

WHEN STATUTORY POWERS DISTRACT: INVOLUNTARY DETENTION AND TREATMENT LAWS, AND LIABILITY FOR HARM

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Appellate courts have rejected claims of misfeasance by statutory authorities vested with involuntary detention and treatment powers under mental health legislation, treating them as statutory liability matters. We argue that requirements for exercise of involuntary detention powers were factually absent in each of the key cases (McKenna, Presland, Kirkland-Veenstra, and Crowley) and consequently the relevant statutory powers were unavailable. Reliance on statutory liability is misguided and these ratios should be avoided. Instead, negligence claims based on breach of the medical practitioner's duty to patients, which survives activation of the involuntary powers, may provide a more appropriate basis for considering future claims of this class.

I INTRODUCTION

This article examines an emerging and controversial vein of Australian jurisprudence regarding the liability of mental health care providers for patients who cause harm to themselves or others.¹

The liability of providers in many cases is governed by the general principles² of medical negligence law: namely, plaintiffs must establish that the doctor or

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1 The focus of this paper is on Australian case law over the past two decades, noting that there have been other significant cases elsewhere, for example the US decision in *Tarasoff v Regents of the University of California*, 17 Cal 3d 425 (1976). See also the UK cases of: *Holgate v Lancashire Mental Hospital Board*, (1937) 4 All ER 19; *Partington v London Borough of Wandsworth* [1990] Fam Law 468; *Palmer v Tees Health Authority* [1999] EWCA Civ 1533 (2 June 1999); *Osman v UK* (1998) 29 EHRR 245 (28 October 1998). Notably, the legal position in the United Kingdom was modified in *Rabone & Anor v Pennine Care NHS Foundation Trust* [2012] UKSC 2, when the court found that health care provider obligations to third parties were affected by the operation of the European Charter of Human Rights. See also Rachael Mulheron, *Medical Negligence: Non-Patient and Third Party Claims* (Ashgate, 2010) 63; David Miers, 'Liability for Injuries Caused by Violent Patients' (1996) 36(1) *Medicine, Science and the Law* 15.

2 Traditionally an area of common law, every Australian state and territory passed legislation codifying and reforming the common law of negligence in the early 2000s in response to the recommendations of the Review of the Law of Negligence: Final Report ('Ipp Review'). See, eg, *Civil Law (Wrongs) Act 2002* (ACT); *Civil Liability Act 2002* (NSW); *Personal Injuries (Liabilities and Damages) Act 2003* (NT); *Civil Liability Act 2003* (Qld); *Civil Liability Act 1936* (SA); *Civil Liability Act 2002* (Tas); *Wrongs Act 1958* (Vic); *Civil Liability Act 2002* (WA) — collectively the *Civil Liability Acts*. These Acts should not be confused with legislation creating discrete statutory powers, duties, and obligations, such as the Mental Health Acts, which provide the substantive basis for the breach of statutory duty cause of action.

other health care provider owed them a duty of care,³ that the duty was breached,⁴ and that the breach caused the harm suffered by the plaintiff.⁵ Frequently the plaintiff will be the person with mental illness.⁶ Sometimes the plaintiff will be a third party who suffers harm.⁷ In theory, the person with mental illness will typically be found to have contributed to the harm. The provider will often be a joint defendant along with the person with mental illness, or the provider may see a reduction in damages based on the contributory negligence of the mentally ill plaintiff.⁸

In some cases, however, hindsight in light of the harmful events suggests that the severity of the person's mental illness might have justified a greater measure of control being exerted by the health care provider in order to minimise the risk of harm.⁹ It is this category of negligence cases, where potential exercise of statutory powers of involuntary detention is raised, that is the focus of this article.

Specifically, the article examines appellate decisions in four key cases: *Hunter Area Health Service v Presland* ('Presland'),¹⁰ *Stuart v Kirkland-Veenstra* ('Kirkland-Veenstra'),¹¹ *Australian Capital Territory v Crowley* ('Crowley'),¹² and *Hunter and New England Area Health Service v McKenna* ('McKenna').¹³

Two of the cases (*Kirkland-Veenstra* and *McKenna*) were ultimately decided by the High Court. Special Leave to Appeal to the High Court was refused in a third (*Crowley*). The fourth (*Presland*) was a NSW Court of Appeal decision on a claim so controversial it resulted in a direct legislative response by the New South Wales Parliament.¹⁴

3 *Sidaway v Board of Governors of the Bethlem Royal Hospital & Maudsley Hospital Board* [1985] AC 871, 893 (Lord Diplock): '[There is a] single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment'. *Gover v South Australia & Perriam* (1985) 39 SASR 543, 551: '[the duty] extends to the ... examination, diagnosis [and] treatment' of the patient and the provision of information 'in an appropriate case'.

4 *Bolam v Friern Hospital Management Committee* (1957) 1 WLR 582; *Rogers v Whitaker* (1992) 175 CLR 479. Note the statutory modification to the Bolam standard in eg *Civil Liability Act 2002* (NSW) s 50.

5 *Chappel v Hart* (1998) 195 CLR 232, 244 (McHugh J); *Tabet v Gett* (2010) 240 CLR 537; *Harriton v Stephens* (2006) 226 CLR 52.

6 *Presland v Hunter Area Health Service* [2003] NSWSC 754 (19 August 2003); *Adams v State of New South Wales (No 2)* [2008] NSWSC 1394 (23 December 2008); *Australian Capital Territory v Crowley* (2012) 7 ACTLR 142.

7 *Hunter and New England Local Health District v McKenna* (2014) 253 CLR 270.

8 Note however that in many instances the person with mental illness is not formally identified as a defendant in civil proceedings, as they may not have any assets available for realisation in the event of a judgment order for damages being awarded against them.

9 *New South Wales v Fahy* (2007) 232 CLR 486 emphasised the requirement that the harm was foreseeable, rather than identifiable purely in hindsight. Many harms which are foreseeable will be obvious with hindsight, however, not all harms which are evident in hindsight will meet the requirement of being foreseeable.

10 (2005) 63 NSWLR 22.

11 (2009) 237 CLR 215.

12 (2012) 7 ACTLR 142.

13 (2014) 253 CLR 270.

14 *Civil Liability Act 2002* (NSW) s 54A, dealing with '[d]amages limitations if loss results from serious offence committed by mentally ill person', was introduced via the *Civil Liability Amendment Act 2003* (NSW) in direct response to *Presland* (2005) 63 NSWLR 22.

In each case, the plaintiffs were ultimately unsuccessful. The procedural histories of each case, however, reveal some of the tensions and uncertainties arising in cases of this type. Differences in judicial approach reflect the disquiet amongst judges and commentators alike about their resolution.

This article examines the development of the law in Australia as it is being applied in this area. It begins by outlining the principles of liability for the acts of people with mental illness. It reviews the facts of each of the four key cases. The relevant provisions of the mental health legislation considered in each of the cases are then discussed, as is the judicial authority on liability of statutory authorities.¹⁵

The article argues that discussion of the statutory powers is misplaced, as the exercise of those powers was not available in any of the four cases as a finding of fact, overlooked by the courts in three of the cases.¹⁶ Furthermore, notwithstanding this judicial oversight, the application of the principle on statutory authority liability from *Sullivan v Moody* ('*Sullivan*')¹⁷ recurrent throughout the judgments, relies on misinterpretation of the mental health statutes. Similar misinterpretation is also evident in comparisons between liability arising from the failure of health care providers to detain patients under mental health laws, and liability of police and other authorities vested with powers to detain and search citizens while conducting investigations.¹⁸ That misinterpretation is inconsistent with the objects of those enactments and more broadly with domestic¹⁹ and international discrimination law.²⁰

The article concludes by outlining a more appropriate framework for considerations of claims of this type, consistent with the broader field of medical negligence, including treatment of mental illness of lesser severity. It also offers a suggestion for legislative reform to clarify a lingering area of judicial uncertainty; that of co-existent negligence law and statutory duties.

15 Case law seems to draw minimal distinction between 'public authority' and 'statutory authority'. Decisions on each, and indeed the terms themselves, are applied interchangeably. Mason J defined a 'public authority as a body entrusted by statute with functions to be performed in the public interest or for public purposes', in *Sutherland Shire Council v Heyman* (1985) 157 CLR 424, 456 [18].

16 *Kirkland-Veenstra* recognised that the powers were not available, however the reason for the unavailability differed from the reasons in each of the other three cases.

17 (2001) 207 CLR 562.

18 The power of law enforcement officers to detain suspected offenders or to engage in social sweeping such as removal of intoxicated people from public places is evident in, for example, the *Crimes Act 1900* (ACT) s 207; *Crimes Act 1914* (Cth) s 3UD; *Criminal Code Act 1995* (Cth) div 105; *Migration Act 1958* (Cth) ss 180, 189; *Australian Security Intelligence Organisation Act 1979* (Cth) s 34K; *Intoxicated Persons (Care and Protection) Act 1994* (ACT) s 4; *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) ss 95, 206; *Police Administration Act 1996* (NT) ss 120C, 128; *Public Intoxication Act 1984* (SA) s 7; *Police Offences Act 1935* (Tas) s 4A; *Protective Custody Act 2000* (WA) s 6.

19 The *Disability Discrimination Act 1992* (Cth) covers both mental illness (s 4 'disability', (a) (f) and (g)) and the provision of health care services (s 4 'services', (e) and (f)). Section 24 makes it unlawful to discriminate against people with disabilities by refusing provision of services, or altering the terms and conditions, or manner, of provision of services, on the basis of the disability. Both publicly provided and privately-provided mental health care services would be captured under s 4, 'services'; providing different treatment or services to a person with mental illness would be captured by s 24.

20 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) arts 12, 14, 17, 19.

II LIABILITY FOR THE ACTS OF PEOPLE WITH SEVERE MENTAL ILLNESS

Determining liability for the acts of a person with severe mental illness,²¹ typically illness impairing that individual's perception or ability to control their actions, is a legal challenge dating back at least to Roman law.²² Currently, there is divergence in the approaches adopted for determining criminal and civil liability. This divergence potentially creates inconsistencies in the event that an individual is found liable in tort for a harm arising from criminal conduct, of which the person has already been acquitted on the grounds of mental illness.²³

The situation is further complicated in situations of multiple causation, where it is alleged that other actors contributed to the mentally ill person's wrongful acts, for example by enabling the person to participate in those acts by failing to adequately treat, supervise, or control that individual.

A *Criminal Liability and Mental Illness*

It is axiomatic that questions about capacity have implications for criminal liability and for care, and have had for many centuries.

