New South Wales
Supreme Court

CITATION :	**PRESLAND v HUNTER AREA HEALTH SERVICE & ANOR [2003] NSWSC 754 revised - 28/10/2003**
HEARING DATE(S) :	14/10/02-17/10/02, 21/10/02-24/10/02, 28/10/02, 29/10/02, 4/11/02-8/11/02, 12/11/02-15/11/02, 18/11/02-22/11/02, 25/11/02-29/11/02, 2/12/02-4/12/02
JUDGMENT DATE :	19 August 2003
JURISDICTION:	Common Law
JUDGMENT OF :	Adams J at 1
DECISION :	Judgment for the plaintiff with costs

CATCHWORDS :	Medical negligence - psychiatric registrar - Patient suffers psychosis with extreme violence - apprehended by police, taken to hospital - assessed as not mentally ill or mentally disordered person - meaning of "continuing condition" - meaning of "for the time being" - adequacy of assessment - relevance of history - nature of criteria under ss 9 & 10 Mental Health Act 1990 - whether liability in tort for negligent failure to detain - patient killed brother's fiancee whilst insane five hours after release
LEGISLATION CITED :	Compensation to Relatives Act 1897 (NSW) s39 Mental Health (Criminal Procedure) Act 1990 Mental Health Act 1990 Fatal Accidents Act 1976

CASES CITED :	AMP v RTA & Anor [2001] NSWCA 186; [2001] Aust Torts Reports 81-619 Bennett v Minister of Community Welfare (1992) 176 CLR 408 Chappel v Hart [1998] 156 ALR 517 Clunies & Camden 1998 QB 978 Crimmins v Stevedoring Industry Finance Committee (1999) 200 CLR 1 Gala v Preston (1990-91) 172 CLR 243 Gollan v Nugent (1988) 166 CLR 18 Haber v Walker [1963] VR 339 Hardy v Motor Insurers Bureau (1964) 2 KB 745 Hill v Constable of West Yorkshire [1989] AC 53 King v Porter 1936 55 CLR 182 March v Starmare (1991) 171 CLR at 517-519 Maynard v West Midlands Regional Health Authority [1984] 1 WLR 634 McNaughten's Case (1843) 10 Clarke & Finnelly 200 Reeves v The Commissioner of Police of the Metropolis [2000] 1 AC 360 Regina v S (1979) 2 NSWLR 1 Romeo v Conservation Commission of the Northern Territory (1998) 192 CLR 431 Sullivan v Moody [2001] HCA 59; [2001] 183 ALR 404 at 417 Wyong Shire Council v Shirt (1980) 146 CLR 40
PARTIES :	Kevin William Presland (Plaintiff) Hunter Area Health Service (First Defendant) Dr Jacob Nazarian (Second Defendant)
FILE NUMBER(S) :	**SC** 20192/98
COUNSEL :	M Lynch, G Craddock (Plaintiff) G Gregg, L Boyd (Defendant)
SOLICITORS :	Legal Aid Commission (Plaintiff) C Hynes, Liverpool Legal Aid Office (Defendants)

IN THE SUPREME COURT
OF NEW SOUTH WALES
COMMON LAW DIVISION

ADAMS J

TUESDAY 19 AUGUST 2003

20192/98

PRESLAND v HUNTER AREA HEALTH SERVICE & ANOR

JUDGMENT

INTRODUCTION

1 On 7 May 1996, the plaintiff was acquitted by Newman J, sitting without a jury, of the murder of Kelley Ann Laws at Jesmond on 4 July 1995 upon the ground that when he attacked and killed her he was in a psychotic state which so affected his capacity to reason that he did not know that what he was doing was wrong and, accordingly, he was not guilty on the grounds of mental illness. His Honour ordered, pursuant to s39 of the *Mental Health (Criminal Procedure) Act* 1990, that the plaintiff should be detained in strict custody in a psychiatric hospital until released by due process of law. Eventually, on 26 November 1997, the Governor ordered the release of the plaintiff. He was discharged from Long Bay Prison Hospital on 8 December 1997 and, in accordance with the recommendation of the Mental Health Review Tribunal, resided at Foster House, an institution managed by the Salvation Army. Although he required readmission to Rozelle Hospital in early January 1998, this was essentially done because of various pressures from the media and his family as a form of respite prior to his release into the community. No psychotic symptoms or ideas of harm to self or others had been demonstrated or elicited during this time. He was discharged from Rozelle Hospital on 6 February 1998 and since then has not required psychiatric care although he has been under the continuous supervision of the Mental Health Review Tribunal.

2 On 3 July 1995, that is to say, the day before Ms Laws was killed, the plaintiff had been brought to the John Hunter Hospital (JHH) by police following an episode of bizarre and extremely violent behaviour. After some treatment, he was transferred to the James Fletcher Hospital (JFH), a psychiatric institution, for assessment. He was released in the company of his brother at about 11am on 4 July and killed Ms Laws, his brother’s fiancée

about six hours later.

3 In substance, the plaintiff's case is that it was negligent of the Hunter Area Health Service, responsible for the operations of the two hospitals to which he had been admitted on 3 July, and the doctor who discharged him, not to have detained him as an involuntary patient under the *Mental Health Act* 1990 (the Act; all legislative references are to this Act unless otherwise stated) an action, which would have averted the tragic death at his hand of Ms Laws, his subsequent incarceration and the distress and economic loss which resulted from these events.

THE LEGISLATION

4 It is useful to set out at the beginning the relevant provisions of the Act as it stood on 4 July 1995. (I interpolate that subsequent amendments, including a major revision in 1997, do not seem to me to have brought about significant changes to the considerations which apply to this case.) The objects of the Act are set out in Chapter 2 as follows –

> "4(1) The objects of this Act in relation to the care, treatment and control of persons who are mentally ill or mentally disordered are:
> (a) to provide for the care, treatment and control of those persons; and
> (b) to facilitate the care, treatment and control of those persons through community care facilities and hospital facilities; and
> (c) to facilitate the provision of hospital care for those persons on an informal and voluntary basis where appropriate and, in a limited number of situations, on an involuntary basis; and
> (d) while protecting the civil rights of those persons, to give an opportunity for those persons to have access to appropriate care.
> (2) It is the intention of Parliament that the provisions of this Act are to be interpreted and that every function, discretion and jurisdiction conferred or imposed by this Act is, as far as practicable, to be performed or exercised so that:
> (a) persons who are mentally ill or who are mentally disordered receive the best possible care and treatment in the least restrictive environment enabling the care and treatment to be effectively given; and
> (b) in providing for the care and treatment of persons who are mentally ill or who are mentally disordered, any restriction on the liberty of patients and other persons who are mentally ill or mentally disordered and any interference with their rights, dignity and self-respect are kept to the minimum necessary in the circumstances."

5 Much emphasis has been placed by the experts called by the defendants

upon the duty for relevant those dealing with mentally ill or mentally disordered persons to respect their civil liberties and exercise their functions in a way that restricts those liberties as little as possible, consistent with appropriate treatment. It is worth observing, however, that there is nothing in the objects of the Act suggesting that the decision as to whether someone is a mentally ill or mentally disordered person should be affected by any notion of civil liberty. Furthermore, s4(2)(a) makes it clear that mentally ill and mentally disordered persons should receive "the *best possible* care and treatment in the least restrictive environment enabling the care and treatment to be *effectively* given" (emphases added). At least so far as the objects of the Act are concerned, the diagnosis of mental illness remains an essentially medical question with the adequacy of diagnostic assessment also to be determined as a medical question and not subject to the policy considerations either stated in the objects or thought to underlie the Act; although it must be determined by a doctor whether a person is a mentally disordered person, this is not a medical question, as reference to the criteria in s10 immediately demonstrates. Similarly, the assessment of the "best possible care and treatment" is a medical question distinct from any policy considerations which are, for all practical purposes, entirely confined to the mode in which that care and treatment, once determined, is to be administered. As will become obvious as I deal with the experts' opinions adduced in this case, this distinction has not, I think, been sufficiently appreciated or, if understood, has not been appropriately applied to the circumstances.

6 It is important next to note that being mentally ill does not render a person a "mentally ill person" within the meaning of the Act. Nor is it necessary for a "mentally disordered person" to have any mental disorder. For the purposes of dealing with a patient in a way which subjects them to restrictions on their liberty, this can only occur where the relevant criteria set out in Chapter 3 of the Act are satisfied: s8. The crucial provisions are s9 (concerning mentally ill persons) and s10 (concerning mentally disordered persons), the terms of which are as follows –

> **Mentally ill persons**
>
> "9.(1) A person is a mentally ill person if the person is suffering from mental illness and, owing to that illness, there are reasonable grounds for believing that care, treatment or control of the person is necessary:
> (a) for the person's own protection from serious physical harm; or
> (b) for the protection of others from serious physical harm,
> and a person is also a mentally ill person if the person is suffering from mental illness which is characterised by the presence in the person of the symptom of a severe disturbance of mood or the symptom of sustained or repeated irrational behaviour indicating the presence of that symptom and, owing to that illness, there are reasonable

grounds for believing that care, treatment or control of the person is necessary for the person's own protection from serious financial harm or serious damage to the person's reputation.

(2) In considering whether a person is a mentally ill person, the continuing condition of the person is to be taken into account.

(3) In this section, " **damage to the person's reputation** " includes damage to the person's reputation among those with whom the person has important personal relationships, where the damage is likely to cause lasting or irreparable harm to any such relationship.

Mentally disordered persons

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

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

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

7 Section 11 provides that certain words or conduct would not render someone a mentally ill or mentally disordered person merely because of the presence of a number of specified ideas or attitudes or because of alcohol or drug use or anti-social behaviour. The requirement that there must be present reasonable grounds for believing that care, treatment or control is necessary to protect the person or others from serious physical injury or from serious financial harm or serious damage to the person's reputation is, of course, not a medical one. Nor, it is very important to note, is the presence of such grounds contradicted by the presence of reasonable grounds for believing that care treatment or control is *not* necessary for the protective purpose. (The potential for financial harm or harm to reputation is irrelevant to the present case and has since been removed from the Act.)

8 "Mental illness" is defined in Schedule 1 as follows –

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

(a) delusions;

(b) hallucinations;

(c) serious disorder of thought form;

(d) a severe disturbance of mood;

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

9 A person may be taken to and detained in a hospital on the certificate of a doctor who has personally examined or observed a person and considers that he or she is a mentally ill person or a mentally disordered person and is "satisfied that no other appropriate means for dealing with the person are reasonably available, and that involuntary admission and detention are necessary": s21(1). There are, therefore, three criteria to be satisfied before a person may be involuntarily detained in a hospital: firstly, the person is mentally ill or irrational; secondly, there are reasonable grounds for believing that care, treatment or control of that person is necessary to protect him or her or others from serious physical harm; and thirdly, no other appropriate means for achieving this end are reasonably available, so that involuntary admission and detention are necessary.

10 In this case, it appears that two police officers exercised their powers under s24 to take persons to a hospital in relation to the plaintiff, who was found in a public place appearing to be mentally disturbed and there were reasonable grounds for believing that he was committing or had recently committed an offence and that it would be beneficial to his welfare that he be dealt with under the Act. Section 29 requires that, where a person is taken to a hospital in these circumstances, he or she must be examined as soon as practicable and at all events within twelve hours after arrival by the medical superintendent and cannot be detained (subject to irrelevant exceptions) unless the superintendent certifies that in his or her opinion the person is a mentally ill person or a mentally disordered person. In this event, the medical superintendent must give the patient an oral explanation and a written statement in the prescribed form of the person's legal rights and other entitlements under the Act. (From the point of view of the staff at the JFH, it might have appeared that the plaintiff was voluntarily admitted as an informal patient although I consider that there was a duty to ascertain whether the police were acting pursuant to s24. For reasons I mention later, I consider that it was at all relevant times quite clear that this was so.) Depending on the condition of such a patient, the medical superintendent may cause him or her to be detained, providing the conditions to which I have already referred are satisfied. The plaintiff's case is that, whatever the status of his initial admission, he should have been detained as an involuntary patient in accordance with Part 2 of the Act. In the result, I do not think that the plaintiff's status when he was brought into JFH matters very much.

11 Division 2 of Part 1 provides for an enquiry to be made by a Magistrate following the detention of someone as a mentally ill or mentally disordered person. Broadly speaking, the person must be brought before a Magistrate as soon as possible, the relatives, guardian and personal friends should be informed, a hearing is conducted in public (unless the patient objects), the person is entitled to be legally represented and an enquiry must be held. The result of the Magistrate's findings are dealt with as follows –

> "51(1) If, after holding an inquiry, a Magistrate is satisfied that on the balance of probabilities a person is a mentally ill

person, the Magistrate must take the action set out in subsection (2) or subsection (3).
(2) The Magistrate may order the discharge of the person to the care of a relative or friend who satisfies the Magistrate that the person will be properly taken care of or order such other course of action in respect of the person (including a community treatment order) as the Magistrate thinks fit.

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

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

12 A person detained under s51(3) is termed a "temporary patient". Such a patient has a right of appeal to the Mental Health Review Tribunal which must consider for itself whether, indeed, the patient is a mentally ill person and it is appropriate that he or she be detained: Division 3 of Part 2 of the Act.

13 It is important to note that the purpose of the inquiry is to determine whether the person is a mentally ill person. The Magistrate is *not* called on to consider whether the person is a mentally disturbed person. Section 52 provides that, if the Magistrate is not satisfied that the person is a mentally ill person, the person must be discharged but the order for discharge may be deferred for a period not exceeding 14 days "if the Magistrate thinks it in the interests of the person to do so". This power is very wide. It does not depend on finding the person to be a mentally disordered person but the Magistrate can consider, as it seems to me, all the risks to health and welfare of the person that discharge might reasonably be regarded to expose the person. Thus, for example, where there is a reasonable risk that the person is, in fact, a mentally ill person but it cannot be said this is so at the moment on the preponderance of probabilities, a Magistrate could, if he or she thought it appropriate in the interests of the person, defer discharge to permit further assessment or further inquiry or to see whether symptoms settle or become more observable or florid or severe. The avoidance of substantial risk to the health or welfare of the person may well, therefore, justify deferral of discharge, even though it is not more probable than not that the person is a mentally ill person. In considering the interests of the person, the interest in being at liberty will be an important consideration: it is obviously not the only one.

14 It will be readily seen that the task of the medical superintendent or doctor who examines a person to determine whether or not he or she is a mentally ill person or a mentally disturbed person is entirely distinct from

the role of the Magistrate and, should there be an appeal, of the Mental Health Review Tribunal. Having regard to the relationship between s51 and s52, this is especially so in respect of a mentally disordered person. It is not appropriate, in my opinion, that a doctor or medical superintendent should be concerned with the attitude that Magistrate might take to either the diagnosis or the detention. In no sense does the Act imply any supervisory role by the Magistrate over the conduct of the doctor. Indeed, this would not be possible as it is evident that the Magistrate is not a legally qualified medical practitioner. The Magistrate is an adjudicator whose job is to decide the questions entrusted to him or her by the legislation in accordance with the evidence which is presented at the inquiry. It is obvious that this procedure is designed to protect persons whose liberty is being restrained but the policy of the Act in this regard is sufficiently and exhaustively expressed in and fulfilled by the exercise by doctors and Magistrates of their assigned functions. In other words, the policy of the Act as to the proper balance between civil liberty on the one hand and treatment and protection of the patient and the public on the other is effected by following its provisions.

15 This discussion is necessary because it was suggested in the defendant's case that the doctor should, as it were, defer to the potential decision of the Magistrate about the diagnosis of mental illness or the need to detain and consider whether the Magistrate might come to the same conclusion as he or she has. In my view, so far from the legislation suggesting the propriety of such an approach, it is contrary to the specific terms of the Act. Furthermore, a person suffering from a mental illness may be detained where there are reasonable grounds for believing that it is necessary to do so to protect that person or others from serious physical harm. The interim, temporary or emergency character of the first instance decision by the doctor is an important consideration in interpreting the nature of his or her responsibility. If there is a bias between protection on the one hand and personal freedom on the other, it seems to me that preference should be given to the former function: to my mind, the primary function of the doctor is the protection of the patient or the public from the risk of serious physical injury. This is especially so when considering the application of s10, which is not the subject of the Magistrate's inquiry under s51. So far as the Magistrate is concerned, it is only if he or she is satisfied on the balance of probabilities that a person is a mentally ill person that the steps specified in s51(2) or (3) are to be taken. If not so satisfied the Magistrate is obliged to order that the person be discharged from hospital, subject to deferral in the patient's interests. It is obvious that the information considered by the Magistrate is likely to be very different to that available to the detaining doctor, not least because of the elapse of time, during which the person is under observation.

16 It is necessary, I think, to add that no standard of proof is imposed on the doctor's determination of whether a person is suffering from a mental illness. It seems to me that the test is that which is usually applied by doctors called upon to make a diagnosis of illness for the purpose of

considering what, if any, treatment the patient needs. Section 10 involves no medical decision and the determination, in substance, depends on the presence of such a degree of irrationality as to provide reasonable grounds to conclude that protection is needed. This is far short of certainty and less than probability: there may well be reasonable grounds for the conclusion, even though the infliction of serious injury is improbable. This reflects the emergency and protective character of the doctor's role and is in line, it is worth observing, with the power of the police to take the person to a hospital.

THE NATURE OF THE DUTY

17 The substance of the plaintiff's case is, as I have said, that the second defendant, Dr Nazarian, should have concluded, when he saw him on the morning of 4 July 1995, that he was not only a mentally ill or a mentally disordered person, but needed to be detained for his own safety or the safety of others, or both. The plaintiff's case is that, had this occurred, it is most improbable that he would have killed his sister-in-law or anyone else, for that matter. It is his case that there is a substantial causal nexus between his release, his later acute psychotic state and his killing of Kelley Laws. The difficult question raised at the outset is whether a failure by a doctor to competently perform his or her duties either at common law or under the Act gives rise to a cause of action where the gravamen of the claim is that the doctor negligently failed to treat someone as a mentally ill or mentally disturbed person. I am not altogether certain that this is a case in which the question of duty is correctly characterised as concerning the exercise of a statutory power. A more appropriate way of characterising the issue seems to me to consider the power of detention (assuming a diagnosis is made that the person is a mentally ill or mentally disordered person) as the statutory provision of a mode of treatment not otherwise permitted by law, thus raising no question of the negligent failure to exercise a statutory duty and whether, if that occurred, a private right of action is conferred. However, having regard to the view that I have formed about the nature of the statutory duty, this is a distinction without a difference in the circumstances of this case.

18 It is not controversial that the defendants owed a duty of care to appropriately treat the plaintiff. The question, therefore, is whether the particular treatment by way of detention (amongst other things) was appropriate and, if so, whether there was a duty to provide it and whether the negligent failure to do so gave rise to a right in the plaintiff to sue for negligence. In *Crimmins v Stevedoring Industry Finance Committee* (1999) 200 CLR 1 at 39, McHugh J set out the considerations as follows –

> "In my opinion, therefore, in a novel case where a plaintiff alleged that a statutory authority owed him a common law duty of care and breached that duty by failing to exercise a statutory power, the issue of duty should be determined by the following questions:

(1) Was it reasonably foreseeable that an act or omission of the defendant, including a failure to exercise its statutory powers, would result in injury to the plaintiff or his or her interest? If no, then there is no duty.
(2) By reason of the defendant's statutory or assumed obligations or control, did the defendant have the power to protect a specific class including the plaintiff (rather than the public at large) from a risk of harm? If no, then there is no duty.
(3) Was the plaintiff or were the plaintiff's interests vulnerable in the sense that the plaintiff could not reasonably be expected to adequately safeguard himself or herself or those interests from harm? If no, then there is no duty.
(4) Did the defendant know, or ought the defendant to have known the risk of harm to the specific class including the plaintiff if it did not exercise its powers? If no, then there is no duty.
(5) Would such a duty impose liability with respect to the defendant's exercise of 'poor policy making functions'? If yes, then there is no duty.
(6) Are there any other supervening reasons in policy to deny the existence of a duty of care (eg, the imposition of the duty is inconsistent with the statutory scheme, or the case is concerned with pure economic loss and the application of principles in that field deny the exercise of a duty)? If yes, then there is no duty."

19 It seems to me obvious that the first question should be answered "yes". The conclusion giving rise to the power to detain is exercised (mental illness or irrationality being present) where there are reasonable grounds for believing that it is necessary to care, treat or control the person to protect him or her or others from serious physical harm. If that condition is not satisfied, the question of detention does not arise. Once the provisions of ss9 and 10 of the Act are satisfied, s20, as I pointed out, prohibits admission to or detention in a hospital "unless the medical superintendent is of the opinion that no other care of a less restrictive kind is appropriate and reasonably available". If the only proper opinion is that no such care is either appropriate or reasonably available, then it follows that the patient must be protected by detention. Question 2 should be answered "yes" for obvious reasons. Question 3 must also be answered "yes" since the very purpose of the statutory power arises where the specified vulnerability occurs. Given the hypothesis that ss9, 10 and 20 require detention, it follows that question 4 should also be answered "yes". Question 5 should be answered "no" since the diagnosis and decisions required of the medical superintendent are essentially factual and do not involve policy in the relevant sense. This is so, even though it is clear that the policy underlying the Act is that detention should be used in appropriate cases for the protection of mentally ill or mentally disturbed persons but only to the

extent that other modes of care are not appropriate and subject to outside supervision. It is wrong, for the reasons I have already expressed, to say that the policy of the Act is to restrict detention: the policy of the Act is to provide for detention but to ensure that it only occurs when it is appropriate. So far as question 6 is concerned, the defendants propose four reasons to deny the existence of a common law duty of care: the creation of a detrimentally defensive frame of mind; the creation of potentially conflicting duties; the potential indeterminacy of liability; and the application of the maxim *ex turpi causa non oritur actio.* The defendants rely on *Clunies v Camden & Islington Health Authority* (1998) QB 978, where the Court of Appeal found that the statutory duty of the authorities to provide after-care services for the plaintiff who committed manslaughter (murder but for his diminished responsibility) following his discharge from hospital until they were "satisfied…[that he] no longer needed them did not give rise to a private cause of action. However, the character of the services was wide-ranging and undefined, co-operation with voluntary services was required and the legislation gave powers to the Secretary of State to investigate and deal with failures such as those alleged. The Court of Appeal thought it was most significant that the relationship of doctor and patient no longer applied after discharge and the after-care services were "different in nature from those owed by a doctor to a patient whom he is treating and for whose lack of care in the course of such treatment the local health authority may be liable": *ibid* at 992. The circumstances of this case are very different. The defendants submit that the Act creates a statutory scheme, "which governs the conduct of medical practitioners [and], with regard to the involuntary detention of patients, it imposes responsibilities and statutory duties owed to individuals suffering mental illness and the public at large". So far as the doctor is concerned, I do not see that this is so. The duty to the public is simply to apply the Act: in applying the Act according to its terms to the plaintiff, the defendants' duties to both are satisfied by the same conduct. It is true that the doctor has a duty to take appropriate action in the event that either s9 or s10 of the Act are satisfied and that this will require consideration of the protection of others than the plaintiff from the infliction by him of serious injury but this is obviously very much in the patient's own interest. In truth, there is no conflict: there are no "inconsistent obligations": see *Sullivan v Moody* [2001] HCA 59; [2001] 183 ALR 404 at 417. As to the consideration that imposition of tortious liability on doctors in respect of their determinations under the Act would lead to a "detrimentally defensive frame of mind", there is no feature of the proposed duty to use the powers given by the Act to appropriately treat a patient which would or should create any degree of defensiveness greater than the conventional common law obligations to exercise due care. The defendants submitted that it was relevant to note that a Magistrate conducting an inquiry is protected from suit and that this indicated that it was not intended by the Legislature to impose liability for negligence on doctors exercising the function of making decisions under s9, s10 or cognate provisions of the Act. To my mind, if it were intended by the Legislature to confer on those

doctors the same immunity from suit as the Magistrate, the Act would have said so: cf s294 giving exculpation from liability of police for injuries or damage caused in good faith. The immunity from suit conferred on Magistrates is fundamental to their exercise of their judicial and quasi-judicial functions as a matter of public policy, without which it is impossible that they could effectively operate. The exercise by doctors of their professional responsibilities, though undoubtedly important, has never been regarded as a public function of the same order and there is no proper basis in the Act for constructing a special rule of immunity in respect of their treatment of patients under the Act, still less for their employers. Reliance was also placed on the decision of the House of Lords in *Hill v Constable of West Yorkshire* [1989] AC 53, in which it was held that the police did not owe a duty to members of the public who suffered injury from the acts of a dangerous criminal who their carelessness allowed to remain at large. As was pointed by Lord Keith of Kinkel (*ibid* at 63), an investigation involves policy decisions and discretions as to such matters as priorities in the deployment of resources, which could not be properly evaluated by reference to common law duties of care or by judicial scrutiny in the course of an action in tort. However, in the present case, no such policy decisions were involved: the relevant criteria for detention are defined in the Act. Indeed, the intrusion of policy considerations, say, as to the resources of the hospitals in question or any other matter not prescribed by the Act into the question whether the plaintiff satisfied the criteria contained in s9 or s10 would have been quite improper. The application of the maxim *ex turpi non oritur actio* is dealt with below in the context of the duty of care. In short, it has no application in the circumstance of this case. Nor is there any real issue concerning indeterminacy of liability. The duty asserted here is that owed to the plaintiff as a patient by the doctor to whom his care is entrusted (cf *Sullivan v Moody, supra*).

20 It follows, as it seems to me, that the defendants owed the plaintiff a common law duty of care and, if they failed in applying to his diagnosis and treatment an appropriate level of care, including detention, then they are liable, subject to the issues of foreseeability of injury, causation and the possible operation of the *ex turpi* principle, to which I will come after dealing with the facts. It may be, although I have not referred to it in this context, that the imposition of a duty to use the powers under the Act in an appropriate case can be implied by virtue of s4(2), to which I have already made reference.

21 The unusual consideration applying in this case is that, essentially, the plaintiff claims that he should have been detained even against his will. For reasons which will become apparent in due course, I do not think that detention, at least in the short term, would have been against his will but the notion that there might be a duty at common law towards a person to restrain that person from causing injury to himself or others is novel (ignoring duties that arise, for example in prisons or other custodial contexts), at least with respect to adults; certainly no other form of medical treatment can be given against a person’s will, however necessary it might

be to preserve their life. This reflects, no doubt, the very high value indeed placed by the law on individual liberty. However, in cases that arise under the Act the question of the extent of the duty of care will only come to be considered if the person should be regarded as a mentally ill or mentally disordered person. Accordingly, where a person refuses treatment because they are a mentally ill or mentally disordered person and would otherwise suffer or cause serious injury, the administration of medicine or even surgery that is necessary to avoid this consequence is not only permitted but required, subject to the requirements specified in Chapter 7 of the Act. Accordingly, I consider that the peculiar nature of the relevant care, treatment or control provided for under the Act did not take it outside the general rule set out above in the above-quoted passage from *Crimmins*.

BACKGROUND

22 The plaintiff was born in October 1958 and, accordingly, at the time of the incidents with which I am concerned was approaching his 37th birthday. His parents are still alive and he has two sisters and a brother, Allan, who is younger than him by several years. The plaintiff attended high school to year 10 and left to take up an apprenticeship as an electrician. (His work history is dealt with below under the heading “Economic Loss”.) In about mid 1994 the plaintiff formed a partnership with a Mr Graham Long, sub-contracting house-cladding work, replacing weatherboards with vinyl, installing windows and undertaking small renovations. During the course of 1995, the partnership employed a Mr William Blake from time to time. The plaintiff had met him at the Hamilton Station Hotel, which he frequented.

23 On Friday 30 June, the plaintiff finished work about 4.30pm and, after dropping Mr Long off at the pub, went home, cleaned up and went down to the hotel for a drink. When he was having his second drink, he noticed the presence of a Mr Hammond, whose nickname was “Popeye”. The plaintiff said that he had seen Mr Hammond assault his nephew in the hotel some weeks before. He said that the attack was unprovoked, that his nephew had been held down by the throat and that Mr Hammond had threatened to kill him. The plaintiff had attempted to defend his nephew but claimed that he was restrained by two of Mr Hammond’s associates. The plaintiff said that Popeye was a very good friend until what he believed to be the assault on his nephew. The plaintiff says that when he saw Popeye the day after this altercation, he said to him, “Don’t you ever touch any of my family again or I will kill you”. When he saw Mr Hammond on 30 June, he insulted him a couple of times. A mutual acquaintance suggested that the two men should go outside to sort the matter out. The plaintiff walked outside with his drink and there was a confrontation between him and Mr Hammond. It became increasingly heated. The plaintiff took particular exception to Mr Hammond repeatedly pointing at his face with his finger and he bit it, although he said this was “not hard”. The plaintiff said that, when this happened, Mr Hammond grabbed him by the throat and smashed his head into a nearby traffic sign, causing a cut to his head. The plaintiff said that the two of them

were on the ground with Mr Hammond starting to choke him when patrons of the hotel came out and separated them. Although the plaintiff was holding a glass at the time, he did not attempt to use it. A friend then took him to his home, which was about 200 metres from the hotel, to treat his cut. This friend was Beth, who had known the plaintiff since they were young. The plaintiff said that when he got home he was very angry and decided that he would return to the hotel to “smash Popeye’s head in”. Beth told him that he could not do this. The plaintiff said that he rang William Blake and said to him that he intended to go to the hotel and repeated the threat, asking for “some backup”. The plaintiff said that Beth left his home and that Mr Blake came about ten minutes later. He discussed taking revenge against Popeye with Mr Blake who said that he will “take care of it, him and his uncle”, who the plaintiff thought was a Vietnam veteran. The plaintiff said that he replied, “No, it is my business” but that Mr Blake responded, “You will get into trouble, just let us handle it”. Some time later, the plaintiff returned to the hotel, as I understand his evidence, with Mr Blake, who said “he was just going down to point Popeye out to his uncle… by placing his hand on his shoulder”. The plaintiff said that he thought that this indication had something or other to do with the fact that Mr Blake’s uncle was a Vietnam veteran but he did not understand what this was about. I think that, in fact, neither Mr Blake nor his uncle went to the hotel. The plaintiff said that he then returned to the hotel and drank two more glasses of beer (I think, schooners) and then returned home.

24 Ms Rouse, who as it happened worked behind the bar at the Hamilton Station Hotel, described the physical conflict involving the plaintiff’s nephew as “a bit of a scuffle between them” and that “Popeye had Kevin on the floor holding him down and someone else had Kevin’s nephew holding him from the back around the throat”. She said that the plaintiff started verbally abusing Mr Hammond, who did not respond “because we all knew that Kevin was having a problem”. Ms Rouse said that, although the plaintiff thought that it was Mr Hammond who had held his nephew around the neck, this was not so, but the plaintiff refused to accept any contradiction. Ms Rouse saw at least part of the fight in which Mr Hammond had pushed the plaintiff’s head into the traffic pole at the front of the hotel and confirmed that he had quite a large cut on his head as a result. Ms Rouse said that later that night the plaintiff returned to the hotel. He was wearing his slippers and pyjamas with a windcheater over the top. She said that she had never seen him behave like this before, that “he was just staring off into space”. She said that she had a brief conversation with him and that he said he had just come into see her for a chat and then he was going home. It appears that the plaintiff returned home without any further incident.

