* and *"any restriction of the liberty of patients and any interference with their rights ... are kept to the minimum necessary"*.[8]

40. The MHA mandated a refusal to detain unless certain opinions were formed.[9] Once a person was detained, the detained person was required to pass through a

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[4] *Graham Barclay Oysters Pty Ltd v Ryan* (2002) 211 CLR 540, 576 [81] (McHugh J) and 596, [145] (Gummow and Hayne JJ); *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 254 [112] (Gummow, Hayne and Heydon JJ).
[5] *Graham Barclay Oysters* (2002) 211 CLR 540, 596-597 [145]-[146] (Gummow and Hayne JJ).
[6] *Graham Barclay Oysters* (2002) 211 CLR 540, 596-597 [146]-[147] (Gummow and Hayne JJ).
[7] ss.4(1)(c) and (d) of the MHA.
[8] s.4(2) of the MHA.
[9] ss.20, 28 and 29(2) of the MHA.

number of stages (or as Garling J in the CA expressed it, *"checks and balances"*)[10] to ensure that a person was only detained after a number of different persons formed the opinion that the person should be detained. A person, such as Pettigrove, taken to and detained in a hospital was required to be examined within 12 hours by the medical superintendent,[11] and could not be detained unless the medical superintendent provided a certificate that the person was mentally ill or disordered.[12] If such a certificate was issued, the medical superintendent was required to cause the person to be examined by another medical practitioner. If the medical superintendent was not a psychiatrist, that other practitioner was required to be a psychiatrist who had to affirm the appropriateness of detention,[13] or the person was required to be released.[14]

41. Each medical practitioner involved in the 'stages' of assessment of the person, before *"causing or continuing"* the detention of the person, was required to form an opinion *"that no other care of a less restrictive kind is appropriate and reasonably available to the person"*.[15] These provisions make clear that the intent of the MHA was to enable detention only as a last resort,[16] and emphasise the importance the MHA attached to autonomy and individual liberty.

**Inconsistency**

42. The *"multi-faceted inquiry"* involved in evaluating whether a relationship between a statutory authority and a class of persons imposes a common law duty of care includes an assessment of the consistency of the asserted duty with the terms, scope and purpose of the statute.[17] If the asserted duty of care would give rise to inconsistent obligations, *"that would ordinarily be a reason for denying that the duty exists"*.[18]

43. The different duties postulated by the majority both involve an extension of the hospital's duty to its patient to take reasonable care to avoid causing the patient foreseeable harm by its acts or omissions, to an obligation to protect a third party from physical harm caused by the patient.

44. A duty of care requiring the hospital to undertake its obligations under Chapter 4, Part 2 by reference to a duty to prevent harm to Rose is inconsistent with the statutory regime - and this is so *a fortiori* if that activity requires the hospital to do

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[10] CA at [236].
[11] ss.21 and 29 of the MHA.
[12] s.29 of the MHA.
[13] ss.32 and 33 of the MHA.
[14] s.35 of the MHA; *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22, 32 [39] (Spigelman CJ).
[15] See sections 20, 21(1)(c) and 35(3) of the MHA; *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22, 32 [40] (Spigelman CJ).
[16] *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22, 100 [296] (Sheller JA).
[17] *Graham Barclay Oysters Pty Ltd* (2002) 211 CLR 540, 597 [149] (Gummow and Hayne JJ).
[18] *Sullivan v Moody* (2001) 2007 CLR 562, 582 [60].

something differently, or in addition, to the statutory powers.

45. Although Macfarlan JA adverted to the issue of inconsistency,[19] his Honour did not reconcile the postulated duty to prevent harm, and the exceptional nature of it,[20] with the hospital's statutory obligations imposed by ss.20 and 35(3) of the MHA, respectively, to discharge a patient if not mentally ill, or to cease detention if other care of a less restrictive kind is appropriate and reasonably available. Those *mandatory* obligations (*"a person must not be admitted to, or detained in or continue to be detained in ..."*: s.20 of the MHA; *"must not ... be further detained ..."*: s.35(3) of the MHA), which the hospital owed to Pettigrove, conflict with the duty to prefer Rose's interests by detaining Pettigrove as an involuntary patient for Rose's protection.[21]

46. Garling J, in dissent, found that the hospital did not owe a duty of the type postulated, which his Honour saw as involving inconsistent obligations between the hospital's duty to its patient, Pettigrove, a duty affected by the MHA, and any duty said to be owed to Rose.[22] The reasons and conclusions of Garling J are correct.

47. As Garling J explained,[23] the inconsistency is seen starkly here where Dr Coombes formed the opinion that Pettigrove's best interests were served by him receiving other care of a less restrictive kind from his long term treatment providers in Victoria, while living at home with his family, rather than being detained in an unfamiliar mental health facility in a different state away from family. The duty postulated by the majority carries the very risk identified in *Hunter Area Health Service v Presland*,[24] *viz.*, of distorting the focus of the MHA

> *"by promoting a bias towards detention, when that should be an impartial decision, taken only when fully justified, if not a last resort."*

48. Macfarlan JA[25] described the duty to prevent harm as consistent with the MHA, because s.4(1) of the Act defined its objects as including *"the care, treatment and control of"* mentally ill persons, and definitional provisions (ss.9 and 10) referred to *"the protection of others from serious harm"*. However, the objects of the MHA do not include the protection of the public, or any individual (other than the patient), and the MHA does not propound a need for such protection as a ground justifying

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[19] CA at [104].

[20] *Smith v Leurs* (1945) 70 CLR 256, 262 (Dixon J); *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 254 [112] (Gummow, Hayne and Heydon JJ). See also *Modbury Triangle Shopping Centre Pty Limited v Anzil* (2000) 205 CLR 254.

[21] CA at [234]-[235] (Garling J); *Hunter Area Health Service v Presland* (2005) 63 NSWLR 22, 45 [116] (Sheller JA).

[22] CA at [241] and [257].

[23] CA at [255].

[24] (2005) 63 NSWLR 22, 120 [377]-[378] (Santow JA).

[25] CA at [104].

the exercise of the power of involuntary detention. As Garling J put it: [26]

> *"Rather, [the MHA] concentrates attention on the provision of treatment for the mentally ill person. The Act specifically acknowledges that involuntary care is to be provided in only a "limited number of situations...": s 4(1)(c). The phrase "... protection of others from serious harm" is only used in s 9,*[27] *and there only as a necessary element in reaching a conclusion that a person is mentally ill. Once such a conclusion is reached, then the question arises as to what treatment ought be provided by the Hospital"*.

49. Although Macfarlan JA saw *State of NSW v Godfrey*[28] as distinguishable,[29] that was so because here the postulated duty was said to be owed only to Rose, with whom there was a relationship, whereas in *Godfrey* the victim was not known to the assailant. However, there is no principled reason for confining the duty only to Rose, and not, for example, as Garling J hypothesised,[30] a hitchhiker or other members of the public who might foreseeably be encountered en route to Victoria.

**Control and indeterminacy**

50. The indeterminate nature of the liabilities thrown up by the postulated duty, including as to its duration, and whether the duty would be confined only to the road trip to Echuca, or extend to any other situation in which the pair might be together post-discharge, is exposed by questions of the type posed by Garling J[31] and demonstrate Macfarlan JA's error[32] in regarding the Hospital as having 'control' over Pettigrove in a manner that makes *Stuart v Kirkland-Veenstra*[33] distinguishable.

51. To the extent that the hospital had control it was confined, limited by the terms of the MHA and following discharge, did not exist. In cases where a duty to control the conduct of a person to prevent harm to another has been found to exist, the capacity to control underpins the obligation; it is essential, failing which the posited duty is not imposed.

52. Macfarlan JA found the element of control because, whilst Pettigrove was in detention at the hospital, it *"had control over him and controlled the source of the risk"*.[34] That was undoubtedly so at the time that Pettigrove was detained as an involuntary patient. However, the critical enquiry is directed not to that time, but

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[26] CA at [231].
[27] sic – it is also used in s.10, but for the same 'definitional' purpose for which it is used in s.9 of the MHA.
[28] [2004] NSWCA 113; (2004) Aust Torts Reports 81-741.
[29] CA at [101].
[30] CA at [243].
[31] CA at [242], [243].
[32] CA at [1], [102]-[103].
[33] (2009) 237 CLR 215.
[34] CA at [103], [107].

to a time when a medical superintendent or medical practitioner formed the opinion *"that other care of a less restrictive kind is appropriate and reasonably available to the person"*.[35] From that point in time, when the hospital must no longer detain, there was no control (or capacity to control) the individual within the MHA, or independently of it.