In his early mediaeval *Laws and Customs of England*, Bracton, for example, commented: 'remove intention and every act will be indifferent; it is your intent which distinguishes your acts, and a crime is not committed unless an intention to injure exists; nor is theft committed without the intent to steal'.²⁴

That principle echoed the statement in Justinian's *Digest*, that in dealing with a person who:

is in such a state of insanity that he lacks all understanding ... you can abandon consideration of the measure of his punishment, since he is being punished enough by his very madness. And yet it will be necessary for him to be all too closely guarded, and, if you think it advisable, even bound in chains, this being a matter of not so much punishing as protecting him and of the safety of his neighbors.²⁵

The *Digest* commented:

- 21 This article focuses on mental illness of the most serious types, whereby the ability of the person experiencing the condition to control their actions and thoughts is questionable. Such situations are comparatively rare; the laws discussed herein relate to these situations specifically, rather than to mental illness as a general condition commonly found within the community but attracting no special legal status due to its minimal impact on the capacity or autonomy of the person.
- 22 Alan Watson (tr), *The Digest of Justinian* (University of Pennsylvania Press, 1998) vol 1, 36.
- 23 Note that reported instances of this occurring are rare: *Presland* (2005) 63 NSWLR 22, 33 [43] (Spigelman CJ).
- 24 Henry de Bracton, *On the Laws and Customs of England* (Samuel Thorne trans, Harvard University Press, 1968) [trans of: *De Legibus Et Consuetudinibus Angliæ*] vol 2, 290.
- 25 Watson, above n 22, 36.

those who have custody of the insane are not responsible only for seeing that they do not do themselves too much harm but also for seeing that they do not bring destruction on others. But if that should happen, it may deservedly be imputed to the fault of those who were too neglectful in performing their duties.²⁶

Sir Edward Coke similarly alluded to the unjustness of holding ‘madmen’ criminally liable for their actions when he said:

the execution of an offender is for example, *ut poena ad paucos, metus ad omnes perveniat*: but so it is not when a mad man is executed; but should be a miserable spectacle, both against law, and of extreme inhumanity and cruelty, and can be no example to others.²⁷

Blackstone referred to a ‘deficiency in will’, which excuses those with a ‘defective or vitiated understanding’ (for example the insane) ‘from the guilt of crimes’ but allows that persons deprived of reason may be confined until they recover their senses and not ‘suffered to go loose to the terror of the king’s subjects’.²⁸ The criminal defence of insanity is well established. *R v Hadfield*²⁹ and *M’Naghten’s Case*³⁰ both contributed to further reform of the defence. The M’Naghten rules,³¹ particularising the tests which must be applied to recognise an insanity defence, have evolved into statutory defences in many jurisdictions.³²

B Tortious Liability and Mental Illness

In contrast to the extensive academic and judicial consideration of liability in relation to crime, the parallel question of civil liability for the acts of people with severe mental illness has received comparatively little judicial attention. The principle that there is no comparable defence in tort to the insanity criminal defence rests principally on three cases: *White v Pile*,³³ *Adamson v Motor Vehicle Insurance Trust*,³⁴ and the Queensland Court of Appeal decision in *Carrier v Bonham*.³⁵

26 Ibid 36.

27 Edward Coke, *Institutes of the Laws of England* (Brooke, 1797) vol 3, 6.

28 William Blackstone, *Commentaries on the Laws of England: Vol IV — Of Public Wrongs* (University of Chicago Press, 1979) 24.

29 (1800) 27 St Tr (New Series) 1281.

30 *M’Naghten’s Case* [1843] All ER Rep 229.

31 *M’Naghten’s Case* [1843] UKHL J16.

32 See for example *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic); *Crimes Act 1900* (NSW) s 23A; *Criminal Justice (Mental Impairment) Act 1999* (Tas); *Crimes Act 1900* (ACT) s 14.

33 (1950) 68 WN (NSW) 176.

34 (1957) 58 WALR 56.

35 [2001] QCA 234.

In *Carrier v Bonham*, the court established that there is no adjustment to the standard of care expected of a person with mental illness, distinguishing it from situations involving child defendants.³⁶

The differing objectives of criminal law and tort law provide as good a basis as any to justify the differential treatment of the same impairment by the two arms of the law. Spigelman CJ summarised the objectives of sentencing in criminal law as follows:

the ineluctable core of the sentencing task is a process of balancing overlapping, contradictory and incommensurable objectives. It has always been thus. The requirements of deterrence, rehabilitation, denunciation, punishment and restorative justice do not point in the same direction.³⁷

Containment for the protection of the public has also been identified as a consideration in sentencing.³⁸ Tort law, in contrast, is more ambivalent on the issue of blameworthiness. Although Lord Atkin famously stated in *Donoghue v Stevenson* that ‘liability for negligence ... is no doubt based upon a general public sentiment of moral wrongdoing for which the offender must pay’,³⁹ negligence also attaches to ‘blameless’ defendants in cases involving strict liability and non-delegable duties of care or vicarious liability.⁴⁰ That is often justified by the objective of compensating the plaintiff for the harm they suffered, and ensuring the economic burdens associated with that harm fall where most appropriate.⁴¹ Reflecting Coke and Blackstone,⁴² it is therefore illogical to punish someone for an act over which they had no control, as the punishment they receive is unlikely to prevent them or deter others from similar wrongdoing in future. Conversely, a plaintiff who suffers an injury as a consequence of the tortious conduct of another still bears the same costs associated with that injury regardless of whether the wrongdoer was mentally ill or not.

C General Principles of Liability: Multiple Tortfeasors, and General Medical Negligence

Multiple causation, where harm suffered by the plaintiff is the result of multiple negligent acts or omissions (often by multiple parties), is recognised throughout

36 Ibid [34] quoting Kitto J in *McHale v Watson* (1966) 115 CLR 199, 213.

37 Chief Justice Spigelman, ‘Judging Today’ (Speech delivered at the Local Courts of New South Wales 2003 Annual Conference, 2 July 2003) <http://www.supremecourt.justice.nsw.gov.au/Documents/spigelman_speeches_2003.pdf>. These five themes recur throughout the literature examining the purposes of criminal law. See, eg, Simon Bronitt and Bernadette McSherry, *Principles of Criminal Law* (Thomson Reuters Lawbook, 2nd ed, 2005) 17–31.

38 *Veen v The Queen (No 2)* (1988) 164 CLR 465.

39 *Donoghue v Stevenson* [1932] AC 562, 580.

40 James Goudkamp, ‘The Spurious Relationship between Moral Blameworthiness and Liability for Negligence’ (2004) 28 *Melbourne University Law Review* 343.

41 Stephen Perry, ‘The Moral Foundation of Tort Law’ (1992) 77 *Iowa Law Review* 449; Mark Geistfeld, ‘Negligence, Compensation, and the Coherence of Tort Law’ (2002) 91 *Georgetown Law Journal* 585; Michael Tilbury, ‘Reconstructing Damages’ (2003) 27 *Melbourne University Law Review* 697.

42 Coke, above n 27; Blackstone, above n 28.

negligence law. Legislative reform in many Australian jurisdictions has replaced the ‘but for’ test of causation criticised by the High Court in *March v Stramare*⁴³ with the ‘necessary condition’ test,⁴⁴ enabling the contribution of necessary but individually insufficient negligent acts to be better recognised as a source of liability. It is not uncommon to see multiple defendants identified in claims of medical negligence.⁴⁵ Frequently these defendants will be individual doctors, and the organisations at whose facilities treatment was provided. In the case of harm to a third party (ie the plaintiff is not the person receiving the medical treatment) where it is alleged that the treatment provided or withheld contributed to the harm, the treatment recipient is also potentially a defendant.⁴⁶

Neither case law nor statute creates any special rules governing joint tortfeasance or contributory negligence in cases involving a mentally ill defendant.⁴⁷ Prima facie, therefore, there is no reason for a provider of mental health care services to avoid liability for their negligent acts which contribute to the harm suffered, provided that the plaintiff can demonstrate the requirements for all negligence claims (existence of a duty of care between the parties, breach of that duty, and causation between the breach of duty and the harm suffered) have been met.

Similarly, if the person with mental illness is claiming their treatment resulted in harm, the ordinary principles governing medical negligence apply. Specifically, the well-established common law duty of care relationship existing between a doctor and patient in the context of providing treatment applies. The standard of care will typically be that established by *Rogers v Whitaker*,⁴⁸ subject to subsequent statutory modifications,⁴⁹ and the plaintiff will need to demonstrate that the doctor’s negligence was a cause of the harm suffered, as per the reformed causation tests discussed in the preceding paragraph. While this seems obvious (Adams J in *Presland v Hunter Area Health Service* described it as ‘not controversial’⁵⁰), judicial consideration elsewhere has typically ignored the existence of a common law duty surviving the mental health legislation, as will be discussed in greater detail in Part VI.

It is worth bearing in mind, therefore, that none of the judgments expressly considered the liability of the person with mental illness regarding either the harm

43 *March v E & MH Stramare Pty Ltd* (1991) 171 CLR 506.

44 See for example *Civil Law (Wrongs) Act 2002* (ACT) s 45(1)(a); *Civil Liability Act 2002* (NSW) s 5D(1)(a).

45 Both *Presland* and *McKenna* identified multiple defendants, including treating practitioners and the authorities responsible for the facilities providing treatment. Examples from other medical negligence contexts include *Melchior & Anor v Cattnach & Anor* [2000] QSC 285; *Boehm v Deleuil & Anor* [2005] WADC 55.

46 Note that reasons such as lack of assets, or the death of the person, may render pursuing them for a contribution in a claim for damages futile; consequently, the liability of some contributors may never be argued before a court.

47 See, eg, *Carrier v Bonham and Anor* [2000] QDC 226. The State of Queensland, as the operator of the hospital, was the second defendant identified in the initial claim; the plaintiff’s claim against the State of Queensland failed on causation in the first instance, and that finding was not appealed.

48 (1992) 175 CLR 479.