THE BLAKE INCIDENT

25 Although it appears that the plaintiff had been acting strangely in a number of respects for some months preceding 30 June 1995, the night of 30 June 1995 (as it seems to me) marks the commencement of a rapid decline into an acute psychotic state. The plaintiff’s narrative of events from

this point becomes increasingly bizarre. Whilst it is, broadly speaking, accurate, I am quite sure that a number of things which he relates and which he still believes to have happened did not do so, except in his own thoughts. The most significant matter falling into this category is his conversations with Mr Blake or, to be more precise, what he believes Mr Blake told him. In most other respects, however, I have concluded that the plaintiff's account is reasonably reliable. I should state that I have no doubt that the plaintiff was doing his best to tell the truth as he recalls it. Generally, I consider that the plaintiff is a reasonably reliable historian of his own thought processes and contemporaneous ideas, that is, of his own "internal" world. Mostly, he is reliable about his movements and about the identities of the persons he encountered from time to time. However, there are a number of events that he believes occurred – mostly concerning what people said to him – that I have no doubt did not occur. I do not doubt that he is relating his experiences of those events but I consider that those experiences were only tenuously connected with reality and cannot be taken as reflecting what actually happened. My impression of the plaintiff's evidence of what happened to him is best described, I think, as the narrating of a dream: detailed, organised but distinctly surreal.

26 The plaintiff said that he could not sleep on the Friday night, since (as I understand it) he was worried about his conversation with Mr Blake. He telephoned him the following morning. I set out the conversation as related by the plaintiff although, if he had a conversation with Mr Blake that morning (and he may well have), I do not believe that it occurred in these terms –

> "I told him, 'I don't want anyone hurt.' He said, 'It's too late now. The wheels are in motion. This is family business now'. I said, 'It is not family business'. I said, 'This is my business. Leave Popeye alone'. He said, 'You won't know nothing about it. We'll get him as he comes out of the pub one night', and I says, 'No you won't'. I said, 'If you do there will be trouble'. I said, 'If you do I will put you into the police' and he just called me a 'filthy weak' C— word. I never spoke to him again that day."

The plaintiff said that he stayed mostly at home during the day on Saturday, going down to the hotel about 5 o'clock. He said he was feeling very miserable and depressed as he thought about what he had done, believing, that he had put his erstwhile friend Popeye in the position "of being seriously hurt". The plaintiff said that he believed Mr Blake's uncle was "a very evil person". There was no basis whatever for this opinion and its presence indicated, at the least, a grave disturbance of the plaintiff's ability to think clearly. The plaintiff said that, when at the hotel, he spoke to a couple of friends and went home at about 9.30pm. He believes he drank at least five or six schooners of beer.

27 The plaintiff said that he left the hotel with one Peter McDonald and the two of them returned to the plaintiff's house. The plaintiff had perhaps one more schooner or its equivalent of beer. Mr McDonald left at about 11pm and the plaintiff went to bed. He said that he only had an hour or two of sleep at most. He said that his thoughts kept "going on", concerning Popeye, his belief that Mr McDonald was "actually a homosexual trying to go to bed with me", and the break-up of his longstanding relationship with a Ms Patricia Brown. He said that he got up on the following morning at about 8am or so "because Bill Blake came around to my house" –

> "He was telling me how he had just done some home invasion. He – some person didn't part pay up for his drugs whatever they were. He told me the best time to get them is in the morning when they are hung over, knocks on the door, races in with, he has got half a baseball bat. He told this person that he would die if he didn't pay up by that afternoon. Then he wanted me to come around for a barbecue at his place. I declined his offer. I had to go around to my father's place to install a new stove for him. He insisted I come around. He told me his wife was making salads and sufficient stuff, and to spend a day with his family. I said, 'I can't'. He repeatedly asked me and asked me. I finally said I would. I went around there at approximately 10 am, 10.30."

28 Mr Blake, his wife, his uncle, and one of his sons, a three year old boy, were there. He said that there was no barbeque on at all, that this was "just crap to get me around there". He said that Mr Blake gave him a beer although he did not feel like it. Mr Blake assured him that he would be all right, and continually brought out stubbies of beer to drink. The plaintiff said that he was drinking slowly and had about six bottles through the course of the day. The plaintiff said that he left Mr Blake's house at about 7pm. During the day he said, Mr Blake repeatedly referred to the plaintiff as "part of this family now". The plaintiff's evidence continued –

> "'What, what sort of family is it?' He said, 'You'll find out'. He kept on going on about family all – I told him I had my own family. I didn't understand what he was on about. He demonstrated with his rats – he has rats in his shed in a cage. He said, 'To join my family you have got to let the rats bite you'. And I can't stand rats. He brought one out, a baby one, to hold in my hand. It was a slimy thing. It didn't have any hair on it. I give it back to him and told him to get rid of it.
>
> Q. Did you take the rat from him?
>
> A. I did. He said, 'Just hold it in your hand' and, you know, sort of – I just don't like them. I can't stand them. I give it back to him.

...

After I give it back to him…he put his actual finger in the cage and let the rat actually bite him. He said rats 'don't hurt' and he had this great gash in his hand, it was bleeding profusely, and I thought he was a bit sick.
Q. Was there anybody else present when this was happening?
A. Yes. His uncle, his wife, and his small child.
Q. So he let the rat bite him, you say?
A. Yes."

There was further strange conversation about the rat, including the son saying, in answer to his father, that he had also been bitten by the rat. The plaintiff said that Mr Blake said that he had been bitten by a female rat and said that he would "get the bitch back later on" by taking the male out of the cage, which would cause the female to "freak out". (I interpolate here that, although I do not believe that this conversation actually occurred, it may be that there was, indeed, some conversation about the rat and that Mr Blake showed the plaintiff the pet rats.) The rats later came to play a prominent part in the plaintiff's psychosis. The plaintiff says that he was shown the pet rats at about 1pm.

29 In addition to beer, he said that Mr Blake supplied him with three cones of marijuana to smoke during the afternoon. Whether this occurred it is impossible to say, though I doubt that it did. Later in the day, the plaintiff said –

"There was one party wanted me to go and have a game of darts. I was feeling very weird at this stage, very lethargic, I had no energy whatsoever. When I walked into the shed I nearly collapsed, like my legs and nearly given way on me, and I said, 'There is something wrong. I have got to go home. I am not very well', and he said, 'Oh, you'll be all right', and I said, 'I have got to go'. He insisted I stay. He said, 'Go for a walk down to the bottle-shop with my uncle and get another carton of beer.'"

30 The plaintiff said the following about playing darts –

"A. In his small shed he had a dart board set up. I walked into the shed. There was – we teamed up. I think it was him and his uncle against me and his wife. It was strange, because every time I would have a shot at the dart board – I used to play competition darts: you always go for the triple 20 – every time I would have a shot there was like a little moth would come out and hover around, and it was just the strangest thing I would have seen, and I said, 'What the hell, have you got a trained moth or something that comes out of your wallet or something?', and he just sort of smiled and didn't say nothing."

31 The plaintiff said that he does not now believe that every time he went to have a shot at the dart-board there was a moth in the way. He said that he believed it was some sort of hallucination caused by Mr Blake putting a drug in the marijuana cones which he was smoking. He said that he had never had a similar experience before when drinking alcohol or using marijuana, adding –

> "I had an experience when I was 21, when I was down the Snowy Mountains, a person that had given me half a trip and said, half an LSD thing, and that sort of was actually terrible, and I said the next day, you know, like, 'I'll never touch that crap again. It is bloody terrible'. But that is similar to the experience I had. Yeah, after that, I think I went to the bottle-shop. I walked with his uncle. His uncle was telling us how he was in Vietnam. He reckoned he was some sort of commando, used to go out in the middle of the night slashing people's throats. He told me he had the record of 30 in one night. I said, '30 in one night?' I said, 'You would have to be killing someone every ten minutes or so', something, and he said, 'Don't ever question me', and he call me a filthy name. He was a person you could not look in the eye. If you looked him in the eye he would say, 'Don't eyeball me', and he would call me a filthy name starting with a 'C'. He was a very strange man. He was just out of gaol apparently for killing or something, he wouldn't tell me, but he told me he shoved the knife into someone. He was a very evil sort of person, I believe, and he made me quite – I was quite wary of him. I was pretty scared of him really. We walked to the bottle-shop. I paid for the beer."

32 The plaintiff said that he felt enervated in a way that he had never felt before in his life, although "I felt all right in my head". He said that he was feeling physically drained and told Mr Blake's uncle that he wanted to go home. But he insisted that he should return to the house. The plaintiff said he did so. When he made to leave several more times, Mr Blake and his uncle insisted that he stay. The plaintiff thought that the trip to the bottle shop occurred about 3.30pm or so. He said that, when he returned, he probably drank one more beer because he was not feeling well. He said that every time that Mr Blake gave him a beer, the bottle was opened and that he did not know if Mr Blake was putting something in the beer or in the cones: "There was something going on". He said that, eventually, Mrs Blake made a stew with sausages, which Mr Blake called "devilled sausages". I think that the plaintiff thought that the name of this dish was significant.

33 Eventually, the plaintiff went home. He said that he was feeling very weak. He remembered asking Mr Blake to borrow a jumper because it was cold but Mr Blake told him that he would be all right. Mr Blake gave him a six- pack of beer since the plaintiff had "paid for it". The plaintiff said that, as soon as he got out of the gate, "the fresh air hit me and I just felt fine

after that". He did not live far away and he walked home. The plaintiff said that when he got home he felt physically a lot better. A friend of his, Ms Carlene Beehan, came around and they talked about the plaintiff's relationship with Popeye. The plaintiff decided that he would attempt a reconciliation and thought of ways in which he could do this. During the conversation, the plaintiff told Ms Beehan that he had visited Mr Blake's house and believed that he had done something to him although he did not know what it was. He said that Ms Beehan told him that he should stay away from Mr Blake as "there is something wrong with that guy, he is evil or something" or something to this effect. Ms Beehan stayed for perhaps an hour and a half, leaving sometime before 10pm. The plaintiff believes that he only slept one hour that night, although he thinks that he went to bed shortly after Ms Beehan left.

34 The following morning, Monday 3 July, the plaintiff went to work, starting at about 7.30am. He worked with Mr Long most of the day, finishing work at about 4pm. He said that he stayed home for a short time and then telephoned Mr Blake to tell him that there was no work for him the following day, although there might be on the Wednesday. In an attempt to convey an impression of the character of plaintiff's evidence, I set out *in extenso* the plaintiff's evidence about what happened that night –

> "He told me to come round, it was time I joined his family. I said 'What's this family business?', and I also asked him 'What are you doing in the esky? Are you playing some sort of mind game?' I said 'What did you put in the cones? [marijuana]' He said 'Nothing'. He said 'Didn't you have a good time?' I said, 'I thought you liked me'. I said, 'There was no barbeque'. He was just getting me round there. I said, 'Don't bullshit me'. He told me to come around. I said, 'No, I'm staying home tonight'. He insisted I come round to join his family. I said, 'What's this family crap about?' He wouldn't tell me. He said, 'You'll find out when you get there'. He said bring the six-pack with me. I went round there, it was probably 7.30, 7 o'clock.
>
> HIS HONOUR: Q. Why?
> A. I wanted to find out what this business was with the family because I believed he was trying to intimidate me. I believed it was some sort of cult or something. He had spoken to me before about this family. He said, 'You've got your own family, I don't mind'. He said, 'My family is bigger than this' and he made a gesture with his arms. I believed it was some kind of cult.
>
> Q. Why did you go round then?
> A. I wanted some proof. I was going to put him in with the police. I remember there was some time before a thing in the paper about this woolshed hired out by police and when he

went there, there was dead chickens all cut up, dead, sort of the wings and everything. That was three or four weeks ago and they reckoned there was some sort of cult thing going on and it was reported in the paper. I went around there. The house was in complete darkness, which it usually was. I knocked on the door. His wife answered and let me in. He said, ‘You're ready to join my family now?’ I said, ‘I'm not joining your family, I've got my own family’. I went into his bedroom. I was sort of going into his wardrobe, I thought he might have had some black cloaks or something in there to hide in there or something and there was nothing in there of course, so I come out and I was pretty agitated at that stage. He said, ‘Settle down, here have a cone’. I didn't know what to do. I ended up having this cone and, as soon as I did, I collapsed on the floor and he was hanging over me laughing his head off saying ‘It's good shit, isn't it?’, and I didn't know what was going on. It was like I was, I don't know, it never affected me, I don't know what was in it. He got his dog to jump all over me. His little boy come over and started laughing at me and I ended up picking him up. I said, ‘I got to get outa here’. I went to go out. He said to me, ‘You'll be back. When you come back you be ready to join my family’. I said, ‘No, I won't’ and when I went to leave he said, ‘You'll be back when you see the light on’ or something. It was weird. I walked out and as I got further away from the house – it was like he lived on a T-intersection and I walked straight up the street. The further I got away from the house it was like I could hear voices in me head telling me to go back, I had to go back and join this family.

CRADDOCK: Q. Just before you go on with that, you say you were hearing voices telling you things?
A. It was like voices or very strong thoughts or something but it was like I had to go back or something. It was weird, it was like, I don't know, I believed he had some sort of hold over me or something. I don't know how, I really don't. I turned around, looked back at his house and Bill was standing in the doorway and he flipped the light switch on or something and the front light come on. It was like, I actually started running back with my bad knee and me knee give out so I got back there. He let me in the door. I said, ‘I'm going to kill your rats’. I said something like rats or something, I said, ‘I'm going to kill the male rat’ and he said, ‘To join my family you've got to scare my son and my wife’, or something.
Q. Sorry?
A. He said, ‘You've got to scare my wife’ or something ‘and my son’ and I was in a very, a bit psychotic then –

OBJECTION.

Q. What do you mean by that?

HIS HONOUR: Q. What do you mean by saying you were a bit psychotic then, what were you describing?
A. I don't know why I went back, I can't think what was telling me to go back. I was –

Q. What were you feeling when you were in the house?
A. When I went back?

Q. You told us that you said you were going to kill his rats?
A. Yes.

Q. And you said, ‘I was feeling a bit psychotic then’. What were your feelings? I mean were you feeling alert, were you feeling confused, were you feeling angry, were you feeling calm or happy, what were you feeling?
A. I was very confused. I really, I was really in a very confused state. I went back and all I did was look into his wife's eyes and she just freaked out, she started screaming and Blake said, ‘You're ready to join my family now’. I said, ‘I’m not joining your family, your family is weird’ and he said, ‘You're not getting out now’ and he called me that filthy C word again and I said ‘You watch me’ and I kicked his screen door out. He told me people had a habit of kicking his door out and it was only held on by a nail so I won't have no trouble. I got to his gate. It was a very high gate and I was trying to get the latch to unlock it and Bill Blake come from behind me, grabbed me around the waist and it was like all my energy sort of dropped, drained out of me body. He laid me down on the concrete and he got on the veranda and stood over me and he said to his wife, ‘Go and get the male Deb’, that was his wife's name. I believe that to be the male rat. I said to him, ‘Do you believe in God, Bill?’ He said, ‘Yeah, I believe in f-ing God, all right’ and straight away he said to me, ‘I’m going to have some fun with you’, that filthy word again, ‘I’ve got to make you kill your mother, your father, I’m going to make you kill your brothers and sisters, I’m going to make you wipe your whole family out and then I’m going to make you burn your house down’.

Q. Were you still lying on the ground at this time?
A. I was lying on the ground and Bill was standing over me with his arms folded. At that stage I had to get out of there. I

got up. I pushed Bill off the veranda. His wife came out with the little boy, holding his hand. She had a cricket bat. She give that to Bill Blake. At that stage the next door neighbour came in, he had opened the gate. I seen the gate open. I pushed past him, went out the gate and we got out there and he said, ‘No-one walks away from my family’ and I said, ‘You watch me, I'm outa here’ and he said to me, he said, ‘Don't ever close your eyes again’ and he called me that word again because he said, ‘We'll get ya’ and then he said, ‘We'll make you do what we told you we were going to make you do’ and with that I thought I had to, because I had threatened to actually put him in to the police. At that stage when I got out the front and told him I would put him in for his bodgie insurance claims, for his house invasions, his robberies he done, I thought I had to have a go at him, so I went to charge for him but I sort of, I just didn't have any energy, I just couldn't even lift my arms and I was just an easy target and he hit me over the head with a cricket bat and I got up and I had another go at him and he hit me over the head with a cricket bat again. I remember I was crawling up the fence –

Q. Was this outside his house or inside?
A. This was outside his house.

CRADDOCK: Q. Outside his yard or in?
A. It was outside, on the footpath.

Q. On the footpath?
A. I remember crawling up the fence. His neighbour had armed himself with a wheel brace at this stage to take the nuts off the tyres with and he said, ‘Don't come near me’ and he called me that filthy name and as I sort of got up Blake come from behind and I remember he hit me in the side of the temple and I must’ve blacked out. I woke up on the footpath still. Blake had me pinned by the arms. Jeremy Hughes was taking me shoes and socks off, the next door neighbour. They were taking my belt out of – I remember Jeremy saying, ‘I can't get his shirt off’ and remember Blake saying, ‘Just rip it off him’. I remember he started screaming at that stage and the next thing I knew I was back in his house and Blake had me pinned by the shoulder and Jeremy had me by the feet. I remember this rat was about four or five feet away. I remember they were trying to get this rat to bite me.

HIS HONOUR: Q. Where was the rat, was it just in a cage?
A. No it was out on the floor in his lounge room and I was

absolutely terrified. I believed if this rat bit me it would take my soul and I remember I started screaming or something and I heard Blake say, ‘Let him up’ and I got up and I remember running blindly and I must have hit a door or something and blacked out again and the next thing I knew I was out the front on the footpath again. Blake was standing with a cricket bat over his head. I just told him – it was like tunnel vision, I couldn't make out things on the side, I couldn't
see very well at all. I remember seeing some blue lights and Blake saying, ‘He's going to kill me’ and the next minute the police officer approached and he looked like someone who had broken into my house a couple of years beforehand and ripped off my video and stuff.

CRADDOCK: Q. When you say he looked like someone?
A. Yes.

Q. Are you saying he resembled that someone?
A. No, that was him, to me it looked like him.

HIS HONOUR: Q. So you believed him to be the person who burgled your house?
A. That is correct.

Q. Have you seen that person who burgled your house?
A. Yes, I knew him.

Q. So he did it while you were watching him?
A. No, no, no, he done it while I was at work one day.

Q. I see, but you knew who it was?
A. I found out who it was.

Q. And you thought this was the policeman, you recognised him?
A. I recognised him as this Tony Dan, because the officer come and informed me that he was in cahoots with Blake, so I attacked him and the next thing I knew I was on the ground. I remember they must have handcuffed me.

CRADDOCK: Q. Just before we go on, when you saw this policeman coming towards you, you thought he was this other person?
A. Yes.

Q. Not a policeman?

A. I think, yeah, I think I could see his uniform but it was like I believed him to be in with Blake or something.

Q. But you thought it was the person who had broken into your house?
A. Yes.

Q. But you could see he was wearing a uniform, could you?
A. I believe so, yes.

Q. Do you now still think that it was that person who had broken into your house?
A. No, not at all, no. I remember they put the handcuffs on me. It was like things were going in slow motion, the handcuffs would come off, I remember I would struggle, I thought they were going to throw me in the rat cage or something. I was absolutely traumatised.

Q. When you say you were absolute traumatised, what feelings were you experiencing at that time?
A. Absolute terror, absolute terror. I could describe it no other way. The next thing I knew I think I was, I had this pain in me chest. It was the worst pain I had ever had, it felt like someone was reaching inside trying to tear out my heart or something and I believed they would try and take me soul. I remember saying, ‘You can't have it, it belongs to God’. The next thing I remember was the ambulance turning up. I remember they looked like members of my family, one looked like my sister Bev and one looked like my brother-in-law. One looked like my brother-in-law Ken Moulton and one looked like my other brother-in-law John Pater. There might have only been two of them, I'm not sure. I remember –

Q. Just before you go on, again when you say that they looked like –
A. Yes.

Q. Do you mean that they physically resembled those persons or did you think it was those persons there at that time?
A. Yeah, I believed it was them, yes. They were sort of, there seemed to be a battle between good and evil or something, I don't know. Like the ambulance people seemed to be God and the police seemed to be on his side, I believed at that time. I remember them injecting me with something. I remember them at that time, I believed the rats were biting my toes, eating my eyes or something. It may be that the

ambulance people were putting actual clips on my toes to see my reaction to pain or whatever. I think that might have been part of the process, I don't know.

HIS HONOUR: Q. You felt something happen to your toes, you believed at the time, that's what you thought it was, the rats eating your toes?
A. Yes, that's right.

Q. But you realised or later realised that was pinpricking?
A. Much later, months later, I remember they injecting me with something. I remember she said, ‘God his eyes are closing’. I remember what Blake said, ‘If you close your eyes again we will get ya’ and I remember I just used all my strength to keep my eyes open then and they put me in the ambulance. I remember flashes of my family going before my eyes, my father or my eldest sister. I remember Mum, I remember yelling out, ‘Not Mum, she didn't do nothing’. I don't remember nothing else until I woke up in the John Hunter Hospital and there was two policemen standing at the end of me bed. They said, the first policeman said, ‘Do you remember us mate?’ I said, ‘Never seen you before in my life’. They said, ‘We arrested you. You were like a wild animal. It took heaps of us to hold you down’ or something. I said, ‘What happened?’, and ‘I can’t remember a thing’ and I couldn't.
Q. So at that stage – are you saying you could not remember what had happened at Blake's house?
A. I could not remember a thing, your Honour. I recall that Blake was actually hitting me with the back of the cricket bat just to amplify the blows and I believe I was very concussed.”

35 Mr Blake made a statement to police on 23 July 1995 for the purpose of the investigation into the death of Ms Laws. Mr Blake’s account of the events of the evening of 3 July, not surprisingly, differs markedly from that of the plaintiff. He said that, at about 5pm on the evening of 3 July, the plaintiff called him at home and said that there was some work available for him late in the following week. He said that he would come around to Mr Blake’s house with a six-pack of beer to tell him about the job. He arrived at about 8pm and the two men sat on the lounge and had a beer. Mr Blake said that the plaintiff was mumbling something but he could not work out what he was saying. Suddenly, he said to Mr Blake, “I have to kill you”. He smiled. Mr Blake thought he was joking so he smiled back. The plaintiff then grabbed him by the throat with his two hands and squeezed tightly. Mr Blake said that Kevin then said, “I don’t think I could kill you”, stood up and walked towards Mrs Blake who was nearby. The plaintiff said something to her but Mr Blake could not work out what it was. He said that the plaintiff jumped up and down around the lounge room and then went into Mr Blake’s

bedroom. Young Timothy Blake (aged 3 years) followed him. Mr Blake thought there was something wrong and also followed. He saw the plaintiff opening and slamming the wardrobe doors while at the same time jumping into the air. Mr Blake took Timothy by the hand and led him out into the lounge room. The plaintiff followed, sat on the lounge and said, “I’d better go”, grabbing his hair at the same time. He stood up, walked to the door and out onto the veranda, with Mr Blake following him. When the plaintiff got to the stairs he said, “So much for the new fence” grabbed the top of the fence and kicked it with his foot about fifteen times, running out onto the footpath towards the street and then coming back. Mr Blake grabbed him around the body as he started kicking the fence again and both men fell to the ground. Mr Blake asked him, “What is the matter Kevin?” The plaintiff said, “Do you believe in God?” Mr Blake replied, “Doesn’t everybody?” Mr Blake said the plaintiff, who had been shaking, appeared to calm down and he helped him up onto the veranda. As the plaintiff got to his feet, he pushed Mr Blake away with his two hands, causing Mr Blake to fall backwards, and ran into the house through the front door. Timothy was then standing in front of the television. The plaintiff grabbed him by the throat with his left hand. Mr Blake tackled him whilst his wife grabbed Timothy and tried to pull him away. Mrs Blake started to punch Kevin in the head with her open hand and managed to pull Timothy out of his grasp. Mr Blake and the plaintiff struggled on the lounge room floor. The plaintiff elbowed Mr Blake in the ribs, forcing him to release him and then ran down the hallway and head butted the back door with such force that the door was holed across the centre. The plaintiff stepped back and kicked the bottom of the door causing another hole. Mr Blake then grabbed Kevin around the body and punches were exchanged. Mr Blake managed to drag the plaintiff to the front gate where his next-door neighbour, Jeremy Hughes, opened the gate for him. The plaintiff then grabbed Mr Hughes by the throat but the two men managed to pull him away and get him out of the front gate. The plaintiff and Mr Blake were still exchanging punches, the plaintiff yelling, “The rats must die”. Mr Blake said that the plaintiff tried to hit him with a piece of lattice (from the fence), which was grabbed by Mr Blake and thrown away. The plaintiff got hold of him and the two men pushed over the fence into the barbed wire whilst they struggled. The plaintiff released his grip after Mr Blake punched him in the face. Mr Blake went inside and got his cricket bat. He ran out onto the veranda and saw the plaintiff coming back through the gate, so he hit him in the middle of the head with the bat. The plaintiff staggered back and then came forward again. Mr Blake hit him a second time on the side of the head. The plaintiff staggered backwards and yelled, “The rats must die”, several times, starting to remove his clothing as he did so. Mr Blake said that he believed that the plaintiff was referring to pet rats that he kept in the garage as pets for his children. Mr Blake said that he and the plaintiff stood facing each other for about five or ten minutes until the police arrived. When they did so, Mr Blake told the officers what had happened but indicated that he did not want to lay any charges and said that he thought that the plaintiff needed help.

36 The police who attended at the scene were Senior Constables Jones and Duffey, arriving at about 8.30 pm in response to a police radio message. Jones said that when they arrived he saw Mr Blake standing with a cricket bat raised above his shoulder facing the plaintiff, who was standing about three metres away. Jones approached Mr Blake whilst Duffey approached the plaintiff. Duffey stood between the plaintiff and Mr Blake and the house. However, the plaintiff appeared to be attempting to get past Duffey towards Blake and the house. Jones said that he thought that it was at this time that he heard the plaintiff talking about rats at his toes and eyes. He also screamed, but wordlessly. The plaintiff attempted to push Duffey aside and appeared desperate to come towards Mr Blake and, of course, Jones who was standing next to Mr Blake. Mr Blake was calm and Jones thought he should give Duffey some assistance. The plaintiff was using both his arms to push the police officers aside. They attempted to restrain him. The level of the plaintiff's aggression increased and the officers forced him to the ground and handcuffed him. Further police officers arrived, as did an ambulance. Jones was unable to recall whether the plaintiff was sober or not. Jones said that the screaming stopped, he thought, sometime after the plaintiff was handcuffed but before the ambulance officers treated him. He was quite sure that the plaintiff had been screaming for over a minute. In due course, the plaintiff was placed in the ambulance and taken to JHH, accompanied by Duffey. Jones recalled that there was a great deal of blood on the upper part of the plaintiff's body, possibly his shirt, as he had been bleeding profusely from his head wound but he could not recall whether or not the plaintiff was wearing a shirt. He did not recall seeing any blood on his trousers.

37 Senior Constable Duffey said that, when he first approached the plaintiff, he was covered in blood from an apparent head wound. He seemed to be, the officer thought, "exhausted but agitated". From the bleeding wound he inferred that the plaintiff was the victim of an assault, especially when he noticed that Mr Blake was holding a cricket bat above his head. Duffey asked the plaintiff to move back but he did not acknowledge this command, continuing to stare at Mr Blake. Duffey then asked Mr Blake to move back. He complied, moving towards Senior Constable Jones. Duffey then approached the plaintiff and asked him if he was okay and what had happened. He said that the plaintiff stared "right through me towards William Blake" and Duffey realised that there was something more to the situation then he had at first supposed. The plaintiff started to move towards Mr Blake. Duffey asked him to stay where he was and put out his hands to indicate this. He said that the plaintiff tried to push past him. The officer took hold of his arm and stepped towards him so that the plaintiff would have been in an unbalanced position with a low fence behind him. Duffey said that he had his hand up across the plaintiff's lower chest to his lower throat with his forefinger and thumb on each side of his neck so that he would have complete contact with the plaintiff and, he thought, be able to keep him under control. Just before this, when the officer had taken hold of his arm, the plaintiff yelled that the rats were eating his eyes and his toes. These words were repeated one way or another, during the entire

incident. He also talked a lot of incoherent and partially inaudible gibberish. In one long, incoherent sentence he spoke about killing and children and mentioned the devil at least once. These things were being said some time between the officers' first contact with the plaintiff and his being placed in the ambulance. Duffey was a strong fit young man weighing about 100 kilograms and, as he put it, "had the leverage over the top of the man that wasn't as tall as me and would have weighed 55 to 60 kilograms". He said that he thought that he had the plaintiff off balance with his back at waist level against a fence and was surprised at the strength the plaintiff displayed using his abdominal muscles to sit up over the fence. Duffey said that this was not the first time he had pinned someone in a similar position where he could control them but it was the first time that someone was able to regain his balance and release his grip, which is what the plaintiff did. He said that the plaintiff again started moving towards Mr Blake. The two policemen then tried to subdue him. Duffey recalls picking him up off the ground and driving him into the ground in a spear tackle. He said that the plaintiff stopped reacting for a short time but then began to flail his arms and was hard to control. The two police officers found it very difficult to restrain the plaintiff to handcuff him. Duffey said that the plaintiff's strength was surprising. Once he had been restrained with the handcuffs, Duffey said, "He just went into a trance". He was muttering and it is possible that at this stage he mentioned the devil and killing the children but Duffey was unsure about this. Duffey thought that the ambulance arrived perhaps ten to twenty minutes after he had first tackled the plaintiff. At this point, Duffey was sitting on the plaintiff to restrain him but he appeared to be in some kind of trance, his eyes were open and fixed, staring straight ahead. Despite attempts by the ambulance officer to evince a pain response, even by pressing in and around his head wound, the plaintiff did not respond. The ambulance officer insisted that the handcuffs should be removed so that the plaintiff could be properly examined. Although he protested about the risk, Duffey did so. The plaintiff then started to throw his arms and legs around and attempted to get off the ground and, as Duffey thought, to escape. It took the two ambulance officers, the other two police who had arrived and Duffey to restrain the plaintiff once more. During this episode, the plaintiff again yelled gibberish, also referring to rats and eyes and rats eating his toes. After he had been subdued again, he was placed on a stretcher and put into the ambulance.

38 As I mentioned, the plaintiff was taken to JHH. He remained in what Senior Constable Duffey described as "a trance-like state and stared straight up at the ceiling of the ambulance" during this journey. Duffey said that, although the ambulance officer spoke to the plaintiff, he did not respond. The patient report made by the ambulance officer states (expanding abbreviations) –

> "Head injury – patient in psychotic state – seeing rats eating his eyes, head butted a door and was also ? assaulted by cricket bat. On arrival patient conscious on footpath. Handcuffed by police. Patient incoherent. Initially thought

> patient had priapism and treatment commenced for spinal injury. On further investigation nil priapism. Patient's head bandaged prior to our arrival. Hypertensive tachycardic. Pupils equal and reacting. Abdomen soft. Chest clear. Redness on chest visible. Limbs intact. Patient agitated/aggressive. Police escort [indecipherable]."

39 I mention at this point (because the reliability of Senior Constable Duffey's evidence was attacked by the defendants) that Duffey stated in his affidavit that the ambulance officer had told him words to the effect that he "must have broken the plaintiff's neck because his penis was very hard and that happens when a man's neck is broken". The affidavit was sworn on 26 September 2002. The condition of the plaintiff's penis was not referred to in the constable's original police statement, made shortly after the incident. To my mind, the first reference to the plaintiff's possible priapism in the ambulance report gives some support for the reliability of Duffey's recollection. However, even if that reference should not be taken to suggest that the plaintiff had an erection, the fact that after the elapse of years Senior Constable Duffey recalls this discussion with the ambulance officer, even if it turned out that the plaintiff had no erection, to my mind provides substantial support for the essential reliability of the constable's account.

40 I conclude this part of the narrative by stating my conclusion that I regard the plaintiff's recollection of his thought-experiences whilst at Mr Blake's house as, in substance, both truthful and accurate. A number of the elements of his account of physical events is supported by the evidence of other witnesses. I accept it also as generally reliable.