**The beneficiary of the power**

53. The statutory regime in Chapter 4, Part 2 does not create any obligation toward any third party. The powers given to the hospital are not directed toward, or for the benefit of, third parties. As Garling J pointed out, in *"limited circumstances, the protection of others from serious harm, is an incident of the proper exercise of the statutory power, and not the aim or purpose of it"*. [36] The 'incident' to which his Honour referred is this: to the extent 'serious harm' is a consideration, it is for the purpose only of determining, pursuant to ss. 9 and 10 of the MHA, whether an individual is a 'mentally ill person' or a 'mentally disordered person'. Even if the powers granted to the hospital are construed as directing some 'benefit' to third parties, the beneficiaries are not identified: it must be that such 'benefit' is for the public at large, not some specific class, a feature which militates against a duty of care attaching to the exercise of the power.[37]

**Vulnerability**

54. Contrary to Macfarlan JA's finding,[38] Rose was not vulnerable in the relevant sense of being unable to protect himself from harm.[39] Rose was not directed to drive Pettigrove to Victoria by Dr Coombes, or for that matter by anyone. Rose volunteered to drive Pettigrove there[40], and he was adequately placed to exercise his own judgment about this, with or without the input of Dr Coombes: Rose was a long time friend of Pettigrove, was aware of his mental health history,[41] had lived with Pettigrove in the period leading up to July 2004, had observed the episode that resulted in him calling an ambulance on 20 July 2004 and had participated in the meeting at 4 pm on 20 July 2004.

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[35] See sections 20, 21(1)(c) and 35(3) of the MHA; *Presland* (2005) 63 NSWLR 22, 32 [40] (Spigelman CJ).
[36] CA at [233].
[37] *Graham Barclay Oysters Pty Ltd* (2002) 211 CLR 540, 574 [79], 576 [81] and 580 [91] (McHugh J); *Stuart v Kirkland-Veenstra* (2009) 237 CLR 215, 260 [131] (Crennan and Kiefel JJ).
[38] CA at [107].
[39] *Woolcock Street Investment Pty Limited v CDG Pty Limited* (2004) 216 CLR 515, 530 [23] (Gleeson CJ, Gummow, Hayne and Heydon JJ).
[40] DC at [26].
[41] DC at [12].

**Breach of duty: section 5B of the CLA**

55. Part 1A of the CLA governs the determination of whether a person is negligent,[42] and ss.5B and 5C of the CLA are specifically directed to questions of breach of duty.[43] The starting point to the enquiry whether there has been a breach of duty requires the proper identification of the 'risk of harm'.

56. The primary judge correctly characterised the relevant risk of harm as the risk of Pettigrove killing Rose.[44] Garling J agreed with that formulation.[45] However, Macfarlan JA held that the relevant risk of harm for the purposes of s.5B of the CLA was the risk of *any* physical harm to Rose, including harm that Rose might suffer as a result of Pettigrove attempting self-harm.[46]

57. Section 5B of the CLA requires the accurate identification of the risk, informed by the actual circumstances in which the harm was suffered; it is only once the risk has been correctly identified in this way that the Court *"can assess what a reasonable response to that risk would be"*.[47] Thus, the section presupposes allegations of breach of duty arising out of the failure to take identified precautions against the risk of harm that materialised. Macfarlan JA erred in not adopting this approach and in identifying, for the purposes of s.5B of the CLA, a risk of harm that was at too general a level of abstraction. Defining the risk of harm in that way distorted the evaluation of the response as required by ss.5B(1)(c) and 5B(2) of the CLA. And, in view of the manner in which Macfarlan JA defined the duty of care as involving the prevention of harm, a finding of breach necessarily followed.[48]

58. Given that:

    a. Pettigrove had no history of violence and the episode that saw him admitted on this occasion did not involve violence;

    b. Dr Coombes considered when assessing him on 20 July 2004 that there was *"no foreseeable risk of...Pettigrove inflicting harm on ... others"*;[49] and

    c. four of the six expert psychiatrists opined that the risk of homicide, viewed

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[42] The term 'negligence' is defined in s.5 of the CLA: *"In this Part...negligence means failure to exercise reasonable care and skill"*.
[43] *Adeels Palace Pty Limited v Moubarak* (2009) 239 CLR 420, 432-433.
[44] DC at [88], [90].
[45] CA at [279].
[46] CA at [110].
[47] *Roads and Traffic Authority of NSW v Dederer* (2007) 234 CLR 330, 351 [59]-[61] (Gummow J); *Vairy v Wyong Shire Council* (2005) 223 CLR 422, 461 [126] (Hayne J); *Shoalhaven City Council v Pender* [2013] NSWCA 210 at [64] (McColl JA; Barrett JA agreeing), [151] (Ward JA).
[48] See *New South Wales v Fahy* (2007) 232 CLR 486, 491 [7] (Gleeson CJ).
[49] CA at [25].

prospectively, was, as the primary judge accepted, 'fanciful',[50]

the correct findings on breach were those made by the primary judge. That is, that the appellant was not negligent because *"the risk of harm was not foreseeable and not so significant that a reasonable person would have taken precautions against it"* and it was *"not probable that harm would occur if care was not taken"*.[51]

59. In applying s.5B(1)(c) of the CLA, Macfarlan JA followed the decision of this Court in *Rogers v Whittaker*,[52] by holding that the *"standard of care relevant to consideration of Dr Coombes' conduct is 'the ordinary skill of a doctor practising in the relevant field'...that is, in psychiatry"* and that, whilst expert evidence assists in determining whether there was breach, *"ultimately the issue is a matter for the Court to resolve"*.[53]

60. As Macfarlan JA's approach acknowledges, the assessment of the conduct of Dr Coombes, as a professional, required consideration of the decision not to continue to detain Pettigrove and, whether, in consequence, there was liability in negligence. This assessment could not occur in the context of s.5B of the CLA without reference to s.50 of the CLA: s.5B of the CLA, subject to causation, determines liability in negligence. Section 5O of the CLA qualifies the operation of s.5B of the CLA, in cases to which it applies, by determining the standard of care. Contrary to Macfarlan JA's conclusion,[54] it is only in this sense that s.50 of the CLA *"provides a defence"*.[55]

61. There are provisions in the CLA which operate as a defence to 'civil liability' and are thus invoked after a finding of negligence. Section 43A is an example. The application of that section involves a 'two-stepped approach' - requiring a plaintiff to make out negligence and then satisfy a further, not inconsistent, statutory test.[56] However, this construction cannot be accommodated in the present situation. Applying a two-stepped approach to ss.5B and 5O would require separate, but potentially inconsistent, findings of negligence: first, an assessment under s.5B of the CLA (applying *Rogers v Whitaker*); secondly, an assessment under s.50 of the CLA (applying the terms of the section).

62. On the findings of Macfarlan JA, the further finding that should have been made under s.5B of the CLA was that Dr Coombes did not act unreasonably in discharging Pettigrove. Macfarlan JA, in reviewing the expert psychiatric evidence adduced at

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[50] CA at [63], [79].
[51] DC at [85], [88].
[52] (1992) 175 CLR 479.
[53] CA at [126].
[54] CA at [159].
[55] See *Dobler v Halverson* (2007) 70 NSWLR 151, 167 [60] (Giles JA; Ipp and Basten JJA agreeing).
[56] See, for example, *Roads and Traffic Authority of NSW v Refrigerated Roadways Pty Limited* (2009) 77 NSWLR 360, 434 [360]; *Kelly v Allianz Australian Insurance Limited* (2010) 57 MVR 80, 89 [39], 96 [75]; *Warren Shire Council v Kuehne* (2012) 188 LGERA 362, 387 [117].

trial, preferred *"the evidence of the experts qualified by the* [respondents]".[57] This included the evidence of Dr Phillips who, as the primary judge found, *"was of the opinion that many of his peers would have seen the discharge as reasonable"*. [58] Macfarlan JA found, at least implicitly, that in relation to the provision of professional services there had been established, relevantly, *"competent professional practice"*, within the terms of s.5O(1) of the CLA, by accepting Dr Phillips' evidence. Importantly, Macfarlan JA did not find that the body of medical opinion generally supportive of the reasonableness of the discharge was 'irrational'.

**Section 5O CLA**

63. The primary judge upheld the hospital's defence under s5O of the CLA, drawing upon the opinions of four of the six psychiatric experts, including that of Dr Phillips, who was called by the respondents, to the effect that a reasonable body of their peers would have discharged Pettigrove in the circumstances.[59]

64. Macfarlan JA held that to establish a defence under s.5O of the CLA, a medical practitioner must show *inter alia* that *"what he or she did conformed with* [sic] *a practice that was in existence at the time the medical service was provided*".[60] His Honour rejected the hospital's defence under s.5O on the sole basis that in determining to discharge Pettigrove, Dr Coombes was not conducting 'a practice' within the meaning of the section.