49 For example *Civil Liability Act 2002* (NSW) s 5O.

50 [2003] NSWSC 754 (19 August 2003) [18].

they or third party plaintiffs suffered, when their acts were a factor in causing that harm. In *Crowley* and *Presland*, contributory negligence by the plaintiff was not raised.⁵¹ In *McKenna* and *Kirkland-Veenstra*, the person with mental illness was deceased by the time litigation commenced.⁵² In *Kirkland-Veenstra*, the person's widow brought claims on behalf of the person, and on her own behalf.⁵³

III 'FROM TIME TO TIME, THINGS GO WRONG': FACTS OF THE CASES

Presland

The case of *Presland* highlighted some of the legal tensions underpinning legal liability and mental illness,⁵⁴ as well as revealing some deeply entrenched societal beliefs about mental illness and negligence.⁵⁵ The facts of *Presland* will be considered in greater detail later in the article. As a brief summary, the plaintiff, Presland, was taken to hospital with head injuries by police responding to reports of a violent altercation. Prior to his admission, Presland had exhibited multiple symptoms of psychosis, and was transferred to the hospital's psychiatric facility. After a short period (less than 24 hours) he was discharged from the psychiatric facility. Six hours later, he stabbed and killed his brother's fiancée, Kelley Laws.⁵⁶

He was acquitted of murder on the grounds of mental illness,⁵⁷ and detained as a forensic patient in accordance with s 39 of the *Mental Health (Criminal Procedure) Act 1990* (NSW).

Subsequent to his release, Presland sued the Hunter Area Health Service, as the operator of both the John Hunter Hospital (general) and the James Fletcher Hospital (psychiatric), and the psychiatric registrar who approved his discharge, Dr Jacob Nazarian. Presland brought an action in negligence for economic loss arising from his incarceration after the death of Ms Laws, and general damages attributable to the trauma and emotional distress occasioned by that detention.

51 *Crowley* (2012) 7 ACTLR 142, [41]. In *Presland v Hunter Area Health Service* [2003] NSWSC 754 (19 August 2003), Adams J at first instance did not discuss a reduction for contributory negligence, suggesting that the defendants did not raise contributory negligence by the plaintiff in their response.

52 *Simon v Hunter and New England Area Health Service* [2009] NSWSC 758 (31 July 2009) [10]; *Kirkland-Veenstra v Stuart* (2008) 23 VR 1, 1 [1].

53 (2009) 237 CLR 215, 223 [3].

54 *Presland* (2005) 63 NSWLR 22.

55 See, eg, Kathryn Peterson, 'Where is the Line to be Drawn? Medical Negligence and Insanity in *Hunter Area Health Service v Presland*' (2006) 28 *Sydney Law Review* 181; Damien Carrick, 'The Case of Kevin Presland', *The Law Report*, 14 June 2005 <<http://www.abc.net.au/radionational/programs/lawreport/the-case-of-kevin-presland/3451078#transcript>>.

56 *Presland v Hunter Area Health Service* [2003] NSWSC 754 (19 August 2003) [2], [104].

57 *Ibid* [1].

The crux of the plaintiff's claim was that the defendants were negligent

not to have detained him as an involuntary patient under the *Mental Health Act 1990*, ... an action, which would have averted the tragic death at his hands of Ms Laws, his subsequent incarceration and the distress and economic loss which resulted from these events.⁵⁸

The judge at first instance, Adams J, found for the plaintiff, and awarded him general damages of \$225 000,⁵⁹ and damages for economic loss.⁶⁰

The public outrage that followed the decision prompted the NSW parliament to amend the *Civil Liability Act 1990* (NSW).⁶¹ Section 54A(1) applies to a liability arising out of death, injury or damage to a person in relation to conduct that would, on the balance of probabilities, have constituted a serious offence if the person had not been suffering from a mental illness at the time of the conduct.⁶² Section 54A(2) provides that no damages under s 54A(1) may be awarded for non-economic loss and no damages may be awarded for non-economic loss or loss of earnings.

Adams J's findings were subsequently overturned on appeal, by a 2:1 majority, Spigelman CJ dissenting. The ratio of the appellate decision was based on the jurisprudence governing liability of statutory authorities, particularly *Graham Barclay Oysters Pty Ltd v Ryan* ('*Barclay*')⁶³ and *Crimmins v Stevedoring Industry Finance Committee* ('*Crimmins*').⁶⁴

In their judgments, both Santow and Sheller JJ discussed the risk that if they rejected the appeal, doctors would become more defensive, detaining patients under the legislation needlessly. Sheller JA stated: '[t]here is no reason whatsoever to doubt that persons working in a psychiatric hospital would be applying their best endeavours to the care of those who come to the hospital. From time to time, things go wrong'.⁶⁵

This comment is disturbing, if only because it demonstrates an acceptance of 'things going wrong' in medicine that would not be tolerated by negligence law in other areas of human activity. It was also prophetic: since *Presland*, there have been three other cases claiming failure of health care providers to exercise involuntary detention powers that have warranted the attention of appellate courts.

58 Ibid [3].

59 Ibid [175].

60 Ibid [176]–[181].

61 *Civil Liability Act 1990* (NSW). See also New South Wales, *Parliamentary Debates*, Legislative Assembly, 13 November 2003, 4980 (Barry Collier, Bob Carr); New South Wales, *Parliamentary Debates*, Legislative Assembly, 13 November 2003, 4992 (Morris Iemma); New South Wales, *Parliamentary Debates*, Legislative Assembly, 19 November 2003, 5347 (Andrew Tink).

62 Section 54A(3) defines serious offence as an offence punishable by imprisonment for six months or more.

63 (2002) 211 CLR 540.

64 (1999) 200 CLR 1.

65 *Presland* (2005) 63 NSWLR 22, 101 [296].

Kirkland-Veenstra

In *Kirkland-Veenstra*, the defendant police officers encountered a man who had clearly been contemplating suicide.⁶⁶ However, on talking with the police officers, the man stated that he had changed his mind and abandoned the plan, and instead intended to go home and ‘talk things through with his wife’.⁶⁷ The police officers permitted him to leave. He subsequently returned to his home and committed suicide a short time later. The plaintiff widow alleged that the defendant police officers were negligent in failing to exercise a statutory power to detain and escort the man to a location for psychiatric assessment available to them under the *Mental Health Act 1986* (Vic). It was the plaintiff’s contention that the police officers owed both her and her husband a duty of care to detain her husband and take him to be examined by a medical practitioner, as authorised under the Act.⁶⁸

The plaintiff’s claim was ultimately unsuccessful.⁶⁹ The County Court initially found that although s 10 created a power, it did not impose a duty to exercise that power.⁷⁰ The Court of Appeal unanimously upheld the plaintiff’s appeal against the County Court’s finding against the plaintiff, and remitted the matter for retrial.⁷¹ The defendants appealed the Court of Appeal’s decision, and the High Court upheld the defendant’s appeal.⁷²

Crowley

In *Crowley*,⁷³ the plaintiff was a man who was left with quadriplegia after being shot by an Australian Federal Police (‘AFP’) officer. At the time of the shooting, he had been exhibiting symptoms of serious mental illness for over 24 hours. The night before he was shot, he was assessed by a clinician from the Australian Capital Territory Mental Health (‘ACTMH’) Crisis Assessment & Treatment Team.

The report from that assessment did not recommend immediate exercise of legislative powers of involuntary detention and treatment. It did however recommend further assessment on the morning of the shooting, and reserved the recommendation of exercise of those powers until that further assessment.

The follow-up assessment did not occur; instead, the plaintiff was shot by police responding to reports of a man threatening members of the public with a Kendo

66 Evidenced by relevant location, paraphernalia, etc. See *Kirkland-Veenstra v Stuart* (2008) 23 VR 1, 4 [11].

67 *Ibid.*

68 *Mental Health Act 1986* (Vic) s 10(4).

69 *Kirkland-Veenstra* (2009) 237 CLR 215, 256 [121], 257 [122], 266 [151].

70 *Ibid* 227 [21].

71 *Ibid* 227 [22].

72 *Ibid.*

73 (2012) 7 ACTLR 142.

Stick and verbally abusing them. When the police officers located the plaintiff, he threatened them, and one officer fired the shot in question in self-defence.

It was not claimed that the police officer was negligent in shooting. Rather, the claim alleged negligence on the part of ACTMH for failing to ‘follow up on a recommendation ... to have a mental health officer assess him on the morning of the day he was shot for the purpose of determining whether to exercise the power of involuntary detention’;⁷⁴ failure of an employee of ACTMH to report observations of the plaintiff’s behaviour on the morning of the shooting;⁷⁵ and failure of ACTMH to notify the AFP of his situation.⁷⁶

Crowley also claimed negligence on the part of the AFP, as part of the Commonwealth, for failing to establish protocols, to supervise and enforce those protocols, and to properly train AFP personnel.⁷⁷ He further claimed that the police officer who fired was ‘negligent in his conduct immediately before and at the time of shooting’.⁷⁸

Penfold J at first instance found for the plaintiff and awarded him \$8 million.⁷⁹ The Court of Appeal, in response to appeals from both the ACT and the Commonwealth, overturned the decision and awarded costs of trial and appeals against the plaintiff.⁸⁰

McKenna

The plaintiffs in *McKenna* were the mother and sisters of a man (Rose) killed by his mentally ill friend (Pettigrove) while driving him from the Manning Base Hospital to Echuca, a distance of some 1100 kilometres, upon his discharge from the psychiatric ward of the hospital, approved by the hospital’s psychiatrist. Prior to his release, Pettigrove had been admitted to the hospital as an involuntary patient under the *Mental Health Act 1990* (NSW). His medical history, which was forwarded to the hospital from his treatment providers in Echuca, indicated that he had been taken to Echuca Hospital by police in January 2001, after attempting to jump in front of traffic. He was subsequently diagnosed with chronic paranoid schizophrenia, which was treated with fortnightly depot injections of Risperidone from 2001 until February 2004. At a meeting with Mr Pettigrove and Mr Rose, which included a phone conversation with Mr Pettigrove’s mother in Echuca, the hospital’s consultant psychiatrist decided to discharge Mr Pettigrove the following day into the company of Mr Rose for the purpose of travelling to Echuca. No decision to provide him with medication was made, nor was there any

74 Ibid 152 [35].

75 Ibid.

76 Ibid.

77 Ibid 151 [32]. Crowley also claimed that the Commonwealth was negligent in use by the AFP of capsicum spray without deciding whether it was appropriate in the circumstances.

78 Ibid 151 [33].

79 *Crowley v Commonwealth of Australia* (2011) 251 FLR 1.

80 *Crowley* (2012) 7 ACTLR 142.

evidence that reinitiating his depot medication was considered by the psychiatrist at that meeting. Topics discussed at the meeting did, however, include routes between Taree and Echuca where psychiatric support services could be obtained, if required, and the possibility of Pettigrove undertaking some of the driving.