JOHN HUNTER HOSPITAL

41 I now come to the events at the hospital, first dealing with the plaintiff's account, the narrative of which set out above ended at the point when he woke up in JHH with two policemen standing at the end of his bed. The plaintiff said that one of the policemen asked him whether he remembered them. The plaintiff said that he had never seen them before in his life. The officers told him that they had arrested him, that he was "like a wild animal" and something like it had taken a number of them to hold him down. He said that he told them that he could not remember what had happened except for Mr Blake hitting him with the back of the cricket bat. He said that the officer told him that he had grabbed a three-year old child, but the Blakes did not want to charge him with any offence "because I was a mate or something". The plaintiff said that he did not believe that he had grabbed Mr Blake's child. Upon this point, as with others, I regard Mr Blake's statement as more reliable. The plaintiff said that, when the police asked him whether there was someone they could contact, he asked them not to call his father since he had a heart condition and asked them to call his brother. This is what the police did and in due course the plaintiff's brother, Allan, came to the hospital. I will come to his evidence shortly. (Senior Constable Jones thought that Allan Presland's demeanour when he was in

the hospital was quite normal and he said he had a normal conversation with him.) The plaintiff said that, after speaking with the police, the next thing that he remembered was his brother asking him what happened and saying, “Apparently, you tried to do away with yourself”, which confused the plaintiff because (on all accounts) he had not done this. The plaintiff said that he told Allan that he did not think that he had attempted suicide but did not know what had happened. He said that Allan went out of the room (I take it for a short time) and when he returned said, “They want to keep you in hospital here for a week because of your head injuries”, to which the plaintiff replied, “Oh all right”. The plaintiff said that at this point, he felt as though someone “had a wire brush going across the top of my head” and someone was growling from “behind”. He said that he “sort of jumped up” wondering what was going on and saw a nurse behind him treating the sutures on his head and, to Allan’s query whether something was the matter, replied to the effect that he did not know but he thought he was “going mad”. The plaintiff said that he recalled his brother going out again and, when he returned, telling him, “They want to take you to the James Fletcher Psychiatric Hospital for a couple of days, how do you feel about that?” The plaintiff said that his response was “Fine, I think I need help, I think I’m going mad, I’m crazy”, or something like that, to which Allan replied that it was all right, he would get help at the hospital and, in effect, that there were doctors able to deal with this problem. The plaintiff responded, “Fine, I need help”. This is an important conversation since, in part, Dr Milton thought that the plaintiff’s physical action of sitting up suddenly indicated a violent response to the suggestion that he needed to stay in hospital. It is obvious, however, that if I accepted the plaintiff’s evidence as to this conversation with his brother, this physical action was not related to his brother’s information. Furthermore, he was apparently willing to stay, indeed, wishing to stay because he was concerned about his mental condition. Allan’s account of the conversation is somewhat different –

> “I said to Kevin, ‘What are you doing with yourself, Kevin?’ and he looked away and said he was going to do away with himself. I said, ‘Don’t talk like that. You have still got me and everyone else thinking of you’. And then he said…he was having a CT scan and I looked at the doctor and he never answered. Mick Duffey spoke up and said he had not had his fractured skull [tested] and then I said, ‘You will be here for a week Kev’. He said, ‘Yeah’ and he lunged out of the bed at me and I said, ‘You will be here for at least a couple of days. Let people take care of you’, and he calmed down. He said something about wanting pyjamas. I said, ‘I will get some pyjamas and that for you’ and that was basically it.”

42 I will come to what the hospital notes show later but it is important to note, at this point, that nurse (Mr Mazun) made a record of a telephone call from Allan some hours later, when the plaintiff had been placed in the ward at JFH, enquiring “as to the health of his brother and [voicing] concerns over

Kevin's impulsive behaviour and suicidal ideation", telling the nurse that Kevin had "stated he was 'going to do away with himself'". This near-contemporaneous note provides confirmation for Allan's evidence in this respect and I accept it. In cross-examination, Allan said that he saw that the plaintiff had a large cut on the top of his head with two big "lumps" on the front of his forehead. He thought that he looked quite unwell. He said that he saw the doctor (although he was not quite sure what his actual status was) behind the bed "sort of attending to his head", although he thought he might have stopped what he was doing during the conversation between him and the plaintiff. Taking what happened as a whole, I consider that, at this point at least, the plaintiff was content to be treated in hospital. Indeed, I think it likely that he felt he needed treatment not only for his head wound but also for his disturbed thoughts and feelings, though I doubt that he had any clear recollection of either his thoughts or his actions at this time. The likelihood is that the plaintiff was, as it were, taking on things as they came. However, I am quite certain that he was compliant. The apparent lunge which Allan thought (I think) exhibited irrational anger was an instinctive response to a sudden onset of pain at the site of his wound, probably caused by some treatment that was then being administered. The apparent reference to suicide seems inconsistent with all accounts of what had happened, including that of the plaintiff, but as I have said, I accept that Allan's recollection in this respect is accurate. This reflects, I think, the plaintiff's confused state of mind, at the very least. I will return to Allan's account of events in due course but I think it useful first to turn to the evidence of the police officers as to what occurred at this time.

43 Senior Constable Duffey said that, at JHH, he spoke to a casualty nurse who was working in the ward and asked her to get the Crisis Team (as to which see later) to attend and assess the plaintiff. The plaintiff had been breath-tested with a negative result. Not surprisingly, and quite reasonably, Senior Constable Duffey believed that the plaintiff was mentally ill. Of course, this is worthless as a medical opinion. However, it seems to me that his conviction of the plaintiff's madness is relevant to solving other questions raised by the evidence, to which I return in due course. Duffey was present when Senior Constable Jones then asked the plaintiff to tell him about what had happened earlier that night. Jones' near contemporaneous statement says that the plaintiff replied, "I don't know, I just cracked. I haven't been the same since I split from my girlfriend about two or three months ago". Jones asked him what that had to do with Mr Blake. The plaintiff said, "Nothing, I have only known him for about six months, I was working with him. I don't want to cause him any hassles or anything. It is not his fault". Jones asked the plaintiff, "What brought this on tonight?" and the plaintiff replied, "I don't know. It's been brewing up for a while". The plaintiff denied that he had been drinking alcohol but admitted that he had "smoked a couple of joints this afternoon". Although, on the face of it, this conversation appears rational, it leaves a number of important questions unanswered. In particular, the plaintiff could not explain and apparently did not recall his bizarre and extremely violent behaviour. Nor was there any

rational connection between his feelings about his girlfriend and the attack on Mr Blake, which appeared to be completely unprovoked and disconnected with his apparently amiable feelings towards him. However, he answered the questions responsively and, I think, was being co-operative.

44 The two police officers accompanied the plaintiff to the radiology section of the hospital where he had a CAT scan, obviously to ascertain whether he had suffered any serious head injury. The plaintiff's description of this examination was that, after talking with his brother, he was wheeled down a dark corridor and placed on something like a table in a big room. The plaintiff said that he thought "it was a morgue or like a big hole" and said that he jumped up and said, "I am not dead, I am not dead". He said that the person who had care of him at this time assured him, "We know you're not dead, we're just doing a CAT scan on your head". This pacified the plaintiff and he said the next thing he knew he was at the James Fletcher Hospital, describing his sense of things as "I don't know if I kept on going to sleep or what, but it didn't seem to be happening". The hospital records show that this transfer occurred shortly after midnight.

45 Following the CAT scan, and whilst the plaintiff was in the casualty section, Senior Constable Jones spoke with Ms Angela Jeffs at 11.20pm. Ms Jeffs was a social worker with some experience of working with persons with disability, including intellectual and psychiatric disability, and commenced employment with the Crisis Assessment Treatment Team at JHH in January 1993. She was not qualified to give a psychiatric opinion. The Crisis Team is a 15-hour per day service with the function, amongst others, of assessing people brought to their attention with possibly compromised mental health to ascertain whether they need psychiatric help. In short, Ms Jeffs' task on the evening of 3 July 1995 was to assess the plaintiff to ascertain whether he needed psychiatric assessment, care or treatment. Ms Jeffs' evidence was, in substance, that she was called to attend the hospital just after 10pm and spoke to police officers (whom we know to be Jones and Duffey) –

> "They gave me a history of a client, who I would be seeing soon, who had been involved in some form of violent interaction with another person. I asked if the other person was also in hospital and they said 'No'. I asked if there were going to be charges laid one way or the other. They said 'No'. I formed an impression of a violent interlude between two men. They did not give an outline of why I had been called."

46 Ms Jeffs said, in effect, that she was given to understand that there was nothing remarkable or strange about the fight between the plaintiff and the other man. She recalled that she was informed that the plaintiff had been injured and was being treated at that time. As it happened, she only had to wait a short time before she was able to interview him. Ms Jeffs said that when she attended on the plaintiff she first asked him whether he would like to speak to her alone or with the police present and that he indicated that he was happy to speak to her on his own. Accordingly, Jones and Duffey left

the immediate vicinity. Ms Jeffs said that she introduced herself to the plaintiff and explained her role with the Crisis Assessment Team, essentially that she wished to find out what was happening and whether “there were any services that may be appropriate for him”. She said that the plaintiff was very polite and willing to speak to her. She asked him what had happened and how he came to be in the hospital. She said that he told her he had “gone around to see his boss” but was unable to give a clear account as to the reason he had done so. Ms Jeffs said that the plaintiff told her that he tried knocking at the door but without any response, that he then started head-butting the door and that his “boss” came out with a cricket bat and hit him. There was no conversation. The plaintiff said that he was then brought to John Hunter Hospital. Ms Jeffs said that the plaintiff did not tell her about anything else that had transpired at Mr Blake’s house. She said that she was trying to find out whether the plaintiff had any hallucinatory or delusional thoughts about Mr Blake which may have motivated him to go to the house. She said that he denied any thoughts that Mr Blake had any special powers or had any control over him. In short, she said that the plaintiff denied anything indicating a delusional state. Her recollection was that the plaintiff just described Mr Blake as “a decent bloke” or “a good sort” and did not appear to have any residual animosity. (I interpolate that this does not signify much, since he claimed – explicitly or implicitly – to have no animosity towards Mr Blake or his family at the time of the attack: rather than mollifying any concerns, it should have provoked them.) She said that she explained to him what hallucinations were. In substance, he denied any form of auditory hallucination but told her that he had had a tactile hallucination concerning rats on his skin in New Zealand when on holiday about four years previously. She said that the plaintiff told her that this experience, which was very distressing, occurred when he stopped drinking after a very heavy binge. She said that he told her nothing about experiencing rats at Mr Blake’s house or at the John Hunter Hospital. He told her that he had been very distressed recently by the break-up of his relationship with his girlfriend, saying that “he still missed her and wanted her to be a part of his life”. He said he was lonely. He told her that he had been drinking very, very heavily the day before but had not had any alcohol on the day of this conversation. She may have discussed the use of illicit drugs, such as cannabis, but does not recall it. Ms Jeffs said that his speech during this conversation was easily comprehensible, that the plaintiff was polite and pleasant and displayed no aggression at any point, nor was he mute at any time and remained responsive to her questions. She said that there was nothing to indicate that the plaintiff had any thought disorder. Ms Jeffs said that, after she spoke to the plaintiff, she briefly spoke with Dr McHue, the emergency doctor, telling him that she thought the plaintiff should go to James Fletcher Hospital to have ongoing further assessment as a voluntary client. Ms Jeffs said that the plaintiff was “more than willing to go to James Fletcher Hospital” for further assessment. Ms Jeffs formed the view that the plaintiff had been “very affected by alcohol some time in the recent past”. She said that she could see no delusional state or evidence of

hallucinations, thought disorder or thought blocking but she thought that there was a possibility that something "connected with the alcohol… warranted further investigation" and this is why she referred him to JFH. She never considered that the plaintiff might need to be made an involuntary patient. Ms Jeffs said she suggested to Allan Presland that it would be a good idea if he accompanied his brother to the hospital. She said that he told her that he would do so. Ms Jeffs said that she did not see the ambulance sheet.

47 Ms Jeffs' notes, which did not (I think) form part of the original hospital notes (although they should have) but were part of the records of the Mental Health Team, kept at a different address, states that she thought the plaintiff's main presenting problem was "alcohol psychosis". Ms Jeffs' note on her referral sheet states –

> "Went to his bosses [sic] and head butted the door and was beaten off by boss with cricket bat. Chased by boss and police. Taken to JHH to assess injuries. Relationship break–up over 12 months ago. Physically fine. Appeared to be psychotic from previous effects of alcohol. Relates a long history of alcohol [*semble* , abuse].
> Main Presenting Problem: Alcohol psychosis."

Concerning the rats, the note states –

> "Involved story about rat (? psychosis) and history of it happening four years ago."

48 I will discuss this matter shortly, but I observe at this point that I do not think that Ms Jeffs' evidence really reflects the sense of this note, especially as to the rats, even if it is taken in isolation. Ms Jeffs was emphatic that she had not been informed by either of the two attending constables that the plaintiff had tried to attack a young child or had made any threats to kill or attack Mr Blake's family. She said that she was told of violence between two grown men and there was no mention of the family or, indeed, of the involvement of any other person. She said that the police did not discuss with her whether the plaintiff should be detained as an involuntary patient or "scheduled" although she was unable to say one way or another whether the police had said to her that they thought he was insane and something should be done about it. Given the circumstances in which the plaintiff came into the control of the police officers, their views about his mental state and the reason they brought him to the hospital, I think that it would be both surprising and most unlikely if the police had not communicated their views about the plaintiff. Nor do I accept that the case would have presented itself as a simple brawl: she herself noted that the plaintiff "appeared to be psychotic".

49 Senior Constable Jones said that he told Ms Jeffs what had happened to the plaintiff at Mr Blake's house, what he saw happen, what he saw the plaintiff do and say and what he was told by Mr Blake that Kevin had done

before the police arrived. Jones had made a note in his official notebook of what he was told, including that the plaintiff “lashed out for my child Timothy”. He said that he told these things to Ms Jeffs because he intended to give her sufficient information to make whatever decisions needed to be made from her point of view concerning the plaintiff’s care. It strikes me as so unlikely as to be fanciful, having come this far, as it were, Jones would keep to himself these important facts, which he knew (having spoken to the plaintiff in the meantime) would or might well not otherwise be made known to the very people he wanted to understand what had happened. He was, it seems, in no hurry to go as he remained at the hospital to escort the plaintiff to JFH. The fact that these matters are not reflected in Ms Jeffs’ notes, of course, gives considerable support to her evidence that she was not told of these things by Jones. Ms Jeffs said that she would have taken particular note of the attempt to attack the Blake child because of her legal obligation to notify DOCS of any child at risk in any circumstances. It is also important to bear in mind that the plaintiff committed an appalling killing relatively soon after his release from JFH the following day and the constable would, I think, have strong motives for (perhaps unconsciously) reconstructing his account to avoid some blame being placed on him for the plaintiff’s premature release but, then, so would Ms Jeffs. Weighing up these competing contentions decisively favours acceptance of Jones’ account.

50 Senior Constable Duffey, who accompanied the plaintiff in the ambulance to the hospital, said that the plaintiff was restrained during the journey and that the ambulance arrived a short time before Constable Jones. He said that the plaintiff was attended by nurses as soon as they arrived at the hospital and he remained close by to take care of his security. He had a brief conversation with him shortly after the initial treatment which, I think, included cleaning his wound. The plaintiff told him that, whilst he was at Mr Blake’s house he saw faces of his mother and other members of his family floating before him. Duffey said that the plaintiff’s behaviour was noticeably different. Although he did not know what had happened and was confused about these events, it was possible to conduct a “rational” conversation with him. Duffey recalled that he and Senior Constable Jones had discussed, back at Mr Blake’s house, what they would do with the plaintiff. He said that they had decided to take him to John Hunter Hospital to get his injuries treated, that they would contact the Crisis Team and then take him on to James Fletcher Hospital. Duffey had, in the previous two years, taken apparently mentally disturbed persons to the James Fletcher Hospital on many occasions and had attended the hospital, he said, “easily a hundred times”. Duffey recalled speaking to Ms Jeffs in the presence of the plaintiff and, possibly, a nursing sister. He said that he could not recall all of his conversation with Ms Jeffs. He recalled that she came in and introduced herself to the plaintiff as being a member of the Crisis Team, that he told her that the plaintiff had been assaulted with a cricket bat because he was trying to get hold of Mr Blake’s children. He told her how the plaintiff was screaming about the devil and rats eating his eyes and toes, about his references to children, the change in his behaviour from extreme violence

to passivity when he was handcuffed, then the renewed violence when the handcuffs were removed and passivity when he was placed in the ambulance after he was subdued, the change at the hospital and the conversation which he had with the plaintiff at the hospital. He said that he tried to fully describe what had happened, to ensure that he was admitted to the James Fletcher Hospital because he believed that the plaintiff was mentally ill. Ms Jeffs, according to Duffey, told him that she intended to talk about what had happened with the plaintiff and, on being requested by her to leave the vicinity, he complied. As that interview finished, Duffey said he returned to the plaintiff's bedside and spoke to Ms Jeffs again, asking her, in effect, whether it was proposed to schedule the plaintiff. He said that she told him that the plaintiff had an "alcohol induced psychoma" (*sic*, obviously psychosis) and would not be scheduled. Duffey said that he told her that the plaintiff had had nothing to drink and was told that this was the reason for his condition. Duffey said that he told her that if she would not schedule him, he would. Broadly speaking, I accept the evidence of Duffey about this conversation, at least to the extent that he gave Ms Jeffs a summary of what had happened leading up to the plaintiff being brought to the hospital, including in particular the plaintiff's extreme violence, the threats to Mr Blake's family, his statements about rats and his conversation with the plaintiff at the hospital. However, I am doubtful that he told Ms Jeffs that if she would not schedule the plaintiff he would, although I do think that this was indeed the constable's attitude. Of course, neither Ms Jeffs nor the constable was in a position to detain the plaintiff as a mentally ill person. That qualification aside, however, I have no doubt that the police officers conveyed to Ms Jeffs, as the representative of the Crisis Team, the main elements of the plaintiff's condition, which justified his being brought to the hospital and their opinion about his mental state. I think that this was all the more likely because the plaintiff's behaviour and demeanour had apparently changed markedly since his arrival at the hospital.

51 Senior Constable Duffey's evidence as to what he told Ms Jeffs, and why, is as follows –

> "HIS HONOUR: Q. What we want is not [the transcript incorrectly states, "in" rather than "not"] a rolled-up description what happened at the scene, but what it is you can recall, even if you can't recall the precise words that you conveyed…?
> A. Yes, I recall telling her that he had been assaulted with a cricket bat, this was because he was trying to get hold of Blake's children. I talked about or inferred things about how he was screaming about the devil, about rats eating his eyes and toes, how he referred to children, how his behaviour changed from when we were at the scene to while we were waiting for the ambulance to while we were with the handcuffs coming off and then changing again before going into the ambulance to go to the Hospital and then his change again at the Hospital and the conversations I have had there.

I tried to fully explain that night to her to get the desired outcome that I wanted.
OBJECTION. QUESTION ALLOWED.
CRADDOCK: Q. What was the desired outcome that you wanted?
A. If his medical situation did not need him to remain at the Hospital, at the John Hunter Hospital, for him to go to the James Fletcher Hospital.
Q. Why did you want him to go there?
A. Because I believed he was mentally ill.

52 In the end, I have formed the clear view that Ms Jeffs' present account of what the plaintiff told her about the rats and what the police officers told her simply cannot be accepted as reliable. Her notes are extremely brief and, although almost contemporaneous, they were made some time later in the car park as she was leaving the hospital that night; they were not intended to form part of any medical record but rather were part of the records of the Crisis Team; action had been taken to refer the plaintiff on to JFH where she no doubt supposed a full history would be taken; and the notes themselves do not contain any reference to rather obvious questions, though there must have been some features that led her to conclude that he "appeared to be psychotic" and that his presenting problem was "alcohol psychosis". The desirability, indeed necessity, for the police to convey to the appropriate members of the hospital staff – in this instance, Ms Jeffs – the extraordinary behaviour which they had witnessed persuades me, in the end, that Ms Jeffs' account, for whatever reason (and I do not attribute any dishonesty to her), is significantly mistaken and the evidence of the officers is substantially correct. Although I appreciate the strength of the defendants' submissions, resting chiefly on Ms Jeffs' notes of the occasion as well as her evidence, I conclude that those notes are significantly incomplete so far as information from the plaintiff and from the police is concerned and that Ms Jeffs has no reliable independent recollection of what she was told. It seems to me virtually certain that the account in the note was obtained from the plaintiff – that is to say, it contains no information obtained from the police. It mentions nothing of the plaintiff's aggression towards Mr Blake, let alone his family, his extreme violence interrupted by periods of apparent catatonia as witnessed by the police and the ambulance officers or anything about rats attacking him. It may be that the plaintiff did not give further information to Ms Jeffs because of confusion or some other reason and some aspects of the account (such as referring to Blake as his boss) do not make sense. But it seems to me to be impossible to accept that the police officers did not mention to Ms Jeffs the salient features of the dramatic and extraordinary events that led them to conclude that he was seriously mentally disturbed and needed to be brought to JFH. Nor do I think it likely that Ms Jeffs would have thought that the plaintiff had been brought to the hospital just to have his head injuries looked to or that the police believed he had merely been in a fight. The

most likely explanation for Ms Jeffs' present account differing from that of the police officers is that she made no note of what they said at the time – confining herself to what the plaintiff said – and her recollection has failed as to what they told her.

53 It is necessary to refer to the records of each of the hospitals, tendered by the plaintiff, on 3 and 4 July 1995. It is not easy to interpret the course of events, because sheets have been removed from the files (no doubt for copying purposes) and replaced in an order which does not appear to be the original order. No doubt because of the criminal proceedings following the death of Ms Laws and the police investigation, as well as this litigation, the records have been examined by a number of persons. I will come shortly to records which, I have no doubt, came into existence but which now appear to have been lost. This is a very unsatisfactory situation. It is elementary and crucially important – whether the particular case is usual or unusual – that the integrity of hospital records be maintained. In this case, although many of the forms have provision for dates, they are undated. Each of the pages should be consecutively numbered as they are placed on the file so that the fact that any documents are missing is immediately obvious as also should be the time at which the document came into existence. In the discussion that follows I have not only carefully examined the photocopies made of the hospital records but have also examined what appear to be the originals. Not only is hospital management at JHH and JFH at fault for not ensuring that the content of the files is properly numbered and dated, as I have mentioned, but there should have been a system for ensuring that the integrity of the file was maintained, despite the need to give access to it and provide copies of the contents. The present confusion has mostly, I think, been brought about by persons later inspecting the records for what might broadly be called the purposes of investigation and litigation but it was the responsibility of the hospitals to have maintained the integrity of their records even so.

54 When the plaintiff was brought to JHH on 3 July, an admission form was made out by a person who does not appear to be identified on the document. As it happened these notes were made by Dr McHue, who was on duty in the emergency ward when the plaintiff was admitted. He could not recall the source of the information which he noted, saying that it could have been the police, the ambulance officers or even ambulance control, who had been in contact, I take it, so that he would be ready when the plaintiff arrived. The note contains the following –

> "Details of incident"
> Apparently head–butted door down. Householder defended himself with cricket bat. Ran away. Chased by police. Spoke of 'rats eating his eyes'. On arrival eyes open, mute, doesn't obey commands. Possible ETOH [and] drug ingestion.
> Place of injury: employer's house."

55 The usual course was for ambulance officers to give a "verbal handover" to the then senior medical member of staff, who happened to be Dr McHue.

He said that he would have expected the ambulance officers to have communicated the important features of the history on the ambulance form and, at all events, it was Dr McHue's normal practice to examine that form in the course of treatment. The ambulance officers had applied a stiff neck collar to the plaintiff in the ambulance, which is standard practice where a patient has suffered a head injury. It was removed in the course of the admission. I note that Dr McHue believes that he made a handwritten note on a *pro forma* document of a conversation with ambulance control, called "a trauma call", but it appears to be missing from the file. I doubt that the details noted on the admission form were given by either of the police officers, though it is not impossible and they have simply been truncated. As is obvious from the above account of the events, it could not be said in any sense that the plaintiff ran away or was chased by police. The more likely explanation of the note, I think, is that this information came from one of the ambulance officers, whose knowledge of the events was unclear. The plaintiff scored only 6 out of 15 on the Glasgow Coma Score, which is done immediately on arrival, thus shortly after 21.03 which the ambulance record shows as this time. Although the plaintiff's eye-opening was spontaneous, he was mute with no motor response. There was no verbal response, even to multi–painful stimuli and no motor response, including to mildly–painful stimuli. Dr McHue commented that no response, even in someone who is deeply unconscious, is very unusual and indicated either that the plaintiff had a mental illness or he may have been pretending to be unwell (both of which possibilities seem to me to be significant).

56 The hospital notes show that the plaintiff arrived at the hospital at 21.10. The following was noted as his presenting problems at triage –

> "Alleged assault. Entered house, shouting and irrational. Has been hit in head by cricket bat. O/A/collar in situ; quiet, staring. Also hit head on door. Remains unresponsive, staring into space. Dressing to head ? laceration arrived with police escort."

At 21.30 and 22.00 he is noted as having his eyes open spontaneously, his verbal response was "orientated", his motor response was "obey commands". This information was obtained by the nursing staff but, obviously, sometime after Dr McHue had noted the initial Glasgow Coma Score as 6/15.

57 The record under the heading "Summary history from police" shows the following –

> "21.30 patient attacked workmate's door [?about] 20.20 – head–butted door down – head–butted hole in interior wall. Police came. Wrestled patient to the ground.
> Now patient catatonic (however, intermittently aggressive). Eyes open. Staring."

It appears this entry was made by the surgical registrar. I think it significantly understates what the police said. However, the

additional information may not have been regarded as important for the purposes of the note-maker. Dr McHue said that he accompanied the plaintiff to radiology for the CAT scan and that this was after his scalp wound was sutured, although as I understand it he had been cleaned up. Dr McHue said that the plaintiff was quiet and co–operative throughout the process. The CT scan showed no abnormality. Dr McHue could not recall whether the plaintiff was still mute when he went for the radiological examination and was unable to recall whether at any stage the plaintiff spoke whilst in Dr McHue's presence. Dr McHue made a provisional diagnosis of minor head injury and psychiatric illness and referred the plaintiff to JFH.

58 As part of the referral process to JFH, Dr McHue spoke to the then psychiatric registrar, Dr Sheng, and sent him a brief referral note. Dr McHue does not recall what he told Dr Sheng but no doubt it was a brief account of what he then knew. Dr McHue's referral to Dr Sheng stated that the plaintiff had been assessed by the Crisis Team as suffering a "? acute alcoholic psychosis". The only reference to the plaintiff's actions, however, was that "he head–butted his employer's door down". Dr McHue also noted that the plaintiff admitted to ingesting a "small amount of pot tonight" but denied drinking alcohol. Test results for this latter substance were to follow. Dr McHue expected that a copy of the John Hunter Hospital notes would have been sent over to James Fletcher Hospital with the patient and I am prepared to infer that this explains the exiguity of his referral letter. There is no evidence, however, that this was actually done, and I am minded to think that it was not. The whole of the material on the JHH file that gave any of the history should have been sent to JFH. It was obviously relevant to the assessment that was to be made of the plaintiff's mental condition. There was no reason to suppose that the plaintiff would be cooperative and, even if he were, what he said might not be reliable and should have been cross-checked with the information that had already been gathered, even though (of course) that also might not have been entirely reliable. In the circumstances of this case, the failure to follow these common sense procedures contributed significantly to the failure of Dr Nazarian to appreciate the seriousness of the plaintiff's condition, although his own conduct was the major factor. Dr McHue said that he doubted there was sufficient evidence to diagnose an alcoholic psychosis, although it is clear that he did not conduct any real psychiatric assessment of the plaintiff (which, at all events, he may not have been competent to undertake). Dr McHue recollected that, when he discussed with the plaintiff his transfer to James Fletcher Hospital, he had no objection and was willing to go. I regard this compliant response (and, as noted above, Ms Jeffs elicited the same response) as most significant, especially in light of what was said to be his negative attitude on the following morning and Dr Milton's guess about it (as to which see later). So far as the note of the surgical registrar that the plaintiff was "intermittently aggressive" was concerned, Dr McHue said that he kept the plaintiff in view for the entire time that he was at the hospital and observed neither verbal nor physical aggression at any time. It seems

that the plaintiff's condition was dynamic.

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59 Let me now move to the events at JFH when the plaintiff was transferred there. As I have mentioned, Dr McHue spoke to the then psychiatric registrar on duty, Dr Sheng. I accept that Dr McHue did not give Dr Sheng any indication that the plaintiff had, before his admission to JHH, been extremely violent and also delusional. His letter of referral noted that the plaintiff had "?acute alcoholic psychosis as assessed by the Crisis Team" and that he had "head butted his employer's door down". There was no Crisis *Team*. The "assessment" was made by Ms Jeffs, who was not qualified to do more than give a preliminary indication of future management. This is no criticism. Her task was to see whether the plaintiff needed to be transferred to JFH for psychiatric assessment.

60 Of considerable importance is the evidence of the police officers as to the information which they conveyed, almost certainly to the triage nurse, when they accompanied the plaintiff to the hospital. Both officers were adamant that a form was necessary for one or other of them to fill out when bringing a patient for assessment which, of course, was the plaintiff's situation. Senior Constable Duffey described the form as requiring an explanation of the behaviour which led the police to bring the patient to the hospital. Senior Constable Jones said that he had a conversation with Dr Sheng in which, he said, he informed him of what he knew about the plaintiff, including, in particular, what had happened at Mr Blake's house. He said that he also told Dr Sheng that he believed that the plaintiff was mentally ill. Jones said that, in addition, he wrote a short version of the facts of the case in the appropriate form which, he said, was handed to Dr Sheng. On balance, I do not think he did, in fact, hand the form to Dr Sheng. I think that, more probably, it was handed over to a member of the hospital staff shortly after the plaintiff's admission. There is no doubt that such a form was required to be filled in by police officers. It seems to me, moreover, that the circumstances of such admissions are so relevant to any appropriate assessment that it was the responsibility of the hospital – one way or another – to ensure that a record was made of the information, if any, in the possession of the presenting police officers. This is especially so, having regard to the responsibility reposed on police officers under s24 of the Act. Such information is all the more important, it seems to me, since the patient is likely to be an unreliable reporter of relevant events, let alone his or her current state of mind (a point made by all of the doctors called by the parties but, at all events, an obvious risk even to a lay person). In this case, the inability of the plaintiff to give an adequate account of and explanation for what had happened at Mr Blake's house, in the context of other bizarre or, at least unusual thoughts, emphasises the importance of the account of both police and, for that matter, the ambulance officers. Most regrettably, the police escort form is not now part of the hospital records. Indeed, so badly are those records maintained, it is not objectively possible (by way, for example, of noting a missing page number) to corroborate the

officers' evidence about filling in and providing the form. In other circumstances, the fact that the form is missing would justify an inference adverse to the record holder, if that holder was (as here) a party. However, as I have already said, the records of the hospitals have been through so many hands that it would be unfair to draw any adverse inference from the fact that an important form is missing. It is obvious that it is not now possible to reconstruct the account given in the form. I am satisfied, however, that it very probably referred to the obvious points: the attack on Mr Blake and his family, including his young son; the lack of any rational motive for so doing; the extreme violence and unusual strength demonstrated by the plaintiff when they tried to prevent him from attacking Mr Blake and restrain him; his apparent catatonia, extreme violence and resumed catatonia; his screaming about rats eating his eyes; and the opinion of the officers that he was mentally ill. Although, as I have said, this form was probably not seen by Dr Sheng (despite his evidence to the contrary, which I think was really a reconstruction from what he expected he did), it should have been placed on the hospital file and should have been available to him. It certainly should also have been available to Dr Nazarian, who saw the plaintiff on the following morning in circumstances which I will relate in due course. If it was not on the file by that time, he should have attempted to locate it. Dr Nazarian's failure to read it was also a significant contributing element in his assessment of the plaintiff's mental condition.