65. That construction, for which no authority is cited, and which was not contended for by the respondents, is not supported by a plain reading of the section. The section does not call for conduct that conforms to 'a practice', but rather, requires that the professional "*acted in a manner ... that ... was widely accepted ... by peer professional opinion as competent professional practice*." Thus, the section focuses on what the professional did (*"the service"*), rather than requiring that what was done constitute the discharge of, or properly be labelled, 'a practice'.

66. The defence provided by the section (*"a professional does not incur a liability in negligence ..."*) is confined to a single, specified context (*viz., "the provision of a professional service"*). The requirements that the defendant be *"a person practising a profession ('a professional')"* and that the professional's impugned actions involve *"the provision of a professional service"* establish the outer boundaries of the section's application. Once the actor and the actions fit within those boundaries, the test for whether the defence is made out involves the enquiry demanded by the concluding words of the section, *viz* whether the manner in which the professional acted *"was widely accepted ... by peer professional*

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[57] CA at [145].
[58] DC at [79].
[59] DC at [93] – [97]; CA at [83].
[60] CA at [160] – emphasis in original.

*opinion as competent professional practice."*

67. The rider in subsection (2) that the peer opinion must not be "irrational" provides a further, and, it is submitted, final constraint.[61]

68. In any event, were it necessary to identify 'a practice', then the conduct of a practising psychiatrist in the clinical setting, exercising the professional judgment involved in assessing the patient, and determining whether other care of a less restrictive kind is appropriate for, and reasonably available to, that patient, should be regarded as constituting a 'practice'. That such assessments and determinations are the very stuff of the treating psychiatrist's daily professional life is plain from the oral evidence of one of the experts, Dr Campbell, given during the concurrent evidence session:[62]

> *"We're all faced as clinicians and all, we all have to make these decisions day in and day out."*

69. Consistently with that unchallenged evidence, the six psychiatrists qualified to provide opinion evidence engaged upon the two 's.5O questions' that the parties consensually put to them in joint conference, without demur or qualification.[63]

70. In concluding that there was no 'practice', Macfarlan JA referred to features of Pettigrove's history, presentation and condition, and of Mr Rose's character and relationship with him, which, his Honour considered, bore, or ought to have borne, upon the decision to discharge. [64] Although these descriptors are not deployed in his judgment, it appears that Macfarlan JA saw the need to consider those *patient-specific* features as rendering the discharge decision *unprecedented*, or *unique* and for that reason, not amenable to the application of any 'practice'. So much may be inferred from his Honour's conclusion[65] that the *"variety of circumstances bearing upon the decision to discharge Mr Pettigrove"* made it *"unlikely ... that there would have occurred in or before 2004 a number of situations in which there were sufficient features in common with the present case to enable it to be said that there was a practice ..."*.

71. In *Grinham v Tabro Meats Pty Ltd* [66] the meaning of 'professional practice', as the term is used in the Victorian equivalent of s.5O,[67] was considered. In rejecting submissions[68] that the doctor's impugned acts were not professional services

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[61] The respondent submitted at first instance, but not on appeal, that Dr Coombes' actions were "irrational"; the primary judge (DC at [97]) rejected that submission.
[62] Transcript 192.5, cited, in this context, by the primary judge (DC at [96]), but not in the CA.
[63] Joint Report questions 11 and 12.
[64] CA at [162] where "a variety of considerations" are itemised.
[65] CA at [165].
[66] [2012] VSC 491 (J Forrest J).
[67] Section 59(1) *Wrongs Act 1958* (Vic).
[68] At [179] and [181].

because they were *"essentially ... an administrative exercise"*, and that the doctor must show that her peers have acted in the same way in a similar situation, the court observed,[69] by way of *obiter*, that:

> *"Peer professional opinion is directed to acceptance or otherwise of the manner in which the professional acted in the circumstances confronting the defendant. It is to this issue that the opinions of the other professionals in the field are directed. It may be that in some cases an opinion is based upon a hypothetical analysis rather than one actually encountered in practice. Whilst this factor may go to the quality of the opinion expressed, what matters is the opinion of the other professionals as to the way in which the defendant carried out or failed to carry out the professional tasks impugned in the proceeding."*

72. That reasoning applies in this case. Given the range of patient-specific clinical decisions made every day by Australian health professionals, Macfarlan JA's construction would deny many the protection of the section, contrary to its plain intent.

**Section 43 of the CLA**

73. The majority of the Court of Appeal found the hospital was negligent in failing to detain Pettigrove and that the precaution that should have been taken against the risk was his continued detention.[70] The majority further held that s.43 of the CLA did not apply, because the respondents abandoned their pleaded case based on breach of statutory duty.[71]

74. Section 43(1) of the CLA refers to liability *"that is based on a breach of statutory duty"* rather than liability *"for"* such breach, or similar. The statutory language thus directs attention to the basis of the liability as a matter of substance, not to the form of the pleading. Section 43 should be understood to cover two kinds of 'civil liability': first, where there is a liability in damages in an action for breach of statutory duty;[72] secondly, where there is a liability in damages in an action based on a *"breach of statutory duty"* – the present case being of this kind (on the findings and conclusions of the majority).

75. The phrase 'based on' in s.43(1) of the CLA recognises that a liability may as a matter of *substance* derive from conduct that would constitute a breach of statutory duty, notwithstanding that as a matter of *form* it is pleaded differently and irrespective of whether the existence of the duty, and its subsequent breach, gives rise to a private right of action. In such a situation, the phrase *"based on"* requires that the 'liability' arise by reference to the breach of a statutory duty.

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[69] At [181] – emphasis in original.
[70] CA at [10(b)], [154].
[71] CA at [167].
[72] *Sovar v Henry Lane Pty Limited* (1967) 116 CLR 397.

76. On the critical duty and breach findings made by Macfarlan JA *viz.*, consistency with the statutory scheme and the common law duty,[73] the statutory scheme being specifically directed to the protection and safety of a particular class of persons such as Rose,[74] and the obligation cast by Chapter 4, Part 2 of the MHA upon the appellant to detain or continue the detention of Pettigrove to prevent harm to Rose,[75] the hospital's liability was in substance a liability based on a breach of statutory duty. Section 43(1) of the CLA was thus engaged.

77. Further, it being accepted on appeal that if negligence be found,[76] it was not *"so unreasonable that no authority...could properly consider the act or omission to be a reasonable exercise of its functions"*, then the consequence provided by s.43(2) of the CLA – the 'negligence' does not constitute a breach of the statutory duty – applied, and operated as a defence to the action.

**Section 43A of the CLA**

78. The majority in the Court of Appeal rejected the appellant's defence based on s.43A of the CLA. Garling J would have upheld it.

79. The appellant argued, by notice of contention, that in determining pursuant to s.35(3) of the MHA that Pettigrove must not be further detained, the hospital, through Dr Coombes, was exercising a special statutory power within the meaning of s.43A of the CLA, or alternatively, that in failing to detain him, the hospital failed to exercise its statutory power of detention.

80. Although Macfarlan JA accepted that s.35(3) of the MHA conferred a *"special statutory power"* as defined in s.43A(2) of the CLA,[77] the defence failed for two, related, reasons. First, Dr Coombes in discharging Pettigrove was not a medical superintendent, and therefore not authorised to discharge him under the MHA.[78] Secondly, there was no 'failure to exercise' any power under s.35(3) of the MHA, and the liability of the appellant was not 'based on' it.[79]

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[73] CA at [95], [104].
[74] CA at [92], [95], [98].
[75] CA at [101, [107], [178].
[76] CA at [180], [284].
[77] CA at [172]. Section 43A(2) of the CLA defines 'special statutory power' as *"a power: (a) that is conferred by or under a statute, and (b) that is of a kind that persons generally are not authorised to exercise without specific statutory authority"*.
[78] CA at [179]. Section 35(3) of the MHA (relevantly) provided that *"if, on examination of a person detained as a...mentally ill person, a medical superintendent is of the opinion that the person is not a mentally disordered person or a mentally ill person or that other care of a less restrictive kind is appropriate and reasonably available to the person, the person must not ... be further detained in the hospital"*. In the Dictionary of terms used in the MHA, 'medical superintendent' in relation to *"...(b) an authorised hospital, means the medical practitioner appointed, under section 220, as medical superintendent of the authorised hospital, and, in Chapter 4,* [which includes sections 29 and 35]*...includes a reference to a medical officer, nominated by the medical superintendent, attached to the hospital or authorised hospital, as the case may be"*. (underlining added)
[79] CA at [178].