Midway through the following day, Pettigrove was provided with a single night's dosage of Risperidone (which may not have been immediately effective), and discharged. Rose and Pettigrove then left Taree, and later that night, Pettigrove strangled and killed Rose while the two men had stopped on the Newell Highway near Dubbo. Pettigrove subsequently committed suicide before the negligence proceedings went to trial.⁸¹

IV AN ODDITY IN LAW AND MEDICINE ... LEGISLATING ON A MEDICAL CONDITION

It is well-established in law that treatment of a person without their consent, in the absence of other lawful justification,⁸² amounts to a trespass in the form of battery at a minimum,⁸³ and may also result in criminal charges. Similarly, detention of a person without lawful justification is a trespass in the form of false imprisonment civilly, and may likewise also attract criminal sanction.

Mental health legislation, with its provisions authorising the involuntary treatment and detention of people with mental illness, is a source of lawful justification for these purposes. Such legislated powers are rare: typically the only other context in which interference with the liberty and physical integrity of a citizen is authorised under legislation is in the context of investigating criminal conduct, such as those powers exercised by police. The powers codified by the legislation are tightly regulated, and subject to a number of criteria (including strict definitional criteria) being met before they become available. In the absence of any of these criteria, purported use of these powers is unlawful, and potentially gives rise to claims for unlawful or wrongful detention, and battery.

The *Lunacy Act 1890* (Vic) is the historical precursor to modern day mental health legislation. Drafted at a time when both medical understanding of mental illness and therapies were far less advanced, the emphasis of the early versions of the legislation was on detention and control, rather than treatment.⁸⁴

81 *Hunter and New England Local Health District v McKenna* [2014] HCA 44, [1]–[2]; *McKenna v Hunter & New England Local Health District*; *Simon v Hunter & New England Local Health District* [2013] NSWCA 476.

82 The most common alternate form of lawful justification is emergency or necessity: treatment is necessary for the preservation of life, or prevention of serious harm. See, eg, *Department of Health & Community Services v JWB & SMB* (1992) 175 CLR 218, 310 (McHugh J) (*'Marion's Case'*): 'Consent is not necessary, however, where a surgical procedure or medical treatment must be performed in an emergency and the patient does not have the capacity to consent and no legally authorised representative is available to give consent on his or her behalf.'

83 *Schloendorff v Society of New York Hospital*, 105 NE 92 (NY, 1914).

84 *Lunacy Act 1890* (Vic) ss 4–6. See also Peter McCandless, 'Liberty and Lunacy: The Victorians and Wrongful Confinement' (1978) 11 *Journal of Social History* 366.

Currently, every Australian jurisdiction is engaging in, or has recently completed, a review of its mental health legislation, prompted in part by consideration of the implications of the *Convention on the Rights of People with Disabilities*.⁸⁵

Despite some differences in the various provisions of the legislation in each jurisdiction, including the terminology and criteria used for mental illness, there are some consistent features.

The legislation's objectives are typically similar. The objectives of the *Mental Health Act 1990* (NSW), applied in both *Presland* and *McKenna*, under the rubric '[c]are, treatment and control of mentally ill and mentally disordered persons',⁸⁶ referred to protection of the civil rights of those persons and facilitation of the provision to them of hospital care on 'an informal and voluntary basis where appropriate' and on an involuntary basis 'in a limited number of situations'.⁸⁷ Parliament's intention, as stated in the Act, was that as far as practicable 'every function, discretion and jurisdiction conferred or imposed' by the legislation is to be effected through the 'least restrictive environment' and any restriction on the liberty, rights and dignity of those persons is to be kept to a minimum.⁸⁸

The objectives of the Victorian legislation considered in *Kirkland-Veenstra*, ie the *Mental Health Act 1986* (Vic) at s 4(2), are worded nearly identically to s 4(2) of the former NSW legislation noted above.

Similarly, the *Mental Health (Treatment and Care) Act* (ACT), considered in *Crowley*, also emphasises the requirement that treatment, care, rehabilitation and protection be provided 'in an environment that is the least restrictive and intrusive, having regard to their needs and the need to protect other persons from physical and emotional harm',⁸⁹ 'in a manner that is least restrictive of their human rights'.⁹⁰

The legislation provides a criteria-based definition for establishing whether a person falls within the scope of the legislation, and can be the subject of involuntary detention.

New South Wales

The NSW legislation in effect for the three NSW cases characterised 'mentally ill persons' as persons suffering from a mental illness, who provided 'reasonable grounds for believing that care, treatment or control of the person [was] necessary for (a) the person's own protection from serious harm, or (b) the protection of

85 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008). The Convention specifically includes mental illness within its scope; some Articles, eg art 12, have particular implications for people with mental illness, as distinct from other forms of disability.

86 *Mental Health Act 1990* (NSW) s 4. The Act has been replaced by the *Mental Health Act 2007* (NSW).

87 *Ibid* s 4(1).

88 *Ibid* s 4(2).

89 *Mental Health (Treatment and Care) Act 1994* (ACT) s 7(d).

90 *Ibid* s 7(a).

others from serious harm'.⁹¹ Such grounds included consideration of the person's continuing condition, including any likely deterioration in that condition and its effects.⁹² A 'mentally disordered person' was one whose 'behaviour for the time being [was] so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control [was] necessary: (a) for the person's own protection from serious physical harm, or (b) for the protection of others from serious harm'.⁹³

The legislation then expressly stated that for the purposes of involuntary admission or detention, and determination of whether community treatment or detention, a 'mentally ill person' or 'mentally disordered person' must satisfy the definitional criteria (above).⁹⁴ Part 2 of Chapter 4 of the legislation, entitled 'Involuntary admission to hospitals', set out the powers, limitations, and conditions attached to involuntary admission. Specifically, s 20 stated that '[a] person must not be admitted to, or detained in or continue to be detained in, a hospital under [Part 2] 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'.⁹⁵

Victoria

Part 3 Division 2 of the *Mental Health Act 1986* (Vic) established criteria for admission and detention of involuntary patients. The person must appear to be mentally ill, requiring immediate treatment that can be 'obtained' by involuntary admission to and detention in a 'psychiatric in-patient service' for that person's 'health or safety ... or for the protection of members of the public', given that 'the person cannot receive adequate treatment for the mental illness in a manner less restrictive of that person's freedom of decision and action'.⁹⁶

Section 10 of the legislation, dealing with the '[a]pprehension of mentally ill persons in certain circumstances', stated that police officers may apprehend and immediately bring before a medical practitioner a person who appears to be mentally ill if there are reasonable grounds for believing the person has recently attempted to commit serious bodily harm or that 'the person is likely by act or neglect to attempt suicide or to cause serious bodily harm to herself or himself or to some other person'.⁹⁷

This section provided the power in issue in *Kirkland-Veenstra*.

91 *Mental Health Act 1990* (NSW) s 9(1).

92 *Ibid* s 9(2).

93 *Ibid* s 10.

94 *Ibid* s 8.

95 *Ibid* s 28 required the medical superintendent to refuse to detain a person if the superintendent was 'of the opinion that the person was not a mentally ill person or a mentally disordered person'.

96 *Mental Health Act 1986* (Vic) s 8. The Act has now been replaced by the *Mental Health Act 2014* (Vic).

97 *Ibid* s 10.

The Victorian legislation did not specifically define mental illness, but in keeping with NSW and the ACT,⁹⁸ it did identify a list of attributes that were not to be used as indicia of mental illness. These included religious, political, and philosophical beliefs and participation in related activities, sexual orientation, intellectual disability, and illegal or immoral conduct, along with drug taking, promiscuity, and anti-sociality.⁹⁹

ACT

In the ACT, the *Mental Health (Treatment and Care) Act 1994* (ACT) defines ‘mental illness’ as a condition that ‘seriously impairs (either temporarily or permanently) the mental functioning of a person’ and is characterised by symptoms such as a severe disturbance of mood, hallucinations or delusions.¹⁰⁰ ‘Mental dysfunction’ is defined broadly as a substantially disabling ‘disturbance or defect’ of comprehension, reasoning, emotion, memory and so forth.¹⁰¹

Section 37 of the legislation provides the statutory basis for involuntary detention of people in the ACT with that mental illness or dysfunction. Such a person may be apprehended by a police officer where there are reasonable grounds for concern regarding serious harm.¹⁰² Involuntary admission and treatment is authorised where a doctor or mental health officer believes that there is a need for immediate treatment/care or that the person’s condition will so deteriorate within three days that the person will require immediate treatment/care.¹⁰³ As with the legislation highlighted earlier in this article, there must be reasonable grounds for believing that ‘adequate treatment or care cannot be provided in a less restrictive environment’.¹⁰⁴ Detention must be necessary ‘for the person’s own health or safety, social or financial wellbeing, or for the protection of members of the public’.¹⁰⁵

The legislation also provides that force and assistance ‘necessary and reasonable’ can be used to apprehend the person to take them to the facility for assessment and treatment.¹⁰⁶

V MEANING AND APPLICATION OF ‘INVOLUNTARY’?

It is clear from the ‘objectives’ sections of each jurisdiction’s legislation, that enforced detention and treatment of people against their will is intended

98 *Mental Health (Treatment and Care) Act 1994* (ACT) s 5.

99 *Mental Health Act 1986* (Vic) s 8(2).

100 *Mental Health (Treatment and Care) Act 1994* (ACT) Dictionary.

101 *Ibid.*

102 *Ibid* s 37(1).

103 *Ibid* s 37(2).

104 *Ibid.*

105 *Ibid.*

106 *Ibid* s 37(4).

to occur in only a very small number of instances, when no other options are reasonably available. This is evident from the references to the Act requiring that ‘restrictions on liberty’ and interference with dignity be kept to the ‘minimum necessary’.¹⁰⁷ Similarly, treatment must be provided in the ‘least possible restrictive environment’.¹⁰⁸

All of the acts clearly envisage, and implicitly or expressly promote, the transition of involuntary patients to voluntary patients. Orders for involuntary treatment and detention are, quite clearly, a last resort, to be exercised only when no other options are reasonably available.

Provision of medical treatment without lawful justification constitutes trespass against the person (battery and potentially assault) under civil law,¹⁰⁹ and is a criminal offence.¹¹⁰ Detention of a patient for the purposes of treatment without lawful justification also exposes the practitioner to civil and criminal penalties for wrongful detention or false imprisonment. Consent is the form of lawful justification most commonly arising in the provision of medical care. To be valid, consent relies on the patient agreeing to the treatment proposed, having been equipped with sufficient information,¹¹¹ and that the patient has the capacity to provide that consent. There is a legal presumption of capacity; it is, however, rebuttable. In the event that a patient demonstrably lacks capacity, a substitute or delegated decision-maker can be authorised to make decisions on that person’s behalf.¹¹²

It is not, however, the only source of lawful authority for interference with a patient’s liberty or bodily integrity for the purposes of providing medical treatment — statute can also provide such justification. Indeed, in the case of mental health legislation, the orders made under the act authorise the treatment (and potentially detention for the purposes of providing treatment) of people with mental illness in the absence of consent.