61 When the plaintiff came into JFH, he was first seen by Mr Mazun, a psychiatric nurse. This was about midnight. The effect of the notes made by Mr Mazun (taking into account both the notes themselves and his evidence), so far as presently significant matters are concerned is as follows –

> "Brought by ambulance officers and two escorting police following erratic aggressive behaviour. Kevin has head-butted a friend's (employer's) door down and exhibited some psychotic features Dr McHue thinks is due to acute alcoholic psychosis. Patient denies ETOH. However, admits to smoking a small amount of THC.
> Drowsy when taken into Admissions Unit on stretcher.
> Patient stated he was calm and keen to talk about presenting problem/precipitants to illness.
> Not much thought disorder but when referred to his own sister, Kevin felt very uneasy and could not elaborate why.
> Unusual or bizarre behaviour: aggressive outbursts at mate's house. Head-butted door.
> No hallucinations but heard voices of family members and misidentified other people for family members (visual hallucinations) during period of erratic behaviour.
> Patient perceives the problem as "battle between the devil and the good fella".
> Patient's attitude to hospitalisation: Feels he needs to be here.

Speech: slurred speech on admission.
Good family support network."

Amongst other things, the repetition of the plaintiff's amenability to remaining in the hospital is significant.

62 Dr Sheng was the psychiatric registrar on duty on the night of 3 July 1995. He recalled getting a telephone call from Dr McHue at John Hunter Hospital some time in the late evening, telling him that he was sending over the plaintiff for a psychiatric assessment. He recalled Dr McHue telling him that the plaintiff thought he was being taken to the morgue when he was being taken for a CAT scan but could not recall being told anything else. Dr Sheng said that Ms Jeffs also spoke to him. He recalled that Ms Jeffs told him that she thought that the plaintiff had exhibited psychotic symptoms early in the night and was suffering from alcohol hallucinosis. She told him that she thought the plaintiff was not suitable for management out in the community by the Crisis Assessment Treatment Team (a significant point, I think), as Dr Sheng had suggested. Dr Sheng recalled that Ms Jeffs told him that the plaintiff would come to JFH as a voluntary patient and that his brother would also attend with the plaintiff. Dr Sheng said that he had a brief conversation with the accompanying police officers. Dr Sheng said that he was told by the police that they had been asked to attend the plaintiff "when he was at his workmate's place, where the assault incident with the cricket bat and the security door had occurred" but that he did not get very much more information from them. Dr Sheng confirmed that a police escort form would have been filled out and was on this occasion. He said that he "would always read the police escort form" but said that he did not think "there was anything additional on the form…which went beyond what Angela Jeffs had told me". I have no doubt that Dr Sheng is telling the truth but I consider that his recollection of what was on the form is unreliable, if he read it, which (as I mentioned) I think is improbable. I think that Dr Sheng is moving from his knowledge that he ought to have read it and his belief that it was his practice to do so to the conclusion that he did read it. Dr Sheng said that if there had been anything in the police escort form that suggested either risk of violence or suicide then he would have included it in his own notes. It is not referred to in his own notes. He has therefore inferred, I think, that, one way or another, he was not informed of the plaintiff's prior bizarre behaviour which would certainly have suggested the risk of violence. As I have said, I believe that the police escort form did contain the salient details of the events at the Blakes' house. It follows that Dr Sheng did not see it, since these details are not noted down in his record and I accept that he would probably have done so.

63 I think that what Dr Sheng really recalls is the substance of his conversations with Dr McHue and Ms Jeffs and that the other aspects of the case have failed his memory, as he has not made a note of them. The other explanation, that the police did not tell Dr Sheng, one way or another, of the plaintiff's bizarre behaviour that led them to conclude that he needed

psychiatric care is so improbable as to lead me to conclude that, on this point, their recollections are more reliable than that of Dr Sheng (or, for that matter, Ms Jeffs).

64 Dr Sheng said that, when he first saw the plaintiff, his head was bandaged and he was not restrained. He said the plaintiff was awake, alert, orientated and cooperative. Dr Sheng's notes commence at 12.16am. The nature of his admission, as a voluntary patient, and the signature on the appropriate form, were raised after the plaintiff was assessed. The plaintiff was taken to the admission unit and spoken to by Mr Mazun in Dr Sheng's presence. Dr Sheng's notes of his interview with the plaintiff are as follows –

> HISTORY, EXAMINATION AND PROGRESS NOTES
> PRESLAND, Kevin William
>
> Sheng (MO) 0016
>
> 4/7/95 Identifying Data
> 36 year old male
> Lives by self
> House
>
> Source of Referral
>
> Transferred voluntarily from JHH in ambulance with police escort.
>
> Presenting Problem
>
> "Split up not long ago and it's just been driving me bonkers"
>
> HPI – Speech slightly garbled
>
> Having an affair with the wife of a friend, but she cheated on both of them. Broke off 12 months ago.
> Now suffering financial strain from mortgage.
> Some other relational problems with nephew and drinking partners.
>
> Has known Bill for a couple of months (works with him). Tonight Kevin used 2 cones of THC and went round to Bill's with a six pack, they started talking and then Kevin snappedstarted making threats. Bill asked him to leave and Kevin head butted Bill's security door, he kicked Bill's fence down tried to tear Bill's gate apart Bill picked up a cricket bat and warned him to keep away from his family Kevin went for Bill and was hit by the cricket bat. Police came and handcuffed Kevin.

At this stage, Kevin had odd thoughts. He thought if he closed his eyes he would die and he had odd perceptual experiences. Everyone looked like someone he knew. When they arrived at JHH, he thought he was dead and in a hearse. He was wheeled down the corridor for a CT scan and thought he was being taken to the morgue.

Additionally, Bill has pet rats, which Kevin was told about on 2/7/95 and Bill showed them to Kevin and Kevin threatened to kill the rats and Bill's family today.

During the CT scan, Kevin snapped back to reality and realised he wasn't dead.

Kevin also experienced auditory hallucinations – low voices, Barely audible which sounded like his parents.

Past Psych Hy
No previous psych illness

Past Med Hy
Stabbed once
Peri-anal abscess

Systems R/V
CVS – NAD
Respiratory – NAD
GIT – NAD
GVS – NAD
Neuro – NAD

Medication: Nil Allergies: Nil

Family Hy
Dad had heart attack, hypertension
Mother suffered from depression

Current History
Lives by self
House cleaning
? 1 illegitimate child

Sheng (MO)

Drug Alcohol
30-200 g ETOH/DAILY
smokes cigarettes

THC daily – 6 cones average
Has tried magic mushrooms once
Has tried LSD twice
Nothing else
MSE
Appearance – Basically healthy looking young man

- Head bandaged

Behaviour - Pleasant

- Friendly and garrulous

Speech - Normal
Thought - Normal – No FTD

- No delusions
- No suicidal/violent ideation

Cognitive - Orientated

- Able to concentrate
- Good memory ~~missing~~ of events

Intelligence - Within normal range
Perception - No abnormalities when seen
Mood - “Very stressed out”
Affect - Reactive and appropriate
Insight - Wants brief admission
Impression: Brief reactive psychosis
DDx - Drug induced psychosis
? Organic psychosis

- Schizophrenic unlikely

Axis II - Deferred
Axis III - Nil
Axis IV - Relationship break-up

- Financial strain
- Drug use

Axis V - Highly functioning gentleman

- Moderately impaired

Plan
1. Admit as informal patient
2. Screened originally at JHH but TFT’s, TPHA, B12 and folate probably not done may be able to be done or sample collected.
3. CT normal.
4. No medications

O/E
Neuro Intact
CVS - JVP not raised

AB - dyskinetic
HS - Dual no murmurs
Chest – Clear
Abdo - Soft
Prominent arterial pulsation
BSN
Sutures in scalp.
Sheng

65 Again, the plaintiff is noted as wanting a “brief admission”. Dr Sheng’s note “? brief psychotic disorder” was probably used in the sense in which the phrase is defined in DSM-IV TR, which is “a psychotic disturbance that lasts more than one day and remits by one month”. Added to Dr Sheng’s notes are entries made by Nurse Mazun and the ward nurse as follows –

“3.7.95 – C Nursing C – P/C from Allan Presland who inquired as to the health of his brother and voiced concerns over Kevin impulsive behaviour and suicidal ideation. Kevin apparently stated he was “going to do away with himself. Nurse Mazun (RN) Admissions

4.7.95 Nursing C Patient oriented to ward and settled quickly. Awake ‘praying’ at 2am. States that he is afraid to go to sleep, because he has ‘seen the devil’ and will die if he closes his eyes. S Rodger RN”

To which Dr Sheng added –

4/7/95 Sheng – Additional – 1506[am. This is difficult to decipher.]
Apparently still exhibiting some psychotic features. See above note.
Stat 100mg Largactil

Sheng”

66 Dr Sheng suggested four differential diagnoses. I do not doubt that Dr Sheng thought that there was, indeed, something seriously wrong with the plaintiff although he had some difficulty, at the time he assessed him, in determining what was actually wrong with him. This was also Dr Phillips’ view, as to which see later.

67 Dr Sheng considered that the nurse’s note about the plaintiff being afraid to close his eyes indicated that he was “apparently still exhibiting some psychotic features” and also thought it reasonable to form the view that he was likely to be a danger to himself, as he had, as communicated by his brother, threatened suicide. However, he thought that it was unnecessary to wake the plaintiff up or revisit him after Allan Presland’s telephone call because the plaintiff was extremely tired and Dr Sheng thought that he was safe in the ward. In Dr Sheng’s opinion, the plaintiff’s fear of going to sleep

because he had seen the devil and would die if he closed his eyes was a delusion – and, I infer, clinically significant. He also thought (as I do) that it was a matter of critical importance, having noted the threat to kill the rats and Mr Blake's family, that the apparent link between these two ideas in the plaintiff's mind needed to be clarified but this was a matter that should be done in the assessment which he expected to occur in the morning.

68 In considering the interview with Dr Sheng, it is very important, as it seems to me, to bear in mind the situation of the plaintiff. He had scarcely had any sleep in the previous forty-eight hours. The events of the previous six hours or so had been extremely traumatic and it cannot be seriously disputed he had been involved in a major violent and bizarre episode. He had been seriously injured. Mr Mazun notes that the plaintiff was drowsy. I have no doubt that he was. The circumstances were, therefore, far from ideal from the point of view of eliciting any narrative that required concentration or patience. It is significant that, at this point, the plaintiff said to Dr Sheng that he wanted to "come into hospital to sort things out". Although Dr Sheng noted visual hallucinations, in which the plaintiff heard voices of family members and thought that other people were family members, he understood this to have been experienced before the plaintiff's arrival at JFH. This was also the case as to the delusions. Dr Sheng also noted that the plaintiff's perception of his problem was that it was a "battle between the devil and the good fellow" but said that this was not of concern to him because, as he explored it in the interview, it was consistent with the plaintiff's religious and cultural background. However, there is nothing in the notes which suggests any explanation for this statement. This omission is significant, having regard to the otherwise unqualified observation on the psychiatric nursing history. I am sceptical that the plaintiff would have explained away his bizarre thoughts in this way. I do not think he was attempting to conceal them, because of what he later told the ward nurse when he was offered a sedative. In the result, I think that this explanation by Dr Sheng is a reconstruction based upon what he thought he would have done but that he did not, in fact, explore the matter, most likely because he had provisionally diagnosed a psychosis and he thought that the plaintiff would be fully assessed in the morning. It may be that he simply asked the plaintiff if he believed in God or was a Christian; either way, the lack of any explanatory note as to what appears, in the circumstances, to be a troubling statement leads me to conclude that it was in fact unexplained.

69 It seems to me that the plaintiff was in the admission room with Dr Sheng for something less than an hour, of which some time was taken up with physical examinations. The plaintiff's account of this conversation refers to matters which, it is clear, were actually discussed. Thus, for example, he refers to Dr Sheng's asking him about whether there was a family history of mental illness, the drugs, if any, he used and how much he drank. As the notes set out above show, Dr Sheng noted that the plaintiff used two cones of THC earlier in the night and told Dr Sheng that he averaged six cones a day. His evidence was that he told him that he smoked something like ten cones a day and sometimes might drink as

much as ten schooners a day. Although these quantities are somewhat greater than those noted by Dr Sheng, I do not think this difference is significant for present purposes.

70 The major difference between Dr Sheng's and Mr Mazun's accounts on the one hand and that of the plaintiff on the other is the plaintiff's insistence that Dr Sheng stopped him from telling him why he was at the hospital, did not ask him about how he got his injury to his head and, strangely, gave him a writing pad and told him to go to a room (by himself) and write down everything he could remember about the night. The plaintiff said that he wrote down what he could remember, about the rats biting him, about being hit with a cricket bat, about Mr Blake telling him that he would "get these white rats to bite me" as some sort of initiation and about his family. The plaintiff said that these events were "starting to come back" and he filled about half a page with his account. He said that he waited for Dr Sheng to return after he had finished writing, for about twenty minutes. I do not doubt that the plaintiff believes his account to be true. He is, however, completely mistaken. There is every reason for accepting the evidence of Dr Sheng and Mr Mazun, and I do. I suspect that the plaintiff is simply confabulating with another occasion upon which he was asked to write his account, perhaps following the death of Ms Laws.

71 The plaintiff recalls that, following his interview with Dr Sheng, he was told to have a shower, given pyjamas and placed in a bed. As he was sitting there, he recalls a nurse saying that she had some medication for him to help him sleep. He said that he told her, "I won't take that medication. I can't sleep tonight". The plaintiff said that the nurse then left the room and returned about three-quarters of an hour later, telling him that he was required to take the medication as it had been prescribed for him by the doctor to make him sleep. The plaintiff said that he insisted that he would not take it, that the nurse said that he could be made to take it, that he said that he was willing to "fight youse all, but I've got to stay awake tonight". The plaintiff said that he asked the nurse "Do you believe in God, lady?", that she looked at him and said that she did, whereupon the plaintiff said to her, "I believe the devil is after me tonight so I have to stay awake". The plaintiff said that the nurse then left the room. He said that Dr Sheng entered the room, perhaps three-quarters of an hour later, stood at the end of the bed, wrote some notes on a chart and left the room. He said that after that he dozed off for a little while and woke up with a "start" with the nurse leaning over him saying, "You went to sleep". The plaintiff said he responded, "Thanks for waking me" and said that he then remained awake for the rest of the night. The plaintiff said that he started to remember "a lot more of what happened". He said that he felt good and he felt safe. He felt that he would be able to "sort this out in the morning" when he talked to the doctors. He said that he believed that he "could even go to the police and have Blake charged with assault…to get him off the street because I believed he was the most evil person that I had ever met". I have no doubt that this is what the plaintiff both believed at the time and presently

believes, though without any rational basis. The plaintiff describes other occurrences during the night involving persons whom I take to be patients but nothing turns on this, to my mind. The plaintiff said that he believed that he only slept for perhaps one half to one hour and remembered waiting a long time before he was told to come and get his breakfast. He said that he was sort of half sitting up to make sure that he would stay awake and noticed, in due course, that it was daylight outside. I think that it is true that, as he said, the plaintiff was frightened of going to sleep and attempted to stay awake because he had seen the devil and would die if he closed his eyes. After all, this fear is corroborated by the nursing notes made at 2am, when the plaintiff was observed awake and praying". Dr Sheng did prescribe Largactil as a sedative, and did indeed make an entry on the notes, on reading the nurse's observation, at shortly after perhaps 3am or 4am (it is difficult to be sure) that the plaintiff "apparently still [is] exhibiting psychotic features". I think that the plaintiff actually slept for more than an hour or so, having regard to the events of the previous twenty-four hours, although it is not impossible that he was awake for some time before breakfast.

72 The plaintiff's account of what ensued when he awoke in the morning, is set out below, as any summary would completely fail to reflect its tone.

> "CRADDOCK: Q. Did you notice at some stage that it was daylight outside?
> A. Yes.
>
> Q. Who was the first person you saw after you noticed that it had become daylight?
> A. I believe a nurse come and got me.
>
> Q. Was that a male nurse or a female nurse?
> A. I'm really not sure. I think it was a female nurse. I'm really not sure. They took me to a, like a breakfast dining area. All the patients were in there. I was directed to a table. I had to get me own breakfast, go to like where the lady had their cooking stuff and had to get milk, and I got some orange juice and Weetbix I think, and a lot of the patients were crowding around the toaster and I thought I might have a couple of pieces of toast and each time the toaster came up they would all bunch on it and grab the toast, and I just asked this bloke to mind a piece of toast for me. He stood guard over the toast and that was great. In the course of that dining I would see doctors outside the room in like an observation area just watching everybody, just observing everybody I suppose.
>
> I remember while I was having breakfast, the guy that was naked walked in [the plaintiff said that he had seen a man during the night walking around the ward and quite possibly did]. He had an Australian football jumper on, football shorts,

joggers, long socks. I said, ‘I didn't recognise you with your clothes on mate’. He smiled at me, got a set of keys out of his back pocket, opened the backdoor and walked out. I thought, ‘Far out’, like he was staff or something to have his own keys. I thought, ‘Oh that's weird’. I talked to some of the patients after breakfast. They were saying, ‘Oh, you'll get out today’ and I said, ‘No, there's something wrong with me, I'll have to see the doctors, there's something wrong with me’. I think I said, ‘I had a fight with the devil last night’ and that was about it.

HIS HONOUR: Q. What did you think was wrong with you?
A. I believed there was something wrong with me head because what I had been seeing, hearing, I really didn't know much about it. I believed that Blake had drugged me but I wasn't sure at that stage. I just knew there was something wrong, your Honour. The next thing they took me to a room next door with all the other patients or the patients sat around in like a semicircle. There was a lady with a whiteboard and she had like a timetable on the whiteboard. On one side there was all these activities, which I didn't know nothing about and on the other side there was like normal activities. The first one was either grooming or lawn bowls and everyone is putting their hand up for grooming and I didn't know what the hell grooming was, so I put my hand up for lawn bowls.

I'm sorry, your Honour, before that she asked other questions. She went around the room, asked everybody their name, then she asked everybody their star sign and when she got to me I said, ‘I don't believe in the stars’. I said, ‘It's a load of rubbish’. She said, ‘I want to know your star sign’. I said, ‘I don't have a star sign’. She said, ‘I want to know your star sign’ and she got quite angry and I said, ‘Well, I think I was born on the 9 October and I suppose that makes me a Libra’. I think that's all and she said, ‘Thank you very much’ and continued around the room. Then going back to the whiteboard, I can’t remember what all the things were but I remember the first and last thing was some activity inside and they specifically said, ‘This one is on the outside, who wants to go on the outside?’, and I put my hand up because no-one else wanted to. They said, ‘No, I'm not going on the outside’ and I said, ‘Oh, I will go on the outside’. I thought it might have been a bus trip or something, I didn't know what it was, and that was about the end of that.

After that a nurse, I know this was a male, it was a male

nurse or Doctor, I don't know, took me into another room and said to me, ‘You're going to be discharged’. He said, ‘Is there anyone coming for you?’, and I said, ‘What do you mean?’, and he said, ‘Is there anyone coming?’ I said, ‘I think my brother's coming’, and he said, ‘Well’ he said, ‘Well, you will find your brother between the hot and the cold but you have got to go to the heat first’. I said, ‘What the hell does that mean?’ He said, ‘Just remember you have got to go to the heat first, you will find him between the hot and the cold’.

I said, ‘I don't want to leave here’. I said, ‘There's something wrong mate’. He said, ‘There's nothing wrong with you, you just drink too much’. I said, ‘What are you talking about mate?’ I said, ‘I didn't have a drink last night’ and he said something else. He said, ‘Just remember what I told you, to go to the heat first’ and I said, ‘The police told me that I grabbed a three year old child last night’. I said, ‘That's not like me, I wouldn't do that’ and he said, ‘You just drink too much. I said, ‘I didn't have a drink last night, what are you talking about? He said, ‘Listen, you walk out of here the same way you come in’ and he said, ‘Just remember what I told you, to go to the heat first’. He gave me my clothes.

I was still in pyjamas at that stage. He gave me my clothes in my hands, which consisted of a pair of jeans, a belt, shoes, socks, my shirt was ripped to shreds, and a jacket. He give me them in me hands and he said, ‘Now go out the same way you come in. By this stage I didn't know what to do so I tried to remember the way to go out. I took a couple of wrong turns. I backtracked and finally found me way to the front desk. I said to the girl on the front desk, ‘Do you know what this hot and cold business means? She said, ‘I don't know what it means. I walked out the front again with my clothes.

CRADDOCK: Q. Just before you go there, after you went on your search for the way out?
A. Yes.

Q. Did you have any contact with anyone else apart from the person at the front desk?
A. I did. I walked past the guy that had the Australian jumper. He still had that jumper on. He still had his shorts, the same clothes that he had on in the dining room in the morning. I walked past him. He said to me, ‘See you later Kev’, just like that. I thought to myself, ‘How the hell do you know my name?’ I had never met him. I thought this was pretty weird. That brings me back out to the front desk. I walked out the

front door. There was a retarded, looked like a retarded chap there. He said, ‘Who are you looking for?, and I said, ‘I’m supposed to find my brother between the hot and the cold, do you know anything about that?’ He said, ‘What colour car you got? I said, ‘There's a blue HK Holden with a white roof’ and he pointed across this field, like an indoor, like a field, like a soccer field sort of thing in the premises.

He pointed to a round building across the field, and he said, ‘You'll find him there, so I walked over. I still had my clothes in my hands. I walked over to this round building. I tried the front door and it was locked. I walked around the building. I tried another door. It was locked. I come back around to the front. I'm thinking what's going on and I walked around again and I found a big steel door and I put my shoulder on it and opened it and it was just an old boiler room and I thought, ‘What's going on’, I can't walk around here all day. I looked down a little bit and I could see signs pointing in different directions. I thought well, that's the entrance. I walked behind some bushes, changed me clothes. I couldn't do anything with my shirt. I think I just threw it there, left it there, just put my jacket on. I didn't put my shoes and socks on.

HIS HONOUR: Q. You didn't?
A. I didn't. I walked up to the bowling club.

Q. Was there a reason why you didn't put your shoes and socks on?
A. I really don't know, your Honour, there was just no reason. I think I threw the pyjamas and the shirt just on the ground or something. I walked out. I went left, up to the bowling club. I thought my brother might be having a cold beer, that's why he might be at the bowing club. He wasn't there. I was thinking about this heat business, I have got to go to the heat first. I walked, then I thought it might be the police, because you know when you see movies the heat is referred to as the police. I walked down to the police station and just as I went to go in I thought I had better put my shoes and socks on. I sat down.

I was just putting my shoes and socks on and the same retarded fellow was come around and he said, ‘I’ve got a note to you for an electrician’ and I said, ‘That's probably me’ and with that he just took off into the police station. I sort of followed him in and the policeman on the desk said, ‘What are you doing here?’ I said, ‘I think that note’s for me. He

said, ‘Don't worry about that’. He said, ‘What are you doing here? I said, ‘Well, I think they sent me down here’. He said, ‘Where are you from?’ I said, ‘From the rat house up the road, they just let me out from there’. He said, ‘What, are you going there? I said, ‘I don't know, I was told to go to the hot and the cold and this was the only heat that I know of’ and he said, ‘Who are you looking for?, and I said, ‘Me brother, I think I'm supposed to meet my brother here’, and he said, ‘What's his phone number?’, and I think I could recall his phone number but I wasn’t real sure because he'd only just moved into his house about a month before. I told him. He rang the number and said, ‘He's not here, he's not answering the phone’. I said, ‘Well, I don't know where he is’. He said, ‘I want you to go there and sit down and shut up‘. I went over. I sat down and I remembered I had a friend I had been doing work for, he was a Detective Sergeant. I thought I could see him and make a statement because I believed I was going to the police station to make a statement because of the police involvement the night before.

I went to approach the desk again to talk to the police officer and he said, ‘I told you to sit down and shut up’ and so I went back over and sat down and I just wanted to see this police officer so I got up then and this time he said, ‘I told you to sit down and shut up, if you move again or say anything I'm going to lock you up right now’ and I didn’t want to be locked up, your Honour, so I went down and sat down and the next minute my brother walked in and he said, ‘What are you doing here?’, and I said, ‘I don't know, they told me to come down here, they told me to come to the heat’. He said, ‘What are you talking about?’ I said, ‘They told me they were playing lawn bowls". He said "What are they doing to you?"’ and I said, ‘Nothing’. With that he said, ‘What we have got to do is go up and see this head Doctor now’ and I said, ‘Okay’ and we walked out of the police station.

On the way up I said, I believe I said to him, ‘I had a fight with the devil last night and I beat him’. He said, ‘What the hell are you talking about?’ He said, ‘You didn't have a fight with the devil, wake up to yourself, you know you are off your head’ or something about telling words. He said, ‘You didn't beat the devil’ or something. At that time I got very worried because I believed my brother that I didn’t beat the devil. We went back to the James Fletcher Hospital and by that stage I was starting to get very nervous and I was starting to become a mess again and starting to get scared again.

CRADDOCK: Q. Just before you go on, what were you starting to get scared of?
A. The devil, I believed that Bill Blake was the devil. I have thought about it. I believed that he was the devil. He told me some time before when he was telling me about how he cricket-batted this guy who grabbed his son that this guy had stood up in Court and pointed to Blake and said that 'He's the devil' and he said, 'Fancy calling me the devil' and they just laughed it out of the Court because this bloke had brought an assault charge against him. I believed that he was the devil. I believed that he was going to make me kill my family.
I went back to the hospital, to go and see Dr Nazarian. I believe my brother sat opposite him and to me. I felt like I was there in the corner but my brother said I was sitting next to him at the desk. I thought – I believed I was actually in the corner. Dr Nazarian spoke to my brother. He said, 'He has been drinking too much. He smokes too much pot. He has been very stressed since he broke up with his relationship with his girlfriend', and I remember just saying, 'Yes, stress". I had my head in my hands and I am thinking the alcohol and pot has got nothing to do with it. By that stage I was getting very nervy. I think he told my brother that I needed drug and alcohol counseling, to go to Kirkwood House and make an appointment. That was about the end of the conversation. We walked out of there. My brother asked me where Kirkwood House was. I said, 'I wouldn't have a clue'

HIS HONOUR: Q. How long do you think it was that you were in Dr Nazarian's office?
A. Five, 10 minutes at the most."

73 It is now necessary that I go back a little to deal with the evidence of Allan Presland. Mr Presland said that he was contacted by Senior Constable Jones around 10.30 on 3 July and told that his brother was at John Hunter Hospital and that he should come up and see him. He said that, when he got to the hospital, Jones told him in substance, that his brother had "lashed out at someone, been hit over the head with a cricket bat over at Islington" (the suburb of Mr Blake's house). There followed some conversation with Ms Jeffs, which I do not need to relate here. Mr Presland said that he then spoke to his brother. During this conversation the plaintiff told Allan that he was "going to do away with" himself, and that he replied "Don't talk like that, you have got me and everyone else thinking of you". Mr Presland said that he told the plaintiff, "You will be here for a week, Kev". He said that the plaintiff said, "'Yeah'", and then "lunged out of the bed at me". I accept that this occurred, as I have already mentioned, but I think that the explanation was that it was an involuntary reaction to some painful stimulus caused by treatment at the site of his head injury. However, Mr Presland thought that it was an aggressive response to the suggestion that he would need to be in

hospital for a week and said, “You will be here for at least a couple of days, let people take care of you” and said that his brother “calmed down”. The plaintiff mentioned needing pyjamas and Mr Presland said that he would buy some for him. I think it likely that there was some other conversation but this has been lost in the mists of time.

74 I should state my impression of Mr Presland as a witness. I have no doubt that he told the Court what he believed to be true. However, it is obvious that he is still very upset at his fiancée’s death, he still has some anger towards his brother – although, I think, this has gradually lessened over time – but he is extremely angry over what he perceives as the failure of those who had the care of his brother to appreciate that he was dangerous and ensure that he remained in the hospital. This anger is directed mainly at Dr Nazarian and the staff of the JFH but also, to some extent, towards the police. This anger was evident throughout his evidence and it was necessary for me on more than one occasion to attempt to calm him down. It seems to me that his recollection of events is very much affected by his strong feelings that the hospital and the doctors failed his brother and, as a consequence, his fiancée was horribly killed. I think the whole situation was very stressful for him and that he did (and does) not listen well.

75 Mr Presland said that no one suggested that he should go to James Fletcher Hospital with his brother. I suspect that this might be true or it may be that he was told this and simply did not hear it. It is unnecessary to determine the question. Insofar as it is relevant, I think that, had he understood that he should accompany his brother to JFH, he would have done so. At all events, he went home and said that he did not go to sleep: “I prayed on my bed for him; couldn’t get to sleep because I was concerned what Kevin told me up there about wanting to do away with himself”. He said that, after he lay in bed for a while, he got up at about 1.30am and rang James Fletcher Hospital to check that he had arrived safely. He was told that he had and he said, “Keep a good eye on him because he contemplates suicide”. He asked whether he could bring anything and was told to bring some clothes for him. It will be recalled that the plaintiff had had no change of clothing and what he did have was bloodstained. Mr Presland asked when he should come up to see him and was told 10am. Mr Presland said that he went back to bed but, before doing so, started packing a bag for his brother with some clothes for his stay. I have no doubt that a conversation of this kind took place and that Mr Presland did indeed pack a bag for his brother, in the expectation that he would need to stay at the hospital for some days. On the following morning, Mr Presland had some chores to do and then went into town to buy some pyjamas for the plaintiff. He took the pyjamas together with a change of clothing in the bag to the hospital. Mr Presland had not visited the hospital before and enquired as to the whereabouts of the Acacia Ward which, he had been informed the previous night, was where his brother was being cared for. He said that when he went to the ward he noticed a nurse in the hallway, who told him that his brother was out playing bowls. She told him to wait in the waiting room, leave his bag in the office, and she would go and get him. Mr Presland

said that he went to the waiting room and noticed a board with a list of activities with his brother's name next to the bowls. The nurse returned and told him that his brother was at the police station. Mr Presland said that he swore and asked what he was doing there. The nurse pointed out that his brother could "walk out any time he wants", no doubt because he was a voluntary patient. Mr Presland then went down to the police station, which was not far from the hospital. When he arrived, he was told that his brother had just walked in and he saw him sitting on a bench, I take it in a waiting area. Mr Presland noted that his head was bandaged and he was wearing a jacket and jeans and a pair of grey shoes. Mr Presland told the police officer that he would take his brother back to James Fletcher Hospital and, taking him around the shoulders, asked him to come back to the hospital. Mr Presland said that the plaintiff then said to him, "Somebody in there told me if I closed my eyes the devil will get me". Mr Presland replied, "Don't listen to that rubbish. That is bullshit, you know". He added, "Come on Kevin, we'll get you back up to the hospital. These people are a bunch of bloody idiots for not taking care of you. We will get you back up there."

76 Although, as will become clear, I have some very real doubts about the reliability of significant parts of Allan Presland's evidence, I have no doubt that indeed he did go down to the police station to collect the plaintiff and that the plaintiff did tell him about being afraid to close his eyes because of the devil. The fact that the plaintiff had made this bizarre suggestion on the way back from the police station could scarcely have led Allan Presland to think that he was well and did not need medical care. To the contrary, I am persuaded that he was very angry with the hospital staff for allowing his brother to walk out of the hospital and was very worried about his brother's mental condition. The plaintiff's journey to the police station is significant since, amongst other matters, it throws some light on accounts of what later happened. That he was brought back to the hospital by Allan is also important though, of course, Allan had left the bag of clothes there.