**The 'unauthorised' discharge**

81. Macfarlan JA found the 'discharge' by Dr Coombes was *"unauthorised"*,[80] because in making the decision, Dr Coombes was not acting as, and did not purport to act as, a medical superintendent within the meaning of s.35(3) of the MHA,[81] with the result that the decision to 'discharge' did not involve the exercise of the special statutory power. This point – about the capacity in which Dr Coombes 'acted' – was not raised at trial, but was permitted, over objection, to be raised on appeal.

10 82. Macfarlan JA reasoned that Dr Coombes, in all his dealings with Pettigrove, *only* acted as the medical practitioner, under ss.32 and 33 of the MHA, who reported to the medical superintendent:[82] the corollary being that the pre-condition to the exercise of the power to discharge under s.35(3) of the MHA was not enlivened. Macfarlan JA further found that, although Dr Coombes was *"undoubtedly a medical officer attached to the Hospital and while it is possible for some, or even all, purposes he was 'nominated by the medical superintendent', the evidence did not reveal whether this was in fact so"*.[83]

83. Despite acknowledging the *"force"* in the complaint made by the appellant that this
20 'point' was taken for the first time on appeal,[84] Macfarlan JA found that as no other doctor was shown to have any involvement in the discharge of Pettigrove and as Dr Coombes was only proven to have acted under ss.32 and 33 of the MHA, *"evidence would not have provided an answer"*.[85]

84. This last finding was speculative, and Macfarlan JA was in error in dealing with the matter in this way. The 'point' should not have been permitted to have been raised. There is, contrary to what Macfarlan JA assumed, no necessary inconsistency in Dr Coombes having 'dual roles': advising and reporting under ss.32 and 33 of the MHA, and an appointment as 'a' medical superintendent. The MHA
30 does not provide that such appointment, unlike the appointment as 'the' medical superintendent, is required to follow, or be evidenced in, any particular form:[86] the medical practitioner need only be *"nominated"* by the medical superintendent.[87] Further, unlike the involuntary admission and detention of a person under the MHA, neither the MHA (nor the regulation)[88] required a prescribed 'form' to be completed when a person was 'discharged'. Nor was there a requirement under the MHA that for a 'discharge' to be efficacious the medical practitioner discharging the person was required to not only be a medical superintendent, but

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[80] CA at [179].
[81] CA at [174] – [178].
[82] CA at [174].
[83] CA at [173].
[84] CA at [173] and the further point relating to the presumption of regularity – see CA at [173] - [174].
[85] CA at [177].
[86] cf. s.209 of the MHA (appointment of medical superintendents for hospital other than authorised hospitals) and s.220 of the MHA (appointment of medical superintendent for authorised hospitals).
[87] see the definition of the 'medical superintendent' in the Dictionary of terms used in the MHA.
[88] *Mental Health Regulation 2000* (NSW).

to signify as much on any discharge form, as Macfarlan JA appears to have assumed.

**No exercise under s.35(3) of the MHA**

85. Macfarlan JA also held that there was no exercise of the power under s.35(3) of the MHA, because the 'case' was not *"based on the Hospital's 'failure to exercise' the power to discharge that was implicitly conferred by s35(3)"*, and nor was that section the basis for its liability.[89] In this last respect, Macfarlan JA held that the 'basis' for the appellant's liability was the *"failure of the Hospital to continue to detain Mr Pettigrove"*.[90]

86. Macfarlan JA's judgment does not engage with the argument put to the Court of Appeal and the primary judge: that is, even if the discharge decision was unauthorised, and for that reason not an exercise of power under s.35(3) of the MHA, then, in circumstances where, on the respondents' case, Pettigrove was a mentally ill person at the time of his discharge, and should therefore have been detained, it was incumbent upon the hospital to exercise the powers of detention under the MHA.

**The 'basis of liability': s.43A of the CLA engaged**

87. In any event, contrary to Macfarlan JA's conclusion, rather than negativing the defence, his Honour's dispositive finding of negligence established it. The 'basis' of the liability of the appellant was its failure to continue to detain Pettigrove.[91] Detention, and continued detention, as an involuntary admission was only permitted by the MHA.[92] Accordingly, as Garling J held, the *"essence of liability in this case must arise as a consequence of a failure by the Hospital through the medical superintendent to exercise the special statutory powers. Such a failure, or omission, is caught by s43A of the CL Act"*.[93]

88. By reason of s.43A(3) of the CLA, the liability so found *"does not give rise to civil liability"*: it was accepted in the Court of Appeal that if negligence be found,[94] then for the purposes of s.43A of the CLA, the failure to detain or continue to detain Pettigrove was not *"so unreasonable that no authority...could properly consider the act or omission to be a reasonable exercise of its functions"*.

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[89] CA at [178].
[90] CA at [178].
[91] CA at [178].
[92] Continued detention could not lawfully be achieved by the hospital doing nothing: s.38(1) of the MHA required the medical superintendent *"as soon as practicable"* to bring Pettigrove before a Magistrate in the circumstances that obtained here, and his further detention could occur only if the Magistrate so directed: s.51 MHA.
[93] CA at [285], [294].
[94] CA at [180], [284].

**Part VII: Legislative material**

89. The applicable legislative material is in **Annexure A**. The *Mental Health Act 1990* (NSW) was repealed by s.200 of the *Mental Health Act 2007* (NSW). Comparable provisions are identified in **Annexure B**.

**Part VIII: Orders sought**

10 1 Appeal allowed.
2 Order that orders (2), (3) and (4) of the New South Wales Court of Appeal be set aside.
3 Verdict and judgment for the appellant.
4 Order that the appellant pay the respondents' costs of the proceedings.
5 Such further or other orders as this honourable Court deems fit.

**Part IX: Oral argument**

20 90. The appellant estimates that it will require two hours for oral argument.

Dated: 25 July 2014

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**IN THE HIGH COURT OF AUSTRALIA**
**SYDNEY OFFICE OF THE REGISTRY** **No. S143 of 2014**

**B E T W E E N:**

**HUNTER AND NEW ENGLAND LOCAL HEALTH DISTRICT**
Appellant

- and -

**SHEILA MARY SIMON**
First Respondent

**WENDY ROSE**
Second Respondent

## ANNEXURE A
## APPLICABLE STATUTORY PROVISIONS

| Legislative provision | Statement as to the applicability of the provision | Page |
|---|---|---|
| Section 3 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The *Mental Health Act 1990 (NSW)* (**MHA 1990**) was repealed by s.200 of the *Mental Health Act 2007 (NSW)* (**MHA 2007**) with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 1 |
| Section 4 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 2 |
| Section 8 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 3 |
| Section 9 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 3 |

| | | |
|---|---|---|
| Section 10 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 3 |
| Section 11 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 4 |
| Section 20 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 5 |
| Section 21 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 5 - 6 |
| Section 28 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 7 |
| Section 29 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 7 |
| Section 30 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 8 |
| Section 32 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 9 |
| Section 33 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 9 - 10 |

| | | |
|---|---|---|
| Section 34 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 10 |
| Section 35 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 10 |
| Section 38 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 11 - 12 |
| Section 51 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 13 |
| Section 208 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 14 |
| Section 209 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 14 |
| Section 220 of the *Mental Health Act 1990 (NSW)* | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 15 |
| Schedule 1, Dictionary of the terms used in the MHA 1990 | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 16 - 22 |
| Schedule 2, medical certificate as to examination or observation of a person | This section is not in force. The MHA 1990 was repealed by s.200 of the MHA 2007 with effect from 16 November 2007. The form of the provision at the relevant time was contained in the MHA 1990, reprint 3. | 23 - 26 |

# Chapter 1 Introductory

## 1 Name of Act

This Act may be cited as the *Mental Health Act 1990*.

## 2 Commencement

This Act commences on a day or days to be appointed by proclamation.

## 3 Definitions

In this Act or in a particular provision of this Act, the following expressions have the meanings set out in the dictionary in Schedule 1:

administration of a treatment to a person
affected person
appeal
assessor
authorised applicant
authorised hospital
authorised officer
behaviour
Board
Chief Health Officer
community counselling order
community treatment order
competent interpreter
continued treatment patient
Court
Deputy President
determination of the Tribunal
Director
Director-General
exercise of a function
forensic patient
function
guardian
health care agency
hospital
informal patient
medical superintendent
member
mental illness
mentally disordered person
mentally ill person
near relative
nearest relative
official visitor
patient
patient's account
person who administers a treatment
person who performs
psychosurgery
premises
President
prison
psychiatric case manager
psychosurgery
Psychosurgery Review Board
responsible medical officer
responsible person
special medical treatment
surgical operation
taking to and detaining in a hospital
temporary patient
treatment plan
Tribunal
welfare officer

# Chapter 2 Objects etc

## 4 Care, treatment and control of mentally ill and mentally disordered persons

(1) The objects of this Act in relation to the care, treatment and control of persons who are mentally ill or mentally disordered are:

(a) to provide for the care, treatment and control of those persons, and

(b) to facilitate the care, treatment and control of those persons through community care facilities and hospital facilities, and

(c) to facilitate the provision of hospital care for those persons on an informal and voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis, and

(d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care.