Kirkland-Veenstra, Presland, Crowley and McKenna were all argued on the basis that a statutory authority should have exercised a power of involuntary detention. Curiously, however, *none* of the judgments explored in detail what was required to establish that treatment or detention would have been involuntary.

The term is not precisely defined in the legislation, however its interpretation in everyday usage and case law indicates a lack of willingness, volition or agreement lies at its heart. The co-existing legislative requirements for both involuntariness and a mental illness or disorder to activate the involuntary detention and treatment powers is under-recognised in the judgments discussed in this article.

107 *Mental Health (Treatment and Care) Act 1994* (ACT) ss 7, 9; *Mental Health Act 1990* (NSW) s 4.

108 *Mental Health Act 1986* (Vic) s 4.

109 *Schloendorff v Society of New York Hospital*, 105 NE 92 (NY, 1914); *Marion’s Case* (1992) 175 CLR 218.

110 See, eg, *Reeves v The Queen* (2013) 304 ALR 251, 258 [35].

111 *Rogers v Whitaker* (1992) 175 CLR 479.

112 For example, by appointment of guardian, or via pre-emptive mechanisms such as execution of an enduring Power of Attorney.

Of the four cases, only *Kirkland-Veenstra*, on the findings of fact, appeared to show conclusively that Mr Veenstra would not have consented to accompanying the police officers to a medical facility if they had elected to use the powers enumerated under s 10 of the Act. Ultimately, Mr Veenstra's voluntary or involuntary status was not an issue, as the High Court found that the police could not have detained Mr Veenstra because he 'did not appear to be mentally ill'. As such, one of the two threshold requirements for the exercise of the power was not met, therefore there could be no duty to exercise that power owed to the plaintiff, Mr Veenstra, or anyone else. Detention of Mr Veenstra in the absence of an appearance of mental illness would have been unlawful, and would have potentially exposed the defendant police officers to liability for false detention or wrongful imprisonment.

In each of the other cases, however, the findings of fact indicate that the persons with mental illness either *did* appear to be willing to receive treatment, or their views on the matter were never expressly sought.

In *Presland*, although there was some evidence to suggest that Mr Presland's brother was agitating for his release from the psychiatric hospital, this evidence was contradictory at best, with evidence provided by the plaintiff himself, and his brother, disputing this.¹¹³ Furthermore, the first instance judge found that there was a significant risk that the plaintiff's answers during the interview with the psychiatric registrar, Dr Nazarian, were susceptible to the influence of his brother being present in the room at the time.¹¹⁴ Certainly, from the findings of fact, there is no evidence to indicate that the registrar took deliberate steps to find out what the plaintiff patient's own wishes were prior to deciding to release him.

In *Crowley*, an assessment under s 37 of the legislation was carried out by a mental health officer. The officer did not find that all the conditions necessary to exercise the power were met; rather, he recommended further assessment of Mr Crowley on the following day.¹¹⁵ One of the conditions for exercising the power under s 37(2) is that 'the person has refused to receive that treatment or care'.¹¹⁶ In *Crowley*, the assessing officer did not specifically determine whether or not Mr Crowley did consent. Rather, there is evidence that he discussed the issue with Mr Crowley's family, and they felt that he would not consent. Failure to consent was not the determining factor in the assessing officer's decision not to exercise the power under s 37. If, however, he had decided to exercise it without determining directly that Mr Crowley did not consent to treatment, he would have been exercising the power unlawfully.

In *McKenna*, there was no suggestion that Pettigrove had recovered, and thus had no further need of treatment. Rather, the decision to discharge him specifically envisaged him receiving care (which he agreed to) while closer to his family,

113 *Presland v Hunter Area Health Service* [2003] NSWSC 754 (19 August 2003) [81], [88]–[89].

114 *Ibid* [92].

115 *Crowley v Commonwealth of Australia* [2011] ACTSC 89 (27 March 2011) [114]–[115].

116 *Mental Health (Treatment and Care) Act 1994* (ACT) s 37(2)(b).

particularly his mother, in order to provide him with support.¹¹⁷ There was no evidence that he would have refused to stay at Manning Base Hospital for additional time to determine that his condition had stabilised prior to being transported back. Indeed, the evidence suggests that the person anxious for his immediate return was his mother, noting that the victim, Mr Rose, had demonstrated his reliance on the opinion of the practitioners caring for Mr Pettigrove to determine the appropriate time for him to undertake the journey.¹¹⁸ There is no clear evidence that Pettigrove had any particular views, positive or otherwise, about remaining in hospital.¹¹⁹

In each of these cases, the courts proceeded on the basis that the relevant involuntary treatment and detention powers were available, notwithstanding that in none of them was there clear evidence that the person with mental illness did not consent. Furthermore, no suggestion that the person lacked the capacity to make such a decision arose on the facts of any of the cases.

In the ACT legislation, lack of consent was a condition for the exercise of the powers;¹²⁰ under the NSW legislation, the heading of the division containing the relevant provisions was '[i]nvoluntary admission to hospitals'.¹²¹ Rules of statutory interpretation indicate that the heading of a Part, such as Part 2 of Chapter 4 of the *Mental Health Act 1990* (NSW), should be read as being part of the Act.¹²² Notwithstanding the absence of the word 'involuntary' within the substantive provisions, it is nonetheless clear that involuntariness is a requirement of the powers. They cannot be exercised against a patient who voluntarily accepts treatment, because to do so would simply not be necessary, and would be inconsistent with the objectives of the legislation.

To that end, the two following conclusions become evident. To be consistent with the objectives of the legislation, it is necessary that any person seeking to exercise these powers must establish that the person with mental illness does not, or cannot, consent to the treatment and detention. Secondly, based on the findings of fact in each of *Presland*, *Crowley*, and *McKenna*, it was never open to the statutory authorities (represented by their employees of the health services and the police) to exercise those powers because it was never established that the person with mental illness lacked voluntariness.

117 *McKenna* (2014) 253 CLR 270, 275 [2].

118 He offered to transport Mr Pettigrove 'when he's well enough'. *Simon v Hunter & New England Local Health District* [2012] NSWDC 19 (2 March 2012) [57].

119 Notes taken contemporaneously to the meeting which at which it was decided to discharge Mr Pettigrove were produced as evidence, and quoted in the judgment: 'Phillip was generally uncommunicative but consensus was decided in favour of Phillip going back to his mum's place in Victoria as soon as possible. Steve will drive him back to [Victoria] leaving Taree early tomorrow morning. Mrs Pettigrove was contacted on the phone and she is most anxious for Phil to return home': *McKenna v Hunter & New England Local Health District* [2013] NSWCA 476 (23 December 2013) [24].

120 *Mental Health (Treatment and Care) Act 1994* (ACT) s 27.

121 *Mental Health Act 1990* (NSW) pt 2.

122 *Interpretation Act 1987* (NSW) s 35(1): Headings to provisions of an Act or instrument, being headings to (a) Parts, Divisions or Subdivisions into which the Act or instrument is divided; or (b) Schedules to the Act or instrument, shall be taken to be part of the Act or instrument.

Noting that the courts in each of the cases did not, erroneously in our view, reach this conclusion, we now examine their findings which were based on liability of statutory authorities, proceeding on the assumption that the statutory powers did not require involuntariness in order to be available.

VI HYPOTHETICALLY, LET'S ASSUME IT DOES APPLY ...

'Policy considerations' have typically been prominent in decisions refusing to recognise a duty of care relationship between a statutory authority exercising a power or duty under legislation, particularly with respect to allocation of resources. Notwithstanding those judgments where a duty of care between a statutory authority and a specific individual has not been recognised, concerns about the potential liability of statutory authorities (particularly with respect to maintenance of public utilities) and the consequences to taxpayers featured prominently in submissions to the 2002 Review of the Law of Negligence, chaired by Justice David Ipp.¹²³ Ultimately, these concerns were reflected in the legislative reform of negligence law undertaken by all Australian jurisdictions in the early 2000s.

The shadow of these 'policy considerations' can be detected throughout the judgments examined in this article. In both *Presland* and *McKenna* they were overt. The Court of Appeal commented extensively, if somewhat illogically,¹²⁴ on the undesirability of defensive medical practices and on resourcing issues. The unpalatability of a tortfeasor 'profiting' from their wrongful acts was a theme of the public commentary surrounding *Presland*.¹²⁵ In *McKenna*, the defendant psychiatrist testified that had Mr Rose not volunteered to transport Mr Pettigrove to Echuca, Mr Pettigrove would not have been released.¹²⁶ The psychiatrist would instead have had to organise an interstate patient transfer, incurring both an administrative burden and, presumably, expense.¹²⁷ That laudable concern to optimise the use of public health resources may be perceived as having unfortunate consequences for Pettigrove, Rose and their families. It also falls within the category of considerations that courts have traditionally resisted finding a duty on for policy reasons.¹²⁸

Consistent with the case law on statutory authority liability, the ultimate ratios of *Presland*, *Crowley*, and *McKenna* all relied on failure to establish a duty of care between the parties, based on analyses of the statutory powers of detention. In so doing, they drew heavily on authority from statutory authority liability cases,

123 Department of the Treasury, *Review of the Law of Negligence: Final Report* (2002).

124 Kathryn Peterson, 'Where is the Line to be Drawn? Medical Negligence and Insanity in Hunter Area Health Service v Presland' (2006) 28 *Sydney Law Review* 181.

125 (2005) 63 NSWLR 22, 106 [315] (Santow J).

126 *Simon v Hunter & New England Local Health District; McKenna v Hunter & New England Local Health District* [2012] NSWDC 19 [56].

127 *Ibid* [28], [56].

128 *Hill v Chief Constable of West Yorkshire* [1988] 2 All ER 238; *Alcock v Chief Constable of South Yorkshire Police* [1992] 1 AC 310.

including McHugh J's six-step test from *Crimmins*,¹²⁹ and the reformulated four-step test from *Barclay*,¹³⁰ to deny recognition of any such duty.