77 When Mr Presland brought his brother back to the Acacia Ward he saw two nurses there. He said that he asked, "What is going on with my brother?" He said that one of the nurses replied, "You will have to have him assessed before you can take him". I am inclined to think that, indeed, he was told this by the nurse. The nurses' evidence in this regard, to which I will come in due course, is certainly that they understood that Mr Presland wanted to take his brother with him. Although I have no doubt that he did not wish to do so, I think it is likely that he was somewhat aggressive and that they assumed that he wished to do so, an assumption built into the information which they gave him at this point. It is, of course, very difficult to reconstruct events now, but it seems to me that the nurses probably assumed that Mr Presland and the plaintiff were leaving because Mr Presland had a bag packed, which they thought was the plaintiff's, and the brothers came in from outside the ward. I think that there was a mutual misunderstanding between the nurses and Mr Presland. I do not believe that Mr Presland understood that they thought he wanted to take the plaintiff out

of the hospital. He was, as it were, focused on his own campaign to get his brother care and I do not think that he really heard what was said to him. Whatever the explanation for the nurses' evidence, however, I have concluded that Allan Presland did not want, let alone, demand the release of his brother and that the plaintiff himself made no such request.

78 To resume his account, Mr Presland asked where the doctor was and was directed to his office across the hallway. Mr Presland retrieved the bag he had brought and had a brief conversation with the doctor. As they had walked down the hallway, Mr Presland said that he remarked to his brother, "It looks pretty newly freshly painted, this would be a good place for you to stay awhile" or words to that effect. When they entered the doctor's office, Mr Presland and the plaintiff sat down at a desk opposite the doctor. Mr Presland's account of what then happened, I am satisfied, is incorrect. In brief, he says that the doctor commented to the plaintiff that he had been drinking a lot of alcohol lately, that the plaintiff did not reply, that the doctor then said, "You have been trying to break up with a woman lately and are under stress", that his brother answered him, saying "Yeah, stress", that he (Allan) said to the doctor, in effect, that his brother's problems had been going on for months and that he needed help and needed it now, but that the doctor told him to take his brother down to Kirkwood House, which had a drug rehabilitation programme, take him to his own doctor and then home and give him some rest. Mr Presland asked for directions to Kirkwood House, which he was given. It will be noted that this account is very similar to that of the plaintiff's. It is obvious that they have discussed what happened at Dr Nazarian's consultation. Their evidence is, in my opinion, a joint reconstruction. It is quite inaccurate, though both the plaintiff and his brother, I believe, think it to be true. Not only is it inherently improbable, given the circumstances, but it is contradicted by the testimony of Dr Nazarian (whose account is also, however, unreliable in some important respects) and, more significantly, by the doctor's contemporaneous notes.

79 At the end of the consultation with Dr Nazarian, Mr Presland took the plaintiff to Kirkwood House but was unable to obtain an immediate appointment. This occurred, I think, because he simply demanded one and did not inform the receptionist that arrangements had been made with Dr Nazarian for his brother to see someone. He left in high dudgeon with the plaintiff. It seems to me that this is significant, because it shows that Allan Presland was frustrated and angry, not because he wanted to get his brother home, but on the contrary, because he was unable to get help for him. However, his stress, ill temper and limited communications skills made it difficult for those with whom he interacted to appreciate what he wanted.

80 Ms Stephanie Thomas was a registered nurse employed at James Fletcher Hospital on duty on the night of 3/4 July 1995. She recalled the plaintiff coming into the Acacia Ward. He was placed in a single room, but it was not locked as the ward was an open one. Ms Thomas said that when the plaintiff first came into the ward he was quite distressed, although he later settled down. She noted that the plaintiff was awake at 2am apparently

praying and that he told her that “he was afraid to go to sleep because he had seen the devil and will die if he closes his eyes”. This did not cause her any particular alarm or concern, because the plaintiff otherwise appeared to be quite settled; he was polite, “appropriate” and calm. Ms Thomas said that she did half hourly rounds and recalls that the plaintiff eventually fell asleep, although she was unable to recall at what point in the evening she made this observation. Ms Thomas said that her practice was only to note if patients were awake on her rounds and the absence of any such note on the clinical records indicates that when she first made her rounds and thereafter the plaintiff was asleep. Although I am somewhat sceptical about the practice invariably being followed, nothing turns on this. Although I think that the plaintiff did not wish to sleep, the fact that he did so is simply evidence of how tired he was.

81 Mr Adam Vincent is a community mental health worker who completed his nursing degree in 1993 and commenced duties at JFH in 1994 as a registered nurse in the acute psychiatric unit. He came on duty on 4 July 1995 at about 7am. He said that breakfast was usually at 8am and the patients were generally finished by about 8.30 or so. About this time, or perhaps as late as 9 o’clock, he recalls a man entering the unit coming from the direction of the front foyer of the hospital. He did not say who he was but it is obvious he was Allan Presland. Mr Vincent recounts a conversation in which Mr Allan Presland quite aggressively demanded that his brother should be “released right now”. He said that Sister Joy Lockett, the sister in charge, then approached him in the corridor and took him to the relatives’ lounge or perhaps the nursing station for a conversation. Following this conversation, Mr Vincent said, Sister Lockett asked him to get the plaintiff from his bedroom and bring him to the nurses’ station or, it may be, to contact the doctor on duty. This cannot be reconciled with the fact that the plaintiff had wandered down to the police station unless it was at this point that his absence was discovered. Certainly, Mr Vincent did not collect him. I am quite satisfied that, despite this evidence, what actually occurred was that Mr Presland asked to see his brother, was told (one way or another) that he was at the police station and went there to find him and bring him back to the hospital. Mr Presland had brought a bag to the hospital for the plaintiff, he had put a change of clothing in it the night before and had purchased pyjamas for him that very morning. He had called during the night to warn the hospital that his brother had threatened suicide. I simply do not believe that he would march into the hospital and, without even asking how his brother was, demand that he be discharged. Nor would such a demand make any more sense after Mr Presland had retrieved the plaintiff from the police station. To the contrary. At all events, this conversation with the nurse must have occurred before Mr Presland found his brother since, when they returned from the police station, they remained together until they left the hospital. Certainly it was in Allan’s interests that some qualified person take care of his brother, about whose behaviour he had been concerned for some time. I do not think that he saw himself or his fiancée, as an appropriate carer – they had their own lives to lead. Indeed, my

overwhelming impression of Mr Presland is that he regarded his brother's behaviour as, to some degree, his own foolishness and was angered by being put to the inconvenience of having to deal with the consequences. The logic of events (as well as my assessment of the witnesses) convinces me that, so far from Mr Presland wanting the plaintiff to be released, he was anxious that he should stay in the hospital to deal with whatever emotional or psychiatric issues were adversely affecting him.

82 Mr Vincent was only asked to recall the particular events of that morning in about the year 2001, although there may have been an earlier oral statement perhaps as long as eighteen months after July 1995. I think that, in the time since the events, his recollection has become confused, possibly with relatives of other patients and, perhaps, by discussion with other staff. For whatever reason, however, I am convinced that he is wrong when he says that Mr Allan Presland insisted or requested, for that matter, the release of his brother. Mr Vincent said that, after the consultation with Dr Nazarian, the plaintiff left the ward. Paperwork was completed for this purpose. The hospital records contain a note, "Patient discharged into brother's care, left ward at approximately 11 am", which was completed by Mr Vincent.

83 Mr Vincent agreed that, if a relative contacted the ward to say that he or she was concerned about the suicide risk of a patient, that patient should be under more frequent observation than would otherwise be the case and a note of those observations should be made. Yet the nursing notes make no reference to any such observations.

84 Mr Vincent said that in July 1995, lawn bowls was not available for patients in the Acacia Ward because the lawn bowls grounds are quite a distance from the hospital building and it was impractical to escort anyone to those activities. Mr Vincent also said that all activities by patients are supervised; they are not left on their own, in particular, they were not permitted outside except for a walk out in the adjacent oval, in which event again, they would be escorted by a nurse. Walks were very limited, he pointed out, because of the limited number of nursing staff available for supervision. What Mr Vincent says strikes me as being entirely appropriate practice in light of the responsibility of the hospital for the patients in the psychiatric unit. However, whatever the explanation, the practice was not followed in relation to the plaintiff. Mr Vincent recalled that around July 1995, it frequently occurred that patients from the Acacia Ward would wander out of the ward and find themselves down at the police station. This evidence seems to be somewhat inconsistent with his earlier statement about supervision. Although Mr Vincent said that, if the plaintiff had gone down to the police station and the hospital had been informed of it, he believes he would remember this occurring and that he has no recollection one way or another of such an event. However, I am certain that it occurred. Mr Vincent also recalls hearing Mr Presland talking to Dr Nazarian in his office in a loud and demanding way, although he could not hear what was being said.

85 Sister Lockett had, as at mid-1995, worked at JFH for many years and had worked in the Acacia Ward for about four years. On 4 July 1995, she was working on the morning shift, having arrived at about 7am. Ms Lockett said that she was first asked to recall what had happened concerning the plaintiff only two days before she gave evidence, although she insists that what she recounts about the matter "is still fairly vivid" in her mind. She supervised breakfast that morning and recalled seeing Mr Allan Presland come into the dining room. She said that he said, words to the effect of "what was his brother doing here, why was he here and he wanted to take him home". If Ms Lockett's evidence is true, Allan Presland not only demanded the release of his brother without even an enquiry as to how he was, despite his call in the early hours of the morning, but asked why he was in the hospital – in the circumstances, a bizarre inquiry. I am satisfied that there was no conversation in the terms or in substance as deposed to by Ms Lockett, although it may well be that Mr Presland demanded to know where his brother was and why he was *not* "here" – meaning having breakfast, or in the ward. Ms Lockett recalled saying to Mr Presland (and, as I have already mentioned, I accept that this might have been said) that he would not be able to take his brother home until he had been seen by the duty doctor. Ms Lockett also recalled that another member of staff told her on the morning of 4 July that the plaintiff had left the grounds but this is something that she may simply have been told much later.

86 I now come to the evidence of Dr Nazarian. Dr Nazarian graduated in 1976 with a medical diploma in the College of Medicine, University of Mosel in Iraq. In 1977, he undertook a twelve-month internship in general hospitals in Baghdad, including neurosurgery, psychiatry, surgery, obstetrics, gynaecology and internal medicine. After his compulsory military service between 1978 and 1980 he was appointed resident medical officer in paediatrics for the first half of 1980 then (as obligatory service) worked as a general practitioner to late 1981. He was psychiatric registrar at a hospital in Baghdad for eighteen months but was unable to continue with post-graduate studies in psychiatry because his scholarship was cancelled during the Iraqi/Iranian War, although he remained a career medical officer in psychiatry and the director of the Al-Kindi teaching hospital for five years to January 1988. He obtained a further scholarship for post-graduate psychiatric studies in 1986 to go to Edinburgh but again, unfortunately, the scholarship was cancelled by the government. At the end of 1988, Dr Nazarian undertook some post-graduate psychiatry studies in Iraq and worked as psychiatry registrar in various institutions until December 1991, when he came to Australia. Dr Nazarian had been granted accreditation by the Royal Australia and New Zealland College of Psychiatry first in 1984 and then renewed in 1988 and he commenced work in Australia in February 1992 as a psychiatry registrar undertaking the second year of training for the RANZCP at JFH, where he mostly worked and was working on 4 July 1995. Dr Nazarian was thus a post-graduate trainee, being a third year registrar, and not a qualified psychiatrist.

87 On 4 July 1995, Dr Nazarian commenced his shift as usual at 8.30am. The plaintiff was allocated to his care at the intake meeting with which he commenced his shift. Dr Nazarian said that he was approached by several of the staff who told him that the plaintiff and his brother, Allan Presland, wanted to leave the hospital, that Allan Presland was asking to discharge him and had been told that he must first see the doctor. He said that the nurses told him that they had both been "hassled" by Allan. Dr Nazarian said that, when he came to the nurses' station he saw Allan Presland asking when the doctor could see his brother and asking to leave. I have already said that I do not accept that this occurred. Aside from the matters to which I have already referred, Dr Nazarian's notes of his consultation with the plaintiff make no reference at all to any request or suggestion that the plaintiff or, for that matter, his brother, wished to leave the hospital. This was a matter of significance since the doctor's evidence, in substance, was that it was a major (indeed, *the* major) influence on the character of the consultation and prevented him from exploring matters that he would otherwise have. Dr Nazarian's notes were as follows –

> "4.7.95 Psych. Regis Nazarian
> 10.30 I saw Kevin with his brother, the brother stated initially that Kevin had an accident which Kevin approved, but later on inquiry about what type of accident, Kevin claimed he was hit on the head by a bat. He admitted drinking alcohol 12–15 schooners and smoking 10–20 cones/day when stressed out. He got separated from his girlfriend recently, claims it was his choice, he didn't love her if she didn't love him. He had a fight with one of his colleagues at work, he claims that the new colleague was trying to boss them. He claims he'll have no trouble in getting back his job.

His family are supportive, they're aware of his alcohol and drug problem so they'll offer him support. He agreed to go to Kirkwood House and other D&A services to seek help.

> Diagnosis - No psychotic illness
> - No major depressive illness.
> Mainly Drug & Alcohol abuse and personal problems.
> No need for follow-ups.

88 My conclusion that neither the plaintiff nor Allan Presland requested discharge is strengthened by the omission from Dr Nazarian's notes of any suggestion that they did so. There were a number of other matters which were relevant to be considered in the doctor's assessment to which no reference is made in his notes. It was argued that I should not place much weight on the omission of any mention of those matters since notes are made in the course of an interview when it may not be desirable to write down a number of matters, either because it is necessary to concentrate on the consultation or because that might indicate to the patient that the matter is of particular importance or both of these reasons and, perhaps,

others also. Of course, the purpose of making such notes is to create a record of the consultation, not only for future treatment by the psychiatric registrar but for reference by future carers or doctors and against failures of recollection which, in the course of any busy practice, are likely. This is so obvious that I accept Dr Nazarian's own evidence to the effect that he made a note of all matters of importance. I should also make the observation, at this point, that of itself the fact – if it were the fact – that the plaintiff wished to leave the hospital is not decisive of the ultimate issue in this trial, since the plaintiff's case is that, whatever his wishes, it was negligent for the defendants to have released him, in other words, not to have kept him as an involuntary patient in accordance with the Act, whether as a mentally ill or a mentally disordered person. To my mind, the significance of the finding that the plaintiff did not express a desire to leave the hospital is that this renders a number of explanations given by Dr Nazarian as to why relevant and important matters were not either raised or explored with the plaintiff unlikely to be accurate; the finding that Allan Presland did not seek the immediate release of his brother similarly removes that explanation for not raising or exploring matters with the plaintiff. At all events, the desires of Allan Presland, however strongly expressed, were only of the most marginal relevance and should have been disregarded. The risk – in the circumstances as described by the nurses and Dr Nazarian himself – that he was overbearing his brother is obvious. It is important to note that, even if the plaintiff and his brother had indicated – however strongly – a desire to leave the hospital, they had consented to seeing Dr Nazarian before doing so and permitted him to assess the plaintiff. The notion that they would have dismissed any opinion that Dr Nazarian expressed concerning the desirability for the plaintiff to remain in the hospital for a short time – perhaps a few days – to enable his condition to be explored and to obtain some explanation for his bizarre behaviour and fearful thoughts is, in my view, fanciful. The significance of these considerations will become more evident as I deal with Dr Nazarian's evidence and the opinions of the defendants' experts. Dr Nazarian also said, and I accept, that he had the plaintiff's hospital file with him during the consultation. That file should have contained the ambulance report, the JHH admission note and the police escort report setting out the details of the events that led to the plaintiff's admission to the hospital. Had they been in the file and had Dr Nazarian given them appropriate consideration, I think it likely that both the consultation and its outcome would have been quite different. However, I think it probable that these documents were not, for some reason, in the file at this point. This, however, is not the end of the matter so far as Dr Nazarian is concerned since I am persuaded that his consultation was, in a number of respects, at all events seriously inadequate.

89 Dr Nazarian said that, after he had introduced himself, he asked the plaintiff how he ended up in hospital and what had happened. He said that Allan Presland told him that it was an accident and the plaintiff agreed with this. These answers, in all the circumstances, are so much at odds with any reasonable view of the probabilities that I have concluded that, somehow or

other, Dr Nazarian has misunderstood what was said or else Allan and the plaintiff had misunderstood the question. Allan knew that there had not been any accident. He had no reason to suggest that there had been or to omit mention of his fear about his brother's threat to kill himself. Dr Nazarian said that he "confronted him gently by saying 'Are you sure?' and then when they noticed that I didn't believe it, well, they backed off and said 'Well, I was hit on the head by a bat'". (This indicates, at least, that neither plaintiff nor Allan reacted angrily or inappropriately to an implicit contradiction.) Dr Nazarian then noted an account which is significantly at odds with what the plaintiff now says – although, I accept that he may well have been confabulating – but which certainly seems to me to be unlikely to have been said. Dr Nazarian said that he verified this account with Allan Presland. Since Allan was not present at any relevant time, and did not claim to have been present, I do not see how this so-called verification could have occurred. It was obviously inappropriate for Dr Nazarian to simply accept Allan's "verification" without exploring its basis and, unless he did so, the "verification" was useless. If Dr Nazarian had read Dr Sheng's notes with any attention, he would have noticed that Allan Presland's presence at the relevant events was not suggested. Dr Nazarian ascertained that the plaintiff had been drinking heavily and also abusing marijuana. It was this conduct which led to Dr Nazarian proposing that he should undertake drug and alcohol counselling. Dr Nazarian asked about the relationship problem but did not, as it seems to me, explore the significance of the issue. However, he said that the plaintiff's demeanour at this time was such that he was not prepared to discuss the matter further and that he decided that he ought not to press it. There was discussion about the plaintiff's plans in which the plaintiff said that he was going to take a few days' leave and go back to work. Dr Nazarian queried this since he understood that the plaintiff had problems in the workplace and asked him whether he would be safe working with his colleagues. Dr Nazarian said the plaintiff said that it would be okay and they would accept him back at work. Dr Nazarian asked the plaintiff about his mood and whether he felt safe about going home. He said that the plaintiff said that he was feeling tired and was "a bit upset" from the events of the night before and the relationship. Dr Nazarian said that the plaintiff did not strike him as being depressed. He said, according to Dr Nazarian, that it was okay for him to go home and Allan Presland added, "We're a big family, we will look after him". Dr Nazarian said that he tried to convince the plaintiff to stay, saying words to the effect "It is too early to leave the hospital, how about if you rest here?" He said that the plaintiff's response was that he "would rather go and rest at home" and that when he asked whether he had support, Allan Presland repeated his observation about being a big family that could look after him. This matter strikes me as being so significant that a note would have been made of it had the exchange actually occurred. I am satisfied that it did not. Dr Nazarian said that he tried to approach this matter another way by saying to the plaintiff that his head needed attending to but got the response, "Oh we will go to the GP. We have got a good GP. The GP can look after that". I am also

sceptical that this was said, having regard both to the lack of a note and to the circumstances. I repeat that I am quite sure that Allan Presland was anxious for his brother to stay in hospital, since he believed that he needed help and that, this being so, I do not accept that he would have suggested that his brother would be better off at home, let alone contradicting the doctor's advice that he should stay in hospital. On every other occasion when the question of staying in the hospital had been raised by medical staff, the plaintiff had responded positively. I do not believe that he had changed his mind. Dr Nazarian confirmed that the conversation ended with his explaining the drug and alcohol counselling service available at Kirkwood House adjacent to the hospital. He said that, whilst the plaintiff and his brother were in the room, he telephoned Kirkwood House and made an appointment for the plaintiff to be immediately assessed. Both the plaintiff and his brother denied that this was done and I note that the clinical record does not mention making an appointment. In the end, I am unable to determine whether such an appointment was, indeed, made. I am inclined to think that it was, but after the plaintiff and his brother left Dr Nazarian's office, since otherwise Allan Presland's behaviour at Kirkwood House does not make sense and I do not think that this is a matter about which he would be confused.

90 Dr Nazarian said that he carried out a mental state examination. No note either of the elements or the fact of such an examination was made by him. He said that although he did not do so formally, he considered the plaintiff's history, his coherence of speech, whether he appeared depressed or indifferent, whether he was restless or agitated, calm or distracted by external stimuli, whether he acted inappropriately, whether his speech was normal or accelerated and whether there were any signs of thought disorder. He said that the plaintiff was calm and co-operative (an important observation inconsistent with the suggestion that the plaintiff was resistant to exploring sensitive issues). He was not restless, his speech was coherent and relevant. The plaintiff said that he was tired. Dr Nazarian asked him how he had slept and said that the plaintiff said that he had slept well, although initially he had problems with sleep because he had been late coming into the hospital. Dr Nazarian said that he did not raise the issue about the plaintiff fearing to close his eyes because the devil might get him. He said, however, that he discussed the issue of the plaintiff being afraid to sleep indirectly because "If you ask direct questions the patients deny it and close the matter" (yet, he asked a direct question about suicidal thoughts – see below). He said that he did this by asking the plaintiff how he slept. If this is correct, it follows that Dr Nazarian regarded this as an important question, as it obviously was, but made no note about the matter. If he had seen the nursing note – and he should have – I find it impossible to accept he would not have recorded that he had asked about sleep and noted the plaintiff's answer, especially in light of Dr Sheng's note about continuing psychotic symptoms. The plaintiff's tiredness, his sleep, his feelings at the hospital, what had happened at the hospital, how his head felt are not mentioned in the notes, either explicitly or implicitly. These were obviously

important matters. I am of the view that Dr Nazarian did not ask how the plaintiff slept, and I do not accept his explanation for not exploring the matter mentioned in the nursing notes. Dr Nazarian said, in relation to the delusions, that he could not elicit any when he followed a line of enquiry about whether the plaintiff was feeling safe to go home, safe about walking in the streets and safe about working. In the circumstances, these questions seem to me to be most unlikely to elicit the kind of delusional fear relating to rats and Mr Blake's behaviour and seeing the devil which were actually the matters troubling the plaintiff. So far as his hallucinations, if any, were concerned, Dr Nazarian said that he took account of his "whole behaviour" and also asked him about hearing voices and he said the plaintiff denied it. Dr Nazarian said "I asked him in a, sort of, whether there were strange things happening to him…at the time of the interview". He also asked him whether he had any strange experiences the previous night or the previous day or so but that the plaintiff denied it. He said this denial is reflected in his note of "No psychotic features". However, there is no such note. The only note in this regard is "Diagnosis:– No psychotic illness". I do not believe that the conversation referred to is reflected in this note. The matter is so obviously crucial and the plaintiff's denial (if he gave one) so plainly important that I do not accept that Dr Nazarian would have failed to note it or otherwise thought that the note "no psychotic illness" was remotely sufficient in light of the notes already made by others. I am satisfied that Dr Nazarian did not make a note of the conversation or its effect because he, in fact, did not make any inquiry: the conversation did not occur. Moreover, I think that, so far from a denial, it is probable that any inquiry would have elicited a response consistent with those that had already been made by the plaintiff to earlier interlocutors. Dr Nazarian concluded that he could not see any psychotic illness, nor a psychiatric disorder. He said that "the only thing which was obvious, there was alcohol and drug abuse, and personal problems". He did not see any psychotic illness or a psychiatric disorder, in my opinion, because he did not conscientiously look for them. I regret to say that I think that Dr Nazarian was merely going through the motions and, even then, only some of them.

91 Allan Presland was able to give information about some of the plaintiff's odd behaviour in the weeks preceding 3 July but did not disclose it to Dr Nazarian. However, it seems to me that Dr Nazarian made no attempt or no serious attempt to question Allan Presland about his knowledge of that history. It is obvious that he should have done so. So far as the plaintiff is concerned, Dr Nazarian was aware that there had been a fight with a work colleague, but he did not ask about the details, saying that he checked them with Allan Presland, although he did not know whether he had been present at the time and did not ask. Dr Nazarian, as I have mentioned, asked the plaintiff if "he would feel safe about going home" although this is not recorded in the notes. He also said that he asked whether he felt that "he was at risk of harming himself" and responded, "It's okay". This is scarcely a responsive answer. The question itself implicitly signals that denial is appropriate or even sought. As with a number of other matters to which I

have already adverted and which I mention below, Dr Nazarian should have asked open-ended questions which could not be responsively answered by a simple yes or no. The presence of suicidal thoughts is so important a consideration, not only for the patient's well-being and care and because of the issues specified in the Act, but also because the issue had been specifically raised by Allan Presland's call to the hospital during the night, that Dr Nazarian should have not only explored the issue but made a note about it. Even accepting (as I do not) that Dr Nazarian raised it with the plaintiff, not getting some information from Allan Presland about the reasons that he made the call, was, I think, incompetent. In the end, Dr Nazarian relies, in substance, upon his unaided recollection. I have concluded that Dr Nazarian did not ask the plaintiff about the risk of suicide and, at all events, if he did so in the terms deposed to, he did so incompetently.

92 I have mentioned Dr Nazarian's evidence that Allan Presland was harassing staff to release his brother from the hospital and the plaintiff had said that he wished to go with his brother. In those circumstances, it seems to me self-evident that he should have interviewed the plaintiff in the absence of Allan Presland, or attempted to do so, because the possibility that he was being overborne by his brother should have been obvious. Yet Dr Nazarian said that he did not see the importance of ascertaining whether it was the plaintiff's independent wish to leave or whether it was his brother's. The fact that he neither did do so nor sees why it was important to do so is part of the picture which supports my adverse opinion of his competence.

93 Dr Nazarian said that he saw the plaintiff in what he described as a "duress situation". His consultation was not an ordinary one: he felt "under duress". Dr Nazarian said that he asked the plaintiff why he wanted to leave and the plaintiff said that he "wanted to be at home, he felt that everything was finished, it was over, he was feeling okay, he wanted to be at home". Although Dr Nazarian said that he made a note of him wanting to go back to work and wanting to be with his family, no note to this effect was made. Dr Nazarian said, in substance, that as the plaintiff was a voluntary patient seeking to leave, he did not feel it necessary to take, or attempt to take, a full history but rather to review his case to establish whether he might be a risk to himself or to others or (at that time) there was a risk to his reputation if he should be released. He said there was a personal history taken by Dr Sheng but a full history "could not be taken" because, as Dr Nazarian saw it, "I was dealing with a crisis situation which was in front of me and a duress situation so it wasn't like in a situation where I am…assessing everything in a quiet room". On the other hand, Dr Nazarian conceded that the plaintiff answered the questions that he was asked and did not refuse to answer any questions which were asked. Dr Nazarian said that he could not have prevented the plaintiff from walking out if he had wished to do so and, when it was pointed out that neither he nor his brother did walk out, but sat in his room, he responded: "But what they were presenting was different, their behaviour, his behaviour was different. If the day before he was accepting

admission and saying, ‘Yes, I want to stay’, when I saw him – he didn’t want to stay – that’s the difference”. The notes do not so much as hint that this was the plaintiff’s attitude, let alone the attitude of Allan Presland. I do not wish to suggest that Dr Nazarian has fabricated it. Rather, I think that he has extensively reconstructed events rather defensively, having regard to the horrific aftermath of the plaintiff’s release.

94 It seems to me that there were a number of obvious points which Dr Nazarian should have explored with the plaintiff and which appeared on the records in the file which Dr Nazarian had read shortly before he interviewed the plaintiff. Those matters included what his actual feelings were at the time of his fight, what threats he made and why he made them, why he head butted the security door and attacked the fence, why Bill [Blake] warned him to keep away from his family, why be believed he hit him with a cricket bat, why and in what circumstances the police came and handcuffed him, whether he thought if he closed his eyes he would die and what was the nature of that feeling and how long he had it and whether he still had it, the extent to which people looked like someone he knew, although they were strangers, his feelings when he was brought to John Hunter Hospital that he was dead and in a hearse and later being taken to the morgue when he went for a CT scan, his auditory hallucinations, why he threatened to kill both Bill’s rats and his family, what he thought about rats (having regard to Mr Mazun’s note of “a bizarre delusional system regarding rats”), whether he still felt that his problem was a “battle between the devil and the good fellow”, where and when had he seen the devil, why he did not want to go to sleep and so on. These matters were, one way or another, put to Dr Nazarian as appropriate for him to have raised with the plaintiff. In substance, Dr Nazarian said that he did not do so in any specific way because he thought that the plaintiff would simply deny these feelings or thoughts and seek to present himself as relatively normal in order to go home. He said that he approached these issues in various indirect ways and was satisfied that they did not present any current problem. I do not propose to set out Dr Nazarian’s evidence on this topic but I thought that what he said and the way he said it (making all due allowance for his language difficulties) was quite unconvincing. I am satisfied that Dr Nazarian did not seek to explore these matters because he saw his role as ascertaining whether the plaintiff appeared then and there to be frankly exhibiting any psychotic or suicidal symptoms and that, as he was apparently calm and rational, did not think he should go further and explore the likelihood that, in fact, this appearance was deceptive. I have already said that I do not believe that either the plaintiff or his brother had indicated, let alone demanded, that the plaintiff must be released. It follows that the underlying basis for Dr Nazarian’s explanation for not exploring the matters that I have mentioned is absent and his explanation must fall away also.

95 On the whole of the evidence, I have formed the view that, more probably than not, had the plaintiff been asked in appropriate, non-leading

and non-threatening ways about the matters which were exhibited on the notes made by Dr Sheng, Mr Mazun and the ward nurse, the plaintiff – especially if he was seen alone – would have disclosed further details which would have been extremely significant (and, having regard to the medical evidence to which I will refer in due course) decisive on the question whether he should have been treated as an involuntary patient.

96 Furthermore, Dr Nazarian should have been informed of the plaintiff's trip to the police station and, had he been so informed, should have asked about how this came about. I think it probable that the plaintiff's answers would have been likely to reveal a significant level of mental disturbance. Dr Nazarian repeatedly referred to obtaining confirmatory responses from Allan Presland with respect to the plaintiff's assertions about going home, feeling safe, the circumstances of the fight, his personal and work situation but did not enquire about the relationship between the plaintiff and his brother, how frequently they communicated, whether he was present at any of the relevant events, whether he was prepared to look after him and how he proposed to do it. There was no guidance about what he should do if the plaintiff started to exhibit unusual or bizarre symptoms again. Yet Dr Nazarian placed great reliance upon Allan Presland's apparent agreement with what the plaintiff was saying. This bespeaks indifference, if not incompetence. Dr Nazarian had no recollection of seeing the police escort form but he was, of course, aware that the police had been involved in bringing the plaintiff to the hospital. He failed to make any inquiry of the plaintiff or his brother about this matter, nor – as I think in the circumstances would have been reasonable, especially if he thought the plaintiff did not wish to be forthcoming about the events that gave rise to his admission – did he make any inquiries about the police escort form, which he knew or ought to have known should have been provided. Dr Nazarian said that he did not inquire from the plaintiff about each symptom and each event "because if I go and ask direct questions the answer would be 'No' and it would be over". He said that the best way was to proceed by way of indirect questioning which was by "asking him about his life…his work…his relationship…and…about his family". However, the Doctor was unable to suggest a way by which the indirect questions which he proposed could shed any light upon the symptoms and events which he said he wished to avoid because he thought the plaintiff might bring the interview to an end. It seems to me that, if the plaintiff did so, that would be cogent evidence that he was, indeed, a mentally disordered person, having regard to the history of the previous fifteen hours or so.

97 Dr Nazarian said, as to the note that the plaintiff "thought he was dead and in a hearse" when he arrived at John Hunter Hospital, that it merely reflected that the plaintiff was frightened and did not reflect any anxiety and commented that this "wasn't the matter in fact that I was dealing with". Whilst agreeing that medicine in general and psychiatry in particular is a highly specialised area of learning, this opinion is so patently silly, especially in light of the note about the plaintiff's remark about suicide, that I think it is a mere rationalisation for the doctor's failure to take the matter up.