(2) It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:

(a) persons who are mentally ill or who are mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given, and

(b) in providing for the care and treatment of persons who are mentally ill or who are mentally disordered, any restriction on the liberty of patients and other persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances.

## 5 Additional administrative objects of Act

In addition to the objects set out in section 4, the objects of this Act are:

(a) to establish the Mental Health Review Tribunal, and

# Chapter 3 Mentally ill and mentally disordered persons

## 8 Criteria for involuntary admission etc as mentally ill person or mentally disordered person

A person is a mentally ill person or a mentally disordered person for the purpose of:

(a) the involuntary admission of the person to a hospital or the detention of the person in a hospital under this Act, or

(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a hospital or other place,

if, and only if, the person satisfies the relevant criteria set out in this Chapter.

## 9 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

## 10 Mentally disordered persons

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

(a) for the person's own protection from serious physical harm, or

(b) for the protection of others from serious physical harm.

**11 Certain words or conduct may not indicate mental illness or disorder**

(1) A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:

(a) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief,

(b) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief,

(c) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy,

(d) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation,

(e) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity,

(f) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity,

(g) that the person engages in or has engaged in sexual promiscuity,

(h) that the person engages in or has engaged in immoral conduct,

(i) that the person engages in or has engaged in illegal conduct,

(j) that the person has developmental disability of mind,

(k) that the person takes or has taken alcohol or any other drug,

(l) that the person engages in or has engaged in anti-social behaviour.

(2) Nothing in this Chapter prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind.

# Part 2 Involuntary admission to hospitals

## Division 1 Admission to and detention in hospitals

### 20 Detention of persons generally

A person must not be admitted to, or detained in or continue to be detained in, a hospital under this Part unless the medical superintendent is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available to the person.

### 21 Detention on certificate of medical practitioner or accredited person

(1) A person may be taken to and detained in a hospital (other than an authorised hospital) on the certificate of a medical practitioner or an accredited person:

(a) who has personally examined or personally observed the person immediately before or shortly before completing the certificate, and

(b) who is of the opinion that the person is a mentally ill person or a mentally disordered person, and

(c) who is satisfied that no other appropriate means for dealing with the person are reasonably available, and that involuntary admission and detention are necessary, and

(d) who is not a near relative of the person.

(2) The certificate is to be in the form set out in Part 1 of Schedule 2.

(3) A medical practitioner or an accredited person who gives any such certificate and who has (directly or indirectly) a pecuniary interest in any authorised hospital, or has a near relative, partner or assistant who has such an interest, must, on giving the certificate, disclose that fact and give particulars of the interest in the certificate.

(4) A person may not be admitted to or detained in a hospital on a certificate:

(a) certifying that the person is a mentally ill person—unless the person is so admitted within 5 days after the day on which the certificate is given, or

(b) certifying that the person is a mentally disordered person—unless the person is so admitted within 1 day after the day on which the certificate is given.

### 22 Assistance by police

(1) A medical practitioner or an accredited person who gives a certificate under section 21 and who is of the opinion:

(a) that the condition of the person in respect of whom the certificate is given is such that the assistance of a member of the Police Force is required to take the person to hospital, and

(b) that no other means of taking the person to a hospital (other than an authorised hospital) are reasonably available,

may endorse the certificate in the form set out in Part 2 of Schedule 2.

(2) A member of the Police Force to whose notice any such endorsement is brought must, as soon as practicable:

(a) apprehend and take or assist in taking the person in respect of whom the certificate is given to a hospital (other than an authorised hospital), or

(b) cause or make arrangements for some other member of the Police Force to apprehend or take or assist in taking the person to a hospital (other than an authorised hospital).

(3) A member of the Police Force may enter premises, if need be by force, for the purpose of apprehending any such person, and may apprehend any such person, without the warrant of a justice.

### 23 Detention on request of relative or friend

(1) A person may be detained in a hospital (other than an authorised hospital) on a written request made by a relative or friend of the person to the medical superintendent.

(2) The medical superintendent may not detain any such person unless the medical superintendent is satisfied that, because of the distance required to be travelled in order to have the person examined by a medical practitioner and the urgency of the circumstances, it is not reasonably practicable to seek to have the person detained under section 21.

the appropriate person may, by order, authorise a medical practitioner or an accredited person and any other person (including a member of the Police Force) who may be required to assist the medical practitioner or accredited person to visit and to personally examine or personally observe the person.

(2) A person so authorised may enter premises, if need be by force, in order to enable the examination or observation to be carried out.

(3) A person who is examined or observed in accordance with this section may be detained in accordance with section 21.

(4) A medical practitioner or an accredited person authorised under this section is required to notify in writing the appropriate person who made the order of any action taken under the order as soon as practicable after the action is taken.

(5) In this section, ***appropriate person*** includes a Magistrate and a person who is employed in the Attorney General's Department and who is a person or a member of a class or description of persons prescribed for the purposes of this section.

### 28 Refusal to detain

The medical superintendent must refuse to detain a person under this Division if the medical superintendent is of the opinion that the person is not a mentally ill person or a mentally disordered person.

### 29 Examination on detention at hospital

(1) A person taken to and detained in a hospital under this Division must be examined, as soon as practicable (but not more than 12 hours) after the person's arrival at the hospital, by the medical superintendent.

(2) A person must not be detained (except as provided by section 37 or 37A) after the examination unless the medical superintendent certifies that, in the opinion of the medical superintendent, the person is a mentally ill person or a mentally disordered person.

(3) A medical practitioner on whose certificate or request a person has been admitted to a hospital must not examine the person for the purposes of this section.

### 30 Information to be given to detained person

(1) The medical superintendent must, as soon as practicable after a person is taken to a hospital under this Division, give to the person an oral explanation and a written statement (in the form prescribed by the regulations) of the person's legal rights and other entitlements under this Act.

(2) The medical superintendent must, as soon as practicable after it is decided to do all such things as may be necessary to cause a person who is an informal patient to be detained in a hospital under this Division, give to the person an oral explanation and a written statement (in the form prescribed by the regulations) of the person's legal rights and other entitlements under this Act.

(3) If the medical superintendent is of the opinion that a person is not capable of understanding the explanation or statement when it is first given, another explanation or statement must be given to the person not later than 24 hours before an inquiry is held before a Magistrate in respect of the person.

(4) The medical superintendent must, if the person is unable to communicate adequately in English but is able to communicate adequately in another language, arrange for an oral explanation under this section to be given in that other language.

### 31 Treatment of patients

(1) A person (including the medical superintendent of a hospital), in administering or authorising the administration of any medication to a person taken to and detained in a hospital under this Division:

(a) must have due regard to the possible effects of the administration of the medication, and

(b) must prescribe the minimum medication, consistent with proper care, to ensure that the person is not prevented from communicating adequately with any other person who may be engaged to represent the person at an inquiry under section 41 (Inquiry concerning detained person).

(2) The medical superintendent of a hospital may, subject to this Act, give, or authorise the giving of, such treatment (including any medication) as the medical superintendent thinks fit to a person detained in the hospital in accordance with this Act.

### 32 Further examination at hospital

(1) If the medical superintendent has, under section 29, certified that a person is a mentally ill person or a mentally disordered person, the medical superintendent must, as soon as practicable after certifying the person, cause the person to be examined by another medical practitioner who is, if the medical superintendent is not a psychiatrist, a psychiatrist.

(2) If the medical superintendent of a hospital (not being a medical officer, nominated by the medical superintendent, attached to the hospital) did not, under section 29, examine the person admitted to and detained in the hospital, the medical superintendent may, subject to subsection (1), be the examining medical practitioner referred to in that subsection.

(3) If the medical practitioner who examines a person under subsection (1) is of the opinion that the person is not a mentally ill person or a mentally disordered person, the medical superintendent must, as soon as practicable after being notified of that opinion, cause the person to be examined by a medical practitioner who is a psychiatrist.

(4) A medical practitioner on whose certificate or request a person has been admitted to a hospital may not examine the person for the purposes of this section.