The four-facet test, formulated by Gummow and Hayne JJ,¹³¹ and cited by Spigelman CJ in *Presland*, is as follows:

An evaluation of whether a relationship between a statutory authority and a class of persons imports a common law duty of care is necessarily a multi-faceted inquiry. Each of the salient features of the relationship must be considered. The focus of analysis is the relevant legislation and the positions occupied by the parties on the facts as found at trial. It ordinarily will be necessary to consider the degree and nature of control exercised by the authority over the risk of harm that eventuated; the degree of vulnerability of those who depend on the proper exercise by the authority of its powers; and the consistency or otherwise of the asserted duty of care with the terms, scope and purpose of the relevant statute.¹³²

The High Court in *McKenna* referred to difficulty in determining the existence and nature and scope of a duty of care. It relied on *Sullivan* to provide the structure to its consideration of a duty of care.¹³³ The Court in *Sullivan* stated:

Sometimes the problems may be bound up with the harm suffered by the plaintiff, as, for example, where its direct cause is the criminal conduct of some third party. Sometimes they may arise because the defendant is the repository of a statutory power or discretion. Sometimes they may reflect the difficulty of confining the class of persons to whom a duty may be owed within reasonable limits. Sometimes they may concern the need to preserve the coherence of other legal principles, or of a statutory scheme which governs certain conduct or relationships. The relevant problem will then become the focus of attention in a judicial evaluation of the factors which tend for or against a conclusion, to be arrived at as a matter of principle.¹³⁴

After providing examples of each type it stated that the second duty, somewhat obliquely described as 'statutory power', was the determinative one in *McKenna*.¹³⁵ However, the principle of inconsistency from *Sullivan*¹³⁶ was also applied extensively in *McKenna*, with the High Court quoting: 'if a suggested duty of care would give rise to inconsistent obligations, that would ordinarily be a reason for denying that the duty exists'.¹³⁷

The High Court went on to state:

129 (1999) 200 CLR 1, [93].

130 (2002) 211 CLR 540.

131 *Ibid* [149] (Gummow and Hayne JJ).

132 *Presland* (2005) 63 NSWLR 22, 27 [10].

133 *McKenna* (2014) 253 CLR 270, 279 [18].

134 *Ibid* 278 [17] quoting *Sullivan* (2001) 207 CLR 562 at 579–580 (citations omitted).

135 *McKenna* (2014) 253 CLR 270, 279 [19].

136 (2001) 207 CLR 562.

137 *McKenna* (2014) 253 CLR 270, 282 [29] quoting *Sullivan* (2001) 207 CLR 562, 582.

Because s 20 of the *Mental Health Act* required that Mr Pettigrove be released from detention unless the medical superintendent formed the opinion that no other care of a less restrictive kind was appropriate and reasonably available to Mr Pettigrove, it is not to the point to decide whether, as the relatives alleged, the medical superintendent did not positively authorise his release from the Hospital (whether under s 35 of the *Mental Health Act* or otherwise).¹³⁸

Despite referring to the other criteria (ie the nature of harm, indeterminacy of class, and coherence) ultimately the High Court relied on the ‘statutory powers’ to conclude:

The powers, duties and responsibilities of doctors and hospitals respecting the involuntary admission and detention of mentally ill persons were prescribed by the *Mental Health Act*. It is the provisions of that Act which identified the matters to which doctors and hospitals must have regard in exercising or not exercising those powers. Those provisions are inconsistent with finding the common law duty of care alleged by the relatives.¹³⁹

In *Crowley*, the ACT Court of Appeal overturned the trial judge’s finding that ACTMH owed a ‘doctor-patient’ duty of care to Mr Crowley, instead finding that any duty of care it owed to him was limited to following up on the events of the initial consultation, a duty which was met when it received the phone call from Mr Crowley’s father the morning after the consultation.¹⁴⁰ The Court rejected the notion that any such duty included a duty to exercise the statutory powers available under s 37, although its reasons for doing so referred to the NSW Court of Appeal in *Presland* (which relied on *Sullivan*), rather than referring to *Sullivan* directly.¹⁴¹

In *Presland*, the NSW Court of Appeal used the coherence test to reach different outcomes. Spigelman CJ found that it did not contribute significantly to his decision: ‘[c]oherence is not, in my opinion, entitled to significant weight in the present context’.¹⁴² Santow J found instead that the introduction of liability, ‘which logically must also apply to decisions to restrain, is likely to induce a detrimentally defensive frame of mind on the part of the decision-maker in either context, so undermining coherence of the statutory scheme’.¹⁴³ Sheller J, in the other majority judgment, focussed on issues related to the unlawfulness of the act and public policy considerations, having initially found a duty of care existed.¹⁴⁴

138 *McKenna* (2014) 253 CLR 270, 282 [32].

139 *Ibid* 283 [33].

140 *Crowley* (2012) 7 ACTLR 142, [392].

141 *Ibid* [382], [391]–[392].

142 *Hunter Area Health Service v Presland* [2005] NSWCA 33 (21 April 2005), [41] (Spigelman CJ).

143 *Ibid* [388] (Santow J).

144 *Ibid* [217] (Sheller J).

Sullivan

In *Sullivan* the courts were asked to consider whether statutory authorities investigating suspected child sexual abuse owed a duty of care to the parents of the children.

The High Court identified the four different categories subsequently utilised by the High Court in *McKenna* in the following way:

Different classes of case give rise to different problems in determining the existence and nature or scope, of a duty of care. Sometimes the problems may be bound up with the harm suffered by the plaintiff, as, for example, where its direct cause is the criminal conduct of some third party. Sometimes they may arise because the defendant is the repository of a statutory power or discretion. Sometimes they may reflect the difficulty of confining the class of persons to whom a duty may be owed within reasonable limits. Sometimes they may concern the need to preserve the coherence of other legal principles, or of a statutory scheme which governs certain conduct or relationships. The relevant problem will then become the focus of attention in a judicial evaluation of the factors which tend for or against a conclusion, to be arrived at as a matter of principle.¹⁴⁵

This analysis is, we argue, more useful than the High Court's summary of it in *McKenna*, as it establishes that the 'statutory power' consideration referred to in *McKenna* actually refers to the identity of the defendant as a holder of statutory power, rather than merely the existence of a relevant one somewhere in the ether, as it were. The examples of such situations used by the High Court in *Sullivan* were *Crimmins*¹⁴⁶ and *Brodie v Singleton Shire Council*.¹⁴⁷

In *Crimmins*, the majority of the High Court found that a duty of care did exist between the defendant, Stevedoring Industry Finance Committee, and the plaintiff with respect to his occupational exposure to asbestos, ultimately causing his death from mesothelioma.¹⁴⁸

Gaudron J stated the following:

It is not in issue that a statutory body, such as the Authority, may come under a common law duty of care both in relation to the exercise and the failure to exercise its powers and functions. Liability will arise in negligence in relation to the failure to exercise a power or function only if there is, in the circumstances, a duty to act. What is in question is not a statutory duty of the kind enforceable by public law remedy. Rather, it is a duty called into existence by the common law by reason that the relationship between the statutory body and some member or members of the public is such as to

145 *Sullivan* (2001) 207 CLR 562, 579–80 [50] (citations omitted).

146 (1999) 200 CLR 1.

147 (2001) 206 CLR 512.

148 (1999) 200 CLR 1.

give rise to a duty to take some positive step or steps to avoid a foreseeable risk of harm to the person or persons concerned.¹⁴⁹

Gaudron J stated that in relation to discretionary powers vested in a statutory body it is not strictly accurate to speak of a common law duty superimposed upon statutory powers. Instead the statute operates ‘in the milieu of the common law’, which applies to the particular body unless excluded.¹⁵⁰ Gaudron J then stated:

Legislation establishing a statutory body may exclude the operation of the common law in relation to that body’s exercise or failure to exercise some or all of its powers or functions. Even if the legislation does not do so in terms, the nature or purpose of the powers and functions conferred, or of some of them, may be such as to give rise to an inference that it was intended that the common law should be excluded either in whole or part. ... Where it is contended that a statutory body is not subject to a common law duty in relation to the exercise or non-exercise of a power or function because of the nature or purpose of that power, what is being put is that, as a matter of implication, the legislation reveals an intention to exclude the common law in relation to the exercise or non-exercise of that power.¹⁵¹

Brodie v Singleton Shire Council considered the liability of local governments with statutory powers for road maintenance and infrastructure, and what circumstances a duty of care between the authorities and users of the roads could apply.¹⁵²

Each case confirms that a statutory authority does not avoid a duty of care by virtue of its identity as a statutory authority; rather the circumstances under which the statutory power or duty exist will be relevant in deciding that question.

In *Sullivan*, the High Court found that recognition of a duty of care owed by the authority to the parents of the suspected victim of child sexual abuse would be inconsistent with the legislative intention behind child protection laws, which required the respondents to treat the interests of the children as paramount.¹⁵³ The responsibilities of those respondents:

involved investigating and reporting upon, allegations that the children had suffered, and were under threat of, serious harm. It would be inconsistent with the proper and effective discharge of those responsibilities that they should be subjected to a legal duty, breach of which would sound in damages, to take care to protect persons who were suspected of being the sources of that harm. The duty for which the appellants contend cannot be reconciled satisfactorily, either with the nature of the functions being

149 Ibid 18 [25] (citations omitted).

150 Ibid 18 [26] (Gaudron J) quoting *Western Australia v The Commonwealth (Native Title Act Case)* (1995) 183 CLR 373, 487.

151 Ibid 19 [27].

152 *Brodie v Singleton Shire Council* (2001) 206 CLR 512.

153 *Sullivan* (2001) 207 CLR 562.

exercised by the respondents, or with their statutory obligation to treat the interests of the children as paramount.¹⁵⁴

Despite references in passing to the issues of indeterminacy,¹⁵⁵ incoherence between the legislation and the asserted duty of care underpins the High Court's decision against recognition of the duty.

The ratio from *Sullivan* has been frequently cited as supporting the principle that a duty of care does not arise with respect to negligent exercise, or failure to exercise, statutory powers, of which the involuntary detention and treatment powers contained in the mental health legislation are an example.¹⁵⁶ Its application to cases involving involuntary detention and treatment of people with mental illness under the Mental Health Acts is, however, flawed, as it fails to establish any incoherence, due to a faulty understanding of the legislation.

Sullivan dealt with the duty of care owed by investigators of alleged child sexual abuse, for example child protection workers and health practitioners, to those people suspected of committing the abuse. The relevant legislation governed the entire field of child protection and investigation of child sexual abuse: practitioners operating under the authorisation of statute cannot do so without that legislation, ie they could not investigate matters of the type relevant to *Sullivan* unless they were authorised to do so under statute. Investigation of child sexual abuse is in no way a private, or non-statutory, function.