98 Dr Nazarian agreed that the plaintiff had been violent the night before he saw him, and had threatened even more serious violence, but considered that the way in which "he put it to me, it was socially driven, it wasn't psychotically driven". Dr Nazarian added: "When I assessed him…going to his family, I didn't see any risk factors – he had the social support, he was making good (*sic*) plans about his future". He said that he did not ask him directly about whether he still saw his problem as being a battle between the devil and the good fellow because he said he could not find any psychotic symptoms and did not know whether he had concluded that his problem was still as he had earlier described it. Dr Nazarian said that, had the plaintiff been actively hallucinating, acutely delusional or totally disorganized, "that would have been a different matter". Dr Nazarian said that he thought that, if there was a psychosis present, it would have come out in delusions, in incoherent speech or other psychotic behaviour in the interview, pointing to the fact that the plaintiff was sitting next to him talking calmly and quietly. However, I think it worth noting that when the plaintiff described to Dr Sheng what he thought his problem was and when he told the nurse that he was frightened of sleeping because the devil might get him, he was also quiet and co-operative, as when he thought he had died and was in the morgue. Typical of Dr Nazarian's approach was that he did not ask about the rats because, as he said, "It…wouldn't have been useful…because it would have come to a denial [and] if you continue denying I cannot do anything". This conclusion was based upon Dr Nazarian's assertion that the plaintiff wished to leave the hospital. I have already said that I do not believe this evidence. But, even if it were true, I do not see why the question ought not to be asked. It is clear that Dr Nazarian's attitude was that unless there were frank psychotic symptoms or suicidal intentions expressed at the time of his interview, he would not detain a patient. As he put it –

> "I cannot go and jump on everyone and put everybody in the wards because yesterday he was suicidal, his Honour.
> HIS HONOUR: Or murderous?
> A. Yes."

99 But, it seems to me, these characteristics were very relevant to an assessment on the following day whether the patient is a mentally ill or a mentally disordered person. Dr Nazarian said that he did not know what the reference in the Psychiatric Nursing History to the plaintiff's "bizarre delusional system regarding rats" was based on but said he did not ask about the rats, since he asked about whether his work colleague would accept him back at work. This reasoning is obscure, to say the least, but at all events, since Mr Blake was not the plaintiff's employer (and I do not believe that the plaintiff would have said that he was) the reasoning is faulty. So far as the note about the threat to kill was concerned, Dr Nazarian said that it was made under the effects of alcohol. There was no evidence of that at all and, in so far as there was any information, it was to the contrary. Dr Nazarian said: "I asked him about his work and whether the boss will

accept him and whether he was safe there and his answer was that he was. So you're talking about going back to the rat, you know. That's as much information as I could get out of him then". It was *not* "as much information as [he] could get out of him then": it was as much information as was responsive to the questions that were asked. However, Dr Nazarian's explanation is based upon a mistaken assumption, which Dr Nazarian never explored, although he should have and, I am convinced, an assumption which was dangerous. The question was not whether the plaintiff felt safe about returning to work. The delusion about the rats occurred at Blake's house; it was about whether Mr Blake and his family were safe. As to the sentence quoted above, it should be evaluated in the light of the fact that neither the plaintiff nor Allan Presland refused to answer any questions.

100 Although Dr Nazarian said that he asked the plaintiff about whether he was having any unusual experiences and "sort of seeing things, hearing things" and that the plaintiff denied this, there is no reflection of such an enquiry in his notes and I do not believe that it was made. I also think that it was inadequate to confine the area of discourse to the immediate present, given the history. Dr Nazarian said that he told the plaintiff, in effect, that it would be good for him to stay in the hospital and that his response was that he would rather go home, which was also his brother's view. I do not believe that a conversation like this occurred.

101 I note from the Doctor's statement, which is undated but apparently made shortly after 25 July 1995, he states that the plaintiff "denied having delusions or hallucinations". It is difficult to know what to make of this, since the Doctor did not ask a question to which this would have been an answer. It is important to note that the statement was prepared at the request of the police and, of course, in light of the tragic death of Ms Laws at the plaintiff's hand. It is inescapable that the Doctor must have considered whether or not he was right to have released the plaintiff when he did. It seems to me significant that, although Dr Nazarian says that he was informed by the nurses that the plaintiff intended to leave the hospital and that he found him sitting with his brother with his bag already packed to leave (this plainly being an assumption), the statement never adverts to any indication given to Dr Nazarian in the interview that he did not want to stay in the hospital and wanted to leave, nor give the slightest intimation that the Doctor was under any difficulty in properly assessing the plaintiff or that the plaintiff was hesitant or evasive in respect of any information the Doctor sought. It may be that Dr Nazarian now believes that his interview was significantly curtailed by what he described as "duress" but his failure to mention this consideration in his statement to the police – considering the purpose for which the statement was obviously provided – reinforces my view that this is very much an *ex post facto* rationalisation.

LEAVING THE HOSPITAL

102 The plaintiff and his brother left the hospital after he was discharged and went to Kirkwood House. The plaintiff's account is as follows –

“We found ourselves at Kirkwood House. There was a lady behind the desk, she had a book in front of her. My brother said, ‘We have been sent here for my brother to get drug and alcohol counselling’. She said, ‘No worries’. She said, ‘You can come back in 3 weeks time’, and with that my brother just blew up. He said, ‘You know, he needs help now. He needs treatment now. What the fuck are you doing’, or something. He really went off and he said just, I think, Nazarian told us we were discharged and my brother just said, ‘You people are f-ing hopeless. I might as well take you home’, or something.

HIS HONOUR: Q. Did Dr Nazarian give you a note of some kind?
A. No. We left. At this stage I was getting very bad. My brother was driving around trying to make me go to sleep. I couldn't go to sleep. He called into a building site where he run into - I seen a friend of his. He got a cigarette off him. I used to smoke small Willum cigars. I could see one of them clearly behind his ear. My brother told me to give them up. I wanted to ask him for it but I didn’t. I don’t believe now that he had one at all. I believe that was a delusion. My brother had to pay a bill. He parked in town. He asked me for a lend of some money. I give him my wallet. He went in to pay the bill. I was trying to go to sleep. I was trying to do what I was told. I couldn’t sleep. I could hear people talking. I could hear my sister and brother in law that live in New Zealand. I could hear them as plain as day. I could hear Dennis Burgess, a bloke that I worked for. I sort of looked up and, of course, there was no-one there.

Q. What were they saying?
A. It was just they were having a conversation outside.

Q. So you couldn't - you don't know what they were actually talking about but you heard their voices?
A. Hear them as plain as day, yes.

CRADDOCK: Q. Where were the voices coming from?
A. Outside the car. It was – because I had my eyes closed, I was trying to go to sleep. I couldn't sleep and – but I could hear them as plain as day, plain as I am hearing now. But I really don't know what they were saying.

HIS HONOUR: Q. You opened your eyes and they weren't there?
A. There was no-one there at all. He parked sort of in Hunter Street, right at the end of an arcade. It was funny because I thought I had seen someone behind a post but when I looked they seemed to duck behind the post. When I looked away

> they would come back out but when I looked directly at them they were behind the post again. I couldn't see them. I started to get worse. I remember then my brother took me to my GP.
>
> CRADDOCK: Q. Before you go on to your GP, you tell his Honour that you started to feel worse?
> A. Yes.
>
> Q. What were you feeling?
> A. I was feeling – starting to feel that terror again, really starting to be very scared.
>
> Q. What were you scared of?
> A. I believed that I had not beaten the devil. He was going to get me. He was going to make me kill my family. That's what I believed. I remember going - he took me to my GP. I remember by that stage I was, like, very stiff. I couldn't walk properly. I remember – I can't remember being in the waiting room. I think we went straight in, I'm not sure. I remember laying on a bench and at one stage I can remember a doctor looking at my eye or something. I don't know how long I was there for."

The plaintiff and his brother then went back to the latter's house, where the plaintiff was going to stay for a while.

103 Allan Presland's account of what happened at Kirkwood House is, in substance, much the same as the plaintiff's and I will not set it out. He recalls leaving his brother at the doctor's surgery for a short time to go to his the plaintiff's house to ensure that no one had broken in overnight and, when he returned to the surgery, the plaintiff was seen by the doctor a few minutes later. He said that he recalled the doctor checking the plaintiff's eyes and changing the bandage. Allan Presland said that all he told the nurse was that his brother needed to see a doctor and did not explain the circumstances. It is clear that he was not thinking very clearly. I think that the doctor simply assumed that the plaintiff needed to be checked because of the head injury. It seems to me that Allan Presland did not appreciate how ill his brother was, which is not surprising considering the way in which he had been treated at JFH.

104 When the plaintiff left the doctor's surgery, he was very quiet. He stayed in the car whilst his brother made some errands and then brought him home, where he lived with his fiancée, Ms Laws. It is clear that the plaintiff was having some bizarre thoughts and made some strange remarks to his brother, who tried to reassure him. The plaintiff had a shower and went to bed at his brother's instruction to try to get some rest. Although the plaintiff was acting oddly, Allan did not think that it was especially significant. After a short time, Mr Graham Long (the plaintiff's employer) and his girlfriend, Beth, arrived. The plaintiff stayed in his bedroom and Allan

and the other two talked in the kitchen, having a cup of tea and a beer when Ms Laws' sister, Nicole, and her boyfriend Tony arrived. The plaintiff got up and Allan cleaned his head because he had been bleeding again. Nicole and Tony left shortly after, when the plaintiff went to bed, and Allan Presland did some domestic tasks waiting for Ms Laws, Tony and another female friend to come home. Shortly after they arrived, the Allan decided to go to the plaintiff's house to get some clothes and tidy up. He noticed, when he told his brother that he was going to his place and would not be long, that he had "a strange look to his eyes" but he thought, "'Kevin is OK, he's still my brother', and then I went round to Kevin's place". It is unnecessary to say more about what ensued whilst Allan Presland was away except that the plaintiff became increasingly disturbed and psychotic and, shortly after 5pm, attacked Ms Laws, stabbing her many times and finally cutting her throat with such force that she was nearly decapitated. Allan Presland left his brother's house after a short time and stopped on the way home at a hotel to speak with Mr Long. He had one quick drink and then went home to find the police outside his house and discover that Kelley had been killed by his brother. The police had subdued the plaintiff and he was placed in an ambulance and taken to JHH under guard, having suffered a number of wounds to his head and face. He was obviously seriously mentally disturbed. The ambulance had been called at 5.50pm and arrived at the hospital about twenty-five minutes later with the plaintiff. On the material before me, it appears that Ms Laws was killed at about 5.30pm. The plaintiff was seen by Dr Marina Vamos at about 10am on 4 July 1995. Her assessment of the plaintiff was somewhat limited by the fact that he had been given medication through the night and was therefore somewhat drowsy. He was, however, "pleasant and cooperative". He told her, amongst other things, that he had "gone to a bloke's house on Monday night to kill his wife and children because he was an agent of Satan and it had to be done". His account of what happened at his brother's house was also bizarre. Dr Vamos noted that he was fully orientated as to place and the day of the week, although he gave the date as 6 or 7 July. He was able to describe the events of the previous few days in a coherent and sequential fashion and denied any current suicidal or homicidal intent. Despite these denials, not surprisingly Dr Vamos considered that the plaintiff should be regarded as a high danger to himself and others. She thought his symptoms were highly suggestive of psychotic illness, possibly paranoid schizophrenia. On 5 July the plaintiff was transferred to the hospital at Long Bay Gaol.

105 The plaintiff was examined by Dr William Lucas in March 1996. Dr Lucas concluded that there was no doubt that the plaintiff suffered from an acute severe psychotic illness at the time he killed Ms Laws. Although he thought that the likely precipitating factor was alcohol withdrawal, the presence of delusional beliefs in particular suggested other possible causes. I agree with Dr Strum that that the plaintiff's mental condition is still problematical, though I do not suggest (indeed, on the evidence before me, I cannot) that he is a danger either to himself or to others.

106 In due course, the plaintiff was charged with Ms Laws' murder and was

brought to trial in this Court before Newman J (sitting alone) in late April 1996. The only live issue in the trial was whether, when he killed Ms Laws, the plaintiff was insane in the sense described in *McNaughten's Case* (1843) 10 Clarke & Finnelly 200, namely whether he was labouring under such a defect of reason caused by disease of the mind as not to know that what he was doing was wrong (see also the *King v Porter* 1936 55 CLR 182 at 189, per Dixon J; *Regina v S* (1979) 2 NSWLR 1). The Crown prosecutor conceded that the evidence – which was all one way – indicated that the plaintiff was, indeed, insane. Newman J, after a thorough analysis of the evidence, came to the same conclusion and brought in a verdict of not guilty on the grounds of mental illness, ordering the plaintiff to be detained in strict custody in a psychiatric hospital until released by due process of law. The correctness of this inevitable verdict was not challenged in the present proceedings. Newman J stressed that the Mental Health Review Tribunal should not review the case on the basis that his Honour "found that the psychotic state in question arose as a result in any way of withdrawal from alcohol". I mention this, since it in part may explain why the plaintiff was kept as a forensic patient for somewhat longer than one would otherwise expect if alcohol withdrawal delirium is the explanation for his mental condition. I will deal with the consequences of this verdict and the disposition of the plaintiff later in this judgment.

PLAINTIFF'S EXPERT EVIDENCE

107 The plaintiff called a number of medical experts qualified in psychiatry. I do not propose to deal with their evidence exhaustively. The discussion that follows refers to what seems to me to be the most significant parts of their evidence, bearing in mind my factual findings.

108 Dr Jonathon Phillips is Chairman of the Committee of Presidents of the Australian Medical Colleges, the body that comprises the Colleges of Psychiatrists, Physicians and Surgeons. He has an extensive and impressive *curriculum vitae* which it is unnecessary to set out. He was plainly well-qualified to express the opinions he gave in evidence. As a witness, I thought he was candid, careful and fair. Dr Phillips made a number of very important points. Although they were made in his capacity as a highly-qualified psychiatrist, I mean no disrespect when I comment that they also seem to me to accord with commonsense. Dr Phillips pointed out that it was crucial that Dr Nazarian (and, for that matter, Dr Sheng) should have taken a history which dealt not only with the situation of the patient in the immediate moment but also in the preceding period, particularly the preceding minutes or hours. This is obviously vital where there was (as here) overwhelming evidence, both objectively and in what was either told to relevant staff or noted in the records or both, that in the few hours before the plaintiff was brought into JHH by the police, he had suffered a very severe mental disturbance, of whatever character. Dr Phillips accepted the strict accuracy of the opinion of Dr Shea (called for the defendant and whose evidence I will discuss shortly) that *at the time* of Dr Sheng's

interview of the plaintiff “none of the four symptoms required to make a diagnosis of mental illness under the *Mental Health Act*” were present. Dr Phillips thought this was “a literal interpretation of the Act, not a practical or clinical interpretation”. Referring to the phrase “for the time being” in s10 of the Act as giving rise to some difficulty of interpretation, Dr Phillips said that, to his mind, the Act is directed at clinicians and doctors and should be interpreted in that light, so that what is important is the clinically relevant period. Thus, although the doctor seeks to make a contemporaneous diagnosis, the “flow of events” must be considered. I agree. The somewhat different requirement in s9 that the “continuing condition” of the person is to be taken into account when considering the question of mental illness shows that, in that context, the whole relevant clinical picture should be considered, including the distinct possibility that symptoms might only be episodically evident, to a greater or lesser degree. Neither s9 nor s10 prescribes any artificial chronological limits on what a doctor might or should think it appropriate to take into account. It seems to me that Dr Shea is quite mistaken when he categorically stated that the phrase “continuing condition” applies only to chronic illness, despite the terms of the section and the way in which the Minister, at least, expected it to be applied, as expressed in his 2nd reading speech –

> “The continuing condition of the person needs some explanation. It is not just the person’s condition at the moment of any examination that has to be taken into account in deciding if he is, or remains, mentally ill. Fluctuations in the mental state of the person are to be taken into account. Should, at the specific time of the examination, the person not manifest one or more of the required symptoms of mental illness, but has done so in the recent past, he may meet the requirements of the definition. This applies at the initial examination at the mental hospital or any subsequent examination. In regard to the determination of dangerousness in a person with a mental illness, previous episodes of dangerousness to himself or others while mentally ill are intended to be taken into account.”

Dr Shea commented that, “The Minister's speech of course is written by somebody in the Health Department, your Honour” –

> Q. So your view is, and I mean no irony in this question at all, that somehow the flaw in the Minister's speech is that he forgot to mention fluctuation, by virtue of amongst other things medication, that that's a qualification which doesn't appear and which I take it you regard as a significant omission?
> A. Yes, your Honour, yes.”

Further discussion is not useful.

109 Dr Phillips pointed out that, although the plaintiff was unarousable in

the course of the initial very violent altercation, he became violent again, he was handcuffed then unhandcuffed and became violent again and described this, accurately in my view, as “a very recent history of highly unpredictable behaviour”. Although the plaintiff apparently remained calm while he was at JHH and thereafter when he was transferred to JFH, it was very significant that this “was on the back of totally unpredictable and quite violent behaviour and in the context of irrational utterances”. This latter aspect continued throughout the period right up to very shortly before the plaintiff saw Dr Nazarian, if one takes into account what he told Allan Presland on his way back from the police station but, even leaving that aside, those statements (to my mind) scarcely indicated a man who was controlled by his sense of reason. Dr Phillips pointed to the plaintiff’s odd perceptual experiences, that everyone else looked like someone he knew, his belief whilst at JHH that he was dead and in a hearse and being taken on a trolley to the morgue, his hallucinations in hearing low voices which sounded like the voices of his parents and so on. Dr Phillips said that, as a clinician with all that information available about the plaintiff’s behaviour in the previous twelve to eighteen hours, if he could not be detained as a mentally ill person, then he could certainly be detained as a mentally disordered person. He said that he would have tried to convince the plaintiff to stay in the hospital as a voluntary patient but that, failing that, he would have held him as a mentally disordered person. I understood Dr Phillips to be saying, not only that he would have detained the plaintiff as a mentally disordered person but that he should have been so detained. It seems to me that this opinion is plainly right.

110 So far as dangerousness is concerned, the most useful predictor of dangerousness is past dangerousness, especially in the context of the reasonable grounds test. There was some material tendered that suggested that past violence was not so useful a predictor as is frequently asserted but here the plaintiff’s previous acts of violence in the immediate past, and the extent, irrationality and motive for the violence so clearly demonstrated the risk that, if he were mentally ill, there could be no real doubt that he came within s10. The terms of s9 and s10 reflect, as I have said, an understanding that dangerousness is not a medical term. It is to be assessed in a practical and common sense way, though no doubt informed by the particular knowledge and experience that a psychiatrist brings to the task. So also, in s10 “irrational” is not a medical term. Again, the risk of the person’s irrationality being dangerous is to be assessed in a common sense way, having regard to the doctor’s medical knowledge. So far as s10 is concerned, I think that the plaintiff was a mentally disordered person within the meaning of the section, certainly when he was seen by Dr Sheng and, though less obviously so (because, I think, Dr Nazarian refrained from adequately examining his rational processes) when he was seen by Dr Nazarian. I think it was known – to a greater or lesser but sufficient extent – to Dr McHue and Dr Sheng that, in the immediately preceding twelve hours or so, the plaintiff had been violent or very violent (Ms Jeffs herself referred to the plaintiff’s unprovoked violence) and that this violence, raising the

likelihood that he might inflict serious physical injury, was irrational. I consider that this was or ought to have been known to Dr Nazarian, either because he should have made inquiries (whether of the plaintiff or Allan Presland or otherwise) or because he should have been informed by the police escort form. Sufficient information was, however, available on the file for Dr Nazarian, at all events, to alert him to the risk that there had been some serious violence and disordered thinking exhibited in the previous twelve hours or so, which should, in turn, have alerted him to the need, nay the necessity, to ensure that he explored the apparently irrational elements of his history to see whether they were still present and whether they represented a risk of serious injury to the plaintiff or others. As I have said, I do not accept that it was improbable that he would have got, at least, some very useful information from one or other or both of the plaintiff and Allan Presland. Every other interlocutor of the plaintiff at about this time noted that he was keen and certainly compliant to requests to explain what had happened and remained calm when he did so. I think Dr Nazarian would have got such information with relative ease and the overwhelming likelihood is that it would have indicated that that the plaintiff had, indeed, been acting with significant dangerousness shortly before he was taken into JHH and then transferred to JFH and was still so irrational as to constitute a danger to himself or others. If this conclusion be correct, it is obvious that there were “reasonable grounds” within the meaning of s10 of the Act that required the plaintiff to be treated as a mentally disordered person and that Dr Nazarian was negligent in failing, in the circumstances as he knew or ought to have known them to be, to perceive that this was so. Thus, I consider that Dr Phillips is right when he says that “from Dr Sheng’s history there were adequate grounds to hold [the plaintiff] as a mentally disordered patient at least for twenty four hours”. Although I consider that there was sufficient for Dr Sheng also to act under s10 of the Act, I think it would have been desirable for him to have sought further information from the police, if he had not seen the police escort form. However, having regard to the fact that the plaintiff indicated that he was prepared to remain in the hospital and that it was in the early hours of the morning, I do not think that he was negligent in directing informal placement in the ward pending further assessment.

111 I take into account Dr Phillips’ opinion, which does not appear to be controversial, that most mental illnesses are confined to a particular period of time, either once in a person’s lifetime or repeated episodes, although there are some illnesses, of which the classic example is chronic schizophrenia, where a patient tends to be symptomatic most, if not all, of the time. If there is a discrete episode then the person will be free of symptoms and then, perhaps, at a time of further stress, another episode will occur. Once a person has had a psychotic episode, however, that person is more likely to have a further episode than otherwise. If a person has a paranoid disorder, and has been symptomatic for a period of time, then although he or she will generally respond well to care, say in sheltered or supervised accommodation, anti-psychotic medication is almost invariably

indicated and without it the likelihood of improvement is reduced. It does happen, however, that persons with brief reactive psychoses settle without medication. A person may well develop a further episode of mental illness or mental disorder even without current stress but stress is usually a very important causal factor either as a precipitant or as an accelerator of the disorder.

112 Dr Phillips makes the point, in respect of the supposition that the plaintiff had merely suffered from a short episode of psychosis that, in all his years of practice, he had never seen a psychotic disorder that lasted less than twenty-four hours. Dr Phillips said that most psychotic episodes do not terminate suddenly. There will almost always be a prodromal phase at the beginning and diminishing phase at the end of a psychotic episode. Over a period of time, the symptoms will become intermittent, begin to fade and finally disappear. Dr Phillips said, in substance, that he was very sceptical that there had been a sudden termination of the plaintiff's psychotic thinking. Assuming that there were psychotic features sometime after 2am as noted by Dr Sheng, he would be surprised if the plaintiff had entirely shed his psychotic symptoms by the time he saw Dr Nazarian, although there may have been some attenuation in its intensity. Having regard to the history overall, including especially the reasons for his going to the police station and his bizarre thoughts as expressed to his brother Allan on his way back to the hospital, just before he spoke to Dr Nazarian, and then his increasingly disturbed thoughts relatively shortly after he left the hospital, I have little doubt that proper, even gentle, probing by Dr Nazarian would have led the plaintiff to exhibit significant disturbed thinking which, taken with the history, would have satisfied s10 of the Act. But even if this degree of certainty is unjustified, I consider that this would have been so to a high level of probability, well past the balance.

113 It is obvious that I agree with Dr Phillips' opinion that it was very important for Dr Nazarian to have established his own history from the patient and carry out his own mental state examination of him, to make an appropriate notation in relation to both and then draw his own conclusions with regard to diagnosis and further treatment and discharge. It was put to him that it was reasonable for Dr Nazarian to rely on Dr Sheng's history and to work through it and seek to identify any points of departure but Dr Phillips said that that was not the preferred way to approach the question although he accepted that, if there is to be an alternative, painstakingly going through Dr Sheng's history with the patient would have been a second best. As I have already pointed out, however, Dr Nazarian did not even do this.

114 Taking only the material disclosed in the notes, Dr Phillips regarded the following as indicating that the plaintiff had wide-ranging and severe symptoms which were not transitory –

In Dr Sheng's notes –

· The plaintiff having snapped

· The plaintiff starting to make threats

· Headbutting the security door

· Kicking Mr Blake's fence down

· Trying to tear Mr Blake's fence apart

· Thinking if he closed his eyes he would die

· Everyone looking like someone he knew

· Thinking he was dead and in a hearse

· Thinking he was being taken to the morgue

· The plaintiff threatened to kill the rats and Mr Blake's family

· The auditory hallucinations: low voices sounding like his parents

Nurse Mazun's notes –

· Bizarre delusional system regarding rats

· Battle between the devil and the good fella

· When a distant patient referred to his own sister the plaintiff felt uneasy and could not elaborate why

From other nursing notes –

· Allan Presland's call about suicidal ideation

· The plaintiff was awake, praying at 2 am, afraid to go to sleep because he had seen the devil and would die if he closed his eyes.

115 To these matters should, of course, be added those of which Dr Sheng ought have been aware, namely the police account of what happened at Mr Blake's house. This is material which also should have come to the attention of Dr Nazarian. It is true that both Dr Sheng and Mr Mazun somewhat qualified the significance of the references to "a delusional system" but, of course, Dr Nazarian was not aware of that. At all events, having regard to the material as a whole, I think that if Dr Sheng had been aware of the plaintiff's earlier experiences, whether a "system" or not, the plaintiff undoubtedly had delusions about rats, and the connection with Mr Blake was indicative of a substantial risk of irrational further violence.

116 I mean no disrespect to the other doctors called by the plaintiff by not referring to their evidence in these reasons; it seems to me sufficient to state that, generally, their evidence supports Dr Phillips' most crucial conclusions. It is not necessary for me to analyse the areas of difference. I regard them as insignificant for present purposes.

THE DEFENDANTS' SPECIALISTS

117 The defendants called Dr Peter Shea, director of the Kestrel Unit, a medium security forensic facility providing accommodation and care for patients designated as forensic patients under the *Mental Health (Criminal Procedure) Act 1990* and the *Mental Health Act 1990*. Dr Shea has a number of academic and post-graduate qualifications together with extensive

professional experience and is undoubtedly highly qualified to express the opinions that he did in his evidence. He is the author of many articles and publications including, in particular, *Psychiatry in Court* and *Defining Madness* (1999). Dr Shea gave a great deal of evidence about the background to the *Mental Health Act* and his view of the interpretation of a number of the crucial provisions of the Act so far as they apply to this case. It is not necessary for me to refer in detail to all of that evidence.

118 In short, Dr Shea's view was that Dr Nazarian acted appropriately in accordance with acceptable medical practice. I propose, in what follows, to deal with Dr Shea's response to what seem to me to be the important issues raised by Dr Nazarian's evidence. I have already said that, having regard to the possibility that the plaintiff was delusional and dangerous, the link between his belief about rats and the threats to kill the rats and Mr Blake's family should have been explored by Dr Nazarian. These matters raised not only the likelihood of delusions but also irrationality and dangerousness. Dr Shea, however, said that it was only necessary for Dr Nazarian to explore whether the plaintiff still had those thoughts (having described them to Dr Sheng) "to some extent", since the purpose for which Dr Nazarian was carrying out the assessment was not to treat the patient. He said that it was not necessary for Dr Nazarian to have explored whether the plaintiff still had those thoughts although it would have been necessary "had he wanted to keep Mr Presland in". Dr Shea then gave the following evidence –

> "LYNCH: Q. Isn't the assessment the same, in order to try and establish whether somebody is mentally ill or mentally disordered, to make the same inquiries, whether they are considering going or considering staying?
> A. Not at all. *Considering whether a person has to stay in hospital is a very – again, this may sound strange – but it is a far more serious matter than determining whether a person should be released from hospital. Because when you want to keep a person in hospital you have to have very, very good reasons for keeping the person there* [emphasis added], and the Act is quite specific on this point as, I think has been mentioned a number of times in the evidence before. When you are considering whether a person should be discharged – sorry, when you are considering whether a person should be released from hospital, particularly if they are, not particularly, but specifically in the case of them being a voluntary patient, then the determination you have to make is whether or not the person would benefit from care or treatment. I must qualify that again by pointing out, and I think it has been pointed out several times in court, that the person who is a voluntary or informal patient has the right to leave the hospital at any time without consultation with the doctor. There is absolutely no requirement that a consultation take place.
>
> ...

HIS HONOUR: Q. We don't need to speculate about what might have or should have happened had he just decided to walk out, do we?
A. No. But Dr Nazarian was – I am trying to put this into the, how can I put it, the broader picture of what Dr Nazarian was there for. He was not there to determine whether – well he might have been – and he wasn't there to determine whether Mr Presland should be kept in hospital at this point in time. That wasn't his function.
LYNCH: Q Why do you say that?
A. Mr Presland was a voluntary patient. What Dr Nazarian had to decide was – he didn't even have to decide actually – what Dr Nazarian was looking at was whether there was a reason for keeping him in hospital, if he needed to be kept in hospital, and there was – in terms of the *Mental Health Act* . That is what Dr Nazarian was deciding at the time, but that wasn't a major focus. An additional focus, which Dr Nazarian I think did take into account was, as you do with all informal patients, if he person is leaving: Do they need any sort of follow up or help, or do you refer them to somebody else, because the whole focus of the Act is getting people out, not keeping people in.
Q. That's an assumption you made in the preparation of your report and the evidence you have given, is it?
A. Yes. Yes."

119 This evidence is somewhat obscure. However, I consider that the notion expressed in the italicised portion of this extract is not only strange but quite wrong. The Act cannot be so interpreted. It is designed to provide a means for the care, treatment or control of mentally ill or mentally disordered persons for the safety of the public or for their own safety. It might be fair to say that the Act is so structured that persons who do not need to be detained should not be detained but the obverse is also clearly the case, that persons who need to be detained should be detained. Furthermore, although the legislation limits cases of detention to those instances where it is necessary, it *is* necessary where there are *reasonable grounds for believing* that it is necessary in the specified circumstances. As I have already stated, merely because there are reasonable grounds for believing that care, treatment or control is not necessary does not negate a positive finding: it is irrelevant. (In this case, I should add, I have concluded at all events that there were no reasonable grounds for believing that care, control or treatment of the plaintiff was not necessary.) Of course, the extent of compulsory care, treatment or control that is necessary must also be carefully weighed and only the least restrictive appropriate and available compulsion can be used. It is only at this point that the issue of the patient's liberty becomes a material consideration and, even then, it is subordinated to the requirement of protection. In applying the criteria and the temporal limit, courts will not readily second-guess the psychiatrist on the spot who

may have to make decisions in far from ideal circumstances, where communication may be difficult or hostile and the information available to the doctor limited both as to extent and reliability. Whether the doctor ultimately forms the opinion that a person has a mental illness is necessarily a matter of judgment as to which, in any particular case, reasonable psychiatrists may quite reasonably disagree, although I think that, if the mental illness is diagnosed, it would be a rare case in which there would be responsible professional disagreement on whether there were reasonable grounds for believing that care control or treatment is necessary for the protection of the patient or other persons. Such a judgment, as I understand the law, will not be negligent.