### 33 Consequence of further examination

(1) If after examination under section 32 by a medical practitioner of a person taken to and detained in a hospital the medical practitioner is of the opinion that the person is a mentally ill person or a mentally disordered person, the medical practitioner must advise the medical superintendent accordingly in the prescribed form.

(2) If after examination of a person under section 32 by 2 medical practitioners neither medical practitioner is of the opinion that the person is a mentally ill person or a mentally disordered person, the person must not (except as provided by section 37 or 37A) be further detained in the hospital.

(3) A medical practitioner who furnishes advice under subsection (1) in respect of a person is wherever practicable required to be available, on reasonable notice, to attend an inquiry held under section 41 concerning the person in order to give evidence concerning the person.

(4) A medical practitioner who furnishes advice under subsection (1) and who has (directly or indirectly) a pecuniary interest in any authorised hospital, or has a near relative, partner or assistant who has such an interest, must, on furnishing the advice, disclose that fact and give particulars of the interest in the advice.

### 34 Formation of opinion as to mental illness etc

The medical superintendent or other medical practitioner, in forming an opinion under section 29 or 32 as to whether a person is a mentally ill person or a mentally disordered person, may take into account, in addition to his or her own observations, any other available evidence which he or she considers reliable and relevant.

### 35 Limited detention of mentally disordered persons

(1) A person who has, under section 29, been certified to be a mentally disordered person and who has not subsequently, on examination under section 32, been found to be a mentally ill person must not be detained in the hospital for a continuous period of more than 3 days (not including weekends and public holidays).

(2) The medical superintendent of a hospital must examine a mentally disordered person detained in the hospital at least once every 24 hours.

(3) If, on examination of a person detained as a mentally disordered person or a mentally ill person, a medical superintendent is of the opinion that the person is not a mentally disordered person or a mentally ill person or that other care of a less restrictive kind is appropriate and reasonably available to the person, the person must not (except as provided by section 37 or 37A) be further detained in the hospital.

(4) A person must not be admitted to and detained in a hospital on the grounds that the person is a mentally disordered person on more than 3 occasions in any 1 month.

### 36 Persons detained after apprehension by police or brought to hospital on Magistrate's order

(1) This section applies:

(a) to a person to whom section 24 (1) (a) applies who has been taken to a hospital under section 24, and

(2) If a police officer is present at the hospital to ascertain the results of any examination or examinations when the decision not to certify a person is made or the relevant opinions or opinion are or is known to the medical superintendent, the medical superintendent must release the person into the custody of the police officer.

(3) If a police officer is not so present, the medical superintendent must, as soon as practicable after that decision is made or the relevant opinions or opinion are or is known to the medical superintendent, notify a police officer at the police station nearest to the hospital, or a police station nominated for the purposes of this section by the Commissioner of Police, that the person will not be further detained.

(4) It is the duty of the police officer notified by the medical superintendent to ensure that a police officer attends the hospital and apprehends the person as soon as practicable after the notification.

(5) The medical superintendent must detain the person pending the apprehension of the person by a police officer.

## Division 2 Inquiries relating to mentally ill persons

### 38 Notice of inquiry and other matters

(1) A medical superintendent must, after receiving advice under section 33 (1) that a person is a mentally ill person or that a person detained under section 29 as a mentally ill person is a mentally disordered person, and after complying with this section, bring the person before a Magistrate as soon as practicable.

(2) On receiving advice under section 33 (1), the medical superintendent must:

(a) inform the person in respect of whom the advice is furnished of the medical superintendent's duty to do all such things as are reasonably practicable to give notice as referred to in subsection (3), and

(b) obtain, or make all reasonable efforts to obtain, from the person the information required to enable the giving of that notice.

(3) The medical superintendent must, in accordance with the regulations, do all such things as are reasonably practicable to give notice to the following persons of the medical superintendent's intention to bring the person in respect of whom any such advice is furnished before a Magistrate:

(a) the nearest relative, if there is one, of the person or a relative nominated by the person,

(b) the person's guardian, if any,

(c) any personal friend or friends of the person, up to 2 in number.

(4) Notice need not be given to the nearest relative or any personal friend of the person if the person objects to it being given.

### 39 Dress

The medical superintendent is to ensure that, so far as is reasonably practicable, a person in respect of whom advice under section 33 (1) is furnished is, when brought before the Magistrate, dressed in street clothes.

### 40 Termination of detention

(1) If, at any time before a person is brought before a Magistrate under section 38, the medical superintendent is of the opinion:

(a) that the person has ceased to be a mentally ill person or a mentally disordered person, or

(b) that other care of a less restrictive kind is appropriate and reasonably available to the person,

the medical superintendent must release the person from detention in the hospital.

(1A) If, at any time before a person is brought before a Magistrate under section 38, the medical superintendent is of the opinion that the person has ceased to be a mentally ill person but is a mentally disordered person, the person must not be further detained for a period of more than 3 days (not including weekends and public holidays).

(2) A medical superintendent may, immediately on releasing a person, admit that person as an informal patient.

### 41 Inquiry concerning detained person

(1) A Magistrate is required to hold an inquiry in respect of the person brought before the Magistrate under section 38.

(2) The Magistrate may appoint a person to assist the Magistrate in respect of the inquiry and a person so appointed may appear before the Magistrate during the holding of the inquiry.

(b) to any evidence given at the inquiry by an expert witness concerning the person's cultural background and its relevance to any question of mental illness.

### 51 Result of finding that person is mentally ill

(1) If, after holding an inquiry, a Magistrate is satisfied that on the balance of probabilities a person is a mentally ill person, the Magistrate must take the action set out in subsection (2) or subsection (3).

(2) The Magistrate may order the discharge of the person to the care of a relative or friend who satisfies the Magistrate that the person will be properly taken care of or order such other course of action in respect of the person (including a community treatment order) as the Magistrate thinks fit.

(3) If the Magistrate is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available or that for any other reason it is not appropriate to take the action set out in subsection (2), the Magistrate must direct that the person be detained in, or admitted to and detained in, a hospital specified in the direction for further observation or treatment, or both, as a temporary patient for such period (not exceeding 3 months) as the Magistrate, having regard to all the circumstances of the case, specifies.

(4) An order or direction made or given by a Magistrate under this section has effect according to its tenor.

### 52 Result of finding that person is not mentally ill

(1) If, after holding an inquiry, a Magistrate is not satisfied that on the balance of probabilities a person is a mentally ill person, the Magistrate must order that the person be discharged from the hospital in which the person is detained and any such order has effect according to its tenor.

(2) The Magistrate may, if the Magistrate thinks it in the interests of the person to do so, defer the operation of an order for the discharge of a person for a period not exceeding 14 days.

(3) Nothing in this section prevents the Magistrate from making a community counselling order in respect of the person.

# Chapter 8 Establishment and administration of hospitals

## Part 1 Hospitals

### Division 1 Hospitals other than authorised hospitals

#### 208 Establishment of hospitals other than authorised hospitals

(1) The Director-General, by order published in the Gazette:

(a) may declare any premises specified or described in the order, being premises to which this section applies, to be a hospital, and

(b) may, in the same or another order so published, assign a name to the premises so specified or described.

(2) The Director-General may, by order published in the Gazette, change the name assigned to any premises specified or described in such an order.

(3) Premises to which this section applies are:

(a) premises which belong to or are under the control of the Crown or a person acting on behalf of the Crown, and

(b) a public hospital within the meaning of the *Health Services Act 1997*, and

(c) (Repealed)

(d) where the person to whom premises belong or who has control of premises, by an instrument in writing given to the Director-General, agrees to the premises being premises to which this section applies—those premises.

#### 209 Appointment of medical superintendents

The Director-General must, by instrument in writing, appoint a medical practitioner as medical superintendent of a hospital, other than an authorised hospital.

(2) The Director-General, pursuant to an application:

(a) may vary any term or condition to which a licence is subject, or

(b) may refuse to grant the application.

(3) If the Director-General varies any term or condition to which a licence is subject, the variation has effect according to its tenor.

### 219 Medical services in authorised hospitals

The holder of a licence must make such arrangements as may be approved by the Director-General for the provision of medical services to patients in the authorised hospital.

### 220 Appointment of medical superintendent

The holder of a licence must appoint a medical practitioner approved by the Director-General as medical superintendent of the authorised hospital.

### 221 Duties of medical superintendent

The medical superintendent of an authorised hospital must cause to be kept such records and furnish to the Director-General such particulars as are approved by the Minister in respect of the admission, treatment, discharge, removal, absence with or without leave or death of each patient admitted to the hospital.

### 222 Appointment of deputy medical superintendent

(1) The holder of a licence may appoint a medical practitioner as deputy medical superintendent of the authorised hospital.