Mental health practitioners, by way of contrast, can and do provide treatment for mental illness outside the scope of the involuntary treatment and detention powers provided by the mental health legislation. Indeed, the majority of patients receiving psychiatric treatment are voluntary patients, and are not reliant on the existence of the powers for treatment. The powers *only* serve to modify the requirement for consent to treatment and detention. They do not affect the treatment provided by creating a special class of treatment options unavailable outside the operation of the legislation.¹⁵⁷ It is clearly wrong, therefore, to say that the provision of mental health treatment is reliant on the existence of the legislation; the extent of any inconsistency between the legislation and recognition of a duty of care is limited to the content of the duty as it relates to the consent of the patient, not to the treatment being provided.

All of this suggests that the duty of care between doctor and patient does survive the existence of a statutory order, and that the order itself only serves to modify the duty as per the consent of the patient, rather than elements relating to treatment or management of medical information.

So, although it would be inconsistent to recognise a duty of care arising in relation to the exercise of a discretionary power to make orders for involuntary treatment

154 Ibid 572 [24], 582 [62].

155 Ibid 582 [61], 583 [63].

156 *Crimmins* (1999) 200 CLR 1; *Brodie v Singleton Shire Council* (2001) 206 CLR 512; *Barclay* (2002) 211 CLR 540 cited in *McKenna* (2014) 253 CLR 270, 279 [18].

157 Conversely, they do not create an immunity protecting poor practitioners from negligence claims either: the standard of care provided to a patient, involuntary or not, remains the same.

empowered under legislation, it is not inconsistent to recognise a duty of care with respect to the treatment provided under those orders. Breaches of that duty in the provision of treatment are actionable accordingly.¹⁵⁸

The cases discussed in this paper examining the exercise of detention powers under mental health legislation¹⁵⁹ can be distinguished from *Sullivan* by virtue of the differences in the respective legislative regimes and contexts.

Child protection, specifically investigation of suspected child abuse, only occurs in the public sphere. There is no lawful avenue for a private citizen to initiate an investigation wholly independent of the involvement of the state: at some point or other, any such investigation will require the involvement of a public authority responsible for the investigation and prosecution of such matters. Consequently, there is no pre-existing or independent duty of care arising between the parties.

Comparisons are frequently drawn between powers of detention and search authorised under legislation in the context of investigating criminal conduct, and exercise of the detention and treatment powers under the mental health acts. We argue that that these comparisons founder for the same reason that *Sullivan* can be distinguished from the mental health cases outlined above.

Just as there is no method for investigating suspected child abuse without the involvement of the state, there is similarly no mechanism for investigating criminal activity without the involvement of the state. Indeed, the fact matrix of *Sullivan* (concerning an investigation of suspected child abuse) is simply an example of a different authority exercising investigative powers in the context of suspected criminal wrongdoing. Powers of detention and physical interference, ie searching, can be vested in any entity with investigative powers under legislation, not simply the police. Other examples may include Customs and Immigration authorities, and regulatory bodies such as ASIC.

Despite well-established recognition of authorities owing duties to the public, the courts have traditionally been reluctant to recognise private duties owed to individual citizens, except under limited circumstances. Once again, policy features strongly as an additional criterion used to limit the scope of reasonable foreseeability in refusing to recognise claims of this type.

In *Hill v Chief Constable of West Yorkshire* ('*Hill*'),¹⁶⁰ the estate of Jacqueline Hill (the last victim of Peter Sutcliffe, the Yorkshire Ripper) filed a claim in negligence against the West Yorkshire police for negligent investigation of a series of previous crimes which, had they been investigated appropriately, would have led to the detention of Sutcliffe prior to Miss Hill's murder.

The House of Lords upheld the decisions of the first instance judge and the appeal court in striking out the application on the basis that it disclosed no reasonable

158 *Civil Law (Wrongs) Act 2002* (ACT) ss 42–3; *Civil Liability Act 2002* (NSW) s 50; *Civil Liability Act 2003* (QLD) ss 20–2; *Civil Liability Act 1936* (SA) ss 40–1; *Civil Liability Act 2002* (Tas) ss 21–2; *Wrongs Act 1958* (Vic) ss 57–8.

159 *Ie McKenna, Crowley, Kirkland-Veenstra, and Presland.*

160 [1988] 2 All ER 238.

cause of action. Their reasons for doing so principally related to the issue of indeterminacy: the requirement that there must be some characteristic specific to the plaintiff sufficient to base a duty of care being owed to her, as distinct from members of the community at large.¹⁶¹ In addition, however, the House of Lords held that recognition of a duty of the type proposed in the claim would be contrary to public policy, as it would not reinforce ‘observance of a higher standard of care’, and instead would potentially diminish the performance of investigatory activities by forcing the police to adopt a ‘detrimentally defensive frame of mind’.¹⁶² In particular, such actions would require consideration of the ‘conduct of an investigation’, which would ‘necessarily involve a variety of decisions to be made on matters of policy and discretion, for example as to which particular line of enquiry is most advantageously to be pursued and what is the most advantageous way to deploy the available resources’,¹⁶³ matters the House of Lords felt would be inappropriate to be called into question. It is significant to note also that the identity of the plaintiff is important in considering whether or not a duty should be recognised.

In *Hill*, the House of Lords emphasised that there was nothing about Miss Hill that put her at greater risk from Sutcliffe than any other member of the community.¹⁶⁴ The House of Lords was focused on the question of whether a duty owed by police could crystallise once a particular member of the public had been engaged with by a suspect, and found that it could not.¹⁶⁵ This is different from the situation where a plaintiff does demonstrate those characteristics which identify them as being at greater risk than general members of the public: an obvious example might be heightened risk of retaliatory harm to a witness, for example, or a former domestic partner of someone suspected of domestic violence. This should be contrasted with the relationships under each of the key cases here, where the plaintiffs were either people who potentially were directly owed a duty of care as patients, or closely related to people who were potentially owed a duty of care as patients. In none of the cases was a plaintiff simply a member of the public who was opportunistically harmed as a consequence of the defendant authority’s failure to exercise powers putatively available to it under legislation.

161 *Ibid.* Lord Keith of Kinkel, applying the reasoning from *Dorset Yacht Company v Home Office* [1969] 2 All ER 564, 243.

162 *Hill* [1988] 2 All ER 238, 243.

163 *Ibid.*

164 *Ibid.*

165 *Ibid.*

Shircore¹⁶⁶ noted that the decision in *Hill* was interpreted as ‘immunity from negligence actions for police when involved in the suppression and investigation of crime’.¹⁶⁷ In other words, *Hill* established a general principle against a duty being owed by police to individual citizens in the absence of exceptional circumstances, of which there are few examples, creating a de facto, if not express, immunity from negligence for police occurring in the conduct of investigations, regardless of the identity of the plaintiff.¹⁶⁸

In considering questions of immunity and negligence, a point of comparison between detention and treatment powers under Australia’s mental health acts and those exercised by police might be the so-called ‘sobering’ or ‘drying out’ powers, whereby police are permitted to detain and transfer citizens to facilities for the purposes of recovering from overconsumption of alcohol or illicit substances.¹⁶⁹

As with the mental health act powers, however, we note that those powers only go to the issue of consent: detoxification can, and indeed typically does, occur in the private, rather than public context. Involvement of the state and hence exercise of the relevant powers only occurs when there is a defect in consent, ie the person refuses to attend or accept treatment. As such, the legislation does not serve to modify the quality of the treatment or care provided to the people who are subjected to those powers. Absent express immunity, the ‘sobering up’ legislation does not seek to modify or exclude the pre-existing common law duties of health

166 Mandy Shircore, ‘Police Liability for Negligent Investigations: When Will a Duty of Care Arise?’ (2006) 11 *Deakin Law Review* 33. Liability arising from police negligence has attracted scholarly attention in Canada, the United Kingdom, New Zealand and Australia, for example in Jennifer Freund, ‘Police Civil Liability for Negligent Investigation: An Analysis of the Supreme Court of Canada Decision in *Hill v Hamilton-Wentworth Regional Police Services Board*’ (2008) 53 *Criminal Law Quarterly* 469; Erica Chamberlain, ‘Negligent Investigation: The End of Malicious Prosecution in Canada’ (2008) 124 *Law Quarterly Review* 205; Rakhi Ruparelia, ‘“Denying Justice”: Does the Tort of Negligent Investigation Go Far Enough?’ (2008) 16 *Tort Law Review* 48; Zoha Jamil, ‘Police Liability for Negligent Investigations: Unravelling the Blanket of Immunity’ (2013) 1(2) *Birkbeck Law Review* 303; Julia Tolmie, ‘Police Negligence in Domestic Violence Cases and the Canadian Case of *Mooney*: What Should Have Happened and Could It Happen in New Zealand’ (2006) 2 *New Zealand Law Review* 243; Stelios Tofaris and Sandy Steel, ‘Police Liability in Negligence for Failure to Prevent Crime: Time to Rethink’ (University of Cambridge Faculty of Law Research Paper No. 39, 2014). Salient Australian case law includes *Heptonstall v Gaskin* [2003] NSWSC 693 (1 August 2003); *Peat v Lin* [2004] QSC 219 (3 August 2004); *Cran v New South Wales* (2004) 62 NSWLR 95; *Courtney v Tasmania* [2000] TASSC 83 (30 June 2000); *New South Wales v Paige* (2002) 60 NSWLR 371; *Wilson v New South Wales* [2001] NSWSC 869 (28 September 2001); *Gibbs v Commissioner of Police* [2000] QCA 33 (21 February 2000); *Mensinga v Commissioner of Australian Federal Police* [2001] ACTSC 46 (18 May 2001); *Grimwade v Victoria* (1997) 90 A Crim R 526 (21 January 1997).

167 Shircore, above n 166, 34.

168 *Hill* has been reflected in more recent UK jurisprudence such as *Brooks v Commissioner of Police of the Metropolis* [2005] 1 WLR 1495; *Costello v Chief Constable of the Northumbria Police* [1999] 1 All ER 550; *Hertfordshire Police v Van Colle* [2008] 3 All ER 122. See also *D v East Berkshire Community Health NHS Trust* [2005] 2 AC 373; *Osman v United Kingdom* (1998) 29 EHRR 245. In *Hill v Hamilton-Wentworth Regional Police Services Board* [2007] 3 SCR 129, the Canadian Supreme Court has taken a different view of liability regarding police negligence.