120 Dr Shea's mistaken view of the Act colours most of his evidence and was stated a number of times in different ways. His supposition about the policy of the Act, rather than an appreciation of the need to apply its provisions, led Dr Shea in the passage set out above to express a fundamental misunderstanding of the task entrusted to Dr Nazarian. Dr Nazarian's primary task was, of course, the care and treatment of a patient who had agreed to be assessed by him with regard to his medical needs, even if (as Dr Nazarian said he believed) it was to obtain approval for an intended departure. This provides the basic starting point for considering the use of the statutory powers conferred by the Act. Since, in some circumstances (such as here), the possible application of the Act needs to be considered, part of the assessment, perhaps most, needs to be undertaken with that possibility in mind, especially because patients who satisfy the criteria for detention *ipso facto* need the care for which the Act provides. It is true that, compulsory powers aside, the doctor has no power to detain the person but he or she is not obliged to consent to a departure that he or she considers is not in the interests of the patient. When the doctor is consulted in this context, there is still a duty to give such advice, care or treatment as can be provided consistently with the right of the patient to leave. Even accepting Dr Nazarian's assertion that the plaintiff said that he wanted to leave, that did not mean that Dr Nazarian should have done other than undertake as full and appropriate an assessment and examination as the circumstances permitted. Even if it be accepted that the plaintiff *wanted* to leave, that he had not yet *decided* to go is evident by his compliance with the request or (as he probably saw it) the requirement that the doctor had to assess him first. The highest the defendants can put their case on this aspect is that the plaintiff intended to leave after he had seen Dr Nazarian. Even on the doctor's evidence, the plaintiff did not attempt to impede his assessment and examination. Detention or otherwise under the Act is but one of the possible outcomes of a consultation. If, during such a consultation, the provisions in s10 are activated by the doctor observing such irrationality "as to justify a conclusion on reasonable grounds that temporary, care, treatment or control of the person is necessary" to protect the person or others from serious physical harm, then – subject to the availability of other appropriate disposition – the patient should be detained unless "no other care of a less restrictive kind is appropriate and reasonably

available": s20 of the Act. Likewise, if mental illness is demonstrated, s9 is activated. If the plaintiff was (on what Dr Nazarian knew or should have known) either a mentally ill or mentally disordered person, then he should have been detained: no other adequate disposition has been proposed by the defendants and none was available on the evidence. It follows, I think, that exploring the issue to which I have referred arising out of Dr Sheng's notes – and that is to take but one of the significant matters – was indeed important and that Dr Shea's opinion that it was not necessary is wrong. Furthermore, the italicised passage in the above quotation from Dr Shea, if applied, would frustrate the protective purposes to which the Act gives expression. The duty of the doctor is to do no more and no less than the Act provides. The "good reasons" are those specified (for relevant purposes) in s9 and s10. As I have already said, it is not for the doctor to balance apparently competing considerations of protection of the person and the public on the one hand and the civil rights of the person on the other. The provisions of the Act themselves construct the appropriate balance.

121 Dr Shea said that Dr Nazarian determined that there were no symptoms of mental illness as defined in the Act and that, (as I understand Dr Shea's evidence) because there was no irrationality *then evident* to Dr Nazarian, the plaintiff was not mentally disordered in terms of s10. It was Dr Shea's opinion that s10 "refers specifically to your assessment at the time you see the person", evidently considering that the phrase "for the time being" in s10 is a reference to the instant at which the assessment is made. I return to this temporal element below. Dr Shea said that, if the plaintiff expressed no suicidal ideation (or, I presume, threats of violence) at the time of Dr Nazarian's assessment and appeared otherwise normal, then there was no particular reason why he should have explored the matter raised by Allan Presland as referred to in the hospital note. Dr Shea emphasised that Dr Nazarian's task was not to undertake what he called "a full psychiatric assessment of the patient". He said that, if Dr Nazarian had decided that the plaintiff was mentally ill or mentally disordered, then he would have needed to consider whether there were reasonable grounds for believing that care, treatment or control was necessary for the statutory purposes and, hence, the question of suicide. (I interpolate that a person *is* a mentally disordered person if there is irrationality justifying care, control or treatment to protect them or others from serious injury. The doctor does not decide that a person is mentally disordered and *then* consider if care etc is necessary. If the person is found to be a mentally disordered person, it is then necessary to consider the degree of compulsion that is necessary, so that the patient will not be detained if less restrictive care is appropriate and reasonably available: s20.) I am of the view that, if there are reasonable grounds for thinking that a patient were suicidal then that would clearly raise the question of rationality and personal safety to which, at least, s10 of the Act is directed, though suicidal thoughts are by no means always irrational. Of course, the expression of suicidal thoughts was not, in the plaintiff's case, the sole worrying feature: there was a constellation of problematical statements about feelings and thoughts that pointed

ineluctably to the precise issue covered by s10 of the Act and, potentially, s9. The fact that he may have been a danger to himself or to others, had attacked others and had said that he wished to kill himself, raised fairly and squarely matters which, in my view, it was the doctor's medical duty to explore. They were not matters of speculative interest or idle curiosity. The mere fact (had it been so) that he wished to leave the hospital should not have prevented the doctor from attempting, at least, to take these matters up to the extent of the plaintiff's consent, although it no doubt provided a context in which the doctor needed to be careful about how he approached them. I agree with Dr Strum's opinion, that an insistence on leaving the hospital at that time would have demonstrated the requisite irrationality in the circumstances of this case and I consider that it could not, consistently with proper medical practice, have been otherwise regarded.

122 Dr Shea also expressed his view of Dr Nazarian's task as follows –

> "HIS HONOUR: Q. …The question is, as I think all of them have been, whether expressly or not, predicated upon the appropriate character of Dr Nazarian's undertaking when he saw Mr Presland. That lies, and I think you understand it, at the centre of this case?
> A. Yes, your Honour. I think I do.
> Q. Mr Lynch therefore is exploring what was his function, as you understood it to be; and he has asked you whether you regard it as part of his function to ascertain, as best he could, whether Mr Presland was mentally ill or mentally disordered within the meaning of the *Mental Health Act* . Are you saying that you cannot answer that question?
> A. No. I can answer it but, again, the answer may not be – I would have – you are seeing a person, because they are a voluntary patient, and that voluntary patient to you, in your discussion with them, does not appear to have any signs of mental illness or mental disorder of that type, you would not then go into a full exploration of the person's history and so on at that point, unless there is some indication that the person is a mentally ill person or a mentally disordered person. You would not carry out a full psychiatric assessment of a person to determine that. In the absence of some sort of – I mean, a person comes into hospital usually, and they have got a document or a series of documents which says so and so, and you look at those and you say, "fine", and then you do your assessment. But having done that assessment, that first assessment, which Dr Sheng did, the next – if things appear normal the following morning then you don't, you don't sit down and go through the whole thing all over again. You don't, you simply don't do that. Nobody does.
> HIS HONOUR: Q. Are you saying therefore that it was not necessary for him to consider whether Mr Presland was mentally ill or mentally disordered?

A. Yes. He had to consider it. I mean he should have considered it but he did not have to do a full psychiatric history or a full mental state examination to determine that. That is simply not done at the point of discharge."

For the same reasons, Dr Shea considered that it was not necessary for Dr Nazarian to explore the statement of the plaintiff about being afraid to go to sleep because he had seen the devil and would die if he closed his eyes. The significance of Dr Shea's assumption about the desire of the plaintiff to leave appears also in the following –

"LYNCH: Q. From a practical point of view, if a person agrees to come to hospital in a state of mental illness or mental disorder, are you saying that in your opinion the practice is that they really have less safeguards as to their protection and the treatment they might receive than persons who come as involuntary patients?

A. Yes. They are approached differently. As I keep repeating, with informal patients, they can simply walk out of the hospital at any time.

...

When a person comes in as an informal or voluntary patient, you don't apply the same rigid standards you will be applying to a person who you wish to admit as a mentally ill person or a mentally disordered person, because those rigid standards are aimed at keeping the person in hospital. They are not concerned with keeping – letting the person go."

123 Dr Shea's evidence, following the same line, was that it was not necessary for Dr Nazarian to explore with the plaintiff why he head-butted the security door or what members of the family he threatened to kill or (I take it) whether he threatened to kill anybody and why. Dr Shea's position in this regard is summed up, I think, in the following answer –

"...this situation occurs dozens of times every day at the James Fletcher Hospital, these sort of things. Patients are just routinely sent home or would walk home by themselves or leave the place. Most of the questions seem to be predicated upon the fact that he then went out and killed somebody. There is no way of predicting that anything like that would have happened. The question is whether what he did was appropriate in terms of what a doctor would normally do in that situation in terms of the *Mental Health Act* and I have already said over and over again that what he did was appropriate in terms of the *Mental Health Act* , in terms of the clinical management of the patient."

124 It is very troubling indeed if patients with a history like that of the plaintiff are "routinely sent home". It may be surmised that very few become homicidal but how many cause serious injury to themselves or others or threaten to do so, without that fact becoming known to the hospital that discharged them? The questions asked of Dr Shea were not

predicated upon the fact that the plaintiff “went out and killed somebody”, nor that anyone should have predicted that he would do so. The question is whether, the other criteria being present, there were reasonable grounds for believing that the plaintiff might seriously injure himself or others. The comment of Dr Shea suggests that he thought that, if suicide, death or serious injury could not be predicted, then s9 or s10 cold not be satisfied. This would be an almost impossible test to satisfy. The doctor is not required to predict the actions of the patient but to assess the risk of serious injury.

125 So far as mentally disordered persons are concerned, the time frame in which the person’s behaviour is to be considered is “the time being”. This phrase was used in s4 of the *Mental Health Act* 1958 in the definition of “mentally ill person” as follows –

> “…a person who owing to mental illness requires care, treatment or control for his own good or in the public interest, and is for the time being incapable of managing himself or his affairs and ‘mentally ill’ has a corresponding meaning.”

In *CF v TCML* [1983] 1 NSWLR 138 Powell J (as he then was) considered the phrase in the context of a finding that the plaintiff’s illness had not rendered her incapable of managing her affairs, providing that she did not take alcohol, the disinhibiting effects of which (in his Honour’s words) “permitted her illness to control her actions”, potentially exposing her and others in the home where she was living to the risk of serious injury. The evidence as to drinking went no further than that she occasionally took alcohol. The issue facing his Honour was whether, although at the moment the plaintiff was sober and able (barely) to manage her affairs, the present likelihood that she would drink meant that she was relevantly incapable of managing her affairs. His Honour said that –

> “the phrase ‘for the time being’ is not to be construed as being limited to the present and the immediately ensuing time; rather it ought to be construed as extending to include the reasonably foreseeable future” [and concluded that]… there being no way in which one could ensure that, if she were discharged, the plaintiff would not again take alcohol, I am not satisfied that the plaintiff is, for the time being, capable of managing herself…”

126 It is, I think, important to observe that the plaintiff undoubtedly suffered from a subsisting mental illness. The test for discharge effectively required that she demonstrate, despite that illness, that she was not relevantly incapable, upon which issue she bore the onus of proof. As I understand it, the defendants rely on *CF v TCML* to argue that, whilst “for the time being” might extend the relevant temporal limit into the future, it commences at the time of the assessment and, thus, what happened before Dr Nazarian’s

interview was not relevant and did not need to be considered by him. I reject this submission. It is clear that Powell J did consider the plaintiff's history for the purpose of assessing her capacity "for the time being". It is, at all events, obvious that the events of the person's past – especially their recent past – are very relevant to appreciate the nature of their "present" and the passage which I have quoted shows, at the least, that the phrase "for the time being" does not describe an artificial, arbitrary or capricious time frame. Applying Powell J's explication of "for the time being" and his Honour's reasoning to s10 of the Act, where there is subsisting irrationality, protection of a person is necessary if there are reasonable grounds for concluding that, in the reasonably foreseeable future, his or her irrational behaviour might cause serious physical injury. I would add, what seems to me to be implicit, that the risk must be a present one, especially having regard to the time frame in which s10 operates by virtue of s35.

127 Thus, information about past irrational behaviour that is available and reasonably regarded as relevant to a reasonable assessment of the patient's present condition must be considered to assess whether reasons for the irrational violence or threatened violence are still present or likely to be present and, if so, to what extent. By "available" I mean information on the hospital file from admitting staff and other material, such as ambulance reports and (where police are involved) the police escort form as well as what might be forthcoming from interviewing the patient. It is quite wrong for the doctor to confine himself or herself to the present demonstration of frankly irrational behaviour or, to put it obversely, to the present exhibition of apparently rational behaviour, let alone to disregard information concerning the person's behaviour that is in the hospital notes because it relates events that previously occurred. Present irrationality – say, delusions that the devil requires someone to be killed – may, and probably will, characterise the person's "behaviour for the time being" as relevantly irrational, even though he or she is presently acting in a calm and apparently reasonable way. Nor are the notions of "behaviour" and "rationality" discrete. Assume, for example, that the plaintiff had told Dr Nazarian that he needed to kill Blake and his family because otherwise the devil would kill him, even though, on one view, his behaviour – calmly describing his state of mind – was not then irrational, yet, as a matter of common sense, that he was behaving irrationally is inescapable. The relevant "behaviour" is not limited to physical actions but encompasses all those thoughts or beliefs that demonstrate the irrationality or otherwise of the patient, that is to say, not only what is done or wanted to be done but the reasons for doing it. This is implicit in the requirement that an assessment be made of the irrationality of the behaviour.

128 In this case, the history of the plaintiff as known – and especially as it should have been known – to Dr Nazarian was such that he should have concluded either that his behaviour "for the time being [was] so irrational as to justify a conclusion on reasonable grounds that temporary care, treatment or control was necessary" to protect him or others (s10) or that he was a mentally ill person, having regard to his "continuing condition"

(s9). So far as s10 is concerned, I consider that no other conclusion was open in the exercise of appropriate professional judgment. So far as s9, is concerned, that would depend on whether the criteria set out in Schedule 1 were satisfied. Although I accept that medical opinion could reasonably differ on whether the plaintiff was a mentally ill person at the time of Dr Nazarian's assessment, if nothing more than was actually elicited by Dr Nazarian and the circumstances of the plaintiff's journey to the police station were not known, I consider that a competently conducted interview would have elicited one or more of the symptoms of mental illness specified in Schedule 1, so that if what Dr Nazarian *should* have known by reference both to the hospital notes and a properly conducted assessment is taken into account, I would conclude that no other conclusion would reasonably have been open except that the plaintiff was a mentally ill person at that time. This conclusion is strengthened if also was taken into account – as I think it should have been – the information in the police escort form as I have inferred it to be.

129 Dr Shea expressed the opinion, at all events as I understand it, that even if Dr Nazarian had determined that the plaintiff was a mentally disordered person it would have been appropriate to take up his brother's offer to take the plaintiff home and look after him, as this would have met the criteria for "care of a less restrictive kind" under s20 of the Act and therefore, even if the plaintiff had met all the criteria for involuntary admission, he could still have been discharged. As Dr Shea – and, more importantly Dr Nazarian – knew nothing about Allan Presland's suitability to give his brother any care, this opinion is obviously unjustified. Moreover, had this been done, some management plan should have been proposed that would have given, for example, Allan Presland some guidance as to what he should do if the plaintiff started to behave strangely or express odd thoughts. In this respect, Dr Nazarian noted that "follow-up" was unnecessary. Nor does suggesting voluntary attendance for drug and alcohol counselling strike me as taking the matter much further.

130 I now come to the evidence of Dr Milton, again a highly qualified psychiatrist. Dr Milton expressed some strong but, I think, mistaken views about the application of the Act to the detention of patients –

> "The philosophy behind mental health legislation in recent years…[is] essentially that patients should not be detained unless there is incontrovertible evidence of them being mentally ill or mentally disordered and hence likely to be dangerous to themselves or others."

Dr Milton said that by "incontrovertible" he meant to say that the doctor "has to be very sure in his own mind and he has to be able to back it up with observations". Dr Milton referred, by way of example, to a case of a doctor who said that he thought a person should be detained, whilst the Magistrate (acting under Division 2 of Part 2 of the Act) considered that the strict terms of the legislation defining

> mental illness in this context did not allow him to be detained and released him, although accepting that there were risks in doing so. After release, the person attempted to kill his brother and seriously injured him. It does not seem to me that this shows that the doctor was wrong. If the Magistrate applied the "incontrovertible evidence" test or the "very sure" test, then he or she was quite mistaken: the prescribed standard of proof is the ballance of probabilities. Dr Milton returned to this theme a number of times in the course of his evidence.

131 As I have mentioned, s9 does not itself impose any standard of proof in determining whether a person is suffering from a mental illness: the standard is that which applies to any medical diagnosis in the ordinary course of the doctor's practice. This opinion is reinforced by the provisions of s34 permitting the doctor, in forming an opinion as to whether a person is a mentally ill person or a mentally disordered person, to "take into account, in addition to his or her own observations, any other available evidence which he or she considers reliable and relevant", a subjective test of cogency, not an objective one. In order to fall within the definition of being a mentally ill person, moreover, once the determination has been made that the person is suffering from the mental illness, all that is necessary is that there "are reasonable grounds for believing that care, treatment or control of the person is necessary" to protect the person or others from serious physical harm. This is not a medical question. The criteria for mentally disordered persons under s10 do not include any mental illness or condition or, indeed, any particular symptom, but merely the requisite irrational behaviour.

132 Section 35 of the Act makes it clear that there could only ever be very limited detention of a mentally disordered person who is not found to also be a mentally ill person on subsequent examination as prescribed by s32 and s33: such a person cannot be detained for a continuous period of more than three days (not including weekends and public holidays) and must not be admitted to and detained in a hospital on more than three occasions in any one month. Section 10 is plainly an emergency provision designed to ensure that a mentally disordered person will be cared for and prevented, so far as is reasonably practicable, from hurting themselves or others in the short term. It is reasonable to regard s9 in the same way, having regard to the interim character of the finding. The threshold of satisfaction should take this into account and doctors should bear in mind that the purpose of the provision is protective.

133 Where the appropriate doctor has determined that a person is a mentally ill person, an enquiry must be held by a Magistrate under Division 2 of Part 2 of the Act. Section 52(1) provides –

> "If, after holding an enquiry, a Magistrate is not satisfied that *on the balance of probabilities* a person is a mentally ill person, the Magistrate must order that the person be discharged from the hospital to which the person is detained

and any such order has effect according to its tenor." [Emphasis added]

> It cannot be doubted that the test applying to a doctor who is considering, at the first instance, whether a person is a mentally ill person, can be no higher than the balance of probabilities. In my view, a forensic test such as the balance of probabilities is inappropriate to apply to the decision required to be made by the doctor under s9 and I have no doubt that the omission to mention any standard of proof was a deliberate one.

134 So far as the temporal dimension is concerned, Dr Milton thought that, in the circumstances here, the plaintiff's behaviour at Mr Blake's place, perhaps twelve to fifteen hours before the interview with Dr Nazarian would be regarded as still being "for the time being", though he thought it somewhat questionable. Although Dr Milton somewhat qualified this opinion, I understood his evidence to be that, taking what happened at Mr Blake's house into account (which, he thought, Dr Nazarian was unable to), at the time the plaintiff saw Dr Nazarian he was a mentally disordered person within the meaning of s10 of the Act, and maybe a mentally ill person.

135 Dr Milton, I think, agreed that when the plaintiff was seen by Dr Sheng he was mentally disordered. Having regard to his subsequent history as it appeared on the notes, namely that he was willing to stay at the hospital to work through the problem, that he had exhibited some psychotic features at about 2am, but thereafter slept for at least part of the night, Dr Milton thought it was appropriate to start from the position that the plaintiff was mentally disordered and set about testing whether that remained the case. In other words, he would presume that the mental condition had been correctly perceived by Dr Sheng and that Dr Nazarian's task was to see whether the plaintiff was still in that condition. Dr Milton readily accepted (as I understand his evidence) that it was desirable for Dr Nazarian to explore the particular problems that had been identified in the history which he had, including what had occurred whilst he was in the ward. However, Dr Milton thought that, if Dr Nazarian perceived (as I have held he had no proper basis for so doing) that the plaintiff would terminate the interview if such matters were touched on, then he was right to talk about somewhat safer topics, such as relationships, work and the like and, if he concluded that he could not go any further but that his general impression of the plaintiff was that he was calm, his cognition was good, he was not looking around as though he was hearing voices, he was oriented in time and not aggressive, on balance, he could conclude that the mentally disordered symptoms were no longer present. My own view about this analysis is that it does not sufficiently take into account the previous significant irrationality, associated as it was with threats to kill and (as reported by Allan Presland), the desire to die. Accepting for present purposes that Dr Nazarian felt he was unable to explore those matters, the irrationality of which they bespoke and the risk to which they were connected *in the plaintiff's mind* had not (and could not have) been dispelled by the interview and it follows that the

plaintiff was still a mentally disordered person, especially in light of the relatively low threshold of certainty posed by s10. I think that, underlying Dr Milton's conclusion, is the opinion with which I commenced this discussion of his evidence, that the level of certainty determinative of the question to be considered by Dr Nazarian was very high.

136 Dr Milton thought that further questioning either by Dr Sheng or by Dr Nazarian would not have revealed additionally clinically significant material, primarily for the reason that the plaintiff was, he thought, "almost certain" to have denied any symptoms or behaviour that suggested he was not completely in his right mind. His principal reason for so concluding is that he believed that the plaintiff and his brother had decided to leave and therefore would not admit to psychotic symptoms. Moreover, Dr Milton considered that the suggestion (not attributed by Dr Nazarian specifically to the plaintiff as distinct from his brother) that the injury to the head was caused by an accident rather than a blow with a cricket bat indicated that they were "denying what is going on", although Dr Milton conceded that Dr Nazarian, on his account, ascertained the truth. (I comment that Dr Nazarian did not suggest it was difficult for him to do so.) Dr Milton also concluded that, even if the plaintiff were not seeking to be discharged, he would not have been prepared to reveal more whilst in the company of his brother. Dr Milton thought, however, that it would not have been useful for Dr Nazarian to have tried to speak to the plaintiff alone, because "people don't like being seen on their own and I think that would have applied here". Dr Milton, however, candidly said that this was "my guess anyway". Although these hypotheses are not unreasonable possibilities, I do not consider that there is any real evidence to support them. Indeed, I am quite satisfied that the plaintiff would have been quite happy to have seen Dr Nazarian by himself and that Allan would not have objected to this course. I have already concluded that it was not the case that either the plaintiff or his brother had decided to leave the hospital. Overall, the matters which I have found above should have been raised by Dr Nazarian were thought by Dr Milton to have been desirable to have raised, subject to the proviso about the nature of the interview itself.

137 Whilst Dr Milton thought that what had occurred at Mr Blake's place was significant and, indeed, was the kind of bizarre behaviour that people with schizophrenia with a potential for bizarre and uncertain violence exhibit, he did not think the material noted by Dr Sheng was adequate "to take the chance with a Magistrate…and treat him as an involuntary patient". It is, of course, necessary to distinguish between the information that Dr Sheng noted, and the information that he had available on the one hand and the information which he ought to have had available or ought to have consulted on the other. I have already said that he ought to have had available and ought to have consulted the police escort form. The point, however, that I wish to make here is that the question whether a Magistrate would form the same opinion as the doctor at first instance is, as I have already said, entirely the wrong question to ask. It would not be surprising if

the Magistrate came to a different opinion to the doctor, one way or another, but that is not a matter that any doctor in Dr Sheng's or Dr Nazarian's position should be concerned about. Moreover, so far as s10 is concerned, the Magistrate plays no role at all. This problem significantly qualifies the utility of Dr Milton's assessment of the appropriateness of Dr Nazarian's consultation.

138 Dr Milton summed up his position as expressed in his report in the following way –

> "The available information, even if one excludes Dr Nazarian's notes, does not suggest that Mr Presland was extremely irrational, especially to the degree where he was likely to place himself or others at risk of serious harm."

It will be observed that, at two points, the test implicitly expressed by Dr Milton significantly differs from the statutory requirements of s10. The extent of irrationality is measured by reference to the risk that the person needed protection from serious self-harm or to protect others from serious harm. Whether the person is " *extremely* irrational" is not the relevant test and, to my mind, significantly undermines the purpose of s10 as imposing far too high a barrier to its proposed use. Secondly, although risk of the relevant harm is the test of the measure of irrationality, its measure for application of the section is the presence of "reasonable grounds that the temporary care, treatment or control" is necessary for the protective purpose. I understand Dr Milton's use of the word "likely" is, again, a higher standard than that required by the section and, again, a standard which, if applied, would undermine the legislative purpose: there may well be reasonable grounds for the relevant belief or conclusion, even though infliction of serious injury is unlikely.

139 The defendants also relied on the evidence of Dr Johnson who was the senior staff specialist psychiatrist at the JFH at the relevant time. He is presently clinical director of the Centre for Psychiatric Therapy, a unit of JFH. He considered that Dr Nazarian's consultation was adequate and discharge of the plaintiff was appropriate. I mean no disrespect to the Doctor when I say that I did not find his opinion of much assistance, primarily because it seemed to me that the assumptions that he made as to the circumstances of Dr Nazarian's assessment and the plaintiff's history differed significantly from my own findings.

140 I have also considered Dr Robbie's careful report, tendered by the defendants. Nothing in it leads to me to change any of my findings of fact, nor my conclusion that Dr Nazarian failed to act with due care for the plaintiff.

141 Although I have not accepted the conclusions of the doctors called by the defendants as to the adequacy of Dr Nazarian's treatment of the plaintiff, I think that I should, in fairness, observe that I do not believe that they were saying more than that that treatment fell within the boundaries of

appropriate professional standards which, as I have mentioned, does not require perfection and must tolerate a certain level of error of judgment. I believe that, had they actually been faced with the plaintiff in the hospital that morning, their interviews with him would have been very different, their conclusions about him would also have been different and they would have acted under either s9 or s10 of the Act to detain him.

THE AFTERMATH

142 Police were called, I think by a neighbour, to the Presland house shortly after 5.30pm on Tuesday 4 July 1995, and arrived at about 5.40pm. Constable Mahon entered the property and, when he was about half way along the driveway, he heard a loud smashing noise and a male voice screaming words which he could not understand. He was joined by two other police officers and the three constables went to the front door where, through the front window, they saw the plaintiff naked and apparently covered in blood. More police arrived. Smashing noises were coming from inside the house. Constable Mahon knocked loudly on the door, said that it was the police and, when the plaintiff came into view, asked him to open the door. He yelled out and ran towards the door, hitting it (I think with his head). The screaming continued and, shortly after, Constable Mahon broke down the door and entered the house, holding his gun. He saw a large amount of blood on the floor and the walls of the room, and smashed furniture. The plaintiff ran from the kitchen with a knife in his right hand held in front of him, moving towards the back door, away from the officer. Constable Mahon tackled him as he went through the door and noticed the plaintiff was covered in blood with an open wound to the top of his head. Eventually he was handcuffed. Whilst police were attempting to restrain him, Constable Price entered the house and said, “It’s too late, she’s dead”. The plaintiff continued to struggle violently, yelling, “I killed her, kill me brother, shoot me”. There were faeces on his buttocks and legs. Whilst the plaintiff was held outside, other police entered the house and found Ms Laws’ body on the floor of the kitchen.

143 The plaintiff was taken to JHH for treatment of his physical injuries. He had multiple lacerations over his entire body with a large laceration to his skull. Although he was conscious, he refused to respond to verbal stimuli and was incontinent. The wounds to his head, his right hand and both feet were sutured. He needed a blood transfusion. He remained under police guard, not surprisingly. An X-ray of his head showed that, although he had no intracranial injury he had a “dent” fracture of the right frontal bone. Violent behaviour recurred and it was necessary to sedate him. Eventually, he became orientated and co-operative whilst restrained and he was seen by Dr Vamos, as I have mentioned.

144 He was then transferred to the psychiatric ward at Long Bay Gaol, where he remained for some five weeks. He was very likely medicated for at least the next few days and said that it was only then that he realised that he had killed Ms Laws. He thought it took him about four or five days to

“straighten out”. I do not doubt that his sojourn in the hospital was traumatic, having regard to the forensic patients who were detained there, some of them very violent. He said that he was threatened a couple of times. Although his brother came for a short visit, he was extremely angry and the plaintiff was, I think, very much alone and frightened. The records show, as I read them, that he was discharged to remand on 3 August 1995. The discharge transfer noted that the plaintiff “remains settled and appropriate except for indifference to his situation”, a feature thought to be abnormal by Dr Nielssen who was then seeing him.

145 The plaintiff was also very afraid in the remand centre because he perceived it (quite rightly) as a very dangerous place. Someone had threatened to kill him. He saw episodes of extreme violence regularly and one assault with an iron bar was particularly horrific. On 10 July 1995, he went to Maitland Gaol for a court appearance. He was seen by the nurse in his cell on the following day, who noted that he was taking his prescribed medication and was “rational, settled – says he is coping well”: The nurse noted “*All* he is frightened of when he goes to the main [gaol] is being raped by other inmates” (emphasis added). This does not need additional comment. The nurse commented that the plaintiff appeared to be “coping too well for the crime he has committed”.

146 The plaintiff was transferred to Maitland Gaol on those occasions when he was required to attend court and would stay at the gaol for several weeks at a time. He described Maitland Gaol, and I think accurately, as a very primitive prison. The cells were tiny, the toilets and floors filthy and the gaol was very crowded. Here, also, he saw many bashings.

147 The plaintiff said that his father visited him a couple of times when he was in Long Bay but he was elderly (about 75 years old at the time, I think) and it was hard for him to travel, whilst his mother was not well enough to come to Sydney although his father brought her to see him at Maitland once. He had been close to his parents and had made a point of seeing them weekly.

148 As the plaintiff came to understand what had happened (although I think his recollection is, to some extent, a reconstruction) after about a month or so, he became very depressed and very ashamed. He said that he became a “staunch Christian” whilst in the remand centre and tried, whilst in custody, to do courses with a psychological content to try to understand himself better. He was very angry with what he believed were lies being told by the doctors and Mr Blake during the court proceedings. Although I have not seen their evidence, I think this arose from the plaintiff’s mistaken reconstruction of events, perhaps more. However, it is not necessary to resolve this problem for present purposes. (I must say that, in his evidence about the killing, I thought there was a distinct flatness of affect and I am not altogether sure that, even now, the plaintiff quite appreciates the horror of what happened. On the other hand, he has no doubt related the event many times and a certain distancing may be necessary to enable him to cope with telling the story.)

149 I have mentioned that the plaintiff was acquitted on 7 May 1996 but, of course, became a forensic patient under the Act. He was detained at the prison hospital at Long Bay Gaol for about eighteen months. He was in C Ward for the first three months of this period. His daily routine was as follows. He woke at about 7am, had breakfast and a shower and was let out into the yard at about 8am. He would “hang around until about 10am and then would have coffee”. He could read but, as I understand it, did not find this easy; he would just “sit out in the yard”. There was a pool table but, of course, many who wished to use it. He returned to the dining room at noon for lunch and was then let out on the other side of the yard where he could play basketball. Occasionally, Catholic nuns visited and he would speak with them. He returned to the ward at 4pm to shower and have tea. He could watch television until 8.30pm and was then locked in his cell until 7am the next morning. He could have a couple of books but was not permitted to have a television or radio.

150 When he was transferred to A Ward, conditions were somewhat less harsh. There was more space, television and radio were allowed in the prisoners’ cells and there was a small gym. Prisoners were permitted to work and the plaintiff got a job doing maintenance, repairing the damage caused by other prisoners to the premises. He would also mow the lawns and keep the gardens. He said that he was prescribed a drug which prevented him from sleeping and gave him very bad headaches and he therefore ceased to take it, although he pretended otherwise. The evidence about this is quite uncertain and, on balance, although I accept that the plaintiff indeed was unable to sleep and had bad headaches, his evidence about being prescribed the drugs despite protests and the doctor’s insistence that he should take it is, I think, too doubtful to rely on.

151 On 26 November 1997, the plaintiff was conditionally released following the recommendation of the Mental Health Review Tribunal by Order in Council. A number of conditions were imposed requiring him to accept supervision and follow medical directions. He was also required to live in accommodation provided by the Salvation Army bridge programme and abstain completely from consuming alcohol or using drugs as well as being required to be of good behaviour. The plaintiff was discharged from A Ward to Foster House administered by the Salvation Army on 9 December 1997. The discharge summary from A Ward noted that the plaintiff maintained regular contact with his parents and his sister. Although possibly regular I think it was infrequent. His interests were noted as leatherwork, sport (cricket), theology studies and model making. It appears he interacted “appropriately” with other patients and staff Intense media interest in his release led to the suggestion that he should move to Rozelle Hospital, which he consented to do in order to avoid media attention. He was at Rozelle for something like six weeks and then returned to Foster House, where he was subject to a 10pm curfew.