(2) The appointment of the medical practitioner must be approved by the Director-General before it takes effect.

### 223 Functions of deputy medical superintendent

The deputy medical superintendent of an authorised hospital has the functions of the medical superintendent of the hospital during the absence, for any cause whatever, of the medical superintendent or during a vacancy in the office of medical superintendent.

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# ▲Schedule 1 Dictionary of terms used in the Act

(Section 3)

***accredited person*** means a person appointed under section 287A to be an accredited person.

***administration of a treatment to a person***, in Division 2 of Part 1 of Chapter 7, includes the performance of an operation on the person.

***affected person*** means a person in respect of whom a community counselling order or a community treatment order has been applied for or made.

***appeal***, in Chapter 10, means an appeal under section 281.

***assessor***, in Chapter 10, means a person nominated as an assessor under section 282.

***authorised applicant***, in relation to **an application for a community counselling order or community treatment order**, means:

(a) the affected person, or

(b) a near relative of, or a relative nominated by, the affected person, or

(c) a medical practitioner who is familiar with the clinical history of the affected person, or

(d) a person prescribed by the regulations as being authorised to make such an application.

***authorised hospital*** means premises in respect of which a licence has been granted to any person under Division 2 of Part 1 of Chapter 8.

***authorised officer***, in relation to **any function conferred or imposed on an authorised officer by this Act**, means a person appointed under section 235 to be an authorised officer and who is entitled to exercise that function.

***behaviour***, in the definition of ***psychosurgery***, does not include:

(a) grand mal, petit mal or Jacksonian epilepsy, or

(b) complex apparently automatic behaviour, whether presumed to be secondary to cerebral dysrhythmia or not,

but does include rage attacks, whether or not associated with epilepsy.

***Board***, in Chapter 7, means the Psychosurgery Review Board.

***Chief Health Officer*** means the Chief Health Officer of the Department of Health.

***community counselling order*** means a community counselling order made under section 118 and for the time being in force.

***community treatment order*** means a community treatment order made under section 131 and for the time being in force.

***competent interpreter*** means a person approved by the Director-General for the purposes of this definition or a person who has such qualifications as may be approved by the Director-General for the purposes of this definition.

***continued treatment patient*** means a temporary patient who is classified as a continued treatment patient under section 57 or 59 or a forensic patient who is classified as a continued treatment patient under section 89.

***Court*** means the Supreme Court.

***Deputy President***, in Chapter 9 and Schedule 6, means a person appointed, for the time being, as a Deputy President of the Tribunal.

***determination of the Tribunal***, in Chapters 9 and 10, includes an order, direction or decision of the Tribunal.

***Director***, in relation to **a health care agency**, means the person who, in an order for the time being in force under section 115, is appointed as Director of the agency and, if a Deputy Director is appointed, includes the Deputy Director.

***Director-General*** means the Director-General of the Department of Health.

***exercise of a function*** includes, where the function is a duty, a reference to the performance of the duty.

***forensic patient*** means:

(a) a person who is detained in a hospital, prison or other place pursuant to an order under section 10 (3) (c), 14, 17 (3), 25, 27 or 39 of the *Mental Health (Criminal Procedure) Act 1990* or section 7 (4) of the *Criminal Appeal Act 1912* (including that subsection as applied by section 5AA (5) of that Act), or

(b) a person who is detained in a hospital pending the person's committal for trial for an offence or pending the person's trial for an offence, or

(c) a person who has been transferred to a hospital while serving a sentence of imprisonment and who has not been classified by the Tribunal as a continued treatment patient.

***function*** includes a power, authority and duty.

***guardian***, in relation to **the exercise of any function under this Act by the guardian of a person under guardianship within the meaning of the *Guardianship Act 1987***, means a guardian who is able to exercise that function.

***health care agency*** means a hospital or other health care service declared by an order under section 114 to be a health care agency.

***hospital*** means:

(a) any premises the subject of an order in force under section 208 by which the premises are declared to be a hospital, or

(b) an authorised hospital.

***informal patient*** means:

(a) a person who has been admitted to a hospital under section 12, or

(b) a person who has been classified as an informal patient under section 54 or 64.

***medical superintendent***, in relation to:

(a) **a hospital, other than an authorised hospital**, means the medical practitioner appointed, under section 209, as medical superintendent of the hospital, and

(b) **an authorised hospital**, means the medical practitioner appointed, under section 220, as medical superintendent of the authorised hospital,

and, in Chapter 4, sections 142 and 143 and Division 2 of Part 1 of Chapter 7, includes a reference to a medical officer, nominated by the medical superintendent, attached to the hospital or authorised hospital, as the case may be.

***member***, in Chapter 9 and Schedule 6, means a person appointed, for the time being, as a member of the Tribunal.

***member***, in Schedule 4, means member of the Psychosurgery Review Board.

***mental illness*** means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:

(a) delusions,

(b) hallucinations,

(c) serious disorder of thought form,

(d) a severe disturbance of mood,

(e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

***mentally disordered person***, for the purposes of this Act set out in section 8, means a person who satisfies the relevant criteria set out in Chapter 3.

***mentally ill person***, for the purposes of this Act set out in section 8, means a person who satisfies the relevant criteria set out in Chapter 3.

***near relative***, in relation to **a person**, means a parent, brother, sister or child or the spouse of the person and such other person or persons as may be prescribed as a near relative of the person.

***nearest relative***, in relation to **a patient** (in Division 1 of Part 1 of Chapter 7) or in relation to **a patient or a person under detention in a hospital** (in Part 2 of Chapter 7), means:

(a) if the patient or person has a spouse and is not separated from his or her spouse by order of a court or by agreement—the patient's or person's spouse, or

(b) except as provided by paragraph (c), if the patient or person has no spouse or has a spouse. but is separated from his or her spouse by order of a court or by agreement, the parents or the surviving parent of the patient or person, or

(c) (Repealed)

(d) if it is ascertained, or not able to be ascertained. that the patient or person has no spouse or surviving parent, or no particulars of the name and whereabouts of any such spouse or surviving parent may be ascertained—such person, if any, as, in the

opinion of the person concerned to identify the nearest relative, has the care, or custody of the patient or person,

but, if the person is a person under guardianship within the meaning of the *Guardianship Act 1987*, means the person's guardian.

***official visitor***, in Schedule 5, includes the Principal official visitor.

***patient*** (except in Division 1 of Part 1 of Chapter 7) means a person who is admitted to a hospital in accordance with this Act and who is in the hospital following the person's admission, and includes a person so admitted while absent from a hospital either with or without leave of absence.

***patient***, in Division 1 of Part 1 of Chapter 7, means a person on whom psychosurgery is or is intended to be performed.

***patient's account***, in Part 3 of Chapter 8, means the account kept in relation to a patient under section 245 (2).

***person who administers a treatment***, in Division 2 of Part 1 of Chapter 7, includes a person who causes a treatment to be administered and a person who knowingly permits a treatment to be administered.

***person who performs psychosurgery***, in Division 1 of Part 1 of Chapter 7, includes a person who causes psychosurgery to be performed and a person who knowingly permits psychosurgery to be performed.

***premises*** includes any land, building and part of any building.

***President***, in Chapter 9 and Schedule 6, means the person appointed, for the time being, as the President of the Tribunal.

***prison*** means a prison as defined in section 4 of the *Prisons Act 1952*.

***psychiatric case manager*** means an officer or an employee of a health care agency who is appointed as the psychiatric case manager of an affected person.

***psychosurgery*** means:

(a) the creation of 1 or more lesions, whether made on the same or separate occasions, in the brain of a person by any surgical technique or procedure, when it is done primarily for the purpose of altering the thoughts, emotions or behaviour of the person, or

(b) the use for such a purpose of intracerebral electrodes to produce such a lesion or lesions, whether on the same or separate occasions, or

(c) the use on 1 or more occasions of intracerebral electrodes primarily for the purpose of influencing or altering the thoughts, emotions or behaviour of a person by stimulation through the electrodes without the production of a lesion in the brain of the person,

but does not include a neurological procedure carried out for the relief of symptoms of Parkinson's disease.

***Psychosurgery Review Board*** means the body of that name constituted under Division 1 of Part 1 of Chapter 7.

***responsible medical officer***, in relation to **a patient**, means a medical practitioner responsible for the clinical care of the patient at the time the clinical care is given.

***responsible person***, in Part 3 of Chapter 8, means:

(a) in relation to a hospital, other than an authorised hospital—the Director-General, and

(b) in relation to an authorised hospital—the medical superintendent of the authorised hospital.