169 See, eg, *Intoxicated People (Care and Protection) Act 1994* (ACT) s 4; *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) s 206; *Police Administration Act 1996* (NT) s 128; *Public Intoxication Act 1984* (SA) s 7; and *Protective Custody Act 2000* (WA) s 6. Other legislation regarding detention is identified at above n 18.

practitioners to provide treatment of an adequate standard,¹⁷⁰ although note the express immunity from liability in negligence granted to police and others.¹⁷¹

The Australian High Court has not directly considered the issue of immunity of police from negligence in the course of investigations. However, as noted above, *Sullivan* provides an example of the High Court's approach to determining whether a statutory body exercising an investigative function owes a duty of care to third parties. That approach stops short of recognising a blanket immunity, instead identifying a list of criteria for determination of whether a duty will or will not arise. Lower level Australian courts have similarly rejected the notion of an immunity protecting police from claims of negligence in the context of investigations, but have noted that they will generally be found not to owe a duty of care based on the facts.

Taken together, it appears that the courts would be likely to apply the criteria from *Sullivan* in determining whether or not a duty of care was owed by a statutory authority engaged in investigation, regardless of the statutory authority's identity. The focal point of enquiry would be the legislated powers available to the authority as part of its suite of investigative tools, rather than the identity of the authority exercising those powers. By extension, those investigative powers are likely to encompass a range of activities, including involuntary detention of suspects (and possibly witnesses) and bodily searches. While those involuntary detention and search powers are analogous to the involuntary detention and treatment powers contained in the mental health acts, the context in which those powers can be exercised is not. For authorities using those powers for investigative purposes, they are typically associated with actual or suspected criminal conduct, generally where the purpose of detention and physical interference is for the protection of the public. Furthermore, the activity they relate to (investigation of crime) cannot be done without the involvement of the state. Issues of 'incoherence' (situations where recognising a duty of care owed to a particular individual is in direct conflict with the duty owed to the public under the policing legislation) are also likely to apply, as they did in *Sullivan*.

Provision of mental health treatment, by contrast, is far more likely to occur without state intervention than with it. The vast majority of people with mental illness who receive treatment do so as private patients, who provide their consent to the treatment, and receive it either as inpatients or in the community. For these people, legislation does not directly govern any aspect of the care they receive for their illness. Instead, a duty of care existing between patient and doctor will be recognised. The only time legislation becomes relevant in the context of treating mental illness, therefore, is when the patient does not or cannot consent to treatment. Significantly, the legislation does not expressly exclude the duty of care arising between patient and doctor under the law of negligence. Indeed,

170 See, eg, *Inquest into the Death of Terence Daniel Briscoe* [2012] NTMC 032.

171 See, eg, s 25 of the *Intoxicated Persons (Sobering Up Centres Trial) Act 2013* (NSW); *Law Enforcement (Powers and Responsibilities) Act 2002* (NSW) s 210.

a number of judges in the cases expressly recognised the doctor-patient duty as surviving any suggestion of involuntary powers.¹⁷²

In this way, *Sullivan* can be clearly distinguished from the current cases because although it is evident that a duty of care would be inconsistent with the activities governed by legislation in that instance, the mental health legislation only concerns the *voluntariness* of the provision of treatment. That legislation is concerned with the questions of volition and confinement that engaged Justinian, Bracton, Coke and Blackstone, but does not in any way affect the treatment provided, once the decision to provide treatment has been taken.

This is significant because in each of *Presland*, *Crowley* and *McKenna* the care provided to the person with mental illness (ie the treatment they received) was criticised. In *Crowley*, the Court of Appeal rebutted those criticisms by finding that ACTMH was not involved in treating Mr Crowley, and so the normal considerations following from a doctor patient duty of care relationship regarding treatment did not apply.¹⁷³

In both *Presland* and *McKenna*, those criticisms were directed at activities going beyond the potential exercise of the statutory powers. In *Presland*, the psychiatric registrar's whole approach to interviewing and documenting the history of Mr Presland was criticised, not just his failure to determine whether Mr Presland was mentally ill.¹⁷⁴ In *McKenna*, the defendant psychiatrist admitted that he would not have discharged Mr Pettigrove in any other circumstances — a decision apparently influenced by the administrative factors rather than treatment principles.¹⁷⁵ In both *Presland* and *McKenna*, these criticisms survived the appeals process.

Viewed correctly, as operating only to overcome defects of consent, rather than to create a modified standard of treatment for involuntary patients, the legislation does not provide coverage to the practitioners in either case. In *McKenna*, the decision not to detain Mr Pettigrove as an involuntary patient would be one to which no duty of care attached. The management of his discharge, however, once that decision was taken, falls very much within the scope of the doctor-patient duty of care, and it is from that duty that consideration of any breach which potentially caused the plaintiff's harm flows.

Finding that a patient no longer meets the criteria for involuntary detention is not tantamount to a finding that they no longer require treatment. Rather, it simply requires that the doctor either obtain the patient's consent, or take steps to terminate their relationship with the patient. What is an appropriate approach to termination of a relationship at the conclusion of an involuntary treatment order is likely to depend on the circumstances; it is most unlikely, however, that the bare minimum standards of expected practice would not include enquiring about how

172 *Crowley v Commonwealth of Australia* [2011] ACTSC 89 (27 May 2011) (Penfold J); *Presland v Hunter Area Health Service* [2003] NSWSC 754 (19 August 2003) (Adams J); *Hunter Area Health Service v Presland* [2005] NSWCA 33 (21 April 2005) (Spigelman CJ).

173 *Crowley* (2012) 7 ACTLR 142, [376] (Lander, Besanko and Katzmann JJ).

174 *Presland v Hunter Area Health Service* [2003] NSWSC 754 (19 August 2003) [90].

175 *Simon v Hunter & New England Local Health District* [2012] NSWDC 19 (2 March 2012) [56].

the patient is going to leave the hospital, and suggesting they consider follow-up treatment or monitoring. In *McKenna*, once the decision to release Mr Pettigrove was taken, planning for his future care became entirely ad hoc. The doctor concerned was aware of, and indeed supported, a proposal that Mr Rose drive Mr Pettigrove some 1100 kilometres from where he was, to Echuca, to receive further and unspecified treatment closer to his family and regular practitioners.¹⁷⁶ Furthermore, Mr Pettigrove was at the last minute prescribed medication to take during the trip.¹⁷⁷ Little consideration seems to have been given to whether the medication would immediately be efficacious (and thus place neither Pettigrove nor his driver at serious risk), or whether it could have side-effects. The treating doctor did not consider using depot medication, a method that had previously been effective in treating Pettigrove's condition, nor does he appear to have engaged with the (presumably) receiving health facility in Echuca with respect to transferring records and planning post-discharge care. Indeed, once the decision that involuntary detention of Pettigrove was no longer appropriate was taken, the quality of the care he received appears to have deteriorated dramatically.

The interpretation of the statutory powers as being inconsistent with other duties of care, including doctor-patient duties, does not further the specific objectives of the legislation or, more broadly, public health and wellbeing. Rather, it merely provides a distraction, diverting the court's attention away from the relevant question which is: would the treatment provided to Mr Rose and Mr Presland have been found to be negligent if there had been no question of involuntariness?

VII CONCLUSION

Even if the involuntary treatment powers outlined by the various mental health enactments were available to statutory authorities in each of *Presland*, *Crowley*, and *McKenna*, *Sullivan* does not provide good authority for failing to recognise a duty of care arising between the parties. The scope of the legislation in *Sullivan* was far broader than the involuntary powers provisions of the mental health legislation and, as such, findings of incoherence between a duty to exercise the power and the statutory provisions do not apply.

If we were to accept that the exercise of powers under the legislation did exclude a duty of care between a patient and doctor, the effect would be to create a two-tier standard of health care for voluntary and involuntary mental health patients. Voluntary patients receiving negligent treatment would be able to bring a claim in negligence, and receive compensation for the consequences of that negligent treatment, while involuntary patients receiving the same negligent treatment would be statutorily barred from recovering.

176 Ibid. *McKenna v Hunter & New England Local Health District* [2012] NSWDC 19 (2 March 2012) [26]–[28].

177 *Simon v Hunter & New England Local Health District; McKenna v Hunter & New England Local Health District* [2012] NSWDC 19 (2 March 2012) [38]–[39].

Such an outcome would not only be in breach of domestic discrimination laws, it would also be in conflict with international human rights obligations, specifically those in the *Convention on the Rights of Persons with Disabilities*.¹⁷⁸ It also suggests that practitioners whose treatment of a patient is questionable need only raise the possibility of involuntary detention in order to avoid detailed scrutiny of whether they actually met the required standard of care. It may be arguable that the third category identified by the High Court in *McKenna* (ie indeterminacy) may have provided a better ratio for refusing to recognise the duty claimed, noting that it, too, may be challenged by precedent from cases such as *Gifford v Strang Patrick Stevedoring*¹⁷⁹ and *Jaensch v Coffey*,¹⁸⁰ both of which recognised duties of care as being owed to family members of the victims of negligently-caused injury or death, who subsequently suffered nervous shock, noting that legislative restrictions on the categories of familial relationship attracting these duties exist in a number of jurisdictions.¹⁸¹

As part of the legislative reform process currently underway, this article suggests that the relevant involuntary detention and treatment provisions of all mental health acts should be amended to expressly require exclusion of voluntariness prior to exercise of the powers. Any official documentation used to support involuntary detention and treatment of patients should expressly require determination of the person's voluntariness, including a description of how that determination was made. In the event that consent was unavailable for reasons of capacity rather than volition, similar documentation of capacity should be required on all documentation supporting the exercise of these powers.

Furthermore, provisions should be inserted clarifying the scope of the involuntary powers ie overriding lack of consent only, not modifying the standard of treatment to be provided, as well as expressly excluding any immunity for negligently provided treatment.

178 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) arts 12, 14, 17, 19.

179 (2003) 214 CLR 269.

180 (1984) 155 CLR 549.

181 See, eg, *Civil Law (Wrongs) Act 2002* (ACT) s 36; *Civil Liability Act 2002* (NSW) s 30; *Law Reform (Miscellaneous Provisions) Act 2010* (NT) ss 23, 25; *Civil Liability Act 1936* (SA) ss 33, 53; *Civil Liability Act 2002* (Tas) s 32; *Wrongs Act 1958* (Vic) ss 72–3; *Civil Liability Act 2002* (WA) s 5S.