152 On 25 March 1998, the plaintiff was released from detention under the Act by Order in Council, upon a number of conditions, essentially that he

accept the supervision of a named clinical nurse consultant and accept directions as to his living arrangements and live in accommodation in metropolitan Sydney. He was subject to return to detention in a psychiatric hospital if the consultant or his treating psychiatrist thought it in his best interests to do so. He was required to remain completely abstinent of both drugs and alcohol. He was explicitly prohibited from travelling to the Hunter Region of New South Wales or to initiate communication with any member of his own family except to the extent that they expressly permitted it.

153 Similar conditions were repeated in May 2001, except that he was permitted to go on work trips of up to twelve weeks' duration as permitted by his case manager and in approved accommodation. He lives under controls which most people would find both intrusive and demeaning. It is likely that he will continue to do so for the foreseeable future. By way of example, I cite a report from his case manager (a psychologist) which contains the following paragraph –

> "Mr Presland recently travelled to visit his father in a Newcastle hospital. The Tribunal was informed of this trip. However, he has indicated that he may plan further trips, as a sister is planning to relocate in the Newcastle area. I am aware that under condition 10 of the order he must provide written notice. The Tribunal may want to discuss this matter with him as he has indicated that future trips are likely."

154 The Order in Council of 16 May 2001 permitted travel to Gosford providing it had been expressly approved in advance by the Mental Health Review Tribunal, subject to any conditions considered to be appropriate. The plaintiff has found this condition difficult to deal with, as it has had the effect of cutting him off from his parents and also his older sister, with whom he was very close. An additional factor is that he feels (perhaps rightly) that his family is frightened of him. I do not doubt that this is very distressing.

THE SCOPE OF THE DUTY OF CARE

155 It is not suggested by the defendants that there was no duty of care on the part of Dr Nazarian to the plaintiff and that it was to exercise reasonable care and skill in the provision of professional advice and treatment. "The standard of reasonable care and skill required is that of the ordinary skilled person exercising and professing to have that special skill": *Rogers v Whitaker* (1992) 175 CLR 479 at 483 (citing English authority which it is not necessary to set out). In this case, although Dr Nazarian had not completed his examinations to qualify as a specialised psychiatrist, he was acting as a psychiatrist. It has not been suggested that the difference in qualifications is material. The defendants argue that the question is not whether some duty of care was owed to the plaintiff but as to its nature and extent. The defendants pose the question in this way: whether the scope of the duty of care owed by the defendants extended to guarding against the risk that the plaintiff would suffer harm as a result of committing a homicide or, in other

words, was the risk that the plaintiff would suffer harm as a result of committing a homicide a reasonably foreseeable risk? I do not think that this formulation correctly states the relevant question. The risk relevant here is that the plaintiff, without appropriate treatment (that is, detention) might suffer harm by seriously injuring himself or another. Having regard to the statutory criteria under s9 and s10, as it happens, the likelihood of such harm is one of the matters a doctor in Dr Nazarian's position must consider. Furthermore, although here the act of the plaintiff that led to his detention, first as a remand prisoner and then as a forensic patient, arose from his killing Ms Laws whilst insane, the same result would as a practical matter have followed from the infliction by him of any serious injury in circumstances which made him liable under the criminal law. And it is almost certain that the same consequences would have followed. Accordingly, it is possible to place too much emphasis on the circumstance that the plaintiff killed a person as distinct from having caused serious injury. I entirely accept, if I may say so, the warning expressed in *Romeo v Conservation Commission of the Northern Territory* (1998) 192 CLR 431 per Kirby J –

> "Attention has been paid in some of the cases, and by some of the critics, to the practical considerations which must be 'ballanced out' before a breach of the duty of care may be found. It is here, in my view, that courts have both the authority and responsibility to introduce practical and sensible notions of reasonableness that will put a brake on the more extreme and unrealistic claims sometimes referred to by judicial and academic critics of this area of the law. Thus, under the consideration of the magnitude of the risk, an occupier would be entitled, in a proper case, to accept that the risk of a mishap such as occurred was so remote that a reasonable man, careful of the safety of his neighbour, would think it right to neglect it." (*Overseas Tankship (UK) Ltd v The Miller Steamship Co Pty Limited* [1967] 1 AC 617 at 642-643; cf *Inverell Municipal Council v Pennington* (1993) 82 LGERA 268 at 276 per Clarke JA). It is quite wrong to read past authority is requiring that *any* reasonably foreseeable risk, however remote must in *every* case be guarded against. Such an approach may result from the erroneous conflation of the three separate enquiries: duty, scope of duty and breach of duty. Although a reasonably foreseeable risk may indeed give rise to a duty, it is the enquiry as to the scope of that duty in the circumstances and the response to the relevant risk by a reasonable person which dictates whether the risk must be guarded against to conform to legal obligations. Precautions need only be taken when that course is required by the standard of reasonableness (*Phillis v Daly* (1988) 15 NSWLR 65 at 73 per Mahoney JA)".

156 In the circumstances of this case, the scope of the duty as defined by

the Act mirrors the common law duty. However, leaving that consideration aside, it seems to me that, had Dr Nazarian properly assessed the plaintiff, he would (and certainly should) have appreciated that there was a substantial risk that if the plaintiff was released, he might well seriously injure himself or some other person. The Act gave him the means to treat the plaintiff appropriately. Releasing the plaintiff into the care of his brother was completely inappropriate, even if the doctor had given him guidance as to how his care could be managed and amounted to an abdication of his responsibility as a doctor.

157 So far as breach of duty is concerned, the generally accepted statement of principle is that of Mason J (as he then was) in *Wyong Shire Council v Shirt* (1980) 146 CLR 40 at 47-48 –

> "In deciding whether there has been a breach of the duty of care the tribunal of fact must first ask itself whether a reasonable man in the defendant's position would have foreseen that his conduct involved a risk of injury to the plaintiff or to a class of persons including the plaintiff. If the answer be in the affirmative, it is then for the tribunal of fact to determine what a reasonable man would do by way of response to the risk."

158 As the defendants rightly submit, errors in clinical judgment may or may not be negligent, depending on whether or not reasonable professional skill and care was exercised in forming the judgment: *Maynard v West Midlands Regional Health Authority* [1984] 1 WLR 634. In this respect, it is important to remember that the assessment of error is being made where the results of the clinical decision are known. Doctor Nazarian did not have the benefit of hindsight. Nor are doctors or, for that matter, any professional persons, required to perform their work according to what, in the argot of modern management is called "best practice". Professional skill and experience will vary: the law requires the reasonable exercise of those skills to a reasonable standard. No doubt perfection is an honourable aspiration but the law does not require it. A number of the defendants' expert witnesses suggested that too much emphasis was placed by the experts called on behalf of the plaintiff on the tragic circumstance that the plaintiff killed Ms Laws relatively soon after he was discharged from the hospital. I think this criticism is unjustified. It seems to me that the plaintiff's experts were very careful to consider Dr Nazarian's conduct prospectively as, indeed, have I. However, it is not right to say that what occurred after the plaintiff left the hospital is irrelevant. It gives useful knowledge about his likely state of mind at the time when he was seen by Dr Nazarian and informs the question whether probing by Dr Nazarian, required by matters already known or which ought to have been known, would have probably yielded useful information. My judgment of the matter has been confined, however, to both the material that was actually before Dr Nazarian, then the material that should have been before him, had the records of the hospital been complete, namely, had they contained the police escort form, and the information gathered at JHH and, thirdly, what Dr Nazarian would probably

have gathered if he had conducted his assessment of the plaintiff in an appropriate way. In respect of each of these scenarios, I have formed the view that, had Dr Nazarian dealt with the plaintiff as an ordinary skilled psychiatrist according to the standard of reasonable care and skill required of such a specialist, he should have detained the plaintiff either as a mentally ill person or as a mentally disordered person. Moreover, had the plaintiff been detained, even as a mentally disordered person and was not found to be a mentally ill person, I am satisfied that it would have been most unlikely that he would have caused serious physical injury to any person after appropriate treatment. Obversely, no psychiatrist of ordinary skill, applying the standard of reasonable care and skill required of such a specialist, would have failed to detain the plaintiff. Even assuming that there was some slightly lesser standard applicable to Dr Nazarian as a third year psychiatric registrar, this conclusion would be the same.

159 It is submitted by the defendants, as indicated above, that "it would generally trespass unacceptably on the operation of the criminal law to allow a person such as Mr Presland, who committed a homicide, to recover damages for injuries", quoting Brennan J in *Gala v Preston* (1990-91) 172 CLR 243 at 273: "There is no duty of care where the admission of the duty would condone a breach of the criminal law." This submission overlooks the crucial fact that the plaintiff was acquitted of the unlawful killing of Ms Laws. Even if it were not for that acquittal (say, if there had been no trial) there could be no doubt that he was insane at the time of the killing and innocent of any crime. If it is relevant, it is also obvious that there was no moral turpitude involved in what he did, given his psychotic state of mind at the time. In *Clunis v Camden & Islington Health Authority* (*supra*) the Court of Appeal applied the *ex turpi* rule to a plaintiff convicted of manslaughter on the ground of diminished responsibility. The Court said ([1998] QB at 989 –

> "In the present case the plaintiff has been convicted of a serious criminal offence. In such a case public policy would in our judgment preclude the court from entertaining the plaintiff's case unless it could be said that he did not know the nature and quality of his act or that what he was doing was wrong."

The Court pointed out that the offence reduced, but did not remove, the plaintiff's responsibility and upheld the defence. Here, the plaintiff was not convicted but acquitted and he was acquitted upon the ground that he did not know that what he was doing was wrong.

160 The defendants point out that the operation of the *ex turpi* principle is not avoided simply because the plaintiff acts legally. In *Hardy v Motor Insurers Bureau* (1964) 2 KB 745, Diplock LJ said –

> "The rule of law on which the major premise is based – *ex turpi causa non oritur actio* – is concerned not specifically with the lawfulness of contracts but generally with the enforcement of rights by the courts, whether or not such

> rights arise under contract. All that the rule means is that the courts will not enforce a right which would otherwise be enforceable if the right arises out of an act committed by the person asserting the right…which is regarded by the court as sufficiently anti-social to justify the court's refusing to enforce the right."

This passage was expressly approved by Brennan J (as he then was) in *Gollan v Nugent* (1988) 166 CLR 18 at 34-35, his Honour commenting –

> "The broad policy that private rights are not enforceable when their enforcement is injurious to the public is not a charter for judicial idiosyncrasy in refusing to enforce private rights. The policy corresponds with the general principles stated in *Chettiar v Chettiar* [1962] AC 294; just as the court refuses to lend its aid to one who founds his cause of action upon an immoral or an illegal act, so the court will not lend its aid to one who seeks it in order to effect an immoral or illegal purpose."

161 It cannot be gainsaid that the killing of Ms Laws was an appalling tragedy that occurred at the hand of the plaintiff but only because of his deranged mind and only because he had been discharged from the hospital where, I have no doubt, he would have been content to remain had he been able to do so and where, at all events, he should have been required to remain. It is obvious from what I have already said about the defendants' conduct who, if anyone, bears moral responsibility for what happened. Of course, the plaintiff cannot succeed unless his injuries were caused by the defendants' negligence. In this case of course, the complicating feature is that the plaintiff's acts were, in a sense, intentional and voluntary. This will usually prevent recovery –

> "When a defendant has a duty to a plaintiff to prevent the occurrence of damage of the kind which occurred and the defendant's breach of duty was a cause of that damage, the damage will be held to be within the scope of the risk which the defendant was required to avoid unless the plaintiff sustained the damage intentionally (or, perhaps, recklessly) or the damage occurred in a manner which could not reasonably be foreseen in a general way." *March v E and M H Stramare Pty Ltd* (1991) 171 CLR 506 per McHugh J at 536.

162 The exclusion of liability is, however, not complete –

> "The fact that the intervening action is deliberate or voluntary does not necessarily mean that the plaintiff's injuries are not a consequence of the defendant's negligent conduct. In some situations a defendant may come under a duty of care not to expose the plaintiff to a risk of injury arising from deliberate or voluntary conduct or even to guard against that risk: see *Chomentowski v Red Garter Restaurant*

> *Limited* (1970) 92 WN (NSW) 1070. To deny recovery in these situations because the intervening action is deliberate or voluntary would be to deprive the duty of any content. It has been said that the fact that the intervening action was foreseeable does not mean that the negligent defendant is liable for damage which results from the intervening action: … *Caterson v Commissioner of Railways* (1973) 128 CLR 99 at 110. But it is otherwise if the intervening action was in the ordinary course of things the very kind of thing likely to happen as a result of the defendant's negligence…". *March v Stramare* (*supra*) per Mason CJ at 517-518

163 *Caterson* is, I think, instructive for present purposes. In that case the plaintiff entered a train standing at a platform to stow some luggage for a friend who was boarding the train, the train started to move without warning and, when he got to the doorway, the plaintiff jumped out, holding a hand bar on the outside of the carriage but he fell between the train and the platform and suffered serious injuries. The question was whether it was open to the jury in these circumstances to find that the defendant had been guilty of negligence which caused the plaintiff's injuries. It was not doubted that the defendant should have foreseen that some people would board the train momentarily and might wish to alight before it moved off. It was also not contested that it was foreseeable that a person would be likely to suffer injury if he tried to return to the platform when the train had started to move off. The Court of Appeal concluded that it could not be foreseen that this would be likely to happen unless the person was attempting to protect himself from some danger of physical injury that he might otherwise suffer if he remained on the train; it was not foreseeable that a man would do anything so dangerous as to jump from a moving train except for such a reason. Accordingly, it was held that there was no duty of care on the part of the defendant related to the injury suffered by the plaintiff or, if there was such a duty, there was no breach of it. The plaintiff succeeded on appeal to the High Court. Gibbs J (as he then was) with whom the other judges in substance agreed, concluded that it was reasonable for the jury to find that the defendant should have foreseen that a person such as the plaintiff might seek to jump from the train which started to move off without warning, even though he was not endangered by remaining on it, pointing to the considerable inconvenience of being carried to the next town eighty miles away, whilst in some cases there might be additional strong reasons to avoid such a trip as, for example, if he had left a helpless child on the platform or a sick wife at home. His Honour observed that it would have been safer to pull the communication cord "but people do not always choose the safer course and it was foreseeable that people wishing to get off the train might try to jump off it while it was moving, because he thought that the speed of the train enabled him to do so without risk of injury, or because he wished to avoid the embarrassment of pulling the communication cord and for that reason was prepared to take a chance of injury, or simply because in the heat of the moment, it seemed to him the

only thing to do" (*Ibid* at 108). Gibbs J pointed out that to find that the plaintiff's act was foreseeable did not determine the question whether his voluntary act in jumping from the train broke the chain of causation between the defendant's negligence and the plaintiff's injuries, although "the intervention of the voluntary act of the appellant did not in itself necessarily have the result that his injuries were not caused by the respondent's negligence": (*Ibid* at 110), adding –

> "In *Summers v Salford Corporation* (1943) AC 283 at 296, Lord Wright said that –
>
> > '…if a plaintiff suffers damage by the defendant's default, the damage may be directly due to that default and recoverable even though the accident and damage would not have happened but for some action of the plaintiff, so long as his action was in the ordinary course of things and, at least generally speaking, was not blameworthy.'
>
> The effect of the intervening action of a third party was recently discussed in *Dorset Yacht Co v Home Office* (1970) AC 1004 at 1027-1030 and in the course of that discussion Lord Reid cited the following passage from *Haynes v Harwood* (1934) 1 KB 146 at 156 –
>
> > 'If what is relied upon as a *novus actus interveniens* is the very kind of thing which is likely to happen if the want of care which is alleged takes place, the principle embodied in the maxim is no defence. The whole question is whether or not…the accident can be said to be 'the natural and probable result' of the breach of duty.'
>
> It is unnecessary to go beyond those propositions for the purposes of the present case. The jury was entitled to consider that the appellant's action of jumping from the carriage was 'in the ordinary course of things' and 'the very kind of thing' likely to happen as a result of the respondent's negligence. For reasons which I am about to give, the jury could also have taken the view that the appellant's conduct was not unreasonable, and that the appellant's injuries were caused by the respondent's negligence."

164 In this case, I have no doubt that the likelihood that the plaintiff might cause another person serious physical injury was, indeed, foreseeable. In the circumstances, his doing so was both "in the ordinary course of things" and "the very kind of thing" that might well happen as a result of the defendants' negligent discharge of him from the hospital. Of course, I use 'ordinary' not to describe what the plaintiff did but the unsurprising (though shocking) course of events.

165 It is clear that the "but for" test of causation is satisfied in this case, although I accept that it is not sufficient for present purposes to determine whether the defendants are liable. The question of causation has been the

subject of considerable judicial and academic debate to which I do not wish to make a contribution. For the present it is sufficient, I think, to adopt the test as stated by Deane J in *March v Stramare* (*ibid* at 522) –

> "For the purposes of the law of negligence, the question of causation arises in the context of the attribution of thought or responsibility: whether an identified negligent act or omission of the defendant was so connected with the plaintiff's loss or injury that, as a matter of ordinary common sense and experience, it should be regarded as a cause of it. (cf *Barnes v Hay* 1988 12 NSWLR 337 at 339). The 'but for' (or ' *causa sine qua non')* test may well be a useful aid in determining whether something is properly to be seen as an effective cause of something else in that sense."

This is not to say that considerations of policy and value judgments are not material: see, for example, *Chappel v Hart* [1998] 156 ALR 517 at 523 per McHugh J. One way in which the "commonsense view of causation" might be stated is –

> "Before the defendant will be held responsible for the plaintiff's injury, the plaintiff must prove that the defendant's conduct materially contributed to the plaintiff's suffering that injury." *Chappel v Hart* (*supra)* per McHugh J at [27]

166 Posing the test as proposed by McHugh J (*ibid* at [46]), as, I should think, the defendants would wish to have it phrased: "Did the defendants' failure to detain the plaintiff cause or materially contribute to him killing Ms Laws?", to my mind the answer must be yes. Indeed, it would be an offence to commonsense to answer this question otherwise.

167 In *Reeves v The Commissioner of Police of the Metropolis*[2000] 1 AC 360, a case in which the de facto wife of a man who committed suicide sued the Commissioner of Police under the *Fatal Accidents Act* 1976 for negligently causing her husband's death, Lord Hoffman said (at 368) –

> "…there is a difference between protecting people against harm caused to them by third parties and protecting them against harm which they inflict upon themselves. It reflects the individualistic philosophy of the common law. People of full age and *sound understanding* must look after themselves and take responsibility for their actions. This philosophy expresses itself in the fact that duties to safeguard from harm deliberately caused by others are unusual and a duty to protect a person of *full understanding* from causing harm to himself is very rare indeed. But, once it is admitted that this is the rare case in which such a duty is owed, it seems to me self-contradictory to say that the breach could not have been a cause of the harm because the victim caused it to himself." (Emphasis added)

It is obvious why I have emphasised the words in italics. This plaintiff was not of “sound understanding” either at the hospital before his discharge or later when he killed Ms Laws. I do not think that there is a material difference for the purposes of considering causation between self harm and causing serious physical injury to another even though, in the latter case, the injury for which the plaintiff seeks compensation comprises the legal and personal consequences of having committed such an act. In *AMP v RTA & Anor* [2001] NSWCA 186; [2001] Aust Torts Reports 81-619, an employee who had been injured in a work accident commenced a common law claim out of time and, when cross-examined on his application for an extension of the limitation period, suffered stress as a result, developed depression and committed suicide eight days after the hearing. The question was whether his widow was entitled to damages for nervous shock and under the *Compensation to Relatives Act* 1897 (NSW). Spigelman CJ cited the observations of McHugh J in *Bennett v Minister of Community Welfare* (1992) 176 CLR 408 at 428 –

> “…the common law concept of commonsense causation accepts that the chain of causation between breach and damage is broken for the purpose of attributing legal responsibility for that damage if there has been an intrusion of ‘a new cause which disturbs the sequence of events, something which can be described as either unreasonable or extraneous or extrinsic.’” (The quotation being from the observations of Lord Wright in the *Oropesa* [1943] P 32 at 39).

168 The Chief Justice said –

> “Actions involving the deliberate infliction of self harm should generally be regarded as ‘independent and unreasonable’ [a quotation from the judgment of Mason CJ in *March v Starmare* [1990-91] 1971 CLR 506 at 517] and as a break in the sequence of events that may otherwise constitute a causal chain for the purpose of attributing legal responsibility…”

The Chief Justice concluded that the conduct of the deceased following the legal proceedings could not be regarded as a response which was causally related to the original injury, so that the causal chain was broken and the widow’s claim must fail. Both the Chief Justice and Heydon JA cited with approval the passage from Lord Hoffman’s judgment in *Reeves* which I have set out above. Heydon JA quoted the judgment of Mason CJ in *March v Stramare* (1991) 171 CLR at 517-519 and then said –

> “[152] These tests raise several queries in relation to the present facts. The Defendant behaved negligently; this set

the scene for the Deceased to sue the Defendant, to suffer depression and to commit suicide; the Defendant's negligent behaviour was in that sense an essential condition for the Deceased's depression and suicide. But was it a 'cause' of those consequences? As a matter of value judgment, is it just to hold the Defendant legally responsible for an injury to the Plaintiff which, though it can be traced back to the Defendant's wrongful conduct, was the immediate result of unreasonable action on the part of the Deceased? Was the injury the consequence of an action by the Deceased which was not independent and unreasonable? Even if, contrary to earlier conclusions, one assumes the depression and the suicide to be foreseeable, was it the case that either of them in the ordinary course of things were the very kind of thing likely to happen as a result of the Defendant's negligence? In particular, is there some reason in commonsense, logic or policy for regarding the Defendant's conduct as the cause of the Plaintiff's loss?

[153] These questions should be answered 'No'. The assumption that the Deceased was of normal susceptibility must be made in relation to causation as it is to be made in relation to foreseeability. It would be bizarre if for part of the analysis he were treated as being of normal susceptibility, but for another part he were treated as being the opposite. Nothing in the law justifies that distinction. On the assumption that the Deceased was of normal susceptibility, to develop depression and then to commit suicide is not reasonable. Developing depression and committing suicide were events which were not only unreasonable, but were independent of the Defendant's conduct. Developing depression and committing suicide were not, in the ordinary course of things, the very kind of thing likely to happen as a result of the defendant's negligence to a person of normal susceptibility. There is no reason in commonsense, logic or policy for regarding the Defendant's conduct as a 'cause' of the Plaintiff's injury in view of the Deceased's depression and suicide. But even if the Deceased is not assumed to be a person of normal susceptibility, the fact that he developed depression and the fact that he committed suicide were not events which were reasonable or in the ordinary course of things the very kind of thing likely to happen as a result of the Defendant's negligence. No considerations of commonsense, logic or policy suggest the Defendant's conduct as the cause of the Plaintiff's injury in view of the Deceased's depression and suicide…[T]hough the Deceased would not have suffered the psychiatric illness which led to his death but for the accident, that psychiatric illness was not

> relevantly related to it; it had only a tenuous connection with it, its manner of causation was different from the manner in which the Deceased's psychiatric illness which was cured before…[he commenced proceedings] was caused. The chain linking it to the Defendant's negligence was different from the chain linking other injuries to the Deceased to the Defendant's negligence, the former type of harm was different in kind from the latter."

169 In this case, the plaintiff was mentally ill or mentally disordered and it was the duty of the defendants to detain him and to care for him so that he was not a risk to himself or to others. The form of his illness or mental condition made him susceptible both to harming himself and seriously injuring others. I see no difference in substance between a bodily illness not treated by appropriate medicine or surgical procedure and an illness or irrational condition of the mind not treated by a remedy reposed in the defendants to be used for his benefit in precisely the circumstances that occurred here. The direct and foreseeable consequence of the violence he then committed was his ensuing incarceration. The infliction of violence by the plaintiff on Ms Laws was unwitting in the relevant sense. Although it was not reasonable, it was that very lack of rationality which permitted, indeed, required, the defendants to detain him and, in the ordinary course of things the infliction of very serious injury or death was the 'very kind of thing likely to happen as a result' of his discharge. I do not see that any considerations of commonsense, logic or policy should operate to break the chain of causation. Indeed, in my view, breaking the chain of causation because the plaintiff acted in a way which was foreseeable and in circumstances which his detention should have prevented, because of the very risk that what he did might occur – when associated either with mental illness or irrationality – would be both arbitrary and capricious. The plaintiff would not have attacked Ms Laws but for his negligent discharge from the hospital, which was required to treat him for the very condition which led to the attack and the connection between his discharge and the attack was substantial. Although it is true that nothing at the hospital caused his illness or mental disorder, the "effective" or "substantial" cause of the attack on Ms Laws was, in all the circumstances, his being discharged from the hospital.

170 In *Haber v Walker* [1963] VR 339, the Full Court of the Supreme Court of Victoria considered the liability of the defendant in negligence for the suicide of the plaintiff's husband whilst mentally unbalanced as a result of serious injuries received in an accident caused by the defendant's negligence. In *AMP v RTA* (*ibid*) the Chief Justice cited [at 22] with approval the following passage from the judgment of Smith J –

> "In the first place a wrongful act or omission cannot ordinarily be held to have been a cause of subsequent harm unless the harm would not have occurred without the act or omission having previously occurred with such of its incidence as rendered it wrongful. Exceptions to this first principle are narrowly confined. Secondly, where the requirements of this

> first principle are satisfied, the act or omission is to be regarded as a cause of the harm unless there intervenes between the act or omission and the harm an occurrence which is necessary for the production of the harm and is sufficient in law to sever the causal connection. And, finally, the intervening occurrence if it is to be sufficient to sever the connection, must ordinarily be either –
>
> > (a) human action that is properly to be regarded as voluntary, or
> >
> > (b) a causally independent event the conjunction of which with the wrongful act or omission is by ordinary standards so extremely unlikely as to be termed a coincidence…"

171 The Chief Justice noted that, in *Haber v Walker*, the question whether "the deceased's conduct could be categorised as a 'voluntary act' could be asked 'in terms of whether or not' the actor should have exercised a free choice" (*Haber v Walker* at 359). In the present case I do not think that the plaintiff's attack on Ms Laws could be described as a "voluntary" act in the sense that he was exercising a "free choice". He was acting – to put it briefly – under the compulsion of his overwhelming delusions and was not, to my mind, acting voluntarily in the relevant sense although he was acting voluntarily for the purposes of the criminal law.

172 For these reasons I have concluded that the plaintiff's fatal attack on Ms Laws and the personal and legal consequences which followed were both foreseeable and caused by the negligence of the defendants.

General Damages

173 The plaintiff is still a relatively young man, it is very likely that he will be subject to significant restraints on his freedom for the rest of his life. In one way or another he is alienated from his family and there is a heavy load of guilt. His time in prison on remand was terrifying nightmare. His incarceration as a forensic patient only slightly less so.

174 It is submitted on the defendants' behalf that general damages would be a small sum upon the ground that the plaintiff, on his own case, would have been detained for a period in any event. This depends, of course, on whether the plaintiff should have been found to be a mentally ill person by Dr Nazarian, in which case he would have been detained at least until the inquiry by the Magistrate. As I have already said I think that probably the plaintiff was a mentally ill person and I am also persuaded that a Magistrate acting properly, would have so found. It is, of course, difficult to predict whether florid symptoms would have again emerged but I think that, with proper treatment, this was unlikely. On my view of the evidence, the plaintiff would probably have been detained for about four weeks or so. It may be that some period of post discharge supervision of about two weeks would also have been necessary. However, for present purposes I think that

can be discounted. If, on the other hand, the plaintiff was found to be a mentally disordered person he could only have been detained in the hospital for a maximum of three days by which time it is not impossible that his condition could have settled, although I think it unlikely. If, of course, he had settled and the intervening assessments had not disclosed a mental illness then I think he would have been well enough to be discharged and I think it unlikely that he would have committed any act causing serious injury. However, I consider (as I have said) it is probable that he would have been detained as a mentally ill person. I have taken the likely period of detention – although it must necessarily be speculative to a substantial degree – into account.

175 I assess general damages at $225,000.

Economic loss

176 The plaintiff was born on 9 October 1958 and, accordingly, is almost 45 years of age. He studied at high school to year 10 and then took up an apprenticeship as an electrician, which he completed but did not obtain an electrician's licence because he failed one subject. He worked variously as a labourer, as a driver and doing electrical work for about a year. In 1976 he got his first full time job as an electrician with a firm for which he worked for about three years (although it changed its composition during that time). At that time he was earning about $500 a week net. He then took up employment as an electrician with a firm called O'Donnell Griffin, where he worked for about two years before leaving in about 1979 to commence a business with a partner installing fans. That business failed and he returned to O'Donnell Griffin in about 1981. He believes that this second period of employment with O'Donnell Griffin lasted for about five years and his take home pay for a forty-hour week was $500-$550. He was also paid for overtime but does not know how much. The plaintiff then moved to another firm, where he stayed for nine months at about the same wages, returning to O'Donnell Griffin after that time, where he remained for another two or three years. He and a partner then set up another business which operated for something like two and a half to three years, but this business ended in mid 1994. At that time he estimated he was taking out of the partnership about $500 a week net. It was at this point that he and his partner, Graham Long, started contracting for a house cladding firm, also installing windows as sub contractors and doing small renovations. The plaintiff was renovating his own house at this time. The plaintiff said that the contracting work was not continuous and that he averaged about two jobs a month, with each job taking roughly a week although, as he and Mr Long got more experienced, they became more efficient. The amount of work that was offered to them increased over time. In 1994 they finished work about a week before Christmas and returned after about four to five weeks, just after mid-January 1995. The number of jobs increased a little, with the partnership attempting to complete one job a week. It was into 1995 that Mr Blake was employed for a few days, six days at the most, as the plaintiff recalled it. The plaintiff continued to work up to 3 July 1995, the day which finished up

with him being taken to hospital in the circumstances which I have described.

177 A final partnership taxation return for the electrical partnership covered the period 1 July 1994 to 26 August 1994. That showed a net income (rounded up) of $6,800 of which, of course, one half was the plaintiff's. The profit and loss statement shows a net operating profit for the year ended 30 June 1994 at (rounding down) $65,500, of which $32,750 was the plaintiff's distribution).

178 It seems to me, therefore, fair to assess the plaintiff's net weekly income in 1994 at near enough to $550 a week. The next year, 1995, is somewhat problematical as the partnership ceased in August 1994 and the only payments that have been documented cover the period 10 February 1995 to 29 June 1995, a period of twenty weeks with a total paid of about $5,000, something like $250 a week. Taking into account the plaintiff's evidence that he was renovating his own home requires some upward adjustment to assess his true earning capacity. Overall, I think that the submission made on behalf of the plaintiff that, had the cladding contracting and renovating business not given him a roughly equivalent income to that which he had been earning previously, he would have sought other subcontracting work. I accept that, at the time of his detention, the plaintiff's capacity for work should be assessed at $550 net a week. The plaintiff's loss of income for the past should therefore be calculated at a net sum of $550 a week for the whole of the period, less a period of six weeks (four weeks in hospital and a further two weeks for follow up attendances) and accepting that his income between February and 30 June 1998 was $4,700 and from 1 July 1998 to 15 March 1999 at a rate of $360 a week. An amount of $4,000 should be allowed in respect of vicissitudes over this period.

179 On 31 July 1998, the plaintiff qualified for a full electrician's licence after completing a TAFE course. Since 15 March 1999, he has been in full-time employment as an electrician and does not claim for economic loss from that date.

180 The parties are to calculate damages under this head in accordance with these reasons and file a judgment by consent, in default of which I grant liberty to apply.

Last Modified: 10/30/2003

181 Accordingly I give judgment for the plaintiff with costs.

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