***special medical treatment***, in Part 2 of Chapter 7, means:

(a) a treatment, procedure, operation or examination that is intended, or is reasonably likely, to have the effect of rendering permanently infertile the person on whom it is carried out, or

(b) any other medical treatment that is declared by the regulations to be special medical treatment.

***spouse*** means:

(a) a husband or wife, or

(b) the other party to a de facto relationship within the meaning of the *Property (Relationships) Act 1984*,

but where more than one person would so qualify as a spouse, means only the last person so to qualify.

***surgical operation***, in Part 2 of Chapter 7, means a surgical procedure, a series of related surgical operations or surgical procedures, and the

administration of an anaesthetic for the purpose of medical investigation.

***taking to and detaining in a hospital*** includes, in relation to **a person who is at, but not detained in accordance with this Act in, a hospital**, the detaining of a person in a hospital.

***temporary patient*** means a person in respect of whom a direction given under section 51 (3) or a determination made under section 57 is in force.

***treatment plan***, in Chapter 6, means a plan that states:

(a) in general terms, an outline of proposed treatment, counselling, management, rehabilitation and other services to be provided, and

(b) in specified terms, the method by which, the frequency with which, and the place at which, the services would be provided,

to implement a community counselling order or a community treatment order.

***Tribunal*** means the Mental Health Review Tribunal constituted under Chapter 9.

***welfare officer*** means a person appointed to be a welfare officer under section 242.

# Schedule 2 Medical certificate as to examination or observation of person

(Sections 21, 22)

**Mental Health Act 1990**

**Part 1**

I, ..... (Medical Practitioner/accredited person)
(name in full—use block letters)

of ..... certify that

on ..... 19.....

immediately before or shortly before completing this certificate,

at .....
(state place where examination/observation took place)

I personally examined/personally observed .....

..... for a period of.....
(name of person in full)

.....
(state length of examination/observation)

I certify the following matters:

1. I am of the opinion that the person examined/observed by me is a mentally ill person suffering from mental illness/or a mentally disordered person and that there are reasonable grounds for believing the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:
   (a) in the case of a mentally ill person:
      (i) for the person's own protection from serious harm, or
      (ii) for the protection of others from serious harm, or
   (b) in the case of a mentally disordered person:
      (i) for the person's own protection from serious physical harm, or
      (ii) for the protection of others from serious physical harm.
2. I have satisfied myself, by such inquiry as is reasonable having regard to the circumstances of the case, that the person's involuntary admission to and detention in a hospital are necessary and that no other care of a less restrictive kind is appropriate and reasonably available to the person.
3. Incidents and/or abnormalities of behaviour and conduct (a) observed by myself and (b) communicated to me by others (state name, relationship and address of each informant) are:
   (a) .....
   .....
   .....
   .....
   .....
   (b) .....
   .....
   .....
4. The general medical and/or surgical condition of the person is as follows:
   .....
   .....
   .....
   .....

5. The following medication (if any) has been administered for purposes of psychiatric therapy or sedation:

. . . . . .

. . . . . .

. . . . . .

6. I am not a near relative of the person.
7. I have/do not have a pecuniary interest, directly or indirectly, in an authorised hospital. I have/do not have a near relative/partner/assistant who has such an interest. Particulars of the interest are as follows:

. . . . . .

. . . . . .

. . . . . .

Made and signed this . . . . . day of . . . . . 19 . . . . .

Signature: . . . . . .

**Part 2**

If the assistance of a Police Officer is required, this part of the Form should be completed.

YOU SHOULD NOT REQUEST THIS ASSISTANCE UNLESS IT IS NECESSARY AND THERE ARE NO OTHER MEANS OF TAKING THE PERSON TO HOSPITAL REASONABLY AVAILABLE.

I am of the opinion, in relation to . . . . . .

. . . . . .

(name of person in full)

(a) that the condition of the person is such that the assistance of a Police Officer is required in order to take the person to a hospital, and
(b) that no other means of taking the person to a hospital are reasonably available.

Made and signed . . . . . 19 . . . . .

Signature: . . . . . .

## Notes

1 Chapter 3 of the *Mental Health Act 1990* states:

### 8 Criteria for involuntary admission etc as mentally ill person or mentally disordered person

A person is a mentally ill person or a mentally disordered person for the purpose of:

(a) the involuntary admission of the person to a hospital or the detention of the person in a hospital under this Act, or

(b) determining whether the person should be subject to a community treatment order or be detained or continue to be detained involuntarily in a hospital,

if, and only if, the person satisfies the relevant criteria set out in this Chapter.

## 9 Mentally ill persons

(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:

(a) for the person's own protection from serious harm, or

(b) for the protection of others from serious harm.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person, including any likely deterioration in the person's condition and the likely effects of any such deterioration, are to be taken into account.

## 10 Mentally disordered persons

A person (whether or not the person is suffering from mental illness) is a mentally disordered person if the person's behaviour for the time being is so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control of the person is necessary:

(a) for the person's own protection from serious physical harm, or

(b) for the protection of others from serious physical harm.

## 11 Certain words or conduct may not indicate mental illness or disorder

(1) A person is not a mentally ill person or a mentally disordered person merely because of any one or more of the following:

(a) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular political opinion or belief,

(b) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular religious opinion or belief,

(c) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular philosophy,

(d) that the person expresses or refuses or fails to express or has expressed or refused or failed to express a particular sexual preference or sexual orientation,

(e) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular political activity,

(f) that the person engages in or refuses or fails to engage in, or has engaged in or refused or failed to engage in, a particular religious activity,

(g) that the person engages in or has engaged in sexual promiscuity,

(h) that the person engages in or has engaged in immoral conduct,

(i) that the person engages in or has engaged in illegal conduct,

(j) that the person has developmental disability of mind,

(k) that the person takes or has taken alcohol or any other drug,

(l) that the person engages in or has engaged in anti-social behaviour.

(2) Nothing in this Chapter prevents, in relation to a person who takes or has taken alcohol or any other drug, the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness or other condition of disability of mind.

2 In addition to matters ascertained as a consequence of personally examining or observing the person, account may be taken of other matters not so ascertained where those matters:

(a) arise from a previous personal examination of the person, or

(b) are communicated by a reasonably credible informant.

3 In the *Mental Health Act 1990* ***mental illness*** is defined as follows:

> ***mental illness*** means a condition which seriously impairs, either temporarily or permanently, the mental functioning of a person and is characterised by the presence in the person of any one or more of the following symptoms:
>
> (a) delusions,
>
> (b) hallucinations,
>
> (c) serious disorder of thought form,
>
> (d) a severe disturbance of mood,
>
> (e) sustained or repeated irrational behaviour indicating the presence of any one or more of the symptoms referred to in paragraphs (a)–(d).

4 In the *Mental Health Act 1990* ***near relative*** is defined as follows:

> ***near relative***, in relation to a person, means a parent, brother, sister or child or the spouse of the person and such other person or persons as may be prescribed as a near relative of the person.

Furthermore, ***spouse*** is defined in that Act as follows:

> ***spouse*** means:
>
> (a) a husband or wife, or
>
> (b) the other party to a de facto relationship within the meaning of the *Property (Relationships) Act 1984*,
>
> but where more than one person would so qualify as a spouse, means only the last person so to qualify.

5 For admission purposes, this certificate is valid only for a period of 5 days, in the case of a person who is a mentally ill person, or 1 day, in the case of a person who is a mentally disordered person, after the date on which the certificate is given.

**IN THE HIGH COURT OF AUSTRALIA**
**SYDNEY OFFICE OF THE REGISTRY**

**No. S143 of 2014**

**B E T W E E N:**

**HUNTER AND NEW ENGLAND LOCAL HEALTH DISTRICT**
Appellant

- and -

**SHEILA MARY SIMON**
First Respondent

**WENDY ROSE**
Second Respondent

## ANNEXURE B
## COMPARABLE STATUTORY PROVISIONS

| *Mental Health Act 1990 (NSW)* | *Mental Health Act 2007 (NSW)* |
|---|---|
| s3 | s4 |
| s4 | s3 |
| s8 | s13 |
| s9 | s14 |
| s10 | s15 |
| s11 | s16 |
| s20 | s12 |
| s21 | s19 |
| s28 | - |

| | |
|---|---|
| s29 | s27 |
| s32 | s27 |
| s33 | s27 |
| s34 | s28 |
| s35 | s31 |
| s38 | s34 |
| s51 | s35 |
| s208 | - |
| s209 | s111 |
| s220 | - |
| Schedule 1, Dictionary of the terms used in the MHA 1990 | s4 |
| Schedule 2, medical certificate as to examination or observation of a person | Schedule 1 |